

# Camden Housing First A Housing First Experiment in London

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## Summary

- Independent evaluative research focused on the Housing First pilot called Camden Housing First (CAMHF) was undertaken by Nicholas Pleace and Joanne Bretherton of the Centre for Housing Policy, University of York, with financial support from the University and SHP. The CAMHF service was delivered by SHP and commissioned by Camden Council, an elected, inner London local authority. The research took place between March 2012 and May 2013.
- The CAMHF service used scattered, ordinary private rented housing and a mobile team of two specialist support workers providing an intensive case management (ICM) service. CAMHF closely followed the operational principles of the original Pathways to Housing (PtH) Housing First service which was developed in New York in the 1990s and was within the US Federal Government definition of a Housing First service. CAMHF also shared core operating principles with the Housing First services that are being piloted across the European Union.
- CAMHF was an innovative use of Housing First because it was designed to support a staircase service system, the Camden Hostels Pathway. Staircase systems use short term, communal and congregate supported housing (hostels) which are designed to resettle lone homeless people into ordinary rented housing, sometimes requiring them to move between different settings, in a process of rehabilitation and training that is designed to make someone 'housing-ready', i.e. able to live independently. CAMHF was targeted specifically on people whom the Camden Hostels Pathway had assessed as unable to live independently, as not 'housing ready', for a period of at least three years, and who had never moved into their own housing. Originally, the Housing First approach had been developed to *replace*, rather than work alongside, staircase approaches .
- CAMHF supported thirteen people during the research period. Service users had extremely high rates of problematic drug and alcohol use and mental health problems. Several had exhibited anti-social behaviour. Most had very poor physical health. They had either never lived independently in ordinary housing or had not done so for many years. All had been assessed by the Camden

Hostels Pathway services as unable to live independently and had lived in the Camden Hostels Pathway, on a *continual* or *recurrent* basis, for at least three years.

- There was some evidence of differences in need associated with gender among the people using CAMHF. Women had more complex needs including needs resulting from experience of domestic/gender based violence.
- CAMHF had successfully housed seven of the 13 people using the service and was working to house the others at the point the research concluded in May 2013. One tenancy had failed after six months. There was clear evidence that CAMHF was delivering housing sustainment for chronically homeless people who had never lived independently before or had not done so for many years.
- CAMHF was successfully using ordinary private rented housing which was secured solely through developing working relationships with estate/letting agents. Tenancies were held directly by the people using CAMHF. The housing was usually small, one-bedroom apartments.
- It took CAMHF an average of 75 days to re-house someone after they had been referred. There were indications that as relationships between the CAMHF team and estate agents/letting continued to develop, the re-housing process was becoming faster. In the context of the London housing market, locating private rented housing in London, that was of a reasonable standard and which had a low enough rent to be covered by welfare payments, was a considerable achievement. The research results did not suggest that the delays between referral and re-housing created operational difficulties for CAMHF.
- There was some evidence of increased engagement with medical treatment and mental health services and also some reductions in drug and alcohol use among people who were using CAMHF. However, some of the small group of service users were not reported as engaging with treatment or as reducing their drug and alcohol use.
- Progress in promoting greater social and economic integration among the people using CAMHF could be slow. While this was a group of people who sometimes had been in paid work at earlier points in their lives, they were all some distance from being employable.
- There was a marked reduction in anti-social behaviour among those people using CAMHF. Some service users who had hitherto been involved in public

nuisance on the streets of Camden or caused disruption within the Camden Hostels Pathway had ceased this behaviour.

- CAMHF was slightly cheaper than the approximate average cost of funding support for 10 hostel bed spaces in a hostel designed to resettle lone homeless people for one year. However, CAMHF appeared to deliver better outcomes in terms of housing sustainment and in terms of health, well-being and anti-social behaviour. CAMHF represented a potentially more *efficient* use of public expenditure in reducing chronic homelessness than alternative services. In addition, CAMHF had lower support costs than some higher intensity and specialist hostels for homeless people, which meant there was the potential to reduce some expenditure.
- The research was observational and focused on a relatively small pilot service designed for a very specific group of homeless people. The results are not generalizable. The research covered a relatively short period of time, which meant not everyone using the service had been housed, and also meant that it was not possible to explore what the long term outcomes of CAMHF might have been. However, the results of this research closely reflect results from the USA, Canada and Europe on the high effectiveness of services following the operational principles of Housing First in reducing chronic homelessness.
- There is sufficient evidence to make a case for the expansion of the CAMHF approach, particularly in areas where suitable social housing is scarce. Ideally, any significant expansion of the CAMHF model should be accompanied by a longitudinal experimental evaluation, using a randomised control trial, to clearly establish the effectiveness of the approach relative to other forms of homelessness service.

# 1 The Research

## Introduction

This first chapter provides an overview of the research conducted by the Centre for Housing Policy at the University of York on the Camden Housing First (CAMHF) pilot. The first section briefly describes the development of the research and the second section describes the methodology employed. The chapter concludes with an overview of the remainder of the report.

## The Development of the Research

The research was developed following initial informal discussions between the research team and a senior Single Homeless Project (SHP) manager in 2010. SHP wanted independent research to be conducted on an experimental 'Housing First' service that they had developed in response to a call from an elected municipality responsible for an area of central London, also known as a London borough, called Camden Council<sup>1</sup>. Like other London boroughs, Camden has both a strategic and a legal responsibility for homelessness within its boundaries<sup>2</sup>.

Camden had allocated a small budget to commission innovative homelessness services. Through the direct support of the Centre for Housing Policy's Director and the University of York, funding was secured to undertake a small piece of research. Some additional financial support came from SHP.

An initial SHP experiment had proved to not be entirely successful. The University started the research when this initial experiment was replaced with the Camden Housing First (CAMHF) service in 2012.

## Methods

The research was a small scale observational exercise that tracked the progress of CAMHF over the course of 14 months. Initial fieldwork visits took place two months

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<sup>1</sup> Camden council is an elected local authority (see <http://www.camden.gov.uk>) administering a central London borough with a population of 220,000 with a physical area of 21.8 square kilometres (London has 33 elected local authorities administering different areas of a city, with a total population of 8.17 million). Camden is relatively densely populated, 101 people per hectare (10,000 square metres), contains relative extremes of both wealth and poverty and is both ethnically and culturally highly diverse, see [http://www.camden.gov.uk/ccm/cms-service/download/asset?asset\\_id=2952535](http://www.camden.gov.uk/ccm/cms-service/download/asset?asset_id=2952535)

<sup>2</sup> <http://www.camden.gov.uk/ccm/navigation/housing/homelessness/>



after the project had come into operation, when CAMHF had just two people using the service, in April 2012, followed by fieldwork visits in July and early August 2012, when CAMHF had been running for six months. A final round of fieldwork was conducted from late March to May 2013, when CAMHF had been operational for just over one year.

On each visit to CAMHF, the staff team took part in focus groups that reviewed progress. In addition, the research team conducted semi-structured interviews with senior management at SHP and attended several of the regular briefing meetings that took place between SHP and Camden Council (see Chapter 2).

Semi-structured interviews with people using the CAMHF service proved a challenge for the research team as the resources available for the research did not allow them to be in London for protracted periods. The people using CAMHF were characterised by high support needs and were not always available when appointments were made to see them, even with help being provided by the CAMHF team. Using a combination of face-to-face and telephone interviews a total of six service user interviews were completed.

The final element of the research involved reviewing the detailed records held on the people using the CAMHF service and talking through and reviewing each individual case with the CAMHF team during the final stage of the fieldwork. As it was not possible to interview every service user, this aspect of the research was very important in establishing a clear picture of what CAMHF was doing and what the service outcomes were.

Ethical approval for the research was secured by double-blind peer review of the research proposal and research instruments (topic guides) through the ethical review process at the University of York. The Centre for Housing Policy follows the Social Policy Association guidelines<sup>3</sup> for the ethical conduct of social research, which centre on ensuring no distress or negative consequences of any sort should arise from someone being a research subject in a research project. In agreement with SHP, a £5 cash 'thank-you' payment was offered to people using the CAMHF service.

Informed written consent was secured by SHP from CAMHF service users to process personal sensitive information. This included a consent to share information relevant

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<sup>3</sup> [http://www.social-policy.org.uk/downloads/SPA\\_code\\_ethics\\_jan09.pdf](http://www.social-policy.org.uk/downloads/SPA_code_ethics_jan09.pdf)

to the research with the research team. Service users had the data sharing arrangements explained to them before being asked to sign. The University stored sensitive individually identifiable data using a 'double lock' policy, anything on paper was held in a locked filing cabinet within a locked office within a building with access controlled by swipe card. Electronic information was held on a central server, rather than a desktop machine, with two levels of password protection. Information on service users was anonymised for the report as was interview and other material from the CAMHF team. Individually identifiable personal information held by the University was irretrievably deleted once the research was complete.

### **About this Report**

The second chapter looks at the ongoing global development of 'Housing First', provides an overview of how the CAMHF approach relates to other Housing First services and looks in more detail at how CAMHF worked in practice. Chapter 3 describes the needs, characteristics and experience of the people using CAMHF at the point of their referral to the service and also provides an overview of their housing histories in the five years prior to their referral. The fourth chapter explores the delivery of CAMHF in detail and the Chapter 5 looks at the views on service users on CAMHF. Chapter 6 contains the conclusions drawn from the research.

## 2 Camden Housing First

### Introduction

This chapter looks at the development and operation of Camden Housing First (CAMHF). The first section of this chapter looks at the origins and spread of 'Housing First' services. The second section describes how CAMHF relates to other Housing First services and provides an overview of how CAMHF worked.

### The Housing First Concept

#### Origins

American longitudinal research in the 1990s found a large, 'transitionally' homeless population with low support needs who appeared to be very similar to other poor, housed, Americans<sup>4</sup>. This transitional group was homeless for short periods for reasons that were social and economic, for example relationship breakdown and loss of work<sup>5</sup>. The same longitudinal research<sup>6</sup> also found a *small* group of homeless people who were homeless on a sustained and recurrent basis. This small 'chronically homeless' group also had very high rates of severe mental illness, problematic drug and alcohol use and poor physical health<sup>7</sup>.

Chronically homeless people used homelessness services for so long, or so often, that they accounted for much of total US expenditure on emergency accommodation. In addition, chronically homeless people also accounted for a disproportionate amount

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<sup>4</sup> O'Sullivan, E. (2008) 'Pathways through Homelessness: Theoretical and Policy Implications', in: J. Doherty and B. Edgar (Eds.) *In My Caravan, I Feel Like Superman': Essays in Honour of Henk Meert, 1963–2006*, pp.71–100. FEANTSA: Brussels. <http://www.feantsaresearch.org/spip.php?article134&lang=en>

<sup>5</sup> Quigley, J.M. and Raphael, S. (2001) 'The Economics of Homelessness: The Evidence from North America' *European Journal of Housing Policy* 1,3, pp. 323–336.

<sup>6</sup> 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, 23-43; O'Sullivan, E. (2008) *op. cit.*

<sup>7</sup> There are various definitions of chronic homelessness. US Federal Government initially developed a definition of "chronic homelessness" specified someone had to be continuously homeless for a year or more, or who have had four or more episodes of homelessness in the last three years, and evidence of two or more support needs including severe mental illness, high drug and alcohol use, limiting illness and disability and learning difficulties. In 2012, this definition was modified and two groups, people living rough and high need groups who are characterised by 'persistent housing instability', closer to the distinction made between high need 'chronic' and 'episodic' groups made by some US academics, see: Housing and Urban Development (2012) *Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations* Washington DC: HUD and references in preceding footnote.

of spending directly associated with homelessness for emergency health, psychiatric, criminal justice and drug and alcohol services<sup>8</sup>.

Recent, robust, longitudinal analysis of national data from Denmark does show the presence of at least one chronically homeless population in the EU, though the group does differ in scale and characteristics from that found in the USA<sup>9</sup>. There are indications that a small chronically homeless population is present in Britain and in other comparable European countries, but the evidence is not as strong as for Denmark<sup>10</sup>.

Closure of the long stay psychiatric hospitals in the USA had led to the development of a 'staircase'<sup>11</sup> service model which was intended to make former psychiatric patients 'housing ready' through a series of 'steps'. In essence, each step was a progression through increasingly less ward-like accommodation and towards a home of one's own<sup>12</sup>. The housing that someone had access to having climbed this staircase has been described as an eventual reward for making oneself housing ready<sup>13</sup>.

The staircase approach has been used in US and Europe as a response to chronic homelessness. In essence, these services use what was originally a mental health service model to pursue *behavioural modification*, centred on total abstinence from drugs and alcohol, engagement with treatment and with being 'trained' to live independently, to make someone 'housing ready'.

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<sup>8</sup> Culhane, D.P. and Kuhn, R. (1998) op cit; Poulin, S.R.; Maguire, M.; Metraux, S. and Culhane, D.P. (2010) 'Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study' *Psychiatric Services* 61,11, pp. 1093-1098 [http://works.bepress.com/dennis\\_culhane/99](http://works.bepress.com/dennis_culhane/99)

<sup>9</sup> Benjaminsen, L. (2013) 'Testing a Typology of Homelessness Across Welfare Regimes' presentation given at the *International Homelessness Research Conference: Advancing the Policy and Practice of Crisis Response Systems* held at The University of Pennsylvania, 3<sup>rd</sup> and 4<sup>th</sup> June 2013 <http://www.sp2.upenn.edu/ihr/>

<sup>10</sup> Jones, A. and Pleace, N. (2010) *A Review of Single Homelessness in the UK 2000 - 2010*, London: Crisis; Busch-Geertsema, V., Edgar, W., O'Sullivan, E. and Pleace, N. (2010) *Homelessness and Homeless Policies in Europe: Lessons From Research*, Brussels: European Commission.

<sup>11</sup> The term 'staircase' is European (Swedish) description of this kind of service model, in the USA it is known sometimes as Continuum of Care approach or Linear Residential Treatment (LRT) model.

<sup>12</sup> Ridgway, P. and A. M. Zippel (1990) "The paradigm shift in residential services: From the linear continuum to supported housing approaches" *Psychosocial Rehabilitation Journal* 13, pp. 11-31.

<sup>13</sup> Tsemberis, S. (2010a) 'Housing First: Ending Homelessness, Promoting Recovery and Reducing Costs' in I. Gould Ellen and B. O'Flaherty (eds) *How to House the Homeless* Russell Sage Foundation: New York

Staircase services do achieve successes with chronically homeless people<sup>14</sup>. However, three operational problems were identified by a large number of evaluations. First, chronically homeless people quite often leave staircase services at high rates, because those staircases require abstinence, compliance with treatment and training for housing readiness. Second, chronically homeless people can quite often become stuck at the first or second step of a staircase, unable to fulfil the criteria required to be judged housing ready, becoming caught in a system that will not re-house them. Third, the regimes within some staircase services have been criticised as harsh and demeaning<sup>15</sup>.

### *Defining Housing First: 'Separating' housing and support*

#### *The American model*

'Housing First' was developed in New York by the *Pathways to Housing* (PtH) organisation in New York<sup>16</sup>. The PtH Housing First model is intended to *replace* staircase services that required housing readiness before offering re-housing<sup>17</sup>. Housing First immediately, or as soon as possible, provides housing using ordinary private rented sector apartments. The PtH Housing First service offers private landlords a complete 'housing management' service, they do not have to deal directly with the people using Housing First, their rent is guaranteed and the tenancy<sup>18</sup> itself is often held by PtH, with people using Housing First service holding a sub-tenancy.

In the PtH Housing First model, access to housing is *not* conditional on abstinence from drugs and alcohol and there is no requirement to comply with treatment for mental or physical health problems. There is no 'staircase', no 'steps', people do not have to be 'willing to change', show abstinence, engage with treatment, or show themselves to be 'housing ready' in any way to access housing. Housing is provided,

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<sup>14</sup> Rosenheck, R. (2010) 'Service Models and Mental Health Problems: Cost Effectiveness and Policy Relevance' in Ellen, I.G. and O'Flaherty, B. *How to House the Homeless* pp. 17-36 (Russell Sage Foundation: New York).

