Housing First Europe
Final Report

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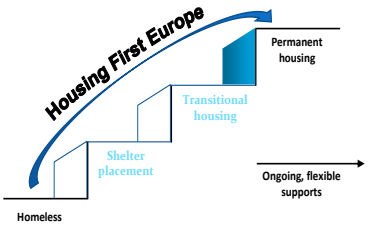

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More Information about Housing First Europe under www.housingfirsteurope.eu.

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Executive Summary

The Housing First Europe (HFE) project was a social experimentation project, funded by the European Commission, DG for Employment, Social Affairs and Inclusion, under the PROGRESS programme from August 2011 to July 2013. HFE's aims included the evaluation of, and mutual learning between, local projects in ten European cities which provide homeless people with complex needs with immediate access to long-term, self-contained housing and intensive support. HFE involved five test sites where the approach was evaluated (Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon), and facilitated the exchange of information and experiences with five additional peer sites (Dublin, Gent, Gothenburg, Helsinki and Vienna) where further Housing First projects were planned or elements of the approach were being implemented. Five project meetings, including a final public conference, were used for the exchange of information and experiences. A high profile steering group has contributed actively to the debates.

The main elements of the Housing First approach have to be seen in contrast to approaches requiring "treatment first" and/or moving homeless people through a series of stages (staircase system) before they are "housing ready". Housing First diverts radically from these approaches, which have been criticized for being ineffective in ending homelessness for people with severe and complex needs and having unintentional negative effects. Housing First seeks to move homeless people into permanent housing as quickly as possible with on-going, flexible and individual support as long as it is needed, but on a voluntary basis. It has gained particular attention in the US, where robust longitudinal research has demonstrated impressively high housing retention rates, especially for the pioneer model of Pathways to Housing in New York. The eight principles of this model, which focuses on homeless people with mental illness and co-occurring substance abuse, are: housing as a basic human right; respect, warmth, and compassion for all clients; a commitment to working with clients for as long as they need; scattered-site housing in independent apartments; separation of housing and services; consumer choice and self-determination; a recovery orientation; and harm reduction.

Methodology: Based on local evaluations of test sites and the systematic collation of results on a number of guiding key questions

HFE builds on existing and on-going local evaluations in the five test sites and it was not possible to devise a common evaluation methodology for all test sites. Local evaluations started and finished at different dates. As a result, diversity in the test sites is observable, in terms of scale and development, and in terms of data collection and evaluation methods.

At an EU level, a number of common key questions have been developed for all five test sites. The key questions were related to the following main topics:

- Numbers and profile of service users (age, sex, ethnicity/places of birth/nationality, household structure, employment status/income, housing/homelessness history)
- Support needs (and changes over time)
- Support provided/received
- User satisfaction
- Housing stability / housing retention rate
- Changes of quality of life/recovery
- Community integration/conflicts
- Costs and financial effects
- Specific positive effects, challenges and lessons learned

Five different test sites in five different welfare regimes, four of them broadly sharing main principles of Housing First as developed by Pathways to Housing, but still differing from the model in some respects. Budapest project special case.

The HFE test sites were located in five countries representing different welfare regimes, and in large cities with quite a variety of local contextual conditions. These conditions were more difficult in Lisbon, and much more so in Budapest, with low levels of subsistence benefits and housing allowances, and barriers for vulnerable people in taking up even this meagre financial support.

In all five test sites the Housing First project was one of the first pioneering attempts to test this approach in an environment dominated either by staircase systems or by emergency provision for homeless people with no or very weak links to the regular housing market. Only the project in Copenhagen was part of a national (and local) strategy to promote and implement the Housing First approach on a wider scale.

None of the HFE test sites was an exact replica of the pioneer project Pathways to Housing although – except for the Budapest project – they have followed this example in many aspects and have broadly followed most of the principles of Housing First as laid down by the "manual" of this project. However, we have not conducted a 'fidelity' test and for some of the principles it was difficult to verify their implementation into practice.

While all HFE projects served homeless people with complex and severe support needs, there might have been some selection of clients in the beginning, based on their willingness and motivation to hold a tenancy. In one of the projects (Copenhagen), congregate housing was used for a majority of service users in the beginning, but during the evaluation period and based on negative experiences with this type of housing, increasing use was made of scattered housing (see further below).

Other aspects in which the HFE test sites diverted from the pioneer project regard the target group (only in Lisbon was this restricted exclusively to people with mental illness), the organisation of support (only in Copenhagen did the project work with an ACT team including medical experts and addiction specialists; other projects – except in Budapest – cooperated closely with such services if needed; peer experts were not employed in two of the five projects), and the use of social housing and direct contracts between landlords and service users.

With the exception of Budapest in some of the points, the HFE test sites all worked with a client-centred approach and individual support plans, having regular home visits as a rule (and with an obligation for clients to accept them), worked with relatively high staff-client ratios (ranging between 1:3-5 and 1:11), and offering the availability of staff (or at least a mobile phone contact) for emergency cases 24 hours a day, seven days a week.

The deviations from the pioneer "model" in terms of organising housing and support confirm a need for "programme drift" and adjustment when transferring an approach to different local conditions. If social housing is an important source for housing vulnerable people and instruments are available to provide priority access to social housing – as it was the case in Copenhagen and Glasgow – it seems obvious to use this resource. If there is a lack of social housing and it is not accessible for homeless people – as in Budapest – or has long waiting lists and private rental housing can be acquired quicker and is seen as more flexible and better placed for community integration – as in Lisbon – private rental housing may be the preferred option. If access to other specialised and mainstream services is relatively easy, the ACT approach might not be necessary (though it might still hold some advantages for people with severe addiction and physical health problems, as is claimed for the Copenhagen project).

The Budapest project was different from the other projects in many respects. It was included as a test site because it was one of the very few programmes in Central and Eastern Europe which was trying to bring rough sleepers directly in mainstream housing with support, sharing some of the basic principles of the Housing First approach. However, some important elements are also miss-

ing: support in Budapest was time limited from the beginning (to a maximum of one year), and far less intensive than in all of the other test sites (1:24). In addition the support was provided by social outreach workers from different services in addition to a full-time job. Financial support for housing of the service users who had basically to search for their homes by themselves – with some support by staff - was also too little and time-limited. In contrast to all other projects, long-term housing retention was not an explicit target of the Budapest project (the main target was to clear a forest area in Budapest of homeless people).

Service user matched different target groups, high proportion of substance abuse in most projects, single long-term homeless men predominate

Data on the demographic and social profile of the project participants demonstrate that HFE test sites have reached their specific target groups, but that these groups differ to a considerable extent. While the Lisbon project had probably the highest share of clients with a psychiatric diagnosis, it had the lowest proportion of people with an addiction to alcohol and drugs. While more than two thirds of the service users in Copenhagen and Budapest indicated a problematic consumption of alcohol and abuse of a variety of substances was also frequent among the service users in Amsterdam, the project in Glasgow targets and reaches a particularly challenging group of heroin users. For all projects support needs because of poor physical health were reported for a considerable proportion of project participants.

The overwhelming majority of participants in all projects were long-term homeless people. Most of them were middle aged (36-45) or older; only in Glasgow were half of the participants younger than 36. A large majority of the participants had no regular employment at the time of entry into the projects and were living either on some sort of transfer benefits or had no income at all. In Budapest a greater share of service users (about a third) either received a pension or had a regular income from work when entering the project, but the majority relied on precarious and irregular jobs as claiming subsistence or unemployment benefits required an official address.

A majority of service users in Budapest lived with family members, partners or friends, while the majority in all other projects were single person households. Participants were predominantly men and nationals of the countries where the projects were located.

Support needs: Housing, finances, mental and physical health, worklessness and social isolation

Support needed for gaining access to housing and for sustaining the tenancy (including contacts with the landlord and neighbours) played a major role in all projects. Making the flat into a home is an obvious need in the period after moving into the flat which can require quite intensive support of a very practical nature (organizing furniture and household items, payment of bills etc.).

Financial problems and unemployment were common problems amongst project participants as well. Partly these problems were exacerbated by the financial requirements of substance abuse and by problems faced in realising existing rights to subsistence benefit. But we should also keep in mind that unemployment and poverty are structural problems, which cannot be “solved” by the Housing First projects. However, the projects could help with getting personal documents organised and claiming subsistence benefits, housing benefits, pensions etc. and this played a very important role in some of the projects.

From Amsterdam, Copenhagen and Glasgow, a lack of social networks was reported as a problem, not for all, but for a significant proportion of service users. To a certain extent, loneliness and social isolation might be an initial “price” to be paid for moving into scattered housing, especially if the new tenants want to cut contact with their former peer networks.

Different patterns of support needed and provided over time, high service user satisfaction

The support provided was generally most intensive in the time around moving into the apartments and diminished after some time, but not for all service users. Generally the dominant areas of support change after a period of turning the flat into a home and dealing with public administration, towards issues of addiction and physical health, overcoming social isolation and finding something meaningful to do. Individual needs differed substantially between participants and it has to be emphasised that there is a group of service users whose needs do not diminish over time, but may rather go up and down or remain on a relatively high level.

We can report a high level of service user satisfaction for the projects were this was evaluated. With very few exceptions, the support provided met the needs of service users. Some of the basic ingredients of the Housing First approach let to high satisfaction on the side of users: that they lived in their own self-contained flats and had the security of being able to remain there; that support was delivered as long as they needed it; that they are accepted as they are and treated with respect and empathy; and that they can be open and honest about the use of drugs and alcohol without the fear of being evicted as a consequence (harm reduction approach). Especially in Glasgow, the inclusion of peer supporters in the support staff was highly appreciated by service users, because they were seen as real experts with relevant lived experiences, non-judgemental and easy to communicate with.

Dissatisfaction – which was rare overall – related in some cases to the support provided (asking for more support), but more often to the choice of housing and in some cases long waiting times before being allocated permanent housing. Such problems reflected structural problems like a shortage of (affordable and accessible) housing of good quality.

High housing retention rates for four of the five test sites

High housing retention rates have been achieved by four of the five projects and the only project where the results were less positive was the project in Budapest, which in many respects departed from the principles of the Housing First approach.

Housing retention rates in Amsterdam and Copenhagen were extraordinarily high (over 90%, even when we focus exclusively at those persons who had been rehoused in the project more than a year ago). In Glasgow, for a smaller project with a group of homeless people generally seen as particularly difficult to house (users of illegal drugs, mainly heroin), a similarly impressive retention rate of over 90% was reported, and for the project in Lisbon the retention rate was still very near to 80% after running the project for more than three years and despite severe cuts in funding in 2012.

Some caution is needed for assessing these overall very positive results. The two projects in Copenhagen and Glasgow were still at a relatively early stage and given the remaining addiction and mental health problems of many service users, a risk of losing their tenancy at some stage still remained. Also, data from the local evaluations included in our HFE-project are not as robust as in other evaluation projects working with randomized controlled trials and no data is available for control groups of homeless people with the same profile receiving “treatment as usual”.

Nevertheless the data confirmed a number of studies in the US and elsewhere that the Housing First approach facilitates high rates of housing retention and that it is possible to house homeless persons even with the most complex support needs in independent, scattered housing. This is even more remarkable as the four successful test sites evaluated in the framework of HFE show some substantial differences concerning the target group, the type of housing and the organisation of services, but share most of the principles of the Housing First approach. As three of the four successful projects also had high proportions of substance abusers, the results add to the evidence of positive housing retention outcomes of the Housing First approach for people with severe addiction, and even for those with active use of heroin and other hard drugs.

Scattered housing preferable for bulk of homeless people with complex support needs, congregate housing with on-site support may be adequate for small subgroup

The Copenhagen project provided an opportunity to compare experiences with scattered site, independent housing (as provided in all other HFE test sites) and congregate housing in the same programme, with support provided by the same ACT team. There were strong indications that gathering many people with complex problems in the same buildings may create problematic environments (often dominated by substance abuse), conflicts and unintended negative consequences. The evaluation showed a clear preference of the bulk of homeless people for scattered housing. The results from Copenhagen suggest that congregate housing should be reserved for those few persons who do either display a strong wish to live in such an environment or have not succeeded to live in scattered housing with intensive Housing First support.