<sup>15</sup> Sahlin, I. (2005) 'The staircase of transition: Survival through failure' *Innovation* 18, 2, pp. 115-136; Pleace, N. (2008) *Effective interventions for homeless people with a history of substance abuse: Lessons from a review of the Global evidence base for Scotland* Edinburgh: Scottish Government. <http://www.scotland.gov.uk/Publications/2008/07/24143449/0>

<sup>16</sup> Claims are sometimes made that Housing First 'originated' in Canada or in California, but 'Housing First' as a coherent philosophy and as a clearly defined service model for chronically homeless people originates from the Pathways Organisation in New York <http://www.pathwaystohousing.org>

<sup>17</sup> The service can also work with people with severe mental illness at risk of homelessness.

<sup>18</sup> Licence or rental agreement.

'first' and then support services made available that are intended to enable a chronically homeless person to sustain their housing and exit homelessness. Crucially, neither access to, or retention of, the private rented housing is conditional on treatment compliance or showing housing readiness. Not only do service users not have to show housing readiness to get housing, they do not have to show they are housing ready in order to retain that housing. PtH refers to this as the *separation* of housing and support.

Importantly, PtH defines the Housing First service model as being in *opposition* to the staircase approach. PtH is described as a more effective response to chronic homelessness because it is supportive, respects the individual and their choices and regards housing as a human right. PtH defines the operating principles of the Housing First service in the following terms<sup>19</sup>:

- Housing as a basic human right.
- Respect, warmth and compassion for all clients (a 'client' is a chronically homeless person using the service).
- A commitment to working with clients for as long as they need.
- Scattered site housing, independent apartments (that clients should live in the community in ordinary apartments, not in a single apartment block).
- Separation of housing and services.
- Consumer choice and self-determination.
- A recovery orientation.
- Harm reduction.

PtH Housing First uses two forms of support. An ACT (assertive community outreach) team and an ICM (intensive case management) team.

The ACT team *directly* provides psychiatric treatment, medical care and drug and alcohol services to chronically homeless people with very high needs. The ACT team includes a range of other direct support, including a trained social worker and a peer specialist, a trained support worker who has personal experience of chronic homelessness.

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<sup>19</sup> Tsemberis, S. (2010b) Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Minnesota: Hazelden.

The ICM team has a case management role and works with chronically homeless people with relatively fewer support needs, although the people being supported by ICM still have sustained and recurrent experience of homelessness, poor mental and physical health and some problematic use of drugs and alcohol. The ICM team provides some direct support itself, though its main role is focused on case management, connecting people with the externally provided mental health, health, support and other services they need<sup>20</sup>. The service provides 24 hour cover using a helpline.

Housing is not provided on a wholly unconditional basis. People using PtH Housing First have to accept the following three conditions to access the service<sup>21</sup>:

- A weekly home visit from PtH staff
- Signing a tenancy or sub-tenancy, which gives them some housing rights and responsibilities for the apartment they living in.
- Sign an agreement guaranteeing that 30% of their available income will help pay the rent.

PtH actively encouraged and participated in experimental (control group) and quasi-experimental (comparison group) research to test service effectiveness. Sustained exits were shown for 88 % of chronically homeless people using Pathways over five years in New York, compared to 47% of formerly chronically people using staircase services. Similar findings were reported in multiple subsequent studies<sup>22</sup>.

The evidence base for Housing First is often regarded as robust by policymakers. Housing First is being explored and tested as an alternative that will, partially or wholly, replace staircase approaches in Canada, Denmark, Finland, France, Ireland, the Netherlands and across the USA itself.

However, as Housing First has spread, the service model has often been modified. This has resulted in two broad types of Housing First service scattered Housing First services (SHF) and communal Housing First services (CHF)<sup>23</sup>.

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<sup>20</sup> Tsemberis, S. (2010b) op. cit.

<sup>21</sup> Tsemberis, S. (2010b) op. cit.

<sup>22</sup> Tsemberis, S. (2010a) op. cit.

<sup>23</sup> Pleace, N. and Bretherton, J. (2013a) 'The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness' *European Journal of Homelessness* 7, 2.



Scattered Housing First is close to the PtH model and can include services that only use ICM, or only use ACT services, as well as those that employ both sorts of intensive, on-going support. Scattered Housing First services use ordinary housing that is scattered across communities and neighbourhoods, like the PtH model, specifically avoiding concentrations of service users in one apartment building or within a specific neighbourhood.

Communal Housing First services follow the same operational principles as PtH but with one key difference. Communal Housing First services, which can also be known as 'single-site' Housing First<sup>24</sup>, provides permanent self-contained apartments within dedicated communal or congregate buildings, with on-site staffing<sup>25</sup>.

The United States Interagency Council on Homelessness defines 'Housing First' services as having the following characteristics<sup>26</sup>:

- Offering permanent housing as quickly as possible for people experiencing homelessness.
- Supportive services that people need to keep their housing and avoiding a return to homelessness are provided. People are assisted in developing or improving skills for independent living while they live in permanent housing, they are not required to complete a 'housing readiness' programme (staircase) first.
- Being in paid work, abstinence from drugs and alcohol and participation in treatment is not required for accessing housing or retaining housing (the 'separation' of housing and support). Housing functions as the foundation from which other goals can be pursued.
- Apartments are not usually shared, though they can be either scattered across an area or provided in communal/congregate settings (blocks of apartments or flats).

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<sup>24</sup> Caton, C.L.M; Wilkins, C. and Anderson, J (2007) 'People who Experience Long Term Homelessness: Characteristics and Interventions' Paper given at the *National Symposium on Homelessness Research* <http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm>

<sup>25</sup> Pleace, N. (2012) ; Kaakinen, J (2012) 'Long term perspectives: From Housing First to Ending Homelessness' *Housing First: A Key Element of European Homelessness Strategies*, 23rd March 2012 Unpublished conference proceedings. French Permanent Representation, Brussels. <http://www.slideshare.net/FEANTSA/juha-kaakinen>

<sup>26</sup> [http://www.usich.gov/usich\\_resources/solutions/explore/housing\\_first/](http://www.usich.gov/usich_resources/solutions/explore/housing_first/)



Similarly, the recent review of the *Housing First Europe* programme, covering pilot Housing First services in Britain, Denmark, Hungary, the Netherlands and Portugal, also defines Housing First in terms of adherence to broad operational principles, rather than the exact replication of the PtH approach<sup>27</sup>. As a recent policy review of the use of Housing First approaches in Australia noted, some modification of the original PtH approach will always be necessary, because of differences in context across different countries<sup>28</sup>.

Alongside the robust American evidence base, there is growing evidence that services that closely reflect the operational principles of PtH effectively deliver housing sustainment for chronically homeless people. An evaluation of the Canadian Housing First *At Home/Chez Soi* programme found 73 per cent of the homeless people using a Housing First service were housed at 12 months, compared to 30 per cent receiving the usual pattern of treatment and support<sup>29</sup>. A recent 'Housing First Europe' research programme found that Housing First projects were delivering housing sustainment rates of over 90 per cent in Denmark, the Netherlands and Scotland and just under 80 per cent in Portugal<sup>30</sup>. A PtH approach being piloted in Ireland<sup>31</sup> and various other Housing First services are being tested in Austria, Belgium, France and Sweden<sup>32</sup>.

However, Housing First is far from being an uncontested solution to chronic homelessness. Some dispute the strength of the evidence base, draw attention to what they regard as the ambiguity of the concept, and question the supposed effectiveness of Housing First compared to staircase approaches<sup>33</sup> (see Chapter 6).

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<sup>27</sup>Busch-Geertsema, V. (2013) *Housing First in Europe: Final Report*

[http://www.socialstyrelsen.dk/housingfirsteurope/copy4\\_of\\_FinalReportHousingFirstEurope.pdf](http://www.socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirstEurope.pdf)

<sup>28</sup> Johnson, G.; Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia* (AHURI Final Report No. 184 AHURI: Melbourne).

<sup>29</sup> Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E. and Ly, A. (2012) *At Home/Chez Soi Interim Report* Mental Health Commission of Canada, <http://www.mentalhealthcommission.ca/English/document/5032/home-interim-report>

<sup>30</sup> Busch-Geertsema, V. (2013) op. cit.

<sup>31</sup> <http://www.homelessagency.ie/Dublin-Homeless-Action-Plan/Housing-First.aspx>

<sup>32</sup> <http://www.socialstyrelsen.dk/housingfirsteurope/>

<sup>33</sup> Pleace, N. (2011) 'The Ambiguities, Limits and Risks of Housing First from a European Perspective' *European Journal of Homelessness* 5, 2, pp. 113-127 <http://www.feantsaresearch.org/IMG/pdf/think-piece-1-3.pdf>

## Camden Housing First

### *The Camden Housing First Model*

Camden Housing First (CAMHF) was developed by SHP in response to a decision to commission an experiment with innovative homelessness services that was taken by Camden Council. In summary, CAMHF operated as follows:

- A team of two specialist floating support workers, with extensive experience of working with homeless people with high needs, were employed to provide an intensive case management (ICM) to up to ten chronically homeless people. A total of 75 hours of staff time was available each week, with each specialist floating support worker having a load of five people each. The service was delivered mainly within normal working hours, but service users had the mobile numbers (cellular phone numbers) of the workers in case of emergency. The two specialist floating support workers were supported by a service manager within SHP. The actual caseload when CAMHF became operational was slightly larger (see Chapters 3 and 4). The approximate annual budget was £90k<sup>34</sup> for a two-year pilot.
- Support was delivered using the operational principles of PtH. However, while CAMHF was open ended, within the limits of the pilot, there was a broad intention that support might start to lessen after a year (although support would go 'dormant' rather than actually stop).
- Housing would normally be provided through the private rented sector. Each service user would be helped to access and retain their own private rented sector flat (normally a one bedroom bedsit/studio apartment) by the CAMHF team.

Unlike PtH, CAMHF did not offer a 'housing management' service to private landlords or have a system that guaranteed payment of rent. Instead, CAMHF developed relationships with estate agents<sup>35</sup>, helping service users to find suitable private rented housing and arrange their own tenancy. The rental agreement, i.e. the tenancy agreement, was between the person using CAMHF and the private sector landlord who owned the property, with an estate agent acting as the intermediary

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<sup>34</sup> €106.9k, \$140.4k (USD), \$153.8 (AUD).

<sup>35</sup> Private sector companies selling housing and/or acting as agents who managing private rented housing on behalf the owners, also sometimes known as letting agents when exclusively renting out private rented sector housing.

that arranged the tenancy. Rent arrears, nuisance or damage to a property would therefore be the responsibility of a CAMHF service user as the tenant.

CAMHF could be broadly categorised as an example of scattered Housing First as the service provided intensive case management (ICM) but did not contain an integral assertive community treatment (ACT) team. A senior SHP manager, interviewed in April 2012, two months after CAMHF became operational, summarised the CAMHF approach in these terms:

*As far as I am concerned Housing First is a very intensive floating support service with the ability to coordinate services around people, should they be willing and want them, that's really what it is and what it does is take people who are not by definition housing ready and house them first...the core is that they are not defined as housing ready and therefore they are being housed first, before they get to be 'housing ready'... However, like the 'true' Housing First<sup>36</sup>, that is not a condition. The condition is that they adhere to the terms of their tenancy and they behave in a way that's neighbourly. And the rest of it is down to them.*

CAMHF took the form that it did for practical reasons. The resources available were not extensive, in part because only a quite small fund could be set aside by Camden Council for experimental commissioning, given Camden's on-going commitments to support existing homelessness services<sup>37</sup>.

The decision to use private rented housing was a result of the context in which CAMHF would be operating. There is evidence of an sustained shortage of all forms of affordable housing in London. Waiting times for social housing in high need areas such as London can be very long and the range of social housing stock available is restricted<sup>38</sup>. In addition, there is evidence that the relatively quicker routes to settled housing provided under the homelessness legislation in England can be inconsistent and difficult to access for lone homeless people, both because of restrictions

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<sup>36</sup> A reference to the PtH model.

<sup>37</sup> Camden Council (2011) Camden's Housing Strategy 2011-2016  
[http://www.camden.gov.uk/ccm/cms-service/download/asset?asset\\_id=2683563](http://www.camden.gov.uk/ccm/cms-service/download/asset?asset_id=2683563)

<sup>38</sup> Whitehead, C. and Travers, M. (2010) *The Case for Investing in London's Affordable Housing* London: London School of Economics  
<http://www.lse.ac.uk/geographyAndEnvironment/research/london/pdf/g15report.pdf>

governing who is eligible for re-housing<sup>39</sup> and because of a range of other barriers to the statutory system for lone homeless people<sup>40</sup>.

British examples of Housing First are unusual at the time of writing. There is an on-going scattered Housing First pilot working under commission from the Greater London Authority<sup>41</sup>, which differs from CAMHF because it has been given priority access to social housing – a rare privilege in London - whereas CAMHF is almost entirely reliant on the private rented sector. One other example, working in Glasgow, is another scattered Housing First service run by Turning Point, focused around a peer-support worker model for chronically homeless people with histories of drug and alcohol use, which again uses social housing<sup>42</sup>.

### *Referral criteria*

CAMHF was an innovative use of Housing First. CAMHF was designed to work alongside an existing staircase system that sought to make chronically homeless people housing ready. This was an atypical use<sup>43</sup> of Housing First model, which was originally developed by PtH as a replacement for the staircase model.

The Camden Hostels Pathway<sup>44</sup> was introduced in April 2007 by Camden Council as a policy response to ending homelessness among people with high needs who were living within the London Borough of Camden and who were street active or living

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<sup>39</sup> The current legal definition is taken from the case of *R. v Camden LBC* (i.e. Camden Council), ex p Pereira (1998) 31 HLR 317, CA which states that a vulnerability, in terms of being eligible for temporary accommodation and priority re-housing under the terms of homelessness law, means that an applicant has to be 'less able to fend for himself [sic] than an ordinary homeless person so that injury or detriment to him will result where a less vulnerable man will be able to cope without harmful effects' see: Hunter, C. (2007) Denying the severity of mental health problems to deny rights to the homeless *People's Place and Policy Online* 2, 1, pp. 17-27.

<sup>40</sup> Anderson, I., and Morgan, J. (1997) *Social housing for single people? A study of local policy and practice Research Report No. 1*, Housing Policy and Practice Unit, University of Stirling; Hunter, C. (2007) op. cit.; Pleace, N.; Teller, N. and Quilgars, D. (2011) *Social Housing Allocation and Homelessness* EOH Comparative Studies on Homelessness, Brussels: FEANTSA; Bretherton, J. et al (2013) "'You can judge them on how they look...': Homelessness officers, medical evidence and decision-making', *European Journal of Homelessness* 7 (1) pp. 69-92.

<sup>41</sup> <http://www.london.gov.uk/>

<sup>42</sup> <http://www.turningpointscotland.com/what-we-do/homelessness/housing-first/>

<sup>43</sup> Pleace, N. (2012) *Housing First* DIHAL.

[www.feantsa.org/files/freshstart/Policy%20documents/2012\\_04\\_27\\_FINAL\\_EN.pdf](http://www.feantsa.org/files/freshstart/Policy%20documents/2012_04_27_FINAL_EN.pdf)

<sup>44</sup> The term 'hostel' is used in this report to encompass all supported housing and transitional housing services that are accommodation based services (delivered with on-site support in communal or congregate purpose built or converted accommodation).

rough<sup>45</sup>. The Camden Hostels Pathway provided around 1,000 spaces, mainly for lone homeless people with support needs, and had four stages:

- Assessment accommodation (short term hostel accommodation while needs were assessed, with a stay of two months or less).
- Specialist supported accommodation (designed to meet specific support needs and including bed spaces designed for people with mental health problems and problematic drug and alcohol use<sup>46</sup> with a stay of 12-18 months).
- Progress accommodation (providing stability to allow homeless people to consider their future housing options, with a stay of 6-12 months with less intensive support).
- ‘Move-through’ accommodation (also sometimes known as ‘move-on’ or ‘transitional’ accommodation that was designed to make homeless people ‘housing ready’, with a stay of approximately 12 months)<sup>47</sup>.

The Camden Hostels Pathway was designed to enable people to achieve housing readiness at different rates, responding to different sets of need. The approach was particular to Camden, but also closely reflected broader British practice, which is more tolerant and flexible than that found in staircase systems elsewhere<sup>48</sup>, for example providing ‘wet’ transitional supported housing that allowed drinking. The goal, however, was the same, to bring homeless people with support needs to a point of ‘housing readiness’.

Once they were assessed as ‘housing ready’ an individual could be referred to the Pathways Move On Team (PMOT). PMOT was designed to place people into ordinary housing, which was most likely to be private rented, given high pressures of demand for social rented housing in Camden (see Chapter 4). PMOT would not take an individual who was not assessed as ‘housing ready’ and someone was not ‘housing ready’ if they were exhibiting challenging or anti-social behaviour,

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<sup>45</sup> Camden council operated a “Safer Streets Team” that used referral to the Camden Hostels Pathway to reduce rough-sleeping (street homelessness) in the borough. The Safer Streets Team secured hostel places for 69 people sleeping rough in 2008/9 and 152 in 2009/10, source: Camden Council.

<sup>46</sup> Both continued use (“wet”) hostel provision that did not require abstinence and ‘dry’ (abstinence based) hostel provision were available.

<sup>47</sup> Camden Council (2009) *Hostels Pathway Handbook: Revised November 2009* London: Camden Council.

<sup>48</sup> Sahlin, I. (1998) op. cit.

problematic drug and alcohol use or had severe mental illness, mental health problems or physical health problems for which they were refusing treatment.

Many homeless people were reported to have successfully passed through the Camden Hostels Pathway and to have been referred to PMOT for re-housing<sup>49</sup>. However, there was a core group with high support needs, anecdotally thought to number as many as 200<sup>50</sup>, who were ‘stuck’ in the Camden Hostels Pathway because they never reached the definition of ‘housing ready’ that would allow referral to PMOT.

CAMHF was designed specifically to take people who were stuck in the Camden Hostels Pathway in order to see if they could be sustainably housed using a Housing First approach. CAMHF therefore took referrals according to the following criteria:

- People who had been living *continuously* in the Camden Hostels Pathway for three years or more.
- People who had *repeatedly* used the Camden Hostels Pathway during the past three years.

It was anticipated that this group of people would present with very high rates of severe mental illness, problematic drug and alcohol use, anti-social behaviour and very poor physical health and sustained histories of homelessness and housing exclusion. That which was anticipated proved to be entirely correct once CAMHF became operational (see Chapter 3). In practice, many of the referrals to CAMHF had been within the Camden Hostels Pathway for longer than three years and some had histories of residence in hostels that extended to well before the Camden Hostels Pathway had been established (see Chapter 3).

An individual reliant on welfare benefits for rent and other living costs would have an extremely tight budget. SHP took the view that people using CAMHF were thought not to be able to afford to live and also pay off any sort of debt. Even

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<sup>49</sup> In 2008/09, 79% of residents within the Hostel and also the Mental Health Pathways were reported by Camden Council to have “made planned, positive moves towards independent living” and in 2009/10 this figure increased to 83% of residents (source: Camden Council).  
[www.camdendata.info/AddDocuments1/Draft%20Evidence%20Base%20Document%20Jan%202011%20-%20version%209.pdf](http://www.camdendata.info/AddDocuments1/Draft%20Evidence%20Base%20Document%20Jan%202011%20-%20version%209.pdf)

<sup>50</sup> Reported in interviews conducted for the research.



dealing with fairly minimal rent or service charge<sup>51</sup> arrears at a low repayment rate was thought to make it likely to be very challenging to maintain independence for long.

SHP therefore developed an additional criteria for referral, which was that no-one could have more than approximately £50 in rent or service charge arrears. Of the 200 or so people identified as 'stuck' in the Camden Hostels Pathway many had significant arrears and were therefore not eligible. This requirement was imposed for what were thought to be practical reasons. Although this £50 limit seems like a form of housing readiness requirement to access CAMHF, it should also be noted that CAMHF was nevertheless, overwhelmingly, focused on chronically homeless people who were defined by the Camden Hostels Pathway as *not* housing ready (see Chapter 3).

Finally, an external limitation existed in terms of who could be referred to CAMHF. This was linked to the operation of the Housing Benefit or Local Housing Allowance system in Britain, which will only pay towards the rent for self-contained housing for an individual once they are aged over 35 (prior to this age, usually only the rent for a room in a shared house or flat will be paid). As the people being supported by CAMHF had very high support needs, including severe mental illness, it was not thought practical to house them in shared living arrangements, therefore the CAMHF service would only usually engage with people aged over 35<sup>52</sup>.

During the early stages of the CAMHF project some difficulties were reported with the operation of the referral process, centring on the appropriateness and a low number of referrals initially being received from the Camden Hostels Pathway. However, these issues were reported as having been resolved by the point of the second fieldwork visit in July 2012.

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<sup>51</sup> Some hostels made a service charge.

<sup>52</sup> There are exceptions i.e. individuals that receive a severe disability premium, certain ex-offenders; who could pose a risk of serious harm to the public. There is also an exception for people who have lived for three months in a homeless hostel or hostels and have been supported to resettle in the community, but the 'three month' rule could have excluded people who were *recurrent* rather than sustained users of the Camden Hostels Pathway and some other ambiguity was perceived by SHP to exist around the rule, see: <http://www.dwp.gov.uk/docs/sar1.pdf>

## ***Management of Camden Housing First***

Management of the CAMHF service involved close consultation with Camden Council. A small steering group, made up of SHP management and representatives of the service commissioners at Camden Council held regular meetings at which progress across the service as a whole – and in respect of individual service users – was reviewed. Referrals to CAMHF were also agreed with a service commissioner at Camden Council.

Operationally, this created a situation in which a high degree of regular, detailed feedback was taking place between SHP as the service provider and Camden Council as the service commissioner. This level of information exchange appeared to have been generally beneficial, as both agencies had a good understanding of what was happening and why at any point in time. Camden Council staff could also see the challenges and issues that could arise for the CAMHF team in delivering housing sustainment.

## **An overview of Camden Housing First**

CAMHF was a scattered Housing First service model using an intensive case management (ICM) approach. CAMHF was designed to support an existing staircase system for the resettlement of homeless people with high needs, the Camden Hostels Pathway. The key features of the CAMHF service were:

- Mobile intensive case management was provided by a team of two specialist floating support workers with a normal caseload of five people each and a total working week of 75 hours.
- Use of private rented housing for which the tenancies were held directly by the people using CAMHF.
- Referral criteria centred on re-housing people who had been continually or recurrently within the Camden Hostels Pathway staircase resettlement system for three years or more. CAMHF service users were chronically homeless people who were defined as not housing ready by the Camden Hostels Pathway services.



## 3 The People Using Camden Housing First

### Introduction

The chapter provides an overview of the characteristics of the people using Camden Housing First (CAMHF) at the point of referral. The chapter begins with a broad description of support needs which is followed by an overview of the recent housing histories of people using CAMHF.

### The People using Camden Housing First

#### *The characteristics of service users at referral*

Table 3.1 summarises characteristics of the people using CAMHF at the point at which they were referred. These data are based on interview transcripts, the review of administrative records and discussion with service users themselves. The data are *approximate* as not every detail of experience, characteristics and needs was always either recalled or recorded. In addition, much of the detailed information that was available on each service user has been broadly summarised in Table 3.1, this was to minimise any risk that an individual using CAMHF might be identified from this report<sup>53</sup>.

The people using CAMHF were a high need group of individuals with sustained experience of the Camden Hostels Pathway. Mental health problems and severe mental illness, poor physical health, problematic drug and alcohol use and anti-social behaviour were all highly prevalent. Either continual or repeated use of the Camden Hostels Pathway, again reflecting the specific focus of CAMHF, was universal, though was far more sustained in some cases than in others (Table 3.1).

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<sup>53</sup> The numbers used in the table do not relate to any designation given to a person by the CAMHF service.

Table 3.1: Characteristics of People who became Service Users at Referral to Camden Housing First

Service user	Gender	Age	Ethnicity	Physical Health	Mental Health	Drugs and Alcohol	Anti-social behaviour on street	Anti-social behaviour in hostels	Criminal record	Time in Camden Hostel Pathway	Sustained/recurrent sleeping rough
1	Female	40s	White British	Limited mobility, HIV positive	Personality disorder	Crack, cannabis, heroin, alcohol	Yes	Yes	No	10 years plus	No
2	Male	30s	Asian British	Respiratory problems, hepatitis C	Not reported	Crack, cannabis, heroin, qat, alcohol	Yes	Yes	Yes	5-10 years	Yes
3	Female	50s	White British	Hepatitis C	Schizophrenia	Alcohol, on methadone script.	Not reported	Not reported	Yes	Up to 5 years	No
4	Male	40s	White British	Not reported	OCD, depression	Alcohol	Not reported	Yes	No	Up to 5 years	No
5	Female	40s	Black British	Not reported	Anxiety, depression	Cannabis, crack, alcohol.	Not reported	Yes	No	5-10 years	No
6	Male	40s	White European	Mobility difficulties	Depression	Heroin, on methadone script, crack, crystal meth	Not reported	Yes	No	10 years plus	Yes
7	Female	30s	White British	Mobility and balance, hearing impairment	Depression	Alcohol	Not reported	Not reported	No	5-10 years	No.
8	Male	40s	White British	Limited mobility	Depression	Heroin (smoking), crack	Not reported	Not reported	Yes	Up to 5 years	Yes
9	Male	50s	White British	Cirrhosis, hepatitis C, epilepsy	Depression	Alcohol	Yes	Yes	Yes	5-10 years	Yes
10	Female	50s	White British	Respiratory problems, limited mobility	Anorexia, depression	Crack, on methadone script	Not reported	Yes	Yes	5-10 years	No
11	Male	30s	White European	Limited mobility	Not reported	Alcohol, heroin, methadone, crack	Yes.	Yes	Yes	5-10 years	Yes
12	Female	20s	White European	Limited mobility	Depression	Tranquilisers, heroin, crack, methadone, valium	Yes	Not reported	Yes	5-10 years	Yes
13	Male	40s	White British	Not reported	Anger management	Alcohol, crack	Not reported	Yes	Yes	5-10 years	No

Table 3.1 shows that some exceptions to the CAMHF referral criteria did exist. Service users 11 and 12 were in a longstanding relationship and were treated by CAMHF (and before that by the Camden Hostels Pathway) as a single household which was jointly assessed and who were to be rehoused together. The status of these two individuals as a couple explains why service user 12 was aged under 30 and supported by CAMHF<sup>54</sup>.

Service users were generally well into middle age, typically aged over 45, and were predominantly White British, with men just outnumbering women (there were seven men and six women). Limitations in physical mobility were quite common, in a couple of instances this was linked to physical disability as a result of accidents or long term limiting illness, though this could also be due to leg ulcers linked to sustained intravenous drug use. One service user was reported as HIV positive, some also had Hepatitis C, which can be associated with intravenous drug use. Illness associated with sustained overconsumption of alcohol was less prevalent, but was also recorded among the service users.

The description of mental health problems given in Table 3.1 is approximate. A formal, recent, diagnosis by a psychiatrist was not always available. However, those service users described as having mental health issues were receiving antidepressants from a GP, had a history of using mental health services, a history of attempted suicide, or current suicidal ideation, or had been assessed by support workers in the Camden Hostel Pathway and/or CAMHF as presenting with one or more 'mental health' issues.

While there were some exceptions, service users tended to lack contact with family, to not be in a relationship and to generally be without social support from friends at the point of referral. A formal assessment of social support<sup>55</sup> was not conducted, but deficiencies in social support were often reported in assessments in the following respects:

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<sup>54</sup> The age restrictions to Housing Benefit did not apply to couples.

<sup>55</sup> Cohen, S. and Wills, T. (1985) 'Stress, Social Support and the Buffering Hypothesis' *Psychological Bulletin*, 98, pp. 310-357.

- *Esteem support*, information that a person is esteemed and accepted by friends, family and a partner, i.e. they are respected by others and draw confidence from that respect;
- *Informational support*, help in defining, understanding and coping with problematic events;
- *Social companionship*, spending time with others in leisure or recreational activities
- *Instrumental support*, the provision of financial aid, material resources and needed services provided by friends, partner or relatives.

Nuisance, or anti-social, behaviour was widely reported, most commonly in hostels and not infrequently linked to evictions from hostels for criminal activity, nuisance or threatening behaviour. In a few instances, service users had been evicted for drug dealing, or had been arrested and imprisoned for drug dealing and lost their hostel place for that reason. Just under half of the service users were reported as having been involved in what was defined as anti-social behaviour on the streets of Camden at the point of referral, with begging and public drunkenness being the main issues reported. A few had received or been threatened with Anti-Social Behaviour Orders (ASBOs)<sup>56</sup> for anti-social activity on the street.

As noted in Chapter 2, the criteria for CAMHF meant that service users did not have substantial debts or arrears on hostel service charges at the point of referral. Some service users were referred with a small amount of debt.

Not all referrals to CAMHF were deemed appropriate and not all of those who were referred to CAMHF chose to engage with the service. However, the numbers involved were very small and almost all the people referred were engaged with and did take up the CAMHF service.

*If [clients] don't engage with us, we can't get them a... flat. We have had a couple of people who we've ended up closing their cases because they've just had no contact with us.* CAMHF team member.

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<sup>56</sup> An order to stop anti-social behaviour which, if broken, can lead to fines and imprisonment, the system was abolished in 2012 and there was a proposal to introduce a similar measure called Community Protection Orders.

### *Recent housing history at the point of referral*

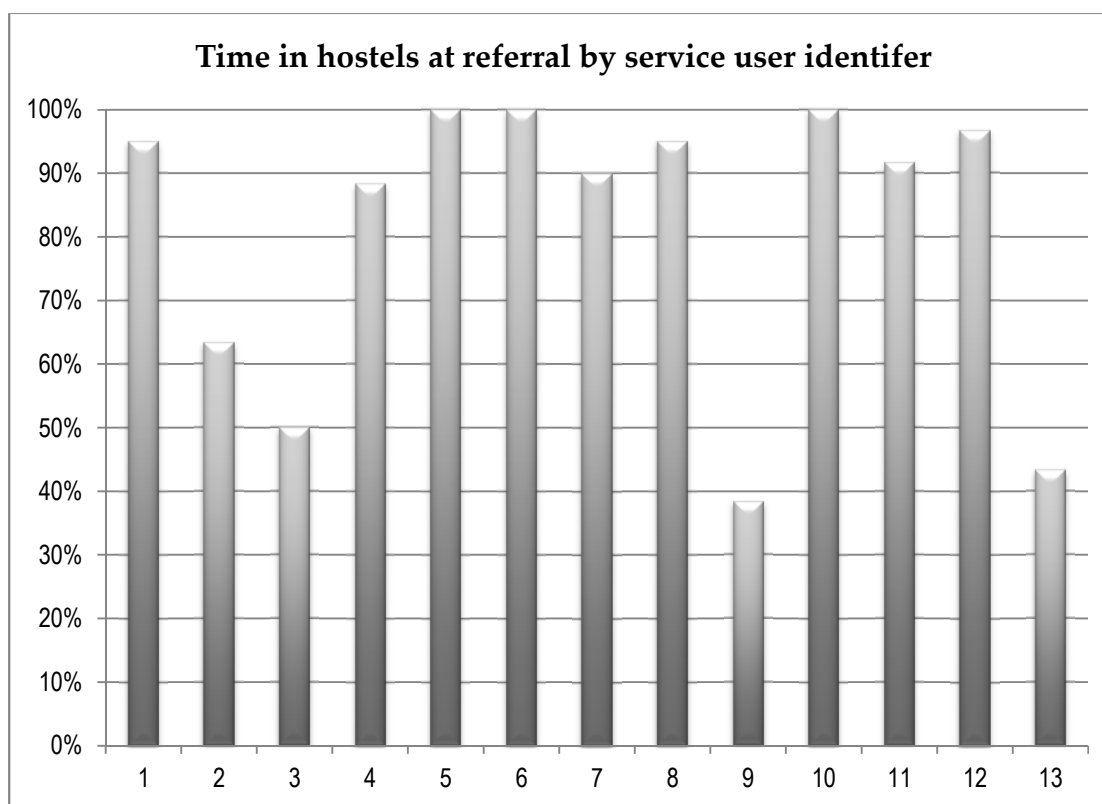
Attempts were made to document the housing history of people referred to CAMHF over the last five years. Sometimes this process was highly successful and precise, because not only was the person there to be asked, but administrative systems within various hostels and other services within Camden documented exactly when someone had arrived at and subsequently left those services. On other occasions this information was much less precise, because information on service use was not available or specific details could not be remembered. Nevertheless, it was possible to establish a broad picture of the housing histories of the people referred to CAMHF at the point of referral (Figure 3.1).