Mixed, but overall positive results on changing quality of life. Progress for the majority in terms of substance abuse and mental health, less positive results for overcoming worklessness, financial problems and loneliness

An overall positive picture regarding changes of quality of life can be reported for four of the five projects. A varying part of those who were addicted to alcohol or drugs have made progress to reduce their abuse or even cease it. Especially for the projects in Glasgow and Lisbon, some remarkably positive numbers are reported, in Amsterdam 70% of all interviewees self-reported a reduction of substance abuse and there are also more positive than negative developments documented by staff in Copenhagen. But for some Housing First participants with problematic use of alcohol and drugs the level of addiction remained the same or even got worse after rehousing. The harm reduction approach applied in all projects means that it would not be reasonable to expect a different outcome. The approach facilitates managing addiction and overcoming it gradually, but abstinence is neither a requirement nor a primary goal. Obviously time and qualifications of the teams in Budapest were not sufficient to organize a successful harm reduction approach for most of the participants in need.

Improvements of mental health problems were reported for a majority of participants who were struggling with such problems in Amsterdam, Glasgow and Lisbon where security of housing and reliability of support were held to be important factors in such improvements (though in Copenhagen staff reported positive changes of mental health for 25 % of service users, but negative changes for 29%). It is clear that stable housing has the potential to increase personal safety and to reduce the level of stress compared to a life in homelessness. The positive developments are often attributed to what is termed "*ontological security*" in the literature: housing provides the basis for constancy, daily routines, privacy and identity construction, and a stable platform for a less stigmatized and more normalised life.

The results were generally less positive with respect to the take-up of paid employment, managing financial problems, and social contacts. In particular, the number of formerly homeless people in paid employment remained low in Amsterdam, Copenhagen, Glasgow and Lisbon. For many, paid employment was a long-term aim and doubts may remain as to whether it is a realistic aim at all for some formerly homeless people. However, quite high proportions of participants in Amsterdam, Lisbon and Glasgow were engaged in voluntary work or other meaningful activity.

While a majority of participants in Glasgow and Amsterdam report an improvement of their financial situation, financial problems were the only area for which staff in Copenhagen reported significantly more negative than positive changes. In Amsterdam it was one of the few areas in which a significant minority (16%) reported a decline, and in Glasgow participants were still struggling with their scarce financial resources. With only time-limited subsidy of housing costs, and no access to any substantial subsistence benefits, the financial prospects were probably most precarious for the participants in the Budapest project.

When placed in scattered housing many formerly homeless people experience feelings of loneliness and social isolation. If they remain in contact with the former peer group (which they do automatically if they are rehoused in congregate housing projects), and are struggling with addiction, problems with managing to reduce their substance abuse tend to be reported. If they try to cut contacts with their former homeless peers – as many rehoused homeless people do – it is not easy for them to create a new social network. However, for almost all projects there are also reports about progress made (by a minority) in reconnecting with family members and estranged children.

Mixed results concerning community integration and neighbourhood conflicts

Neighbourhood conflicts played a minor role for the Housing First projects in Copenhagen, Glasgow and Lisbon, where constructive solutions could be found in most of the rare cases that occurred. In Amsterdam, nuisance complaints were reported against a third of all service users over a period of five years. Two-fifths of these complaints could be resolved in a relatively short period of time, with the tenants remaining in their homes, some participants got a second chance in another flat and only three persons were evicted during that period because of nuisance. In all cities where this was analysed (including in Amsterdam, with a relatively high number of nuisance reports) housing providers gave very positive feedback on the way neighbourhood conflicts were handled by service providers.

From the test sites where community integration was measured the results were mixed too. While some of the project participants were engaging in activities in their community, and met some of their neighbours regularly, others "kept their privacy" and were less active.

Given the complex support needs of most of the programme participants, further integration might take more time for some of them and structural constraints (lack of money for going out, having guests and participating in activities which require resources) play a role as well.

Indications that HFE projects less expensive than providing temporary accommodation for the same period, but further cost effectiveness studies needed

We have indications from three of the five HFE test sites that it would have been more expensive to provide the project participants with temporary accommodation for homeless people during the same time that they have used the Housing First project evaluated. But none of the projects has produced more robust data on previous service use and on the duration of support needed by the Housing First service. It is important to stress that intensive support such as that provided in Housing First projects requires considerable funding, and homelessness for people with complex support needs cannot be solved by providing "housing only" or with low level support. While our test sites with high housing retention rates indicate a high cost effectiveness of well-resourced Housing First projects, further research with more robust and longitudinal data and direct comparison of different services will be needed in this field.

Challenges and lessons learned: securing quick access to housing, some risks for clients after settling with a fixed address, providing attractive and client centred support, securing continuous funding

One of the main challenges for most of the Housing First projects related to securing quick access to housing (and long waiting times especially in case of scattered social housing). The projects can help their clients to overcome barriers for access to housing but they are all working within structural constraints including the local shortage of affordable housing.

Once housed with a fixed address some of the tenants may face prison charges for offences committed earlier or find their low incomes further reduced by creditors claiming back old debts. It may also be difficult for some of the rehoused persons to overcome loneliness and social isolation and some may experience a "dip in mood", especially if they live alone and have cut ties with

former peer networks dominated by problematic substance use. If they don't cut such ties they often find that "managing the door" might be a particular challenge.

The Housing First approach involves a change in the balance of power between service providers and service users, as compared with more institutional provision. To prevent disengagement of programme participants once they have been allocated permanent housing, support staff needs to make support offers which are oriented towards the individual goals of programme participants and to meet their needs and preferences.

Problems in securing continued funding were particular challenging for the sustainability of the project in Lisbon. In Budapest, one of the main challenges making it difficult to reach more sustainable results was the time-limited and too limited amount of individual funding available for project participants who were not fit enough for employment and a particularly weak provision of general welfare support for housing costs and the costs of living.

Test sites serve as example for other pilot projects and some scaling up on the local level

Only in Copenhagen, where the test site was already part of a wider (and nation-wide) strategy to implement the Housing First approach, and in Amsterdam (this time at local level), can we find plans for scaling up the Housing First approach. In the other test sites there was interest from other cities to work with the same approach in local pioneer projects or plans from the organisation to replicate their work in other locations and with other target groups. Plans and on-going projects to implement the approach on a wider scale (outside the HFE test sites and peer sites) are reported for example from France and Belgium, from Austria, Finland, Norway, Sweden and the Netherlands. It remains to be seen to what extent these plans go beyond single projects for a very strictly defined target group and how the positive results of the HFE project and positive experiences made in other projects will influence further development of the Housing First approach in Europe.

Recommendations

The positive results of four of the five Housing First test sites show that the Housing First approach is to be recommended as a highly successful way of ending homelessness for homeless people with severe support needs and helping them to sustain a permanent tenancy. They show that the majority of the target group, including people with severe addiction problems, is capable of living in ordinary housing if adequate support is provided. The eight principles developed by Pathways to Housing appear to be a useful device for developing Housing First projects, including the recommendation to use predominantly ordinary scattered housing. and independent apartments not concentrated in a single building.

Important elements for success of the Housing First approach are:

- Quick access to housing: in countries where allocation of social housing to homeless people is possible, social housing may be a useful resource. Elsewhere, private rented housing or even the use of owner occupied housing may dominate. Approaches as practised by social rental agencies or by the Y-Foundation in Finland may be useful in getting access to housing in the private rented and owner occupied sector for use in Housing First projects.
- Housing costs and the costs of living must be covered long-term for those persons who cannot earn enough money by employment. This can be a particular problem in countries with a weak welfare system as we have seen in the test site in Budapest.
- Multidimensional support of high intensity must be available as long as it is needed. Our examples show that this can be organized in different ways and if close cooperation between medical experts and addiction specialists is possible they do not necessarily have to be integral part of the support team (as in the ACT approach). However ACT has proved to be a positive approach for people with severe mental and physical health problems and addiction.

- Housing First programmes should carefully consider how to deal with nuisance and neighbourhood conflicts and should make clear agreements about that with both the service users/tenants and the landlords. Our test sites show that successful management of such problems (if they occur at all) is possible in most cases under this condition.

The risk of failure of schemes which do not procure long-term funding for housing costs and more intensive and specialized support is relatively high as we can see from the evaluation of the Budapest test site.

Housing First support staff have to meet particular requirements: they need to show respect, warmth and compassion for all service users and put their preferences and choices at the very core of support work. They have to be able to build up trusting relationships, and their support offers have to be attractive and meet the individual needs of their clients, always based on the firm confidence that recovery is possible and aiming at the highest level of integration possible.

However, expectations of policy makers and service providers need to remain realistic. Ending homelessness provides a platform for further steps towards social inclusion, but is not a guarantee for it and for the most marginalised individuals relative integration might often be a more realistic goal. Nevertheless, further attempts to successfully overcome stigmatisation, social isolation, poverty and unemployment are needed, not only on the level of individual projects, but also on a structural level. The same applies to structural exclusion of vulnerable people from housing markets. The debate on Housing First should be used to (re-)place access to housing at the centre of the debate about homelessness while emphasising that housing alone is not enough for those with complex needs.

Promotion of the Housing First approach as an effective method to tackle homelessness is recommended at all levels, local, regional and national as well as at the European level. Mutual learning and transnational exchange should be continued on Housing First. Policy frameworks as the European Programme for Social Change and Innovation, the European Platform against Poverty, and the Social OMC (Open Method of Coordination) may be used for this at EU-level.

The Housing First approach is a perfect example for social investment and should be further developed as a key element of integrated strategies to tackle homelessness at all levels.

The EU's structural funds should be used to support the development and scaling-up of Housing First to promote social inclusion and combat poverty, support the transition from institutional to community-based care and as a form of social innovation. The European Social Fund can be used to support services to promote the inclusion and empowerment of homeless people whilst the European Regional Development fund can support infrastructure/housing. A multi-fund approach is particularly relevant for Housing First implementation.

For the period 2014-2020, the EU Programme for Social Change and Innovation (EPSCI) should be used to further develop the Housing First approach in EU contexts. It would be useful to build upon the findings of Housing First Europe to further experiment and evaluate aspects of Housing First as an effective approach to tackling homelessness.

The Commission should support a network of European experts on the Housing First approach which could give useful advice for the development of local projects and continue the process of mutual learning.

Training of key players at different levels of homeless policy-making and service delivery is an important element of scaling-up the Housing First approach and could be supported by the European Commission.

At all the levels mentioned, the Housing First approach may at least comprise an element of (local, regional, national and European) homeless strategies, but might also be used for a more fundamental change of paradigm, departing from staircase systems and provision which primarily focuses on emergency measures.

The focus of HFE was on relatively small local projects for people with complex support needs. It is still a matter of debate whether the Housing First approach should be reserved exclusively for this relatively small subgroup of homeless people. It would be useful to test and evaluate the effectiveness of services following the same principles for people with less severe needs and for strategies implementing the Housing First philosophy in broader "housing led" strategies. Several countries and cities have claimed to implement such strategies and it would be useful to promote information exchange and mutual learning between them and evaluate the effectiveness of such strategies.

In such a context, innovative methods of needs assessment and of methods of financing flexible support are needed to secure that floating support is sufficient and matching the individual needs but also doesn't overstrain the financial capacities of those responsible for funding it.

Further research is needed in the following areas:

- Cost effectiveness of the Housing First approach (taking into account previous service use and duration of support provided);
- Gender and age specific requirements and effects of the approach for example on young homeless people under 25 should be analysed in detail;
- More in-depth and comparative evaluation of the use of evidence based methods of social support, such as Assertive Community Treatment, Intensive Case Management and Critical Time Interventions and their applicability for different groups of homeless people and in the field of homelessness prevention.

Relevant authorities at different levels should move this research agenda forward. The Horizon 2020 programme could be a useful framework in this respect.

Part I. Project Context: The Housing First Approach and Implementation in Europe

1 Introduction

This is the final report of the Housing First Europe (HFE) project, funded by the European Commission. In this Part I of the report we will provide an overview of HFE, explain the Housing First approach and current debates about it, and present the projects which have participated in HFE as well as some other Housing First projects implemented in Europe which were not partners in the HFE network. In Part II we will present the methodology of the project and the results of the evaluations of five HFE test sites in greater detail. Part III contains conclusions and recommendations, and Part IV the references used in this report.