Figure 3.1 shows the approximate percentage of time that service users were reported to have spent in temporary supported housing and hostels<sup>57</sup> during the past five years, as measured from the point at which they were referred to CAMHF. The percentage is based on a total of 60 months, so a report of 100 per cent for a particular service user means that records showed they had spent the entire 60 months (i.e. five years) in one or more hostels.

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<sup>57</sup> As noted in Chapter 2, the term 'hostels' encompasses accommodation based services.

Figure 3.1: Approximate hostel use in last 5 years by service users at referral



Source: Camden Council recording of housing histories during last five years

The lower percentages shown for some people in Figure 3.1 signify one of two broad housing histories. The lowest percentages, i.e. under 50%, were people who had been in the Camden Hostels Pathway on a sustained and/or repeated basis for less than five years (but at least three years, reflecting the referral criteria to CAMHF discussed in Chapter 2). This usually signified they had returned to Camden from elsewhere within the last 3-4 years<sup>58</sup>. The percentages that were between 60% to over 90% were people whose sustained and repeated experience of hostel use over five years was punctuated by other experiences, but who had nevertheless spent the bulk of their time within hostels.

The people using CAMHF had lived in an average of four hostels during the last five years<sup>59</sup>. The highest number recorded was eight hostels and the lowest was two, with the 13 service users being reported as living in a total of 58 hostels between them

<sup>58</sup> These individuals would have had a local connection to the London Borough of Camden.

<sup>59</sup> The median figure was also four hostels.

during the five years preceding their referral to CAMHF<sup>60</sup>. Beyond their tendency for sustained and repeated residence in hostels, the people who used CAMHF had five main characteristics at the point of their referral:

- A tendency to have moved between several hostels during the last 3-5 years. This could be because they had exhibited anti-social and in a few instances, criminal, behaviour and been evicted from one hostel and been moved to another. The people using CAMHF had also sometimes been moved because their length of stay in a particular hostel had exceeded the maximum allowed length, or because the Camden Hostels Pathway was attempting to progress them towards 'housing readiness' (see Chapter 2).
- A low rate of living rough (street homelessness), both in terms of the frequency and the duration with which living rough had been experienced. Four people had experienced living rough in the last five years, one of whom had experienced it more than once. While data on the duration of these experiences was approximate, they were typically less than three months.
- Limited experience of precarious informal arrangements, such as an informal flat or house sharing arrangement, including 'sofa surfing' during the past five years. Again, data on this tended to be approximate, but the periods involved were generally quite short (under three months). Three people were reported as having 2-3 experiences of precarious informal arrangements (also sometimes known as hidden homelessness<sup>61</sup>) during the past five years.
- For a few service users, time in hostels was intermingled with time in prison. Arrest and imprisonment was sometimes a reason why hostel accommodation had been lost. However, it was *uncommon* for the service users to have recently served a sentence of more than a few weeks for a low level offence (e.g. petty theft or a minor drugs offence). A very small number of service users had a history of more serious convictions and thus of sustained imprisonment, but this was not in the recent past. Four people had been imprisoned one or more times, all for brief periods, in the last five years.

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<sup>60</sup> Based on Camden Council data, as noted above these were sometimes approximate rather than exact records.

<sup>61</sup> Reeve, K. with Batty, E. (2011) *The hidden truth about homelessness: Experiences of single homelessness in England* London: Crisis [http://www.crisis.org.uk/data/files/publications/HiddenTruthAboutHomelessness\\_web.pdf](http://www.crisis.org.uk/data/files/publications/HiddenTruthAboutHomelessness_web.pdf)

- No recent history - and in most instances *no history* – of living entirely independently, or even semi-independently with floating/mobile support, in ordinary housing. None of the individuals referred to CAMHF had any recent experience of living in their own home and only one had experience of privately renting a home during the last decade.

### *Social and economic integration at the point of referral*

Community participation was not a feature of the lives of the service users at the point they were referred to CAMHF. In some cases, their relationships with other citizens in Camden were partially characterised by a history of anti-social behaviour.

Experience of formal economic activity in the sense of paid work was quite common among the service users, but most had not actually worked for years. Several had held paid jobs for some years before becoming homeless. Six service users had work experience ranging from working in a care home, being an electrician, ICTs, carpentry, catering (including waiting on tables and one service user who was a trained chef). The other service users tended not to have been in sustained paid work. However, none had been in paid work within the last 3-4 years, as at the point at which they were referred to CAMHF.

### *The women using CAMHF*

As the CAMHF service developed, the CAMHF team began to report that there were some gender differences within the group of people using the service. The group using CAMHF was very small and had met the referral criteria for the service (six women and seven men). This meant they were a group that in no sense 'representative' of chronically homeless people within Camden or across London. However, from the perspective of some of the CAMHF team, some women were presenting with more complex needs than was the case for some of the men.

*Personally I think women are more complex, and women just tend to have more emotional difficulties... women are much more damaged before they come to services anyway, you know,...a lot of women sort of have the issues around domestic violence, sexual violence, and about children being taken into care...you know about how society expects them to be, I think that causes more issues and feelings of failure. CAMHF team member.*



*I think with the women I work with, they've all had a loss of sorts, whether it be family, children, something like that. Whereas the men that I work with, have actually had a professional career, before being homeless, so then there's a big loss of pride, being able to provide, have a family or the possibility of having somebody or something. So, I think the common denominator is a lot of loss which makes it complicated anyway, but what they have lost is to a degree different things. CAMHF team member.*

The evidence base on women's homelessness is inadequate across Europe<sup>62</sup>. However, there is research suggesting that the experiences reported by the CAMHF team, in terms of the gender differences in the need they were encountering, may also exist at a wider level. One recent European level review of the evidence about women's homelessness showed the same high rates of domestic/gender based violence and also a tendency for lone homeless women to have lost contact with their children or having their children taken into care<sup>63</sup>. Recent research in Ireland<sup>64</sup> also found a group of chronically homeless women who had needs and experience of domestic or gender based violence that appears very similar to those reported among the women using CAMHF. While no conclusions can be drawn about the nature of women's homelessness from the research on CAMHF for the reasons given, some of the differences in needs linked to gender reported by the CAMHF team are nevertheless also reported in other research. Important questions exist about the differential experience that women may have of chronic homelessness.

### ***Users of Camden Housing First compared to other Housing First services***

The small group of people who used CAMHF bore a close resemblance to the 'chronically homeless'<sup>65</sup> or 'long term'<sup>66</sup> homeless groups targeted by Housing First

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<sup>62</sup> Baptista, I. (2010) 'Women and Homelessness' In E. O'Sullivan *et al* (Eds) *Homelessness Research in Europe*. Brussels: FEANTSA. pp. 163-186. See also the *Women's Homelessness in Europe Network* (WHEN) <http://www.womenshomelessness.org/>

<sup>63</sup> Baptista, I. (2010) *op. cit.*

<sup>64</sup> Mayock, P. and Sheridan, S. (2012) *Women's 'Journeys' to Homelessness: Key Findings from a Biographical Study of Homeless Women in Ireland*. Women and Homelessness in Ireland, Research Paper 1. Dublin: School of Social Work and Social Policy and Children's Research Centre, Trinity College Dublin.

<sup>65</sup> Kuhn, R. and Culhane, D.P. (1998) *op. cit.*; Poulin, S.R.; Maguire, M.; Metraux, S. and Culhane, D.P. (2010) *op. cit.*

<sup>66</sup> Kaakinen, J (2012) *op. cit.*

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services in the US, Canada and Europe<sup>67</sup>. The CAMHF service users were also a group of people who were very long term or repeated residents of homeless hostels who had high needs, they were not people with recent, sustained or recurrent, experience of living rough or living in precarious or interim arrangements.

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<sup>67</sup> Busch-Geertsema, V. 2013 op. cit.; Goering, P. *et al*, (2012) op.cit.; Pleace, N. (2012) op. cit.

## 4 Delivering Camden Housing First

### Introduction

This chapter explores the outcomes achieved by Camden Housing First (CAMHF) during the period of the research. The following sections explore the outcomes achieved by CAMHF in terms of housing sustainment, dealing with health and support needs that might threaten housing sustainment and in respect of social integration. This discussion is followed by an examination of the cost effectiveness of CAMHF, which explores cost offsets from using CAMHF. Finally, the chapter provides an overview and summary of the key outcomes achieved by CAMHF.

### Housing Sustainment

#### *Effectiveness*

Table 4.1 summarises the housing sustainment achieved by CAMHF for service users as at 1<sup>st</sup> April 2013. There was strong evidence that CAMHF was delivering housing sustainment for a group of chronically homeless people without any recent – and often no – history of living independently in their own home.

Five service users had been rehoused and had sustained housing for at least five months, with four out of the five staying in the private rented sector housing that the CAMHF team had secured for them and one making a planned move to another private rented studio flat. Two people using CAMHF had been rehoused more recently. One tenancy had broken down at six months, following issues with other people moving into the flat. This tenancy was nevertheless sustained for six months by someone who had never lived independently in ordinary housing for that length of time before.

Housing had not been secured for four service users as at 1<sup>st</sup> April 2013. Most of these individuals (two of whom were a couple, see Chapter 3) were more recent referrals, as three of this group had been referred to CAMHF in late 2012. A fourth individual had been referred earlier in 2012, but it had been determined in consultation with Camden Council that they were eligible for social rented housing because of their extremely poor physical health. The scarcity of social housing in

Camden meant that this was taking time to arrange but it was expected that this fourth individual would be housed by a social landlord.

One individual (service user 13) had been housed for a long period in temporary accommodation provided by Camden. This individual was a ‘legacy’ client from an initial service pilot, which was not the subject of this research (see Chapter 1), who had been transferred when CAMHF began operation. The under 35 years of age rule for Housing Benefit/Local Housing Allowance was due to be introduced in April 2013, and this meant this individual may have been expected to move from this temporary accommodation.

*Table 4.1: Housing sustainment among CAMHF service users at 1<sup>st</sup> April 2013*

Service user ID	Housing status	Duration (days)	Duration (months)
1	1 move	363	11.9
2	No moves	250	8.2
3	No moves	243	8.0
4	No moves	230	7.6
5	No moves	56	1.8
6	No moves	55	1.8
7	No moves	154	5.1
8	Not yet rehoused	0	0.0
9	Lost tenancy after six months	181	6.0
10	Not yet rehoused	0	0.0
11	Not yet rehoused	0	0.0
12	Not yet rehoused	0	0.0
13	Temporary accommodation.	880	28.9

There are some caveats to be noted about these findings. Housing had not always been sustained for very long at the point the research came to an end. Some service users had been in their new housing for less than two months, although several had been housed for six months or more. Longitudinal monitoring would need to be undertaken to establish whether CAMHF could achieve the levels of housing sustainment achieved by PtH in New York. More generally, the relatively recent arrival of Housing First services in the EU means that the existing European evidence base, for the moment, is often relatively short term<sup>68</sup>. Additionally, while service users had been successfully engaged, not all had been successfully housed at the point the research came to an end. While there was an expectation that housing

<sup>68</sup> Busch-Geertsema, V. (2013) op. cit.

sustainment would be successfully delivered for this group, there was not yet firm evidence that this would be the case.

### *Delivering housing sustainment*

Difficulties in securing enough adequate housing for CAMHF were anticipated from the outset of service development. CAMHF was designed with the assumption that social rented housing would not usually be available for most service users<sup>69</sup>, which meant that, like the original New York PtH Housing First service, CAMHF would have to use the private rented sector (see Chapter 2). Two main difficulties were anticipated in using mainly private rented sector housing:

- Private landlords would often be reluctant to let to people reliant on welfare benefits to pay their rent and their living costs, particularly in a context where a great many employed people were seeking private rented housing. There would also be reluctance to let housing to formerly homeless people, particularly those with on-going issues around drug use, antisocial behaviour, a history of criminality or mental health problems.
- There was relatively little adequate private rented housing in Camden that was affordable to someone reliant on welfare benefits, or on a relatively low wage. The location of Camden in central London meant a small studio flat (without a separate bedroom or kitchen) in Camden could command a rent well in excess of the Housing Benefit limit.

These issues meant that CAMHF had been designed with the assumption that most of the ten people using the service would be housed outside Camden in other areas of London with relatively lower private rent levels. Although a relatively 'low' London rent, for a one bedroomed or studio apartment, with a low enough rent to be eligible for welfare benefit assistance (see below), would still be at least £800 a month and sometimes more<sup>70</sup>. In practice, by April 2013, the CAMHF team had often been able to house service users in two nearby areas, Islington and Enfield, and an early worry that service users would end up scattered across outer London had, so far, been avoided.

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<sup>69</sup> See Chapter 2.

<sup>70</sup> Approximately €950 per month, \$1,248 (USD), \$1,363 (AUD) (2013 rates)

CAMHF service users directly held ordinary tenancies for the private rented housing they occupied (see Chapter 2). Estate agents<sup>71</sup> and private rented sector landlords had to be persuaded by the CAMHF specialist support workers to directly let housing to formerly chronically homeless people.

Initially, the CAMHF team reported considerable difficulties in securing suitable private rented housing either within or reasonably close to Camden. Two months after CAMHF became operational, the team reported they were spending much of their time trying to bring estate agents<sup>72</sup> on board.

*Most of our time is going on trying to find properties, we've only housed one client at the moment. We're still feeling very positive about the project, currently it's getting letting agents, we've got four that will work with us.*  
CAMHF team member, April 2012.

*We'd like to be able to offer people a choice about where they are going. But it's difficult. It's going to depend a lot on what we can find. If someone's got like links to a certain area, they are going to want somewhere that makes the most of those links, like if someone's got family they want to be within a particular area. We'd try to house them somewhere within a reasonable distance of that, but it depends on what we're going to be able to get in terms of landlords.*  
CAMHF team member, April 2012.

The quality and affordability of some of the housing that was available from the private rented sector presented challenges to the CAMHF team. All CAMHF service users were reliant on Housing Benefit. The welfare system designed to assist low income households with housing costs when renting housing, was governed by a number of restrictions. One of these restrictions faced by CAMHF was the 'cap', a limit on the total amount of rent that could be paid to someone who was eligible for Housing Benefit<sup>73</sup>.

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<sup>71</sup> Private companies that act as managing agents for people renting or selling housing.

<sup>72</sup> See Chapter 2.

<sup>73</sup> Housing Benefit is designed for low income and unemployed households, it wholly or partially meets the costs of renting privately or from a social landlord. There are multiple restrictions governing the amount that is paid and whether or a household is eligible for Housing Benefit. A 'Local Housing Allowance Limit' is set for each local authority area, which is the maximum level of rental costs that will be paid to any household, this is known as the Housing Benefit 'cap' (limit) <https://www.gov.uk/housing-benefit/overview>

*Generally in London at the moment, one bed studios are just gold dust...they've gone up more than what the cap is allowing, so- landlords can get a lot more for their property than they can from someone on Housing Benefit and there are no incentives anymore to rent to people on Housing Benefit. CAMHF team member, July 2012.*

*Because of the Housing Benefit cap and everything else, we're only getting the lower end of the market anyway, and we've met some real charlatans that have really wasted our time...fortunately we know enough about the market luckily to stop that happening...CAMHF team member, July 2012.*

*A lot of the stuff that we've been offered is disgusting...they always charge the upper limit of the benefit cap, regardless of standard. CAMHF team member, July 2012.*

Attitudes from some estate agents were found to be negative. The CAMHF team reported a need to 'charm' estate agents and had developed ways of describing the CAMHF service that were designed to overcome what could initially be hostile attitudes towards the idea of letting private rented housing to formerly homeless people or more generally to people reliant on welfare benefits.

*The thing we use as the main selling point is, as opposed to someone just walking off the street, this tenant will have somebody going in there, like several times a week, and making sure anything that could be an issue is nipped in the bud straight away, they also never have to deal with the tenant directly, they deal with us, professionals, that's the kind of thing we sell it on. CAMHF team member, July 2012.*

*Just explaining what our service is, what we're looking for, I think initially I would start off like that, now I just go and say 'do you accept people on Housing Benefit?' and a lot just say no, I'm sorry and then the other estate agents who go, yes we do have some properties, and then I sit down and say a bit about the service. And the ones that are a bit more open to listening to you,*

*actually have worked with councils<sup>74</sup> before.* CAMHF team member, July 2012.

By early 2013, about a year into operation of CAMHF, these difficulties in accessing private rented housing were being overcome by the Specialist Floating Support Workers within the CAMHF team. Working relationships had been developed with several estate agents. A positive experience in letting private rented housing to one CAMHF service user, i.e. the person paid their rent and was not disruptive, led estate agents to offer additional private rented housing to CAMHF service users.

However, challenges over the availability, standard and cost of private rented housing in, or near, central London remained constant for the CAMHF team, as did the challenges resulting from the attitudes of some estate agents. Finding suitable housing was still sometimes difficult.

*It's the same as the last time I spoke to you, I saw a place last week, week before, had a shower in the hallway, I actually called [London Borough] to check whether it had planning permission.* CAMHF team member, March 2013.

However, as noted, by 1<sup>st</sup> April 2013, eight service users been housed with one failed tenancy. Being able to secure housing was seen as being almost entirely the result of the relationships the CAMHF team had developed with estate agents.

*Yeah, that's the reason we've got housing, because of the relationships.* CAMHF team member, March 2013.

Experience was also enabling the CAMHF team to learn how to approach new estate agents and develop new relationships. The process of developing new relationships with estate agents had become more effective over time.

*The first thing he said was- "I don't want any druggies, I don't want any junkies, I don't want any ex-cons" and, of course, but we spent what, an hour and a half, two hours with him and it ended up with him showing us properties and in the end he's housed our clients...and that's all just because*

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<sup>74</sup> Boroughs or councils refers to the 33 elected municipalities in London.



*of building the relationships, it's not because of anyone coming forward saying 'yeah, I want to work with your clients'.*- CAMHF team member, March 2013.

Over time, the CAMHF team had built up relationships with estate agents to a point where adequate, affordable private rented housing was more readily, if rarely immediately, available for the people using CAMHF. Re-housing had not, overall, been a very quick process, with an average duration between referral and moving into a flat in the private rented sector of 75 days<sup>75</sup>, among the eight people who had been housed in the private rented sector.

From the perspective of some advocates of Housing First models, difficulties in not always being able to house someone quickly would be seen as a limitation. One reason for this is that some risks to well-being from being homeless are sometimes thought to continue as long as someone is not adequately housed in their own home (see Chapter 5). Another is that the relationship between a Housing First service and an individual is seen to be built up from a starting point of rapid re-housing<sup>76</sup>.

CAMHF is best described as a service that put chronically homeless people into housing *comparatively quickly* given the extremely challenging context in which it was operating. It should be noted that London has one of the most expensive and highly stressed housing markets in Britain, a country that is not characterised by an abundance of adequate, affordable housing<sup>77</sup>. In practice, immediately re-housing is also not always possible for other Housing First services using private rented housing. For example PtH Housing First in New York has to sometimes use temporary accommodation for short periods<sup>78</sup>. Operationally, for CAMHF, the wait for re-housing did *not* seem to create any issues with service user engagement or eventual housing sustainment, perhaps reflecting the level and intensity of support people using CAMHF were receiving. This was also a group of people who were accommodated in hostels where they had been for years, so awaiting housing from CAMHF meant a relatively short additional time living in environments they were well used to.

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<sup>75</sup> Median of 77 days.

<sup>76</sup> Tsemberis, S. (2010a) op. cit.

<sup>77</sup> Bramley, G.; Pawson, H.; White, M.; Watkins, D. and Pleace, N. (2010) *Estimating Housing Need* London: Communities and Local Government.

<sup>78</sup> Tsemberis, S. (2010a) op. cit.

One final point is worth noting and this related to the housing expectations of the people using CAMHF. These expectations could vary. For some, there was a willingness to accept almost anything that could be their own home, for others, expectations could be unrealistic.

There was still, from the perspective of the CAMHF team, a kind of ‘myth’ among some homeless people that spending sufficient time in the homelessness system would eventually lead to a social rented tenancy. A social rented tenancy offered a number of potential advantages over private renting. These advantages centred on a greater security of tenure, significantly more space within generally better standard accommodation and also a more affordable rent<sup>79</sup>. However, access to social housing supply in London had become so restricted as to make social renting effectively inaccessible<sup>80</sup>. A reality in which the *only* housing option was a small, privately rented flat, which was probably going to be a studio flat, without a separate bedroom or kitchen, and which was not probably not going to be within Camden itself, did sometimes have to be explained.

*When we first meet with people, you explain, this is how most people live in London, there are no council [social rented] flats, [and] who can afford to buy a place? I live in a private rented flat, all the people I know live in a private rented flat, so I can say to people, I understand, and I really do understand, because this is how I live...CAMHF team member.*

<sup>79</sup> Social rented tenancies are still often provided on a ‘home for life’ basis, providing tenancy conditions are not breached and the rent is paid. It is common practice to offer only short-term tenancies in the private rented sector in the UK, e.g. 6 or 12 months.

[http://england.shelter.org.uk/campaigns/why\\_we\\_campaign/improving\\_private\\_renting](http://england.shelter.org.uk/campaigns/why_we_campaign/improving_private_renting)

Private rented housing is more likely to be in bad condition than social rented or owner occupied housing. The 2011 Survey of English Housing estimated that 5.4 million homes (24%) were ‘non-decent’, i.e. in poor repair and/or lack basic amenities. Overall, housing conditions were improving, but the rate at which housing was found ‘non-decent’ was lowest in the social rented sector (17%) and highest in the private rented sector (35%).

<sup>80</sup> In March 2013, the Greater London Authority reported that 380,301 Londoners were on social housing waiting lists, a 56% increase in the level reported in 2003 (242,389) equivalent to 4.65% of the usually resident population of 8.17 million people source: <http://data.london.gov.uk/datastore/package/households-local-authority-waiting-list-borough>

There is longstanding evidence that access to the social rented sector through the statutory homelessness system is uneven for lone homeless people with high support needs, with legislative and administrative restrictions on access, social housing shortages and negative or prejudicial attitudes towards some homeless people as potential tenants all forming barriers, see: Anderson, I., and Morgan, J. (1997) *Social housing for single people? A study of local policy and practice* Research Report No. 1, Housing Policy and Practice Unit, University of Stirling; Hunter, C. (2007) ‘Denying the severity of mental health problems to deny rights to the homeless’ *People, Place and Policy Online* 2 (1) pp. 17-27; Reeve, K. with Batty, E. (2011) *The hidden truth about homelessness: Experiences of single homelessness in England*, London: Crisis <http://www.crisis.org.uk/publications-search.php?fullitem=310>

*Half of us live in house shares anyway. We can't afford our own place!*  
CAMHF team member.

## Addressing Support Needs

### Effectiveness

Table 4.2 summarises the achievements of CAMHF in meeting the support needs of the people using the service as at 1<sup>st</sup> April 2013.

Table 4.2: Support needs among CAMHF service users at 1<sup>st</sup> April 2013

ID	Housed	Use of treatment physical health	Use of mental health services	Changes in drugs and alcohol use	Anti-social behaviour
1	Yes, one move.	GP <sup>1</sup>	No change, not engaged	Reduction still using alcohol and crack, not using heroin.	Improved, one incident then ceased
2	Yes	GP	Not applicable	Reduction Cannabis and alcohol still be used but not using heroin or qat	Improved, ceased
3	Yes	GP	Improved Mental health services & support group	Reduction in alcohol use, detoxification planned	Not applicable
4	Yes	GP	Improved Mental health services	Reduction in alcohol use and periods of abstinence	Reduction, minor incidents
5	Yes	GP	Improved GP treatment	Reduction in crack use.	Improved, ceased
6	Yes	GP	Not applicable.	No change. Heroin use.	Improved, ceased
7	Yes	GP, OT <sup>2</sup>	Improved GP & OT	Improved Alcohol worker	Not applicable
8	No	Not engaged	No change not engaged	No reported change. Crack/ heroin use.	Not applicable
9	Lost tenancy	Not engaged	No change not engaged	No reported change. Alcohol use.	No change, loss of tenancy
10	No	Hospital (inpatient)	Improved day centre	No reported change. On methadone script.	Improved, ceased
11	No	Attending clinic	Not applicable	No reported change to drug use	Improved, ceased
12	No	GP	No change, already in treatment	No change.	No change, on-going issues
13	Temp accom, rent arrears	GP	Improved, mental health services	Reduction alcohol use, but crack use ceased.	No change, on-going issues

<sup>1</sup> General Practitioner (family doctor) <sup>2</sup> Occupational Therapist.

Progress in addressing support needs was variable. However, there was considerable evidence of better engagement with health and mental health services and some indications of positive changes in use of drugs and alcohol. Four successes were notable, alongside the achievements of CAMHF in enabling housing sustainment:

- Registration with and use of a General Practitioner<sup>81</sup> (GP) service. In several cases the two specialist floating support workers in the CAMHF team reported that this was the first time that an individual had ever had an ordinary GP registration. GP registration is important as GP surgeries are effectively the gateway to wider National Health Service (NHS)<sup>82</sup>. Registration with a GP also helps ensure continuity of care. GP services have a lower financial cost than using emergency services in a hospital or specialist NHS or charitably funded services for homeless people and people sleeping rough<sup>83</sup>, which would have often been the only other option widely available to CAMHF service users prior to GP registration.
- Wider engagement with treatment for mental health problems, sometimes through use of both GP services and mental health services. Some engagement with mental health services was already in place at the point referral to CAMHF had occurred and contact with these services had been maintained. However, additional contact with mental health services also resulted from support from CAMHF. However, not all service users with severe mental illness or mental health problems had engaged with treatment.
- Alcohol and drug use, while remaining constant for a few people as at April 2013, had reduced, or changed beneficially, for some other CAMHF service users. In two cases, people who had been using heroin had stopped and in a further two cases work was on-going to reduce problematic drinking.
- There was a marked reduction in reported anti-social behaviour among some CAMHF service users who had previously exhibited anti-social behaviour. It is important to note that the people who had been involved in anti-social

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<sup>81</sup> Family doctor.

<sup>82</sup> <http://www.nhs.uk/>

<sup>83</sup> London does possess a number of specialist primary care services for homeless people (for example Great Chapel Street, <http://www.greatchapelst.org.uk>) but these services would not necessarily be within easy reach of the people using CAMHF services.

behaviour within Camden had often been moved some distance away from Camden. However, they were not reported to be returning to Camden, nor to be exhibiting anti-social behaviour on the street in the new areas they had moved to. Anti-social behaviour within hostels was not always recent, but it was also the case that with one exception - which led to a single, planned, move from one private rented flat to another - that the rehoused CAMHF service users were not causing neighbour disputes.

Financial management by the people using CAMHF appeared to be generally good. This must be seen in the context of referrals to CAMHF only including people without a history of serious rent arrears or service charge arrears, in that it would be anticipated that whatever their other needs, this was a group of people who had, more or less, kept control of their finances (see Chapter 2). Alongside this, it is important to also note that the financial management shown by the people using CAMHF was occurring in a very different context to when they were living in a hostel. Whereas the only payment might have been a service charge in a hostel, as a private rented tenant they were now responsible for managing all household bills.

Similar outcomes have been reported in research on other Housing First services, with high rates of success in housing sustainment for chronically homeless people being accompanied by positive, but also some more varied, results in relation to health, mental health and drug and alcohol use<sup>84</sup>. Some criticism has been directed at the Housing First approach on this basis (see Chapter 6).

### *Separating housing and support*

*Clients don't have to change, that's what makes this a Housing First service, so you're accepting someone in their entirety.* CAMHF team member.

Following the operational principles of the PtH model (see Chapter 2), CAMHF placed emphasis on the choices of service users being respected. The service was described by the CAMHF team as client-led.

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<sup>84</sup> Pleace, N. (2011) op cit; Johnson, G.; Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia* AHURI Final Report No. 184 AHURI: Melbourne.; Busch-Geertsema, V. (2013) op. cit.

*I suppose it is focused on what they want to do, what their goals are...there may not be that many options in terms of where they can move to, but what they do day to day, how they structure their day, what services they link into, what plans they want to work on first...it is very client-led in that way.*  
CAMHF team member.

The goal of CAMHF was seen by the CAMHF team as developing and improving skills for living more independently in the community, but not necessarily as expecting someone to reach a point where they were able to live without any support. CAMHF was open ended, within the time limit of the pilot, and while there was a broad goal to try to reduce support over the course of the first year where possible, there was not a policy to cut-off support after one year. Again, this approach reflected the broader operational principles of Housing First approaches (see Chapter 2).

*People are so institutionalised, all these things people don't know how to do, they've never even thought about, people can be like a kid, leaving home for the first time, you know, but these people are much older and have much less confidence. But it's an entirely different mind-set to living in a hostel with all the rules ...that are being forced upon you...to being self-directed, that is a massive shift, and that's the ultimate dream, for people to be in charge of themselves and to manage themselves.* CAMHF team member.

*Some people always need some support, I don't think that's an indicator that it's not succeeding, if people feel more included in society and their community and are more confident, can realise they have some potential, some self-worth and ultimately that will help them to live more independently.*  
CAMHF team member.

Like other Housing First services, CAMHF sought to encourage and support 'positive' behaviours among the people who were using the service. There were three areas in which the CAMHF service sought to encourage 'positive' behaviour:

- Encouragement and support to use health, mental health, social work and drug and alcohol services (this reflected the 'recovery orientation' of Housing First, see Chapter 2).

- Building up self-confidence, through enabling and supporting the people using CAMHF to handle practical tasks and engage with services independently, promoting independent living skills, also sometimes known as ‘daily living’ or ‘life’ skills<sup>85</sup>.
- Supporting people using CAMHF with managing their finances ensuring that rent, utility bills and other charges relating to their home and frequently checking the housing situation of service users.

People using CAMHF who had been rehoused generally ensured their bills were paid and seek help from the specialist floating support workers if they ran into financial difficulties. This was the one area where the CAMHF team took on more of a ‘regulatory’ role.

*The one thing that will be different is that you will pay the rent. What you do with the services and how you live is entirely your choice. CAMHF team member.*

Unlike some models of Housing First<sup>86</sup>, CAMHF worked on the basis that service users were directly responsible for their own finances and also directly responsible for their own tenancies, which they held. All financial decisions were made by the service users and there was no use of sub-tenancies or leasing arrangements by CAMHF. CAMHF service users were immediately responsible for their own homes once they had been housed. The support available was extensive, but, ultimately, service users had the same level of individual responsibility as any other individual would have in their own home.

However, successful financial management and compliance with the terms of a tenancy was not necessarily associated with other ‘positive’ changes in behaviour. For some people using CAMHF, the successful management of their home could seemingly co-exist with occasionally ‘going on a bender’<sup>87</sup> when, and if, their finances permitted them to do so. Research from the USA and Europe also shows

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<sup>85</sup> Jones, A., Quilgars, D. and Wallace, A. (2001) *Life Skills Training for Homeless People: a review of the evidence*, Edinburgh: Scottish Homes.

<sup>86</sup> Tsemberis, S. (2010b) op. cit.

<sup>87</sup> Colloquialism for sustained bout of drug and/or alcohol consumption over the course of two or three days or more.



that successful housing sustainment and continued drug and alcohol are not necessarily mutually exclusive, if a Housing First service is in place<sup>88</sup>.