The report draws heavily on the results of five evaluations carried out in the cities of Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon.

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3 Overview on the Housing First Europe Project

Housing First Europe (HFE) was funded from August 2011 to July 2013 under the PROGRESS programme of the European Commission (DG for Employment, Social Affairs and Inclusion) as a "Social Experimentation Project". HFE aims included evaluation of, and mutual learning between, local projects in ten European cities which provide homeless people with complex needs with immediate access to long-term, self-contained housing and intensive support.

Homelessness exists across the EU, even in developed welfare states. The need for innovation in the homeless sector is therefore crucial, especially given increasing awareness that the shelter system and other types of temporary accommodation are not providing long-term solutions to homelessness. Housing First approaches have been argued to be highly effective in tackling long-term/chronic homelessness, which is why they have received broad interest in Europe. The approach was originally developed in the United States and has been used predominantly to tackle chronic homelessness, especially of people with serious mental health problems and co-occurring substance abuse. Housing First, as it was pioneered by the organization *Pathways to Housing* in New York, has demonstrated high degrees of success in both housing and supporting those who are homeless with multiple and complex needs.

In contrast to 'staircase' approaches, which predominate in many European countries and which require homeless persons to show evidence of being 'housing ready' before they are offered long-term stable accommodation, Housing First projects place homeless people directly into long-term, self-contained housing with no requirement that they progress through transitional programmes. But Housing First does not mean "housing only": substantial and multidisciplinary social support is provided to re-housed homeless people on an "assertive" basis, though their tenancies are not conditional upon them actively engaging with such support or complying with therapies to achieve sobriety.

In most European countries there is still a widespread belief that homeless people with complex support needs cannot sustain a tenancy. The Housing First model has proved in the US that this is untrue. In fact, the US evidence indicates that the vast majority of homeless people - including the very most vulnerable with the most complex needs - can sustain a tenancy as long as appropriate support is on offer.

In five European cities (the "test sites": Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon) Housing First projects were tested and evaluated from a European perspective, with a view to providing greater clarity about the potential and the limits of the approach and its impact on homeless people's lives. HFE facilitated mutual learning with additional partners in five "peer sites" (Dublin, Gent, Gothenburg, Helsinki and Vienna), cities where further Housing First projects were planned or being implemented. This work was conducted with the support of a steering group which included FEANTSA and HABITACT as European stakeholders, experienced researchers, representatives of national homelessness programmes and Sam Tsemberis, the founder of Pathways to Housing in New York. The overall partnership approach of HFE therefore involved a wide range of stakeholders including NGOs, service providers, local authorities, universities and public authorities.

HFE was implemented through two principle strands:

1. In a research and evaluation strand the opportunity of ongoing local evaluations of five Housing First projects in the test sites was used to develop key research questions for all five evaluations in order to synthesize local results on a European level and draw conclusions about the effectiveness of the approach. The key research questions allowed for detailed information about the organization of the local Housing First projects; access criteria; profile of clients; flow of clients through the projects and information about length of stay and numbers and reasons for drop-outs; support provision and support needs; costs involved; and effects on quality of life etc.

2. A mutual learning strand brought together different stakeholders and the representatives of all peer sites and test sites to discuss the results of the assessments, and generally facilitate exchanges on different Housing First projects across the EU and beyond (e.g. USA, Canada). All total five meetings (of the steering group and project partners) were used to discuss commonalities and differences between the projects and common challenges in developing mutual understanding on Housing First concepts. Meetings were held in all test site cities, including a final public conference in Amsterdam.

The main contractor of HFE was the Danish National Board of Social Services (Servicestyrelsen; with Birthe Povlsen as the main responsible person) and the coordinator of the evaluation and exchange strands was the author of this report.

For the test sites a number of basic conditions were formulated to increase comparability and a certain degree of minimum fidelity with the Housing First model as tested in the US. The minimum requirements formulated for the selection of test-sites were the following:

- Projects should provide service users with self-contained living units (e.g. not hostel accommodation);
- Tenants should have some form of secure tenure;
- Services should target people with mental illness/drug/alcohol problems or other complex support needs (i.e. who could not access and sustain housing without support);
- Pro-active support should be offered (but housing should not be conditional on acceptance of this actively offered support);
- Access should not be conditional on stays in other types of transitional accommodation or any other type of "preparation".

4 The Housing First Approach and Current Debates

The Housing First approach has received a lot of attention among researchers, policy makers and practitioners in Europe in recent years. One of the reasons for this might be that it fits with broader long-term trends in the development of services for people with support needs (the mentally ill, frail older people, vulnerable young people) including:

- De-institutionalisation and decentralisation of service provision
- Normalisation of living conditions (including housing conditions)
- Individualisation of support.

The approach, by providing homeless people with immediate access to ordinary scattered housing and on-going support (at least in the most common variations of the model), also fits a long-term tendency away from place-centred support (supported housing) to person-centred support (support in housing; see Edgar *et al.,* 2000 and Busch-Geertsema 2012).

Furthermore it is an alternative to staircase systems and approaches which claim that people must be made "housing ready" outside the regular housing market before they can get access to ordinary and permanent housing in a final stage. Staircase systems – though still dominant in much European homelessness provision at the local level – have faced increasing criticism over the past few decades (see Sahlin, 1998 and 2005; Busch-Geertsema and Sahlin, 2007; for a critique of the American "Continuum of Care" approach see Rigway and Zipple, 1990).

The idea of a staircase of transition is that different types of accommodation-based services with different levels of standards, autonomy and control (such as low-standard shelters, temporary accommodation for specific groups, (shared) training flats or transitional flats) are organised like a ladder or a staircase, comprising a number of steps or rungs for the homeless client to climb up, ultimately exiting from homelessness through acquiring a regular flat with full tenancy rights. Meanwhile, homeless persons are expected to solve "underlying" problems (e.g. by paying off old debts, ceasing to abuse substances, starting work) and obtain "training in independent living" while being monitored by social workers. The assumption is that the clients gradually qualify for regular housing. In this model the degree of privacy, autonomy and freedom as well as the quality of the accommodation increase in an upward movement (as a kind of reward for good behaviour and success in overcoming problems) while the degree of supervision and control decreases.

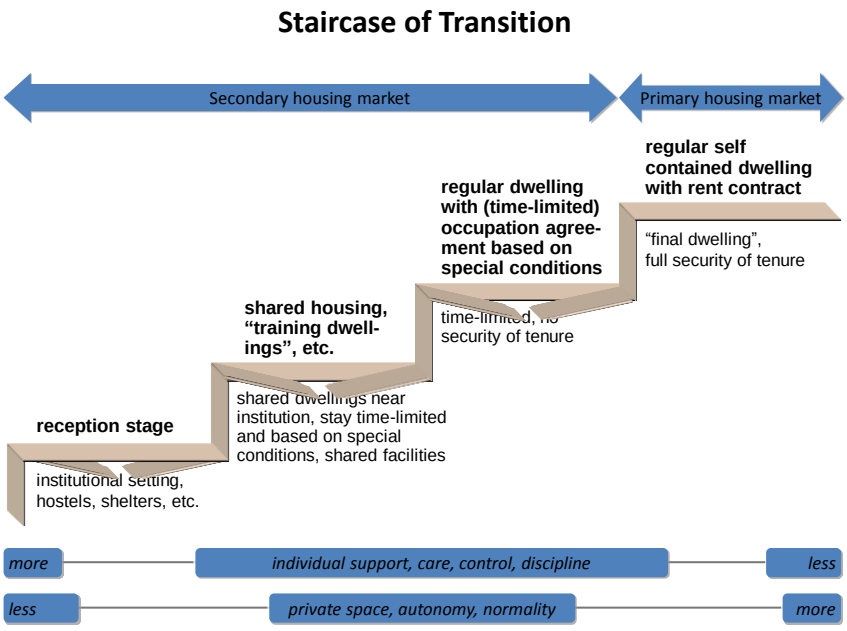
The critique of this approach points to the problem that those who do not “improve” in this system are stuck on a rung, while those who “misbehave” or fail to comply with treatment or support programs are either "relegated" to a lower step or pushed down to the bottom floor, often a night shelter.

A number of key problems with the staircase approach have been identified:

- stress and dislocation caused by the need to move between different accommodation-based projects,
- lack of service user choice and freedom combined with standardized levels of support in the different stages of residential services,
- decisions about when and where clients are placed are made by service staff and clients are afforded little privacy and control (at least in the “lower” stages),
- skills learned for successful functioning in a structured congregate setting are not necessarily transferable to an independent living situation,
- the final move into independent housing may take years, and between the different stages many clients get “lost”,
- revolving door effects and an entrenched group of “frequent flyers” stuck within the system.

Support systems relying on such approaches have been criticized for "administering" or "managing" homelessness instead of ending it (Burt and Spellman, 2007). Sahlin (2005) found for Sweden that in those cities with a staircase approach, homelessness increased rather than decreased, contrary to what was originally intended. Since more people were evicted or transferred to lower steps in the staircase, than were upgraded to higher steps, and as there is a continuous flow of new homeless people, the local staircase typically tends to expand on the lower rungs, while the top steps make up a bottleneck.

Chart 1

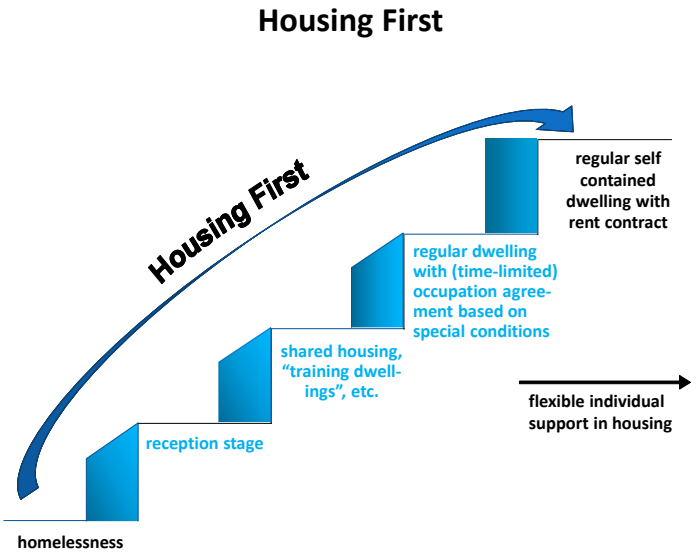


Adapted from Sahlin 1998

The Housing First approach has been developed in contrast to such approaches requiring people to get housing ready or undergo “treatment first”. The alternative concept seeks to move homeless people into permanent housing as quickly as possible, arguing that housing is a fundamental

right for all, and should not have to be "earned" by solving individual problems, change of behavior etc. Support is provided to those homeless persons who need it, but sobriety and/or motivation to change are not requirements for getting access to permanent and self-contained housing, nor can a failure to comply with support services lead to an eviction. Compliance with normal residential tenancy laws is the only requirement. An essential premise within this approach is that social service interventions can be more effective when provided to people in their own home. Choice and a feeling of security and stability regarding housing and support are important elements of this alternative strategy.

Chart 2



Reintegrating homeless people into permanent housing with support is by no ways a completely new approach in Europe and a number of studies have shown that homeless people with support needs are indeed able to sustain a regular tenancy when provided with adequate support (Dane, 1998; BBR 1998 and 2003; Busch-Geertsema, 2005; Fitzpatrick *et al.*, 2010; Crane *et al.*, 2011). This might also be a reason why stakeholders in the UK and in Germany, for example, often claim that the Housing First approach does not imply as great a paradigm shift as in the US and that they are "doing it already" (Johnsen and Teixeira, 2010 and 2012). But the usual support may often be of a considerably lower intensity, time limited and based on certain conditions, and does not necessarily imply the same effectiveness as methods such as Assertive Community Treatment or Intensive Case Management.

However the Housing First approach *is* innovative as it opposes the notion that homeless people require any "preparation" outside the regular housing market and it favours quick allocation of permanent housing with on-going support even to people with the most serious and complex problems such as mental illness and co-occurring substance abuse. The focus of these Housing First projects on people with high support needs - providing them with housing and support without fixed time-limits and with a particular emphasis on choice and harm-reduction - are key elements of this innovation.

The term "Housing First" has been used in different contexts, for example as a slogan against the "work-first"-ideas of American workfare concepts as well as a concept for rapid rehousing of homeless families (see Lanzerotti, 2004, who claims that the approach was developed by the organisation "Beyond Shelter"). It has also been used for a broader general philosophy aiming at integrating all (or almost all) homeless people as quickly as possible into permanent housing (not transitional housing and temporary accommodation) and providing core services for them when housed on a voluntary basis (see Roman, 2011; Busch-Geertsema 2012). But – as mentioned already – the term Housing First achieved the greatest attention as a service model developed first

by Pathways to Housing in New York where it was tested for the particular target group of homeless people with mental illness and substance abuse and produced impressively high retention rates (of between 78 and 88 %) in a number of studies (Tsemberis and Eisenberg, 2000; Tsemberis, Gulcur and Nakae, 2004; Siegel *et al.*, 2006; Stefancic and Tsemberis, 2007; Pearson *et al*., 2007; Nelson *et al.*, 2007; Tsemberis *et al.*, 2012), among them several randomized controlled experiments, often praised as the "gold standard" of programme evaluation.

Pathways to Housing has recommended eight principles of Housing First (Tsemberis 2010b: 18), namely

- housing as a basic human right
- respect, warmth, and compassion for all clients
- a commitment to working with clients for as long as they need
- scattered-site housing; independent apartments
- separation of housing and services
- consumer choice and self-determination
- a recovery orientation
- harm reduction.

We will come back to these principles in our presentation of evaluation results of the HFE test sites.

But Housing First is not a protected term. The success of the Housing First approach in the US and the fact that it was adopted and promoted at federal level as an evidence-based method to reduce "chronic homelessness" led to the re-labelling of a variety of existing projects – often quite distinct from the pioneering model of Pathways to Housing – as "Housing First", making the term more ambiguous. Similar developments have been reported for Europe (Pleace, 2008 and 2011; Busch-Geertsema *et al.*, 2010; Johnsen and Teixeira, 2010 and 2012) and other continents (like Australia and Canada, see Johnson *et al.*, 2012, and Waegemakers Schiff and Rook 2012). While this led members of Pathways to Housing to work on a fidelity scale for their model others argued that some adaptations of the programme are inevitable when transferring it to differing local and national contexts. But all agreed that it is important to identify the most essential elements of the Housing First approach to maintain a clear core of what is meant by it.

Some of the authors mentioned before (and others like Kertesz *et al*., 2009; Kertesz and Winer, 2009, Atherton and McNaughton-Nicholls, 2008; McNaughton-Nicholls and Atherton, 2011; Stanhope and Dunn, 2011) have argued that the results of the Housing First approach, while being accepted as very good in terms of housing retention for the groups served, are "underwhelming" in terms of further integration (such as overcoming addiction problems and social isolation, and integration into employment) and that the effectiveness of the approach for people with very severe drug and alcohol addiction has not yet been sufficiently proven. At various times it was also emphasised that the effectiveness of the approach in other national and local conditions as those in the US has still to be analysed. Evaluation results of HFE test sites might help to fill some of these evidence gaps.

Nicholas Pleace (2011), summarising some of these arguments in his Think Piece on "The Ambiguities, Limits and Risks of Housing First from a European Perspective", commented that the focus of the Housing First approach on homeless people with complex support needs risks drawing attention away from structural causes of homelessness: "*Emphasising the characteristics of vulnerable individuals who represent a minority of homeless people downplays the scale of homelessness and the role of labour markets, welfare systems and limited access to affordable housing in homelessness causation*" (ibid.: 122; for several responses to Pleace's Think Piece see vol. 6.2 of the European Journal of Homelessness).

Pleace (2012), in an attempt to differentiate different types of the Housing First approach, implemented in Europe and elsewhere, distinguishes three types of services:

- Pathways Housing First, following the original model most closely, using scattered, independent housing and providing directly psychiatric, drug and alcohol, social work, medical and other services to chronic homeless people with complex problems, but also brokering such services and connecting clients to them.
- Communal Housing First, using congregate housing with services on site, but sharing most of the other essential elements of the Housing First approach (such as security of tenure, consumer choice, and harm reduction);
- Housing First 'Light' services, delivered in ordinary private rented or social housing by a team of mobile support workers. While this type shares important elements of the other Housing First approaches it is used also for prevention services and for homeless people (including homeless families) with lower support needs and does not directly provide medical, psychiatric or drug and alcohol services.

While this was a useful first attempt to differentiate existing services and approaches it has not proved a useful typology for differentiating the test sites evaluated in the framework of the HFE project. As we see below, only one of these HFE services provided directly medical, psychiatric and drug and alcohol services and only one of the services housed (some) service users in congregate housing with on-site support. But all of the projects served homeless people with complex and severe support needs and have provided (with exception of one project) support of high intensity. None of the test site projects could be classified as Housing First 'Light' services and none of them was an exact replica of the Pathways to Housing approach.

The test sites evaluated in the framework of HFE show that the essential principles of the Housing First approach as developed by Pathways to Housing might be followed to a large extent but that those projects following the main principles might nevertheless be differentiated according to the three dimensions: the target group; the type of housing provided; and the organisation of support (without judging if one of the projects is more "Pathways Housing First" than the other).

Regarding the target group, we may find programmes which are strictly focussed on diagnosed mentally ill people (as indeed Pathways to Housing does) and are strongly embedded in the mental health sector (this is also the case for two large evaluation projects outside the HFE network, namely the "chez soi" projects in France and in Canada). Other projects are open to homeless target groups with other complex problems, for example substance abusers who are not diagnosed with mental illness. And finally there are projects targeting homeless people with less severe support needs. At least with respect to the HFE test sites, such projects (for people with less severe support needs) were not accepted in the HFE network. While most Housing First projects seem to target single people, homeless families may of course also be a target group of the approach.

Regarding the type of housing, Housing First projects using scattered, independent housing (as recommended by Pathways to Housing) are probably the predominant type implemented in Europe, but it is evident that a number of projects presenting themselves as Housing First (and being presented as Housing First in the literature) provide permanent housing in congregate settings with on-site support. As we will see, a mix of both kinds of housing provision in the same Housing First programme was found in HFE as well (in one of the test sites and in one of the peer sites).

Finally, social support, while always being of a certain intensity, including home visits and coordination with other specialist and mainstream services, differs as to the extent to which they include different disciplines, especially medical services, addiction experts and experts on employment. They also differ in the role they give to peer experts.

Accepting a relatively broad range of projects as practising the Housing First approach makes it necessary to define limits as to what cannot be defined as Housing First. It should be clear that

approaches requiring preparation, therapy, abstinence and for homeless persons to complete one or several steps in a programme to make them "housing ready" outside the housing market before being accepted into the programme cannot be termed Housing First. The same is true for programmes which offer transitional housing, temporary accommodation and other types of housing where the stay is time-limited and dependent on the duration of support. Shared housing could only be accepted in Housing First projects if it is the expressed will of individuals to live together. Projects which evict tenants because of reasons over and above those which are standard in rental contracts (such as for substance abuse or not complying with specific support measures or therapies) may not be termed Housing First either.

Apart from the debate about the definition of Housing First projects and their risks and limits, there is also a debate as to whether Housing First should be reserved as a term for specific projects for a particular target group, and such be "part of the menu" of a differentiated set of services for homeless people, or if it amounts to a strategic level change of paradigm regarding service provision for all homeless people. The Jury of the European Consensus Conference, organised under the Belgian Presidency in 2010 discussed both the Housing First approach as a model for serving homeless people with complex support needs as well as broader strategies following the Housing First philosophy: "*Given the history and specificity of the term 'Housing First'*", the jury recommended to use "*'housing-led' as a broader, differentiated concept encompassing approaches that aim to provide housing, with support as required, as the initial step in addressing <u>all</u> forms of homelessness".* Accordingly the Consensus Conference Jury called for a "*shift from using shelters and transitional accommodation as the predominant solution to homelessness towards 'housing led' approaches. This means increasing the capacity for both prevention and the provision of adequate floating support to people in their homes according to their needs.*" (European Consensus Conference, 2010: 14, 16).

While a number of European countries and cities have claimed the Housing First philosophy as being an important principle of their homelessness strategy in this sense, such strategies were not evaluated in the HFE project. Housing First Europe focused exclusively on individual rehousing projects for homeless people with complex support needs.

5 The Implementation of Housing First Projects in Europe

Many, but not all, of the projects included in the HFE project have followed the approach of Pathways to Housing to a greater or lesser extent and were among the first pioneers to test the Housing First approach in their local and national contexts. In the following we present those projects being partners of HFE as test sites (being evaluated) and as peer sites (in the process of implementing Housing First principles, but not evaluated in the framework of HFE). We will also mention some other relevant projects in Europe insofar as we know about them, but without aiming at a full coverage of all existing projects claiming to practice Housing First in Europe.

5.1 HFE test sites

The project in **Amsterdam** (Discus Housing First) is one of the "oldest" Housing First projects (and the first one in the Netherlands, established in 2006) and has already served a relatively high number of service users (more than 120 in 2011). It is operated by the NGO "HVO-Querido" and cooperates closely with municipal health services and local housing associations. The main part of the funding is paid by National Health Insurance. In addition, service users pay a contribution to care costs (varying from 122 to 209 euros per month) and are responsible for rent payments for which they may receive rental allowances from the state. The aim of the Discus project is to house homeless people with complex and multiple problems: "*Both psychiatric and addiction problems are inclusion criteria for Discus: meaning the program serves a doubly diagnosed population*". The target group are people "living on the streets" who are referred to Discus by a group of professionals under supervision of the municipal health service of Amsterdam. They are provided with

housing on condition that they cooperate with income management (i.e. to avoid rent arrears and to settle existing debts). Discus works with a client-centred, strength-based (i.e. focussing on the strengths of their participants rather than exclusively on their problems) and harm reduction approach. Support is provided by staff of Discus in close cooperation with community psychiatric nurses on a 24/7 availability basis. In 2011 Discus staff comprised 19 workers with diverse backgrounds. The psychiatric nurses are not employed by the NGO HVO-Querido: treatment and social support are separate responsibilities. Housing is mainly provided in self-contained social housing scattered throughout Amsterdam which is rented by HVO-Querido and sublet on the basis of a combined “rent-and-care contract" to the service users. After a period, the tenant may have the opportunity to acquire a direct contract with the housing association. By the end of 2011 Discus were working with five housing associations (all information from Wewerinke *et al*., 2013: 7-11).

The project in **Copenhagen** (ACT in Copenhagen) is the only test site which includes psychiatric staff and addiction specialists in one integrated Assertive Community Treatment (ACT) team. It is also the only test site which uses both scattered self-contained social housing (where about two fifth of the service users have been housed) and communal housing (where a number of flats (around 18-20) are concentrated in one building or in small terraced houses) and some of the service users were even housed in group homes, where a part of them had to share facilities (kitchen and bath). This project is imbedded in a nation-wide homelessness strategy (see Hansen, 2010). The project started in 2010 and is operated by the city of Copenhagen. It is funded by the municipality and by national government subsidies. Service users have to pay the rent from their subsistence benefits or pension. The multidisciplinary team (including social support workers, a nurse, a part-time psychiatrist, a part-time addiction councillor as well as a social office worker and a job centre worker) provides floating support to a group of formerly homeless people who are referred by the municipality’s homelessness unit. The ACT-team focuses on homeless individuals with complex support needs (substance abuse, mental health problems etc.), for whom support from a regular social support worker is assessed not to be sufficient and who are not clients of the mental health system already (as diagnosed mental health patients). There are no conditions regarding treatment or sobriety and a harm reduction approach is used.

While at the onset of the ACT-programme a decision was taken by the municipality to assign most service users to three communal housing units (a fourth one came into use later and the use of one of one of the group homes was discontinued), positive experiences with independent housing and the negative effects of congregating many individuals with the same problems in the same place let to increased use of scattered social housing. The municipality of Copenhagen can allocate one third of all housing units which become vacant in public housing to households in priority need of housing. As demand generally exceeds supply and waiting lists are long it can take about four months or longer to acquire an apartment this way (all information from Benjaminsen, 2013).