## *Providing support*

### *The process of delivering support*

According to the CAMHF team, support needs ranged from an absence of basic living skills through to an extreme lack of confidence linked to very low levels of self-esteem. CAMHF service users had various support needs arising from poor physical and mental health and problematic use of drugs and alcohol (see Chapter 3).

As noted above, most of the people using CAMHF had often not lived independently before, while the remainder had not lived independently in ordinary housing for many years. From the perspective of the CAMHF team, this lack of experience could make the idea of an independent home seem intimidating to some service users.

*Just getting bills, it's completely alien, they just don't know what to do with them. Real anxiety over those sort of things, just organising information, files, where to keep things.* CAMHF team member.

However, it was the combination of limited experience, poorly developed coping skills and low self-esteem with support needs, that, from the perspective of the CAMHF team, presented the real challenges in delivering support. The core approach taken by the team was to encourage independent living skills, support engagement with health and support services and generally build up capacity to self-care and self-manage, processes that could be combined with efforts to promote self-esteem by helping someone feel more 'capable'. This meant that the specialist floating support workers were in some senses never dealing with a single issue, it was always a set of interconnected support needs that had to be addressed.

*We hope, as much anxiety as there is around coping skills, we hope that we can get people to be more confident, and if they can't manage a particular thing themselves to access someone who can help them with it. Like with*

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<sup>88</sup> Tsemberis, S. (2010a); Busch-Geertsema, V. (2013).



*benefits<sup>89</sup> claims, there are places that will help you with that, it's about getting the confidence to go yourself, rather than having to rely on us. CAMHF team member.*

*It is very holistic, in that sense, because you just can't separate out one need from another, not in this work. CAMHF team member.*

Patience, centred on allowing people using CAMHF time and space, and in not having unrealistic expectations, were frequently emphasised by the CAMHF team. In practice, this meant that the first steps towards a more independent life might take a long time to arrive and might initially only be very small.

*I think the level of support needed, it's so simple, so basic, it's like the first time they moved out of home... It really is working in little baby steps...showing how stuff we just take for granted works. CAMHF team member.*

*It's often on a really, really simplistic level, you know making phone calls for people, they are always like 'I don't want to do it, I can't do it, I can't do it' and it's always a case of supporting them over and over again until they can do it. CAMHF team member.*

*It's been a slow process getting [service user] to open up and talk about these issues, she thinks, I suspect part of it is that [service user] thinks she does not deserve any help...she sort of says 'I won't qualify for it', 'I don't need that' so it's a slow process to get her to, because all the support is obviously self-directed, to actually get her to engage with certain services, it's a process of persuasion. CAMHF team member.*

Alongside this, the CAMHF team made the point that, although on the surface, the people using CAMHF appeared to have 'similar' characteristics, there was a complex reality of *variation* in need. Some other models of Housing First also operate

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<sup>89</sup> i.e. welfare benefits.

with an assumption that different service mixes may be required for each service user<sup>90</sup>.

*Mixed bag really, I mean I've got one client who has very high needs in terms of physical health and substance use and just every aspect really needs coordination and then I've got another person who really just does not need the same level of input, it's really variable. CAMHF team member.*

*I mean there's always the basic stuff when people move into the flat, but how someone manages the move is completely different, who organises it is completely different, so there are few standard things, but actually they are all pretty different. CAMHF team member.*

The CAMHF service users were people who had been within the Camden Hostels Pathway, often for many years, without their homelessness being successfully addressed. For the CAMHF team, this could mean that their initial encounters with service users involved working against their cynicism about CAMHF as a service framed within a general distrust of homelessness service providers.

*With practical stuff we get people to get bank accounts and do work around understanding about bills, really practical kind of stuff, applying for benefits that kind of thing. We spend a lot of time kind of cultivating the relationship between ourselves and the service user. Lots of people who have been in the [Camden Hostels] Pathway for a long time, in the system, kind of feel resentful towards workers generally, you know, everyone hates their key-worker don't they?...We spend a lot of time, showing that, although we're the same kind of role as the key-worker, we are the person who will support them, sort things out...we have the advantage that we are going to be getting them a flat, so they kind of have to talk to us anyway, but we do sort of spend time on that relationship, making it trusting, we do a lot of work around the emotional stuff as well, because that's going to be impact everything. CAMHF team member.*

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<sup>90</sup> For example the different uses of ACT and ICM teams within the Pathways Housing First model (see Chapter 2).

### *Managing a supportive working relationship*

Two issues that could arise in a supportive working relationship with chronically homeless people were talked about by the CAMHF team. The first issue was the management of emotional boundaries, including isolation and boredom among people using CAMHF. The second issue was management of a process that aimed to encourage and support, but never to 'push', the people using CAMHF towards behaviours that would reduce risks to their well-being and enhance their chances of housing sustainment.

Someone who has been socially isolated for prolonged periods may emotionally over-react towards a worker whose job is to be concerned about their well-being. The phenomena of homeless people describing support workers as 'friends' or 'best friends', rather than seeing only what a support worker regards as a 'working relationship', has long been reported by homelessness research<sup>91</sup>. Awareness that such problems could occur was built into the delivery processes for CAMHF and the specialist floating support workers were also highly experienced individuals with access to support from their line manager. The parameters of the working relationship were made very clear to someone using the CAMHF service from the outset and management of inappropriate emotional responses was not viewed as problematic. The relationship with a service user was described as needing to be honest and open, but also as boundaried, because it had to be focused on effective service delivery.

*I think that rapport is really important, because there's a level of honesty required that there doesn't need to be there in a hostel. Yeah, in a hostel, whenever there is a crisis, it's dealt with, there's a team there to do whatever, but when someone is on their own, you kind of, because we do want them to succeed, we do have to build a really quite intense rapport, obviously with the boundaries still in place as well, it is a fine balance, that relationship is very, very important. CAMHF team member.*

Dealing with social isolation and boredom was closely linked to the successful management of emotional responses from service users. As noted above, several of

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<sup>91</sup> Pleace, N. (1997) 'Rehousing single homeless people' in Burrows, R.; Pleace, N. and Quilgars, D. (eds) *Homelessness and Social Policy* London: Routledge, pp. 159-171.

the people using CAMHF lacked social supports at referral. The approach of the CAMHF team was that while they could not under any circumstances act as 'friends', when isolation and boredom arose, they could use these as a way to help encourage engagement with the outside world.

*[service user] has talked about being bored, and I've tried to use the boredom as a tool, to discuss what else he would like to do, that was the catalyst for getting him involved in activity and to discuss detox, he's still quite passively engaged with it, but he's been to the service. CAMHF team member.*

The CAMHF team were clear about the line between encouraging and supporting someone, which was the proper role of CAMHF, and effectively pushing someone into something they did not want to do by insisting that they act in a particular way.

*So much of it is about treating an adult like an adult, getting your message across, most of the time with humour, and actually being there when they do change their minds about things. CAMHF team member.*

*It's not really for us to tell somebody what to change, we can advise and give them their options or explain the consequences, but without the nagging thing attached to it. CAMHF team member.*

### ***Safety and risk management***

The people using CAMHF were in some instances individuals who had been assessed by other homelessness services as representing a risk. That risk could be to themselves, for example in those cases where someone had attempted suicide, or was thought to be exhibiting suicidal ideation. Potential risks, in a few cases, involved a history of aggressive behaviour and actual violence towards other hostel residents, or towards hostel staff .

Referral processes involved the sharing of any risk assessment that had been completed when an individual was within the Camden Hostels Pathway. No issues were reported around the sharing of information about potential risk, or information sharing more generally, when it came to people being referred to CAMHF from the Camden Hostels Pathway. In addition, it was sometimes the case that referrals came

from SHP run hostel services within the Camden Hostels Pathway, which meant that an individual referred to CAMHF could already be known to the CAMHF team.

As there were potential risks, the specialist floating support workers tended to supplement the documentation that was available at referral with their own enquiries, to be clear who exactly they would be working with. There was no evidence that CAMHF did not engage with people exhibiting high levels of need and what could be extremely challenging behaviour, nor was there any evidence of reluctance by the CAMHF team to engage with people with a history of threatened or actual violence.

*For every referral we get, as well as the referral process, we do our own digging, we get as much, as clear a picture as possible. But there are, there will be, clients who show a certain level of aggression.* CAMHF team member.

The resource levels available to CAMHF were limited (see Chapter 2), but there was scope to undertake double visits, involving both specialist floating support workers at once, when a particular risk was thought to exist. This was not something that was regularly found to be necessary. As of April 2013, there had been one reported incident where a specialist floating support worker had been physically threatened by someone using the service, which incident had been successfully contained. Preparatory meetings, those initial meetings with a specialist floating support worker prior to moving someone into a flat, were also seen as an important part of assessing risks for an individual and for CAMHF as a service.

*...that's part of the reason for the first couple of weeks of meetings...is to explain to someone how intensive the work is. Because it's not just about what we're asking people to look at and to manage, it's about the change they'll be making as well, but if someone's not able to manage those meetings - we go to the place where they live - if someone's not able to manage that, then that would be an indicator of how chaotic they are.* CAMHF team member.

## **Social and Economic Integration**

Homeless people are quite often *portrayed* as deeply alienated and very far removed from normal social and economic life. Recent research shows that chronically homeless people have complex and varied relationships with family, friends and

society and shows that there are dangers in thinking of chronically homeless people as necessarily being very 'distant' from the rest of society<sup>92</sup>. For example, several of the CAMHF service users had quite lengthy careers before they became homeless, had been in relationships and had children.

There is also a need for caution in talking about the social and economic integration of homeless people. Social integration can sometimes be judged according to whether someone is socially engaging with neighbours and participating in community activities. However, rates of community participation and contact with neighbours, for example, are often very low among ordinary British citizens, who can have extensive, but geographically dispersed, social networks, and who may rarely, if ever, interact with the people living near them<sup>93</sup>.

The CAMHF team reported that sometimes service users had to learn or re-learn the sets of behaviour that were seen as normal by society. Challenges in social interaction were not universal, some people using CAMHF were articulate and well used to engaging successfully with a range of service providers and with wider society, but, for some of the people using CAMHF, it could be more difficult.

*Suddenly you are in a flat, how do you see yourself in the community? With this client group it is very easy to go "oh these are all my problems", which you would not do in normal social settings, and be judged on that. CAMHF team member.*

The process by which this socialisation of the people using CAMHF took place was described as being slow, hesitant and also fragile. The CAMHF team talked about both the successes and the challenges that could arise as people using CAMHF were settled into their neighbourhoods.

*There is a local florist, who, two very lovely women have taken [service user] under their wing and [service user] goes and sits there and has a cup of tea and if they are busy [service user] gives them a hand, that's a really positive relationship. CAMHF team member.*

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<sup>92</sup> O'Sullivan, E. (2008) op. cit.

<sup>93</sup> Savage, M.; Bagnall, G. and Longhurst, B. (2005) *Globalization and Belonging* London: Sage.

*It's a massive thing, for people who've been like completely socially excluded from mainstream society to then actually be a part of it, you know they may not be the most productive members of society, but they are still part of it...CAMHF team member.*

Although they might present with issues including mental health problems and problematic drug and alcohol use, several of the people using the service were described as capable of being highly socially functional. In other words, some of those people using CAMHF were described as able to 'pass'<sup>94</sup> for short periods, presenting themselves as 'normal', at least in the sense of what other people defined as 'normal'.

*...whether or not you'd be able to get them through a viewing with a letting agent, which takes about 15 minutes and then sign up, the tenancy sign up, which will take about half an hour, maybe an hour, its whether you can get someone through those things without the letting agent going "you know what mate? Not a chance, go away, get out of my office". We do have conversations with people about how they should present, get suited and booted<sup>95</sup>, scrubbing your nails and people do take it quite well actually. CAMHF team member.*

Economic integration, in the sense of the people using the service securing paid work, was not an immediate goal for the CAMHF service. The degree to which people using CAMHF were distant from the experience of working in the formal economy was, as noted above, highly variable. Among the service users there were skilled workers, including a chef and an electrician, and also people who had little or no experience of paid work. In those cases where people had a work history, including those who had once had skilled jobs, it was years since they had last been in paid work (see Chapter 3).

Engagement with education, training and employment was thought to be a difficult goal to achieve and as sometimes being unrealistic, at least in the short term, by the CAMHF team. In some cases, people using CAMHF were viewed as too ill or

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<sup>94</sup> 'Passing' refers to an individual's capacity to conceal characteristics that might otherwise lead to their being stigmatised and encountering prejudice, see: Goffman, E. (1963) *Stigma* London: Penguin.

<sup>95</sup> i.e. dressed in a smart and presentable way.



disabled to be able to undertake most forms of paid work, and sometimes on-going drug and alcohol use and mental health problems could also act as barrier to education, training and employment. At the point of the last stage of fieldwork in March to May 2013, none of the people using CAMHF were engaged with formal education, training or in paid work. There is wider research evidence suggesting that particular challenges exist in attempting to connect long term/chronically homeless people and people engaged in problematic drug use in education, training and employment<sup>96</sup>.

*Anything slightly structured with the clients we are working with is a massive, massive achievement, so paid work is not something we would envisage within the next year with any of the people we are working with.*  
CAMHF team member.

## Cost Effectiveness

CAMHF had an approximate support cost of £9k per person per year, or £173 per person per week<sup>97</sup>. This compared to average support costs of £10.6k, per person, per year, to provide support for someone in a hostel designed to resettle lone homeless people (£203 per person, per week)<sup>98</sup>.

These costs did not include rent. Approximately £9.6k per year would be needed for a CAMHF service user unable to pay their own rent. The rent for a CAMHF service user would be at least £800 per month or £185 a week, and sometimes more, for a one bedroom or studio apartment in the private rented sector. Similarly, an extra £10.4k per year would be needed to meet the rental costs for someone in a homeless hostel. A hostel designed to resettle lone homeless people would typically charge

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<sup>96</sup> Singh, P. (2005) *No Home, No Job: Moving on From Transitional Spaces* London: Off the Streets and Into Work; Kemp, P. and Neale, J. (2005) 'Employability and Problem Drug Users', *Critical Social Policy*, 25, 1.

<sup>97</sup> Based on a £90k budget, €106.9k, \$140.4k (USD), \$153.8 (AUD) per year, with CAMHF supporting ten service users at any one time.

<sup>98</sup> Hostel and supported housing costs supplied by Camden Council, November 2012. Figures given are approximate as contractual relationships between Camden and homelessness service providers meant the precise amounts paid were kept confidential. Based on projected expenditure for 2012/13, the support costs for a single bed in a hostel for single homeless people or single homeless women within the Camden Hostels Pathway was an average of £205 per week, with a median cost of £192 per week. Total support costs for Camden Council could vary from an (approximate) low of £125 to a high of £600 a week, depending on the extent and nature of support a hostel was providing.



approximately £200 per week, i.e. £860 per month, for rent<sup>99</sup>. In both cases, the full cost of rent would have been met by the welfare benefits system, as these rent levels were within the cap (limit) set by the Housing Benefit system.

In 2012, average weekly total costs for someone living in a hostel, designed to resettle lone homeless people, including both support costs and rent, would be around £403 per week<sup>100</sup> (£203 of which was support cost). This compared to an approximate average total weekly cost of £358 for CAMHF (£185 of which was rent and £173 of which was support costs)<sup>101</sup>.

Potentially, CAMHF could cost significantly less than some more specialist hostels, once someone had been housed. Average support costs were £338 per week for intensive, specialist drug, alcohol and mental health hostels, plus approximately another £200 for rent (i.e. around £538 a week<sup>102</sup>). This compared to £173 for CAMHF support costs and £185 a week in rent (£358 a week, on average), i.e. approximately £200 a week less. However, the extent of any financial savings would be determined by the time someone actually spent in specialist hostels offering more intensive support. In addition, the specialist hostels may provide health and care services that would otherwise be funded by the National Health Service (NHS) or Camden social services, so that while more expensive than CAMHF, a specialist hostel might be reducing costs for health and personal care providers while it is working with a chronically homeless person.