The project in **Glasgow** (Turning Point Scotland Housing First) is the smallest of the five test sites but particularly ambitious in focusing exclusively on homeless people with active addiction (most of them heroin users). It also stands out for its extensive use of peer support workers with histories of homelessness and substance misuse. The project is operated by Turning Point Scotland, a non-profit NGO providing a range of support services for adults with complex needs all over Scotland. The Glasgow Housing First pilot started in October 2010 as the first project in the UK implementing the Housing First approach. Funding is procured mainly by the NGO itself with subsidies provided by the Big Lottery Fund and by Greater Glasgow and Clyde Health Board. Housing costs have to be paid by the homeless service users themselves (with support from Housing Benefit). The support team consists of a service co-ordinator, two assistant service co-ordinators and four peer support workers, all employed full-time. Housing is provided in self-contained, scattered social housing let by a number of housing associations. Service users' access to social housing is facilitated by the Scottish homelessness legislation whereby specific households “accepted” by local authorities as homeless are entitled to be rehoused in “settled” accommodation. In Glasgow they will then be referred to housing associations which are expected to house them within a

relatively short period and with an ordinary rental contract and unlimited lease. The target group of the Glasgow project are "statutorily homeless" people who qualify for a referral under the homelessness legislation, who have a current drug, alcohol or poly-substance misuse problem and whose needs are not being met by current services (all information from Johnsen with Fitzpatrick, 2013).

The project in **Lisbon** (Casas Primeiro) supports homeless people with mental illness in accessing and maintaining independent apartments following the Housing First approach. It is the only test site which follows the pioneer Pathways to Housing in New York in renting self-contained apartments from the private rental sector (scattered in ordinary neighbourhoods) and subletting them to service users. And it is the only test site for which a psychiatric diagnosis is a criteria for admission. The project started in 2009 and is operated by the non-profit NGO AEIPS (Associação para o Estudo e Integração Psicossocial). For the first two years the project was funded by the national Social Security Institute. In 2012 overall funding was severely reduced (by about 45% compared to the previous year), and was diversified to include several new sources in addition to the Social Security Institute, such as the City Hall and local foundations. Following these cuts and in order to secure the sustainability of the project, rent subsidies from the project budget were reduced (with lower rents negotiated with landlords and higher subsidies procured from elsewhere), the number of service users had to be decreased (from 60 to 50) and staff numbers had to be reduced from six to four. Service users have to contribute 30% of their income to their housing costs, with the remainder paid by the project or other sources. Referrals to the project come from the city's outreach teams and other relevant organizations, or through recommendations from other programme participants. The criteria for admission is to be a homeless person with mental health problems, and priority is given to those who are living on the streets, to those who have the longest homelessness histories, and to women. Apartments are rented from private landlords, the programme does not rent more than one unit in any one building or street. AEIPIS holds the lease, as well as the contracts with water, electricity and gas suppliers. Subtenants get a lease without time limit (all information from Ornelas, 2013).

The **Budapest** project (Pilisi Forest Project) was special in many respects. It was the only test site to be found in any of the Central and Eastern member states of the European Union which followed at least some of the principles of the Housing First approach. It started in January 2007 and ended in December 2009, and the main goal of the project was to re-house homeless people living in the forest areas of Budapest that belong to the Pilisi Forest Company. The Forest Company aimed to clean and restore forest areas for recreational purposes. The project was coordinated by the Public Foundation for the Homeless (Hajléktalanokért Közalapítvány) and involved seven different organisations (most of them non-profit NGOs) providing the support and helping with access to different types of accommodation. Funding was provided from national sources. The target group were people living in the forest territories (usually in huts, abandoned buildings or tents). Project participants were able to choose between different types of accommodation, rented apartments being only one of several options, though it was the type most frequently chosen. Other types of accommodation were trailers in a caravan park, rooms in workers' hostels, buying their own property (usually in the countryside) or – in a few cases – a place in a homeless shelter. The services provided included financial support with housing costs and case management by outreach workers (all information from Fehér/Balogi, 2013).

The project was included in HFE as it shared important elements of the Housing First philosophy such as direct integration of rough sleepers into regular housing (at least for some of the participants) with support, no further conditions for participation (such as sobriety or "housing readiness"), a strong emphasis on choice and some flexibility to adjust financial subsidies accordingly. But it was also clear from the beginning that the conditions of the project (low level and time limited funding and structural constraints in the context of a fairly weak welfare system) were very different from the other projects and achieving long-lasting sustainability of the rehousing process was not the primary aim of the Budapest project.

5.2 HFE peer sites

The conditions for the HFE test sites were less strict and for some of the projects questions may be raised as to whether they are correctly classified as Housing First projects. These projects were not evaluated in the context of HFE, and accordingly the information presented is mainly based on data provided by the local HFE partners.

The project in **Dublin** (Housing First Dublin) started in 2011 and is operated by the Dublin Region Homeless Executive. It is financed by local authority funding and aims to end chronic rough sleeping by providing self-contained, independent, scattered housing with intensive case management support on a visiting basis. The target group for the project is enduring (long-term) rough sleepers with a broad range of support needs (mental health, addiction etc.). There is no need to be "housing ready" before admission to the programme. Participants must accept home visits and pay rent. It was planned in 2011 to provide at least 23 enduring rough sleepers with scattered housing (not more than 20% in any housing block), using social rental housing as well as housing from private landlords. Service provision was intended to be organised by a team visiting the formerly homeless people regularly in their homes and using a case management approach.

The project in **Ghent** (Intensive Housing Counselling) started in 2008 already and is also operated by the local authority using local authority funding. The housing department of the municipal Social Welfare Center in cooperation with eight social housing companies provides priority access to 43 social housing units per year for (mainly single) homeless people. The target group in Ghent are "structurally homeless people" who have repeatedly changed between different types of accommodation without the prospect of permanent housing in the near future. Conditions of admission are a local connection (for example having had a fixed address in Ghent for at least three years during the last 6 years, or having children attending school in Ghent), a minimum duration of homelessness, an income below the ceiling for social housing and accepting "housing consultancy and guiding measures." Housing is provided in social housing dwellings throughout the city. Services aim at structuring the transition towards living alone in a tenancy, acquiring domestic skills to maintain the home, integration into the neighbourhood, making links with medical care suppliers, assessing support needs and building a network of support services. Intensive Housing Counselling is provided by four housing consultants, an administrative worker and a half-time coordinator.

The project in **Gothenburg** (Housing as a Foundation) started in 2011, is operated by Gothenburg's municipal Office of Social Services and financed by local authority funding. The aim is to integrate homeless people "with a longer history of homelessness" from temporary accommodation into permanent housing with support. In 2012 the project served 28 service users (4 women and 24 men), mainly older people, most of them having drug and/or alcohol problems. Housing was provided in 12 apartments scattered throughout Gothenburg and its suburbs which were rented by the project from private and municipal landlords, with the remaining 16 apartments congregated in one building with on-site support. The latter are provided with an unlimited lease while for those in scattered housing this is just a long-term ambition at present. In 2012 services were delivered by seven "treatment assistants" who had their office in the communal housing block and visited service users in scattered apartments at least once a week. Individualized support is aiming at integration into the neighbourhood, regular rent payments and maintenance of the apartment as well as helping with daily activities.

Aurora House in **Helsinki** started in 2010 and is operated by the non-profit NGO Helsinki Deaconess Institute. Funding is provided from national and local sources, Aurora House was developed as part of a national strategy to end long-term homelessness in Finland (see Tainio and Fredriksson, 2009 and Busch-Geertsema, 2011c). Aurora House provides permanent self-contained housing congregated in one building with on-site support for long-term homeless people (most of them single, but also to couples). Service users (all long-term homeless persons) are selected by Helsinki City Social Service Department. Most of them have substance abuse problems, often combined

with mental illness and physical health problems. The accommodation provided is congregated in one single building on eight floors, consisting of 125 apartments (123 studios and 2 two room apartments), most of them with kitchenette and bathroom. The eight floors are divided into smaller units (with 15-21 apartments each) and each unit has a living room where tenants can spend time together if they wish. Tenants hold an unlimited tenancy contract. The support provided on-site is of varying intensity and follows individual service plans agreed with the service users. Tenants use public (social, health) services when needed. There is a participatory community development programme for tenants and staff, including environmental work for integration in the neighbourhood.

The "Wohnbasis" in **Vienna** was developed in 2005. It is operated by a local authority company (wieder wohnen limited) and financed by the City of Vienna. The target group are homeless families who get priority access to 50 scattered site municipal apartments and support. Conditions of admission are a local connection (minimum stay of 8 months in Vienna), a legal status of residence, and no previous eviction because of disturbing behavior. The families have to be quite independent and to have an intention to take over the renal contract after a while. The 50 apartments house approximately 190 persons, and a mix of family types with one and two parents of different age. The 50 apartments are scattered in the municipal housing stock, rented by the municipal company and let to the families with a 'user agreement' first (lacking security of tenure). The goal is that the families will take over an unlimited rental contract with full tenancy rights after they have settled successfully. Nine workers (including five social workers, two house technicians, an apartment coordinator and the team leader) provide support (in the flat as well as in an office). Social work support includes the development of a support plan, support with tenancy problems and specific social and health problems, and families are accompanied to different appointments, facilities, doctors etc. if needed.

5.3 Other Housing First Projects in Europe (not being partners of HFE)

In a number of European cities which were not partners of HFE Housing First projects have been implemented in recent years. We can only mention here some further examples without aiming at a complete list of Housing First projects in Europe and without being able to test to what extent the projects mentioned really follow Housing First principles in practice.

Probably the most prominent example are the four French cities Marseille, Lille, Toulouse and Paris, where the Housing First approach is being tested and evaluated in a randomized controlled trial with homeless people diagnosed as mentally ill (*Un Chez-Soi d'abbord* project). As mentioned above, Finland has a national program to end long-term homelessness and apart from the HFE partner project in Helsinki, a number of further Housing First projects were implemented and are currently being evaluated in Finland. In Denmark Housing First is the overall principle underlying the national homelessness strategy which has run from 2009 to 2013. Besides the ACT-programme in Copenhagen, Housing First projects have been established in 17 municipalities testing two other support methods – Intensive Case Management and Critical Time Intervention. In Sweden some other Housing First projects have been launched, besides the HFE partner project in Gothenburg, for example in Helsingborg and Stockholm (both are subject to external evaluation), in Malmö, Karlstad, Örebro, Sollentuna and Uppsala. Most of these projects are pilot projects or small-scale services. In Norway the development of Housing First projects started during the period of HFE funding, with Bergen being one of the first cities to implement the approach. In the Netherlands about ten projects – apart from the HFE test site in Amsterdam – claim to have realised the Housing First approach, most of them being launched between 2011 and early 2013. They are located in The Hague and Utrecht, in Dordrecht, Eindhoven, Haarlem, several cities in North and Middle Limburg, and in Tilburg and Zwolle. In Austria we can find further Housing First projects in Vienna and in Salzburg and in Belgium a national programme to fund Housing First experimentation in five cities was under consideration at the time of writing this report. In Germany (as in the UK) there are a number of floating support services (and social rental agencies)

showing similarities with the Housing First approach. But many of the German projects are embedded in a local staircase system, so while they do not make it a condition to have gone through previous stages, many of their clients are referred to them by other organisations when deemed "housing ready". The projects in Germany have developed without reference to the Housing First approach. For further examples see the evaluation results of the HFE test sites, where we also asked to report on plans to upscale the approach.

6 Conclusion

In this Part I of the HFE final report we have given an overview of the HFE social experimentation project, funded by the European Commission from August 2011 to July 2013. It involved five test sites where the approach was evaluated (Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon) and facilitated mutual learning with five additional peer sites (Dublin, Gent, Gothenburg, Helsinki and Vienna) where further Housing First projects were planned or elements of the approach were being implemented. Mutual learning was supported by a high profile steering group. The project was implemented through two principle strands, a research and evaluation strand, and a mutual learning strand. Five meetings were used for exchange of information and experiences and for discussing a number of specific themes regarding the Housing First approach.