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<sup>99</sup> Hostels may also make a personal service charge which would again be paid by the welfare benefits system, which in some instances may be quite high because it includes, for example, the cost of providing meals. Rent levels may also have sometimes been higher.

<sup>100</sup> Some hostels may also have made additional supplementary charges.

<sup>101</sup> Total costs may have been higher as rent levels for CAMHF service users and hostel residents may sometimes have been above these figures. Caps limited the amount of Housing Benefit that could be claimed towards rental costs during 2012. As of April 2013, income from welfare benefits, such as disability benefits and unemployment benefits cannot exceed £350 per week for a lone person, this includes welfare benefit contributions towards rental costs. <http://www.dwp.gov.uk/docs/hb-benefit-cap-draft-regs-2012-memorandum.pdf>

<sup>102</sup> Source: Camden Council, November 2012, figures are approximate.

Table 4.3 summarises the approximate cost differences between CAMHF and hostel services.

*Table 4.3: Approximate relative weekly expenditure for CAMHF and hostel services*

Type of service	Weekly support cost	Difference from CAMHF	Weekly rent cost	Difference from CAMHF	Total cost	Total difference from CAMHF
CAMHF	£173	£0	£185	£0	£358	£0
Hostel	£203	+£30	£200	+£15	£403	+£45
Specialist hostel	£338	+£165	£200	+£15	£538	+180

*Figures for hostels are approximate averages (source: Camden Council). Figures for CAMHF are also an approximation (source: SHP). Rent levels may have been higher for CAMHF service users and for hostel residents in some cases.*

Table 4.4 summarises the expenditure on support costs which Camden Council had potentially saved, using average (mean) and median support costs. The data are based on the time people using CAMHF had not been in hostel places as at 1<sup>st</sup> April 2013.

The cost of CAMHF was approximately £90k per year (see Chapter 2). The cost of support provided by CAMHF had been offset by approximately a £70k reduction in spending in hostel support costs (based on average hostel support costs, see Table 4.4).

Over the life of the CAMHF service, up until 1<sup>st</sup> April 2013, just under £70k of the total £90k support costs for CAMHF could have been offset by savings in expenditure on hostel support costs (see Table 4.4). The potential savings shown in Table 4.4 would have been higher if the people using CAMHF would have otherwise been resident in specialist drug and alcohol/mental health hostel provision (£338 in support costs on average, compared to £173 for CAMHF).

Table 4.4: Estimated savings in hostel support costs generated by CAMHF

Service user ID	Days housed at 1 <sup>st</sup> April 2013	Weeks housed at 1 <sup>st</sup> April 2013	Average weekly hostel support costs	Total estimated savings in hostel support costs
1	363	51.9	£203	£10,536
2	250	35.7	£203	£7,247
3	243	34.7	£203	£7,044
4	230	32.9	£203	£6,679
5	56	8.0	£203	£1,624
6	55	7.9	£203	£1,604
7	154	22.0	£203	£4,466
8	0	0.0	£203	£0
9	181	25.9	£203	£5,258
10	0	0.0	£203	£0
11	0	0.0	£203	£0
12	0	0.0	£203	£0
13	880	125.7	£203	£25,517
Total	2,412	344.7	-	£69,974

Figures for hostels are approximate averages (source: Camden Council).

Table 4.4 assumes that the CAMHF service users would have remained in hostels if CAMHF had not been available. However, based on the use that CAMHF service users had hitherto made of hostels, there are reasonable grounds to assume that most would have remained in hostels if CAMHF had not been available. Actual cost offsets are not possible to calculate because the pattern of hostel use that the people using CAMHF would have had, in the absence of the CAMHF service, is not known.

CAMHF potentially represented a more *efficient* use of public expenditure because it had better outcomes in terms of taking chronically homeless people out of homelessness and had also achieved successes in relation to health, well-being, drug and alcohol use and anti-social behaviour (see Table 4.2). It is noteworthy that CAMHF was not necessarily markedly cheaper than hostel services, either in terms of support costs or rental costs. CAMHF appeared to deliver better outcomes for chronically homeless people overall, making it a potentially more efficient use of money, but CAMHF was not a low cost homelessness service. These estimates need to be treated with some degree of caution, however, as when the research stopped, not all CAMHF service users had been housed and some had not been housed for very long (see Chapter 6). The evidence from elsewhere in the world also suggests that Housing First services are a generally more *efficient* use of existing resources -

because Housing First reduces levels of chronic homelessness more effectively than staircase services - but also that Housing First is not a low cost service model<sup>103</sup>.

There are other variables that should ideally be incorporated into any cost benefit analysis. Positive outcomes were not universal, but CAMHF had reduced anti-social behaviour and appeared to be helping some people towards better health and well-being (Table 4.2). There are potential economic gains for Camden in reducing the kinds of nuisance behaviour on the street that some chronically homeless people using CAMHF had presented with in the past, and which CAMHF had sometimes ended. There may be savings in the medium term for NHS services if some people using CAMHF start to see an improvement in their health, particularly if their use of emergency hospital and emergency psychiatric services is reduced.

CAMHF might potentially have raised some costs. For example, support from CAMHF may enable people to access NHS, social work and other services that they needed, but were not hitherto engaged with. In the short term, while the well-being of CAMHF service users would increase through better access to necessary health care, the total costs to the public purse might, at least temporarily, increase.

The temptation, for some policy makers and commissioners, will be to 'dilute' the Housing First model, lessening the intensity of the service, reducing the range of support provided, significantly increasing the number of people that each worker has to support and also time-limiting support. This effectively changes a Housing First approach into a *low intensity* housing-led service, using a case management model, such as the tenancy sustainment service model which is widely used in Britain and Northern Ireland<sup>104</sup>. Tenancy sustainment services can be effective<sup>105</sup>, but they are not a form of Housing First<sup>106</sup>.

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<sup>103</sup>Culhane, D.P. (2008) 'The Cost of Homelessness: A Perspective from the United States' *European Journal of Homelessness* 2.1 (2008): 97-114.

[http://works.bepress.com/dennis\\_culhane/82](http://works.bepress.com/dennis_culhane/82)

<sup>104</sup> [https://supportingpeople.st-andrews.ac.uk/publications/annualReports/Annual\\_Report2011\\_12.pdf](https://supportingpeople.st-andrews.ac.uk/publications/annualReports/Annual_Report2011_12.pdf)

<sup>105</sup> See Lomax, D. and Netto, G. (2008) *Evaluation of Tenancy Sustainment Teams* London: Department of Communities and Local Government.

<sup>106</sup> Pleace, N. (2011) op. cit; Pleace, N. (2012) op. cit.; Pleace, N. and Bretherton, J. (2013a) op. cit.

## Camden Housing First Service Outcomes

This research presents evidence that CAMHF was delivering housing sustainment for chronically homeless people with very high needs, who had either never lived independently, or had not done so for a long time. There was evidence that improvements to health and well-being resulted from engagement with CAMHF and also of reductions in anti-social behaviour.

The CAMHF service was engaging with one of the hardest to reach groups of chronically homeless people in London. CAMHF was successfully working with, and had also re-housed, people who had been assessed as not 'housing ready' by homelessness services within the Camden Hostels Pathway.

Limitations exist for any homelessness service and CAMHF was not an exception. In common with many other Housing First services which have been evaluated, gains in well-being and positive changes to drug and alcohol use were neither immediate nor universal. Housing had not been secured or sustained, for all service users at the point the research came to an end.

The challenges around securing and sustaining an adequate supply of affordable housing in the private rented sector in London were, and will remain, considerable. CAMHF was unlikely to be able very quickly re-house someone. The findings on the limitations of CAMHF need to be balanced against what it is realistic to expect a single service intervention to achieve (see Chapter 6)

## 5 The Views of Service Users

### Introduction

This chapter explores the views of the people using Camden Housing First (CAMHF) about the service. The chapter is based on six qualitative interviews with the people using CAMHF that were conducted both face-to-face and over the telephone during the July 2012 and May 2013. The chapter begins with a discussion of the sense of ‘home’ that the people using CAMHF had, and what resettlement into ordinary housing could mean to them. This is followed by a review of service users’ opinions about the support that CAMHF was providing.

### Housing and ontological security

*I'd been living in the hostel so this is great.* CAMHF service user.

Ontological security, a sociological term, refers to what might be termed ‘life security’, which is the need that everyone has to feel safe, that their life is not out of their control and is stable and predictable, all of which are important in making most people feel secure. Part of this ‘life security’ comes from our relationship with where we live, which relates not only to physical accommodation but also our emotional response to that accommodation. In Australia<sup>107</sup> and the USA<sup>108</sup>, the concept of ‘ontological’ or life security has been used to try to understand homelessness in a broader sense than the simple lack of adequate housing.

The European Typology of Homelessness (ETHOS) addresses some of the issues by defining homelessness not simply in terms of a lack of housing, which it calls the ‘physical domain’, but also in terms of the ‘legal domain’ and the ‘social domain’. Homelessness according to ETHOS is centred on a lack of suitable housing (the physical domain), a lack of legal security, i.e. security of tenure in the form of a legal tenancy or deed (the legal domain) and a lack of private living space in which someone can enjoy normal social relationships, which is closely linked to the

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<sup>107</sup> Johnson, G. and Wylie, N. (2010) *This is not Living: Chronic Homelessness in Melbourne*  
<http://www.sacredheartmission.org/Assets/Files/J2S1%20This%20is%20not%20living.pdf>

<sup>108</sup> Padgett, D. (2007) ‘There’s no place like (a) home: Ontological security among persons with a serious mental illness in the United States’ *Social Science and Medicine* 64, pp. 1925-1936.

difference between somewhere being 'home' and just a building one lives in (the social domain)<sup>109</sup>.

There was evidence from the interviews with people using CAMHF that the service was improving their ontological security in two senses. First, CAMHF was removing them from living situations in hostels, in which they did not feel that life was safe, secure or predictable. Second, CAMHF was providing them with housing that they could regard as a 'home' for what was often the first time in their lives or after experiencing a prolonged period of homelessness.

Some people using CAMHF talked about hostels as spaces in which they felt they were exposed to behaviour that they wished to get away from. Their own home, or the chance of their own home, offered what was seen as a better alternative.

*Circular thing, you know, day to day, have to go out, look for money, got no money, have to steal something, you know what I mean, so, once you are fed up with that...you don't want to be around people that still carrying on with it, because although you've stopped it's always in your face, you know what I mean? CAMHF service user.*

*A lot of users about the place and I have found it quite hard to try and say no. CAMHF service user (interviewed while still within hostel).*

*When you live in a hostel...eighty per cent of your neighbours...are users and they knock on your door, not wanting drugs but wanting something to use for the drugs, like a lighter. They remind you of the drugs...twenty-four hour contact with drug addicts. CAMHF service user.*

For some of those people using CAMHF who had been rehoused, having their own living space, their own front door and feeling safe and secure in a home of their own was very important. Life was described as better, more secure and also as happier.

*You feel more human. When you live in the hostel...it's like an open prison. You cannot take anybody there... it's like freedom. CAMHF service user.*

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<sup>109</sup> <http://www.feantsa.org/spip.php?article120>

*It's kind of nice. No-one is being the boss, I am the boss...I am a fan of my own space.* CAMHF service user.

*It has changed...before I had depression but it's not so bad now.* CAMHF service user.

*More freedom...you don't feel like you're living in your own place when you live in a hostel....you feel like you're living with your mother!* CAMHF service user.

The value of a home was also talked about in terms of the need to make sure nothing went wrong. For example, one CAMHF service user talked in terms of budgeting very carefully to ensure that there was no risk of rent arrears or problems in paying the utility bills.

*I'm just determined to keep it...keep up with the rent and paying the bills.* CAMHF service user.

The anticipation of what a home was going to be was important to some of those people using CAMHF who were interviewed prior to the point of re-housing. The sense of having a secure place to live and a private space that they could control could very important to service users and appeared to be the major reason for engaging with CAMHF. Some research in the US has suggested that successful engagement of Housing First services with chronically homeless people has rested in part on the promise and delivery of their own home<sup>110</sup>.

*Well, when I get there I'm going to paint it, I'm doing a red, black and white scheme, for me this I want to be my last move...it is about time I settled, I've been a bit of gypsy, been here there and everywhere, but the flat means a lot to me, a Hell of a lot, when I got accepted on the scheme, it wasn't that long ago, we're talking a month ago, and all this has happened, it's gone quite quickly, and it's been done to plan, you know what I mean, so yeah...to feel settled.* CAMHF service user (interviewed while still in hostel).

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<sup>110</sup> Tsemberis, S. (2010b) op. cit.



There could however be some issues with the housing that CAMHF was able to access. London's housing market meant that the options available to someone reliant on benefits to pay the rent were restricted. Housing was checked by the CAMHF team, and the best available was secured but always within the constraints of what could be afforded for people reliant on Housing Benefit (see Chapter 4).

*I think its ok but it's got a lot of problems...It's an old property.* CAMHF service user.

*I like the area but I don't feel too safe in my flat because of the lack of security on the door.* CAMHF service user.

Housing could not generally be secured within Camden itself (see Chapter 4). Sometimes, as the CAMHF team noted, service users were not always entirely realistic about what was going to be available to them.

*What I want is to be able to live in Camden in a rent controlled situation where I can live on my own, pay my rent and go back to work.* CAMHF service user.

## **Meeting support needs**

### ***Overall views of CAMHF***

*It's been helpful... you know what I mean, got me into this place, away from things I didn't want around me, and trying to help me get back on my feet...CAMHF service user.*

*It's been brilliant, yeah, very good, she's [specialist floating support worker] been brilliant, and she's always, when she's said she's going to be there, she's been there, not let me down, you know? She came with me every time to view the flats because we've viewed three, she was there with me, she didn't let me go on my own. And every now and then she rings me and asks me how I am... CAMHF service user.*

Views of the CAMHF service were generally positive. Service users tended to praise the extent and quality of the support they had received from the CAMHF team.

*I've found it to be great...just the general support.* CAMHF service user.

*She's been a hundred per cent behind me...[support worker] has been very supportive.* CAMHF service user.

*I think it's a very good service, do you know what I mean, a good management team...I feel like I've got somebody around me.* CAMHF service user.

*They were on top of everything and it was very quick.* CAMHF service user.

*It's very good...SHP helped me with everything.* CAMHF service user.

### ***Managing their housing***

Management of their housing could be a challenge for the people using CAMHF because their finances were often very restricted. None was in paid work during the period of the fieldwork for the research. There could be concern about meeting the costs of utilities, particularly paying gas and/or electricity bills.

*...the lighting and water, so deducting all that, deducting my food, deducting my dog's food, all that...so it's going to be quite tight, you know, budgeting and that, it's not like in a hostel where you don't pay your rent or the bills.*  
CAMHF service user.

*I don't hire nothing, I don't take out no loans, you know because I am fearful of being able to pay them back, you know I don't do overdrafts.* CAMHF service user.

### ***Health and well-being***

The people using CAMHF generally had rather poor health status and also presented with high rates of problematic drug and alcohol use. When asked about their health and use of drugs and alcohol, they reported the same patterns to those indicated by the CAMHF team, sometimes better engagement with support and treatment, but no sudden gains in their health or well-being over the period covered by the research.

These findings have to be seen in the context of the people using CAMHF being characterised by long-term limiting illness and physical disability. They were also sometimes people with a long term history of mental health problems and sustained, problematic, use of drugs and alcohol (see Chapter 3). In some senses, while their health and well-being may have had considerable potential for improvement, some of their conditions could only be treated and mitigated, rather than cured. For the most part, this was not a group of people who would enjoy full physical health again in their lives and who knew this to be the case.

*Health is fair, won't get better or worse, TB has damaged my lungs, got Hep C in the hostel, that will get better.* CAMHF service user.

*I can walk about, but the mental side, that is not so clever<sup>111</sup>.* CAMHF service user.

*Do get depressed. Anxious. Once in a while, all them wasted years, my health I done to myself, wonder how long I am going to live now.* CAMHF service user.