The main elements of the Housing First approach were presented and contrasted with approaches requiring "treatment first" and/or moving homeless people through a series of stages (staircase system) before they are "housing ready". Housing First diverges radically from these approaches which have been met with increasing criticism over the past few decades for being ineffective in ending homeless for people with severe and complex needs and having unintentional negative effects. Housing First seeks to move homeless people into permanent housing as quickly as possible with on-going flexible and individual support as long as it is needed, but on a voluntary basis, emphasising choice and self-determination of service users as an essential element and using a harm reduction approach. It has gained particular attention in the US, when robust longitudinal research has showed impressively high housing retention rates, especially in the model developed by the pioneer Pathways to Housing project. The eight principles of this model, which focusses on homeless people with mental illness and co-occurring substance abuse, are: housing as a basic human right; offering respect, warmth, and compassion to all clients; a commitment to working with clients for as long as they need; scattered-site housing in independent apartments; separation of housing and services; consumer choice and self-determination; a recovery orientation and harm reduction.

A number of important themes of current debates about the Housing First approach have been presented in this Part I, such as the ambiguity of the term being used for a variety of projects and strategies for different target groups, and scepticism about its effectiveness for certain groups like homeless people with very severe drug and alcohol addiction and in different national and local contexts. Scepticism was also expressed about the non-housing outcomes of the approach (regarding substance abuse and overcoming social isolation and worklessness).

It was a condition for HFE test sites to target and re-house formerly homeless people with mental illness/drug/alcohol problems or other complex support needs and as we will see in Part II it does not make sense to term any of the test sites "Housing First 'Light'", given the intensity of support provided and the support needs of service users. However it seems useful to analyse projects as to the extent to which they follow the main principles of Housing First as laid down by Pathways to Housing and where they differ from each other in regard of target groups, type of housing provided and the organisation of services which we will do below for the HFE test sites.

In Part II we will now explain in more detail the methodology of the research and evaluation strand of HFE and discuss in detail the results of the local evaluations of the five test sites.

Part II. Evaluation of Housing First Europe Test Sites

1 Methodology

HFE builds on existing and on-going local evaluations in the five test sites, rather than attempting to devise a common evaluation methodology for all test sites, primarily due to funding constraints. With the budget given and the variety of projects included it was impossible to aim at randomized controlled trials or any other more robust research method for the European project.[1] Furthermore none of the local evaluations included a control group and local evaluations started and finished at different times. The evaluation in Amsterdam was a one-off exercise, carried out in early 2011 (the period of data collection was December 2010 – May 2011, but data on housing retention data were updated for November 2012)[2] and the evaluation in Budapest was a retrospective evaluation of a project which had ended in 2009 already. Only the evaluations in Copenhagen, Glasgow and Lisbon were ongoing during the funding period of HFE (and the Glasgow evaluation was still ongoing in 2013, with more interviews planned for the period after delivery of the final report for HFE). But these three evaluations had also started before the European HFE project began and had developed their own evaluation tools.

As a result, diversity in the test sites is observable, in terms of scale and development, in terms of data collection and evaluation methods. This posed a challenge for analysis at a cross-national level, but also provided the opportunity to profit from different perspectives on a diversity of project practices.

At an EU level, a number of common key questions were developed for all five test sites. The key questions related to the following main topics:

- Numbers and profile of service users (age, sex, ethnicity/places of birth/nationality, household structure, employment status/income, housing/homelessness history)
- Support needs (and changes over time)
- Support provided/received
- User satisfaction
- Housing stability / housing retention rate
- Changes of quality of life/recovery
- Community integration/conflicts
- Costs and financial effects
- Specific positive effects, challenges and lessons learned

The mutual learning strand of HFE (involving the peer sites and the steering committee as well as the test site representatives and researchers) facilitated intensive discussions of the test sites' interim results. At the HFE meeting in Budapest, in September 2012, invited guests from Sweden, France, Norway and Finland reported about Housing First projects which were not involved as partners of HFE and have presented plans and first evaluation results regarding these projects. A number of themes and questions have been discussed at the HFE meetings, such as

[1] It should be mentioned in this context that parallel to HFE a multi-site randomized trial of Housing First in the French cities of Marseille, Lille, Toulouse and Paris was started ("*Un Chez Soi d'abord*"), but results were not published before this report was written.

[2] The evaluation report for Amsterdam is mainly based on Maas *et al*. (2010). Housing retention rates until 2012 have been updated on the basis of Wewerinke *et al* (2013).

- Why Housing First?
- Which target group?
- Which kind of housing?
- What type of support for whom under which circumstances?
- Needs assessment and vulnerability indices
- Cost effectiveness of Housing First

Coming back to the test site evaluations, Table 1 gives an overview of evaluation details. For a detailed description of evaluation tools used in the local evaluations the reader is referred to the local evaluation reports. All evaluations used interviews with service users and most have also used project administrative data on the total number and social profile of service users involved in the programme, length of time housed, etc. Nevertheless the degree to which interviews with service users were structured varied considerably. While the interviews in Budapest and Copenhagen were mainly qualitative and narrative, interviews in Amsterdam and Lisbon and to a small extent also those in Glasgow contained a number of standardized and structured questions for quantitative analysis. In Amsterdam, for example, elaborated scales for measuring loneliness and the quality of life (Lehmann Quality of Life Scale) were used, in Glasgow a Severity of Dependence Scale (SDS) to measure the severity of addiction, in Lisbon a Community Integration Scale and a Service Satisfaction Scale, etc. Only in Lisbon and Glasgow were services users interviewed twice during the HFE funding period.

Table 1: Evaluation Details

	Numbers involved in HF programme by end of 2012	Numbers of service users included in evaluation	Number of project participants interviewed for HFE report	Time frame for evaluation
Amsterdam	122	123 persons served 2006-2011 in 100 dwellings. For housing retention update 165 clients served 2006-2012	64	10/2010 – 7/2011 One-off; update of housing retention rates for November 2012
Budapest	152, but only some were rehoused in regular housing and reference year is 2008-2009	152	14 (in 11 interviews)	Ex post: 2007-2009
Copenhagen	92	76 served by the programme (2013)/ 64 housed from July 2010 to end 2012	15	7/2010 – 1/2013, on-going
Glasgow	22	22 project participants/16 housed by end 2012	21 wave one, 13 wave two (at time of HFE report)	10/2010 – 3/2013; ongoing locally until 9/2013
Lisbon	74	74	50 (2011) / 45 (2012)	1/2011- 2/2013

As well as project administrative data and interviews with project participants, interviews with service provider staff were a third important source of information in all projects. In Amsterdam and Budapest client data and assessments of clients were also reported in written questionnaires and in Copenhagen assessments of individual clients from the perspective of support workers were inserted in a monitoring data base every quarter. Additional sources of information were nuisance data collected from housing associations and the NGO operating the project in Amsterdam, interviews with key stakeholder agencies in Glasgow (to learn more about their assessment of the project´s strengths, weaknesses and overall effectiveness), and interviews with the owner of a caravan park and a focus group discussion with homeless people in a forest colony in Budapest. It should be emphasized that all five evaluations were conducted by independent researchers, based at universities or research institutes, and not by the organizations operating the projects.[3]

This report is mainly based on a synthesis of the local evaluation results and the answers given to the key questions on the European level. The key questions as well as a draft synthesis of the results were discussed in several of the HFE meetings. All local evaluation reports are available at the homepage of HFE (www.housingfirsteurope.eu). The local evaluation reports follow the overall structure of the HFE key questions, but some of the questions could not be answered by local evaluations. Generally the samples were too small to for an analysis of differences regarding sex or different age groups. As no comparison groups were used it was also not possible to prove developments and changes described as clear effects of the approach. Information on the cost-effectiveness of the approach remained rather limited.

The synthesis report also uses additional information provided in HFE meetings and results from discussions at these meetings.

For parts of the synthesis some judgement calls were necessary. This relates for example to the analysis of aims and principles which are categorized and discussed using the main principles of Pathways to Housing as one of the pioneers of Housing First (as published in the "manual", Tsemberis 2010b: 18). HFE has not employed a "fidelity test" and the first overview of the test sites indicates already that none of the projects might claim to be an exact replica of Pathways to Housing in New York. But still we can discuss the evidence available from the five test sites in relation to the principles formulated in the Housing First manual.

Judgements were also needed in order to apply a more uniform definition of housing retention as one of the most prominent measures of the effectiveness of the Housing First projects. For details see the respective chapter.

2 Commonalities and Differences between the Five Test Sites

2.1 Aims and principles

In the following we return to the eight principles of Housing First as recommended by Pathways to Housing and analyse the organisation and delivery of housing and services at the test sites as far as they are known from the evaluation reports and the discussion at the HFE meetings.

Housing as a basic human right implies that no "housing readiness" is required before admission to the programme and that it is open to the "most vulnerable" homeless people without preconditions for sobriety or readiness to accept therapies etc. In the HFE test sites this principle was fulfilled with some caveats. The data below show that there can be no doubt that people with

[3] The researchers in Budapest are employed by the organization which had coordinated the programme under focus here. But the service providers in Budapest were different organisations and there can be no doubt that the rather critical evaluation of the Budapest project was not "softened" by the position of the researchers.

complex support needs were accepted and housed in all projects and that in none of them sobriety or a willingness to accept a therapy was required. However, almost all projects require as condition for admission a "*motivation*" (Amsterdam) or "*holding a desire to sustain a tenancy*" (Glasgow). In Amsterdam income management or debt services are a condition insisted upon by the housing associations cooperating with the housing provider. For the Copenhagen project it is reported that according to the team leader "*there are individuals who have so severe support needs that these needs cannot be met by ACT-support and whom it is therefore not possible to assign to the programme. These are for instance individuals with intensive care needs, such as a need for intensive daily support, and who are the target group for (..) institutional accommodation with full-time on-site support. There are also some substance abusers who have been assessed not to be possible to house and support through the ACT-programme, due to very chaotic behavior*." (Benjaminsen, 2013: 16). However, the same team leader stressed that the project has accepted quite a number of people with chaotic behaviour and only very few extreme cases were not accepted.

All in all there are no signs of any systematic "creaming" or "cherry picking" of participants in the projects. Only the evaluation report from the Budapest project, where in principle all homeless people from the forest had access to support by the programme, mentions that some service providers preferred to work with people with partners or children and with some kind of income or a motivation to get such an income, but other service providers in the same programme had no such preference criteria. These criteria also have to be seen in the context that financial support by the project in Budapest was extremely limited in amount and duration and that welfare provision in Hungary for covering the costs of housing and living for unemployed people is extremely poor.

Admission criteria in Amsterdam, Copenhagen, Glasgow and Lisbon included the obligation to accept a visit to their homes at least once per week (six visits per month in Lisbon), which is in line with the conditions of Pathways to Housing. Service providers emphasized that the cases where such visits were refused were relatively rare in practice and would usually lead to a number of additional attempts to get in touch.

Payment of rent was another condition for getting a tenancy. In some projects this was further regulated by the condition of income management (in Amsterdam) or a strong encouragement to agree to direct transfer of rent from subsistence benefits (in Copenhagen; Housing Benefit is routinely paid directly to social landlords in Glasgow). In Lisbon (as with Pathways to Housing in New York) participants had to agree to pay 30% of their income towards rent costs.

Respect, warmth, and compassion for all clients is a very important principle of the Housing First approach, but is rather difficult to evaluate and measure whether it is fulfilled in practice. In some of the evaluations aspects of these basic requirements are mentioned when users emphasized that they don't have to lie about addiction issues, when they praised staff for not being judgmental or when they were convinced that they could count on the service whatever would happen. We will turn later to what we know about satisfaction of service users. But it should be emphasized here, also as a result of the discussions at HFE meetings, that the individual ability of support staff to show compassion, warmth and respect and to build up trusting relationships with the service users is an important success criterion, which should not be underestimated.

A commitment to working with clients for as long as they need was made by all projects with the exception of the Budapest project where funding for financial as well as social support was restricted in general to one year only. It is important to note that the commitment to work with clients as long as they need has of course important implications with respect to the need for open-ended funding. During the evaluation the number of clients who stayed housed but had stopped receiving support from the Housing First project because their support needs had diminished was rather low in all of the five test sites. If a project experiences cuts in funding – as was the case for the project in Lisbon – this clearly poses a serious problem for keeping this commitment (but could be managed in Lisbon for the large majority of programme participants).

Scattered-site housing in independent apartments were offered to project participants in Amsterdam, Glasgow, Lisbon, and to some of the service users in Copenhagen (where congregate housing and even group homes were used for the other service users). In Budapest help with renting scattered private housing was one of several options open to the service users. The different types of housing used in Copenhagen provided the opportunity to analyse the impact of housing types, though doubts can be raised about whether group homes where people have to share kitchen and sanitary facilities can still be called Housing First. We will come back to this point and also to the issue of different ways to procure housing further below.

Separation of housing and services is a principle which is described in the Pathways to Housing manual mainly as one of organising the two kinds of services separately within the same organisation. When a project participant has a crisis and needs to be admitted to a clinic, a detoxification centre or is sent to prison he or she can still receive support from the programme and – as long as rent costs are covered – can also sustain the tenancy. If the client is evicted because of a lease violation, support can still go on and the person can be supported in finding another home. And if support needs diminish the client can remain as a tenant without receiving any support from the programme any more: "*A client does not need to move out of the apartment or transition elsewhere in order to graduate from the PHF program. Graduation simply means that PHF services are discontinued or the client receives less intensive services through a community-based program and continues to live at home*." (Tsemberis, 2010b: 25). In general this principle also applied for the HFE test sites in Amsterdam, Copenhagen, Glasgow and Lisbon. Limits are however set by local or national regulations regarding the coverage of housing costs by housing benefit or social assistance in cases of long-term imprisonment or hospitalisation.

In some of the projects the separation of housing and services goes further than in the pioneer model of Pathways to Housing. While the organisation in New York rents the flats from private landlords and sublets them to the service users, only the service providers in Lisbon and in Amsterdam (the latter using social housing instead of private rented housing) have been following this model. In the other three test sites the tenants have direct contracts with the owners of the house (in Glasgow and Copenhagen they are tenants of social housing), so that housing and services are separated even more strictly than in the pioneer model. In terms of a potential conflict of interests and tenant security this can be seen as a positive aspect in these European models, but in terms of being able to offer alternative accommodation in case of an eviction and with respect to the sometimes considerable waiting times for social housing it might also have some disadvantages.

Consumer choice and self-determination are important elements of the Housing First approach but again quite difficult to evaluate. They relate to different aspects of choice, like the area where the service users want to live, the neighbourhood, the type of apartment, furniture, household items etc., but more importantly they relate to letting the clients define their own recovery goals and taking these goals seriously in providing support. The evaluations do not tell us too much about this aspect.

In all projects participants had some choice regarding the housing they wanted to live in, though some of the options implied longer waiting times: for example, waiting lists existed for scattered housing in Copenhagen, while in some of the communal housing there were vacant places and no waiting list existed. If participants in Glasgow wanted to live in a more popular neighbourhood they had to wait longer for a suitable vacancy, as would be true for any social housing applicant. For the Budapest project it was emphasised that the flexibility of funding allowed project participants to chose on an individual basis which type of accommodation they wanted to live in, of course within the limitations of the funding available.

Regarding the individual's recovery goals and participants' influence on the type and intensity of support, we can only report here that individualized support plans were developed with the participants in Amsterdam, Glasgow, Lisbon and with most of the service users in Copenhagen. In Am-

sterdam the analysis included a more detailed account of the extent to which the support provided matched the needs of the service users from their perspective. This was the case to a considerable extent. Below we will return to the issue of service users satisfaction, and present data indicating relatively high satisfaction of users in the projects where this was part of the evaluation (Amsterdam and Lisbon).

Recovery orientation and a harm reduction approach: All the HFE test sites accepted active users of drugs and alcohol as project participants and placed particular emphasis on the reduction of the negative consequences of harmful behaviour related to drug and alcohol abuse. Due to the limited resources available (and a lack of qualified personnel) it was probably most difficult for the service providers in Budapest to achieve any sustainable and positive effects in this regard. An orientation towards the recovery of their clients was also essential for all projects, though we do not have any more detailed analysis of the methods used and on the ways how the recovery orientation was secured in relationships between staff and clients.

Summing up and keeping in mind that we have not conducted a proper fidelity test, we can state that, with the exception of the project in Budapest, the HFE test sites have broadly followed most or all of the principles of Housing First as laid out by Pathways to Housing in New York. Some caveats apply: there might have been some selection of clients in the beginning, based on their willingness and motivation to hold a tenancy; congregate housing was used in Copenhagen; and we have only limited information on the degree of choice and self-determination service users had in the different projects.

The Budapest project was included as a test site because it was one of the very few programmes in Central and Eastern Europe which was trying to bring rough sleepers directly into mainstream housing with support, sharing some of the basic principles of the Housing First approach. However, some important elements are also missing: support in Budapest was time limited from the beginning, and – as we will see – far less intensive than in all of the other test sites. Capacities to achieve a harm reduction approach and further recovery were therefore limited. In contrast to all other projects, long-term housing retention was also not an explicit target of the Budapest project (the main target being to clear the forest of homeless people). We therefore need to keep in mind for what follows that the test site in Budapest was not really practising the Housing First approach, but rather some elements of it – and in a relatively weak welfare context where housing costs and the costs of living are not covered to any reasonable extent by basic benefits for those who are without income from work.

2.2 Different national and local backgrounds

Readers of this report should always keep in mind the great variety of local contextual conditions in the five test sites. This applies to the accessibility of housing in the five cities, the role of social housing, the availability of social benefits and housing allowances, the availability and accessibility of mainstream social and medical services, project funding and many more aspects which we cannot present and analyse in sufficient detail in this report.

Each of the five test-sites belongs to a country with a different welfare regime:[4]

- Denmark (test-site: Copenhagen) represents the social-democratic welfare regime, classified as redistributing wealth and having a relatively generous system of social welfare, housing and unemployment benefits.

[4] The typology of welfare regimes drawn upon here was introduced by Esping-Andersen (1990) and there is a vast literature discussing this typology and trying to develop it further. For recent work discussing the relationship between welfare regimes and homelessness see Fitzpatrick and Stephens (2007), Stephens *et al*. (2010) and O'Sullivan (2011).

- The Netherlands (test-site: Amsterdam) are often seen as a hybrid of the social democratic welfare and the conservative welfare regime, the latter being classified by limited redistribution of wealth and group-related risk pooling with earnings-related benefits for those who have participated in the labour market.
- The UK (test-site; Glasgow) represent the liberal welfare regime, characterized by an emphasis on free markets and a residual welfare safety net, which is means tested and seeks to provide minimum benefits against poverty rather than redistribute wealth.
- Portugal (test-site: Lisbon) is classified as one of the Mediterranean welfare regimes, where people in need rely heavily on informal family support and state welfare measures are poorly developed and minimalist in nature.
- Hungary (test-site: Budapest) represents the conservative post-socialist welfare regime with a moderate degree of employment protection and transfer oriented labour market measures.

It a recent study on the interaction of welfare regimes, labour markets and housing systems comparing a selection of European representatives of all welfare regimes (including all nations where the HFE-test sites are located except Denmark; instead Sweden represented the social-democratic welfare-regime in this study) and analysing the impact on homelessness among others, the following conclusions were drawn: "*Welfare regimes were clearly relevant to outcomes for homeless people – the strongest mainstream protection to those at risk of homelessness was offered in the social democratic/hybrid regimes we studied (Sweden and Netherlands), and the weakest protection was to be found in the Mediterranean regime (Portugal) and, even more so, in the transition regime (Hungary) (although it is possible that extended families may play a stronger safety net role in these welfare contexts than in north western Europe). One might expect the UK, as a liberal welfare regime, to offer weak protection to homeless people. However, along with Germany, the UK probably has the most sophisticated targeted interventions on homelessness, especially with respect to homelessness prevention. These targeted interventions seem capable of 'overriding' difficult structural contexts to deliver reasonably good outcomes for homeless people, albeit that the supply of affordable housing accessible to vulnerable groups seems a consistent constraint across all of the countries studied, particularly in pressurised regions and where social housing providers are not obliged to prioritise homeless people and others in the most acute need.*" (Stephens at al, 2010: 257). And the authors add that "*…indeed all of the countries studied, with their widely varying welfare and housing system contexts, were able to provide examples of effective targeted interventions on homelessness*" (ibid.).

Hence, while context matters when it comes to the details of local project conditions and while the role of access to housing for vulnerable groups is mentioned as a particular challenge here (see next section) we may assume that even under difficult structural conditions successful targeted interventions are possible.

All the five test site countries have a system of subsistence benefits and housing allowances to some extent, but access to these types of benefits and their function in practice as a safety net against miserable living conditions is obviously very different. While no problems for take up of subsistence benefits were reported from Amsterdam, Copenhagen and Glasgow, this was a problem for homeless people in Lisbon and especially in Budapest even after they have been rehoused.

In **Lisbon** the minimum social income is only paid to people in need if they sign and comply with an inclusion contract and are enrolled in the Jobcentre in their neighbourhood. "*The maximum value they may receive is 178.15 Euro which does not allow people to have a decent minimum and be able to afford a house*" (Ornelas, 2013: 15). Usually it takes quite some time until the administrative procedure is completed and regular payments are made. The Casas Primeiro project helped their tenants to apply to a charitable emergency fund in Lisbon to receive an intermediate payment to cover their living costs until social benefits were approved. For covering part of the housing costs the same charitable fund of Santa Casa de Misericórdia was approached. Homeless

people who are not enrolled in the Housing First programme often face a big barrier because landlords' demand a guarantor and 3 months' rent paid in advance.

In **Budapest** the conditions for receiving the minimum social income are similar. In addition, since 2012, one has either to work or volunteer for 30 days during the year to be eligible for the basic benefit. The monthly amount paid for the minimum benefit was appr. 70 Euro in 2013. There is no or almost no housing allowance available in Hungary, and administrative burdens are often a significant barrier for applying for the small amounts available at all. "Housing maintenance support" paid by the state does not subsidise the rent but the costs of utilities and usually does not exceed the amount of 10-25 Euro per month. There is no rent subsidy paid by the Hungarian state and while local authorities can provide additional benefits to help with housing costs, the sums paid do not offer real help for those with no or very low incomes. For the re-housed homeless people – as for other tenants as well – it is a particular problem that in order to be eligible for any housing allowance they would need to register their address officially. However, many landlords deny their tenants the right to establish a legal address in their property, because they would have to pay income on the rents received in this case. This problem, lack of an official address despite being a tenant, was brought up several times in the Budapest evaluation report and also made it difficult for re-housed programme participants to access existing mainstream social and health services (Fehér and Balogi, 2013: 4,5).

None of the other evaluations reported particular challenges in cooperating with mainstream services. In some cases close cooperation was part of the concept, for example cooperation with psychiatric nurses in Amsterdam, in others cooperation was facilitated by regular meetings with other social services, accompanying clients to meetings with them, or including them in a steering group for the project (e.g. in Glasgow). However, it was emphasised as a particular strength of the Copenhagen project, where staff of the job centre and the social service was an integral part of the project team that they were able to prevent sanctions against the formerly homeless people and look for suitable activation offers (see also below the section on organisation of support).

Except for Copenhagen where the Housing First approach is defined as an essential element of the national homelessness strategy and is practised in other projects as well, in none of the test sites was it a significant feature of a local or national strategy. All of the projects were pioneer projects experimenting with the approach for the first time in a service sector for homeless people which was either dominated by the staircase system (as in Amsterdam and Glasgow) or by a system which predominantly focused on emergency services for homeless people with no or very weak links to the regular housing market.

Summing up: it is important that the different local and national contexts of the five HFE test sites are taken into account when comparing the evaluation results of the five Housing First projects. All five test site countries represent a different welfare regime with a different type of provision of welfare and – though not always directly related – a different development of a minimum safety net for marginalised groups. While no easy and direct conclusions can be drawn about the influence of welfare regimes on the extent and structure of homelessness in individual countries and while the accessibility of housing for vulnerable groups is a particular important influencing factor we can also assume that despite the variation in conditions successful targeted interventions on homelessness are possible even in difficult structural contexts.

Structural conditions were certainly more difficult for the projects in Lisbon and Budapest with low levels of subsistence benefits and housing allowances and substantial administrative barriers for claiming the small amounts available, especially in Budapest.