Some people using CAMHF talked about reducing and changing, though not necessarily stopping, their use of drugs and alcohol. In terms of alcohol, if someone using CAMHF reported a change, it was a reduction on consumption, though this was not always a reduction to within what are regarded as safe limits<sup>112</sup>. With drugs, there might be a shift away from Class A substances and towards Class B and C drugs<sup>113</sup>. Some service users also reported they were seeking help with drinking or with drug use, which was generally with the support of CAMHF.

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<sup>111</sup> 'clever' used as slang term for 'good'.

<sup>112</sup> The limit for women and men recommended by the National Health Service is the equivalent of 2-3 or 3-4 units a day. A large can of beer is 2 units and a large glass of wine is 3 units.

<sup>113</sup> Different forms of drug carry different legal penalties, with Class A being treated the most seriously and Class C the least seriously. Class A drugs include crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth). Class B drugs include amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine) and Class C covers anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), ketamine, piperazines (BZP). Legal enforcement has become more challenging as new substances appear at a rate that exceeds the speed with which they can be assessed.

*I'll be honest with you, if someone's wandering around in the street and smoking a spliff or whatever, I'll smoke a couple of puffs or whatever, but I ain't paying for it. CAMHF service user.*

*I do drink every day, 5-6 cans, that is cutting down, that is half of what I was drinking...detox is being sorted out...sometimes I do not drink until the afternoon...I don't get the shakes. Not as bad as some, don't wake up with the shakes, but I want to sort it. CAMHF service user.*

### ***Boredom, isolation and social support***

Boredom and isolation could sometimes be issues for the service users. One CAMHF service user who was interviewed at the point at which they had just moved into a private rented flat without a working television talked about how important television was to them. More generally, several people using CAMHF spent significant time watching television, including some people who had limited mobility.

*I do get bored, I love my TV...I like to watch other people's issues, it makes my problems not look as bad. CAMHF service user.*

However, some of the people using CAMHF had social networks and were able to spend time with family and friends. There was also the potential to use their flats as a means to socialise, to have people visit and stay in a way that had not been possible when they were in a hostel.

### **The views of service users**

The findings of the interviews with CAMHF service users were generally very positive about the support they were being provided with. Those who had been rehoused at the point of their interview were generally, though not universally, pleased with their housing and reported positive feelings about their homes, emphasising the improvements brought about by having their own space. There were also some positive comments about being removed from the proximity from drugs and alcohol that could be feature of life in some hostels.

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Gains in health and well-being, as well as in social support, could sometimes be variable according to the people using CAMHF. Health could be damaged to a point that people were going to remain ill for the rest of their lives and issues around mental health problems, boredom and isolation could also be on-going for some respondents.

## 6 Conclusions

### Introduction

This final chapter discusses the findings of the research. The first section of this chapter is a discussion of the effectiveness of Camden Housing First (CAMHF). The second section of this chapter relates the findings of this research to wider debates about Housing First.

### Effectiveness

#### *Ending homelessness*

The main finding of this research was that CAMHF was *stopping* chronic homelessness. The people being housed by CAMHF were people who had become 'stuck' within a staircase system which had defined them as not being housing ready. CAMHF was not universally successful, nor during the period covered by the research, had CAMHF achieved housing sustainment for long periods. In addition, some of the people using CAMHF were awaiting re-housing when the research came to an end. Nevertheless, CAMHF was housing chronically homeless people whom other homelessness services had repeatedly assessed, over periods of three years or more, as being *unable* to live in ordinary housing.

CAMHF had successfully housed a small group of chronically homeless people who had either never lived independently before or had not done so for a long time. The CAMHF team also successfully engaged with chronically homeless people with very high support needs whom other homelessness services had found to be challenging to work with. There was evidence of improved engagement with health services, some reductions in drug and alcohol use and reductions in anti-social behaviour. Again, this success was not universal or consistent, but there was evidence of improvements to well-being resulting from using CAMHF.

This was all achieved using only private rented housing, affordable by people reliant on welfare benefits, within the highly stressed housing market of one of the most expensive places to live in the world<sup>114</sup>. The outcomes that CAMHF was able to

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<sup>114</sup>[www.london.gov.uk/priorities/housing-land/publications/london-housing-market-report-q4-2012](http://www.london.gov.uk/priorities/housing-land/publications/london-housing-market-report-q4-2012)

deliver were produced by a two worker team with 75 hours per week between them and a service manager who had other responsibilities alongside the CAMHF service.

### *The reasons for the effectiveness of Camden Housing First*

The research findings indicate that there were seven main reasons why CAMHF was achieving the successes which are described above:

- Resource levels were, in the British context, relatively high in terms of the time that the specialist floating support workers were able to devote to each person using CAMHF.
- CAMHF staff were experienced professionals who had longstanding histories of working in homelessness services and with chronic homeless people. The CAMHF team were also familiar with working within Camden and the surrounding areas.
- The CAMHF team had rapidly familiarised themselves with the private rented market and with the estate agents that were potential sources of suitable housing. Careful building and maintaining of relationships with estate agents was the reason why CAMHF had been able to provide suitable private rented sector housing.
- The intensive case management (ICM) provided was highly flexible and adaptive, allowing the CAMHF team to meet a wide range of support needs.
- While there was a broad goal to reduce support over time, when and if independence increased, CAMHF was providing open-ended support that could be reactivated if issues arose sometime after re-housing. The continuity of the relationship between the specialist floating support workers and the people using CAMHF was also important in building working relationships, trust and delivering positive outcomes.
- There was clear and careful management of the working relationship between the CAMHF team and the service users. This did not preclude issues and challenges arising, but it was clear what CAMHF could address and at what point needs should be addressed by referral to other services, if the service user agreed to it.

- Reflecting wider evidence, the decision to follow a Housing First approach directly contributed to positive outcomes that CAMHF achieved (see chapters 2, 4 and 5).

### *Expansion of the Camden Housing First approach*

There is sufficient evidence from this research to consider expansion of the CAMHF approach. Possible areas for expansion are twofold.

First, it seems probable that the CAMHF approach would be effective in supporting the larger group of people with high support needs who have become ‘stuck’ in the Camden Hostels Pathway. A larger service, using more specialist housing support workers could be built. Equally, the CAMHF model could be more widely applied in London.

Expansion of the CAMHF approach would have to be combined with an expansion in resources and the current staff ratio of one worker to an active caseload of no more than five would have to be retained. If CAMHF were working with a caseload of 80 service users, it would need to have 16 specialist support workers with an active caseload of five service users each.

Similarly, the use of highly experienced professional staff which was a feature of the CAMHF project would need to be replicated because only such staff can be expected to engage successfully with such a high need group. Training is important here, but so too is experience. This is not an easy group of people to work with. Equally, the skillset of workers needs to include the capacity to successfully engage with private landlords and estate agents.

Second, it seems logical to consider targeting a CAMHF approach on chronic homeless people before they even enter the Camden Hostels Pathway or equivalent services elsewhere in London. CAMHF can be used as Housing First models were intended to be used, i.e. to *replace* at least some of the hostel provision for chronically homeless people that uses a staircase model.

Again, it is important to emphasize that CAMHF in common with all Housing First models, while it delivered exits from chronic homelessness, was an efficient but not low cost solution. Concerns about a dilution of the Housing First model to a point



where it becomes ineffective have been raised in Ireland<sup>115</sup> and the USA<sup>116</sup>. For Housing First to work, it has to be properly resourced and that may mean it is not necessarily much cheaper, although it is potentially more effective, than staircase services or hostels.

Any expansion of the CAMHF approach should be accompanied by an experimental evaluation. This would create a more robust evidence base to help establish the relative advantages and disadvantages of the CAMHF approach in direct comparison to other forms of services. A large trial of a bigger service, with a client load of at least 40 or more, would also be recommended.

Working in London presents unusual difficulties. London has a chronic shortage of adequate and affordable housing, meaning that any Housing First service using either social rented or private rented housing (or both) is likely to run into some difficulties in securing enough suitable housing fast enough. Efforts to improve London's housing situation continue<sup>117</sup>, but are small in relation to the extent of unmet housing need. Whenever Housing First tries to work in London, finding adequate, affordable housing in a suitable location will be a challenge. Equally, Housing First services will be dependent on access to the other services, including health, addiction, mental health, social work and other supports that chronically homeless people may need. If health and other services are cut or are hard to access, a Housing First service using intensive case management will face an uphill struggle.

## **The research and wider debates about Housing First**

CAMHF was not directly compared with the Camden Hostels Pathway<sup>118</sup> by this research. CAMHF re-housed chronically homeless people that the Camden Hostels Pathway had assessed as being people it could *not* refer to the Pathways Move on Team (PMOT) and who therefore could not be re-housed via the Camden Hostels Pathway. The relative effectiveness of CAMHF compared to the Camden Hostels Pathway is thus not something this research can report on, because the Camden

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<sup>115</sup> Pleace, N. and Bretherton, J. (2013b) *Finding the Way Home: Housing-led responses and the Homelessness Strategy in Ireland* Dublin, Simon Communities of Ireland.

<sup>116</sup> Tsemberis, S. (2011) Observations and Recommendations On Finland's "Name on The Door Project"

From a Housing First Perspective

[www.housingfirst.fi/files/1242/Tsemberis\\_2011\\_-\\_Observations\\_and\\_Recommendations.pdf](http://www.housingfirst.fi/files/1242/Tsemberis_2011_-_Observations_and_Recommendations.pdf)

<sup>117</sup> <http://www.london.gov.uk/priorities/housing-land/publications/london-housing-strategy>

<sup>118</sup> See Chapter 2.

Hostels Pathway and PMOT had not actually attempted to re-house the people who were re-housed by the CAMHF team.

As noted in Chapter 1, this research is a small observational study focusing on a pilot service that was only designed to support ten people at any one point in time. CAMHF was also a specific, unusual, use of a Housing First approach for a particular group of people, effectively working alongside the kind of staircase approach that Housing First was originally designed to *replace* (see Chapter 2). Finally, the research covered only a relatively short period. The medium or long term results from using a CAMHF model might differ from what is reported here and not everyone had been housed by CAMHF when the research came to an end. The results from this small research project are not generalizable.

Yet this research reports results that are very similar to those reported by research on Housing First services conducted across in Canada, Europe and the USA. It is a point worth making that the observational, quasi-experimental and the few experimental, randomised control trials that have been carried on Housing First out *all* point the same way. While other services, such as the staircase approach, do have successes, research shows time and time again that services following the operating principles of Housing First all seem able to generate higher rates of housing sustainment than other services for chronically homeless people. Housing First ends chronic homelessness more consistently than other forms of service intervention<sup>119</sup>. Canada, Denmark, Finland, France, Ireland and the Netherlands have followed the USA in developing homelessness strategies that include Housing First. Housing First is being widely piloted across Northern Europe.

Having noted the successes of Housing First in ending chronic homelessness it is important to avoid becoming uncritical of the Housing First approach or to fail to acknowledge that it has limitations. Housing First is not a panacea for chronic homelessness, nor is it claimed to be by those who support the Housing First concept<sup>120</sup>.

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<sup>119</sup> Busch-Geertsema, V. (2013) op. cit.; Pleace, N. (2012) op. cit.; Tsemberis, S. (2010a) op. cit.

<sup>120</sup> Busch-Geertsema, V. (2012) The potential of Housing First from a European Perspective, *European Journal of Homelessness* 6.2, pp. 209-216.

Housing First services, as was the case for CAMHF, are not able to engage with every single chronically homeless person successfully, even if they do produce housing sustainment for most of the people using them. Equally, while Housing First services do deliver improvements to health and well-being, results in respect of drug and alcohol use, mental health problems, physical health, social and economic integration are not universally good<sup>121</sup>.

Housing First has been criticised for delivering less than staircase services, i.e. as promoting itself based on successes that are confined to housing sustainment, rather than making someone fully 'housing ready' in the way staircase services are intended to do<sup>122</sup>. The evidence base has been criticised, both in terms of criticisms of the quality of the evidence collected and in accusations of selective targeting of Housing First services on groups likely to yield impressive looking results<sup>123</sup>. Conversely, Housing First has also been subject to criticism from Europe that it is less distinctive from staircase services than is claimed - since the ultimate goal is to get chronically homeless people living as independently as possible, i.e. 'housing ready' – meaning that Housing First is ultimately seeking to modify behaviour as much as provide support, and is not actually a choice-led approach<sup>124</sup>.

These arguments are not entirely without foundation. Yet arguments in favour of staircase services are becoming hard to sustain when those services generally fail to deliver the levels of housing sustainment which are being achieved by Housing First services across a range of contexts and countries. Equally, the evidence base for Housing First now comprises multiple studies from multiple countries, not just data from America. This makes an argument that all studies on Housing First are limited, biased or selective increasingly difficult to sustain.

It is true that by the standards of some Northern European service models, services like PtH Housing First, do exercise more control over how individuals live their

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<sup>121</sup> Pleace, N. (2012) op. cit.

<sup>122</sup> Rosenheck, R. (2010) 'Service Models and Mental Health Problems: Cost Effectiveness and Policy Relevance' in Ellen, I.G. and O'Flaherty, B. *How to House the Homeless* Russell Sage Foundation: New York, pp. 17-36.

<sup>123</sup> Pleace, N. (2011) op. cit.

<sup>124</sup> Hansen Ljöfstrand, C. and Juhila, K (2012) 'The Discourse of Consumer Choice in the Pathways Housing First Model' *European Journal of Homelessness* 6,2, pp. 47-68

[http://www.feantsaresearch.org/IMG/pdf/ejh6\\_2\\_article2.pdf](http://www.feantsaresearch.org/IMG/pdf/ejh6_2_article2.pdf)

lives, albeit far less so than some staircase services<sup>125</sup>. There may be some potentially interesting lessons for America here. In Britain, 36 years of homelessness legislation has established a convention that a full tenancy is what someone who is homeless should be provided with. By contrast, PtH Housing First tends to use sub-leasing arrangements, creating the flexibility to rapidly move someone if the need arises, but service users do not have the same housing rights as an ordinary citizen living in private rented housing would have. CAMHF seemed to be able to work effectively on the basis of immediately giving chronically homeless people a direct contract for their housing, i.e. their own tenancy and the same housing rights as anyone else renting privately. Similarly, European models of Housing First are also tending to give their service users direct contracts, again without creating operational problems<sup>126</sup>. This suggests that PtH and similar models of Housing First could move even further away from the staircase model and create a greater degree of separation between housing and support.

The weight of evidence currently suggests that Housing First services that follow the broad operating principles of PtH Housing First are effective, just as CAMHF appeared to be effective, in ending chronic homelessness<sup>127</sup>. Precise replication of any Housing First model, such as PtH, as has been argued very persuasively by Australian research, is not going to be possible outside its country of origin, because Housing First has to be adapted to the specifics of different contexts<sup>128</sup>. An inability to entirely replicate PtH Housing First does not seem to be an issue that limits performance, if the core elements of harm reduction, the separation of housing and support and the provision of intensive, open-ended support services are all in place.

Finally, CAMHF can be seen as evidence that a willingness to experiment and take risks remains important in reducing chronic homelessness. For both SHP and Camden Council, the decision to explore a new way to respond to chronic homelessness has shown positive results.

*It is trying to achieve solutions for people for whom solutions have not been available, they've just been going round and round, so in a way, if I'm talking*

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<sup>125</sup> Tsemberis, S. (2010b) op. cit.

<sup>126</sup> Busch-Geertsema, V. (2013) op. cit.

<sup>127</sup> Pleace, N. (2012) op. cit.; Pleace, N. and Bretherton, J. (2013b) op. cit.

<sup>128</sup> Johnson, G.; Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia* AHURI Final Report No. 184 AHURI: Melbourne.

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*in commissioning-speak though, it's enduring exits from the pathway, sustained tenancies...that there will be offsets in terms of behaviour here in Camden, effects on local services, but I think in many ways, for me, the biggest thing, it will allow, if it works, it will show that you can't shunt everybody onto an escalator and expect them to behave in one particular way. And that if we are going to be putting our money where our mouth is, we have to look at a variety of solutions to problems and not one size fits all, and that we need to keep searching for what they might be, because clearly what we have here now is not a solution. So, we have to find something else and this may or may not be it. SHP manager (April 2012).*