While in Budapest administrative barriers were also blocking access to mainstream services for many project participants, none of the other project evaluations reported particular problems of cooperation with mainstream services, but were keen to facilitate such cooperation with a variety of measures.

In all test sites the Housing First project was one of the first pioneering attempts to test this approach in an environment dominated either by staircase systems or by emergency provision for homeless people with no or very weak links to the regular housing market. Only the project in Copenhagen was part of a national (and local) strategy to promote and implement the Housing First approach on a wider scale.

2.3 Provision of housing

We have already noted that only the project in Lisbon followed the example of Pathways to Housing in renting and subletting flats from the private rental market. While the Amsterdam project also rented and sublet housing to project participants, social housing from housing associations was used in this case.

Social housing was used in three of the test sites but not in the two others. In both of the countries where it was not used (Portugal and Hungary), the stock of social housing is either extremely small and not accessible for large numbers of homeless people (as in Hungary) or (as in Lisbon) has long-waiting lists and is situated at the margins of the city, often with poor infrastructure and not well connected by public transport. In Lisbon private rental housing was preferred because it was better placed to support community integration, easier and faster to get access to, and more flexible (moves of project participants within the stock are easier) On the other hand social housing stock in Amsterdam, Glasgow and Copenhagen is available for much larger parts of the population, not only for marginalised households (the Netherlands, the UK and Denmark are among the European countries with the highest share of social housing as a proportion of total housing stock).[5] And in all three countries municipalities have instruments to influence the allocation of social housing which were particularly important for the Housing First projects in Glasgow (Scotland) and Copenhagen (Denmark).

The UK, including Scotland, has a "statutory homelessness system" which was introduced in 1977 and gives certain households who are accepted as homeless by local authorities a legally enforceable right to be rehoused in "settled" accommodation. In Scotland there is a duty also on housing associations to rehouse statutorily homeless households referred to them by local authorities and they can only refuse such referrals in very limited circumstances. Normally the expectation is that they will rehouse referred households within six weeks, but if the households have a preference for specific areas of the city waiting times may be considerably longer. In Glasgow the local authority relies entirely on housing associations for rehousing homeless people as the city has transferred all the council housing stock to housing associations (see Johnsen with Fitzpatrick, 2013: 4). Project participants in Glasgow receive a direct and unlimited rental contract with the housing association (a Scottish Secure Tenancy).

In **Copenhagen** the municipality can assign one third of all housing units becoming vacant in public housing to households in priority need of housing. Homeless people with social problems are not the only priority group, but are "competing", for example, with single mothers, persons with physical disabilities or mental illness and other groups. As demand exceeds supply waiting time is about four months, for younger people and people with pets waiting time can be far longer. All project participants of public housing in Copenhagen get a permanent ordinary rent contract.

As mentioned before, about three fifths of the project participants in Copenhagen were provided with accommodation in congregate housing, where all residents were formerly homeless people

[5] According to Dol and Haffner (2010: 67) the proportion of social housing as percentage of total dwelling stock was as high as 32% in the Netherlands and 19% in Denmark in 2008, and as low as 3% in Hungary, a country with the extraordinary high proportion of more than 90% owner occupiers. Recent data for the share of social housing in the UK and Portugal (which are not provided by Dol and Haffner) can be taken from Pleace *et al*. (2011: 40/41): According to that source the proportion of social rental housing was 18% of the total stock in the UK and 15% in Portugal.

or otherwise socially vulnerable persons. One of these four congregate units was a large ten-storey block with a total of 70 apartments which had previously been a residential unit for mentally ill persons and had common rooms and staff-facilities in the ground floor. 11 apartments in this house were used for some time by the Housing First project with ACT support, but after conflicts in the house the service users were offered relocation into other housing, mainly into independent public housing. The second communal housing unit was a shared group home with 20 rooms dispersed in six apartments in an ordinary apartment building in the inner city. In each flat the residents had to share a bathroom and kitchen. A number of rooms were reserved for persons of Greenlandic origin. In summer 2012 only 15 of the 20 rooms were used because many potential tenants did not want to live there and preferred scattered housing in self-contained flats, but also because people using hard drugs are not allowed to live there (while the use of alcohol and hashish was tolerated). A number of residents at this place had already been living there before the ACT team started to provide support to them in the framework of the Housing First programme. The third communal housing unit was another group home with room for ten residents. While there were two self-contained flats with own kitchen and bath, residents of the other eight rooms had to share facilities. As with the other group home only some of the rooms (seven out of ten) were occupied because potential tenants did not want to live there and during the year 2012 it was decided to offer the Housing First project participants in this building to move to other accommodation. All but one had done so by the time of the last interview. Finally a new communal housing unit came into use for the Housing First programme in Copenhagen in summer 2012 consisting of 18 small terraced houses, each with own kitchen and bathroom. There are no on-site staff and no common rooms available at the new unit (for further details see Benjaminsen, 2013, 18-21). We will come back to a comparison of experiences in the different communal housing units and in scattered housing in Copenhagen. Suffice it to note here that some doubts can be raised about whether we should speak at all about Housing First in regard to the group homes where people had to share facilities. While tenants had a permanent contract the description indicates that it was very similar to hostel-style accommodation. It is interesting to note that there were conflicts in two of the communal housing units and two of them were more or less given up on as housing options for the Housing First project. While waiting lists existed for the scattered apartments in public housing, rooms in the group homes remained vacant.

In **Amsterdam** the Housing First project used social housing as well, but here the service provider cooperated closely with five social housing associations and held the main contract with them while the service users got a "lease and care contract". They can get a direct contract with the housing association if they become more independent, which was accomplished for 16 out of 165 service users registered between 2006 and the end of 2012. Influence of the municipality on the allocation process is nevertheless evident as it is reported that the City of Amsterdam plans to make available 240 housing units, or even more, for Housing First in the future (Wewerike *et al.*, 2013: 10 and 34).

In **Budapest** the rehousing project was not in a position to actually provide housing directly to homeless people from the forest. They had a limited amount of money per client at their disposal for bearing part of the housing costs and it was clear from the beginning that this money would not be directly handed out in cash to the client but used to pay, for example, for a deposit and a diminishing part of the rent during the first year. The average amount available per person and year for covering the costs of housing was 800 Euro. Given that a small independent apartment in Budapest costs at least 140 Euro per month plus utilities, and even a single room in a private apartment costs at least 100 Euro plus utilities, it was clear that the amount available was too small to cover the full costs of housing even for the first year. In addition, landlords usually demanded one or two month deposits when signing the contract. "*The amount of housing support usually decreased as time went on, so tenants had to pay a growing rate of the costs of their housing – eventually ending up paying it all by themselves." (Fehér and Balogi, 2013: 12).* As there is no rent subsidy available from the Hungarian State renting a flat or a room in an apartment was only a feasible option for those with some kind of stable income (from pensions, benefits or paid work)

and it was easier for people who could share the costs with others, for example a partner in a couple or a family. Six persons were supported to buy their own property. In Hungary almost 90% of the population own their own property, but in the project the amount of financial support only allowed for buying "*property of very low quality (or a container home), that needed renovation or lacked water, electricity and gas. Mostly these properties are located in the countryside far from bigger cities which decreases the chances of finding a job.*" (ibid.: 17). Project staff helped the participants in their search for housing and people from the forest could make phone calls, use the internet and advertisement papers in day centres and offices. In most cases it was the homeless people themselves who found their housing, although searching for it often took three to four months and many experienced discrimination because of their Roma background. Staff also accompanied the participants to meetings with landlords and were always present at the signing of the contract and when the deposit or (parts of) the rent had to be handed over to the landlord.[6]

Other housing options for homeless project participants in Budapest were workers' hostels, a homeless hostel in a few cases with high support needs, and trailers. Trailers were seen by some support organisation as a financially sustainable option in the long term which could suit the people coming from the forest (for instance, where they could bring all their belongings including pets). Some trailers were bought by the Public Foundation for the Homeless and put up in a trailer park where the project participants could rent them at 67 Euros for rent and common expenses per month plus electricity costs. After two years the residents could "inherit" the trailer and become the owner of it. However, questions may reasonably be asked about including this type of accommodation as a suitable means of providing "Housing First": "*Although after a while new residents of the trailer park formed a community, support workers feel that the park can lead to further segregation of clients. It is on the border of the city, far from everything and residents cannot mingle with people from other social backgrounds. They keep on living with others on the margin of society. In this situation, employment could be the only field of integration for them. Many people worked for the trailer park owner, which could lead to further isolation*." (Ibid: 16)

We will therefore focus further below on those project participants in Budapest who have rented a dwelling or a room in an apartment or (in a few cases) have bought their own property. 59% of the project participants in Budapest have been "housed" in this sense.

Summing up the results on the provision of housing we should first emphasise that getting access to housing is of course an essential requirement of any Housing First project and that in the HFE test sites this is organised in quite different ways. Social housing is used where it is available as a considerable proportion of the housing stock and is accessible because municipality have the right (and in Scotland even the duty) to allocate parts of social housing to people in urgent need, including homeless people. In Amsterdam social housing is rented by the service provider and sublet to Housing First programme participants. Private housing (and other types of accommodation) was used in Budapest, because the share of social housing is extremely low and not accessible for large numbers of homeless people and in Lisbon, because social housing had long waiting lists and private rental housing could be acquired quicker and was seen as more flexible and better placed for supporting community integration of Housing First participants.

In three of the five test sites (Glasgow, Copenhagen and Budapest) direct and unlimited contracts between landlords and Housing First participants were the rule while in two projects (Lisbon and Amsterdam) the organisations providing the support rented the apartments and sublet them to the programme participants. In the first version separation of support and housing is further developed than in the Pathways to Housing model (regarding the legal

[6] It is worth noting that landlords often refused to give a receipt for the deposit as well as to sign a rent contract in some cases because they are responsible for declaring the rent as income towards the tax authorities, which most private landlords in Hungary do not do.

division of roles). In general the latter version might facilitate quicker availability of alternatives in cases where a tenant has to leave a dwelling because of a violation of the lease or conflicts with neighbours. But – in contrast to the pioneer project in New York – the offer of a second and third dwelling for project participants was less frequent. In Amsterdam only eight out of 56 tenants included in the evaluation study of 2011 lived in a second dwelling provided by the NGO operating the project and only one in a third dwelling. 87% had always lived in the same dwelling during their participation in the project (Wewerinke, 2013: 21). It should also be noted here that there was a considerable number of programme participants in Copenhagen and Glasgow who were still waiting for allocation of scattered social housing at the end of the evaluation period due to rather long waiting times for receiving a flat.

Finally the fact that in Copenhagen apart from scattered housing the ACT approach was also practiced and evaluated in communal housing provided us with the opportunity to compare the advantages and disadvantages of the two approaches.

2.4 Organisation of support

In all test sites staff visited the formerly homeless people at their new homes and in Amsterdam, Copenhagen, Glasgow and Lisbon the acceptance of weekly home visits (in Lisbon of six visits per month) was a condition for admission into the programme. In the four test sites mentioned staff were available (on call and for a crisis intervention) 24 hours a day, seven days per week.[7] Some of the project managers report that this availability (often secured by a mobile phone) was quite important for the participants to provide a sense of security, but that emergency calls at night or during the weekends were very rare in practice.

Another common feature of support was that it was described as client-centred and worked in most cases with individual support plans. Motivational interviewing was used in several projects.

Only one of the five test sites, the project in **Copenhagen**, followed the pioneer model of Pathways to Housing in providing integrated support by an Assertive Community Treatment (ACT) team which incorporated a nurse, a psychiatrist and addiction specialists as integrated part of the team. It should be mentioned here that Pathways to Housing also uses an Intensive Case Management team. In their manual the differences are described as follows: "*ACT teams generally serve clients with severe psychiatric disorders and work as a team; ICM teams serve those with moderate psychiatric disorders. While an ACM team is typically composed of specialists, ICM teams are composed of generalists who work individually; they also broker services from other agencies and entities. Both types of teams manage a wide array of clinical and support services, delivered mostly in the client's own environment*" (Tsemberis 2010b: 89). In Copenhagen ICM is also used for integrating homeless people under the Danish homelessness strategy (which generally follows a Housing First philosophy), but this was not evaluated for the HFE project.

The ACT team in Copenhagen consisted – at the time of the evaluation - of social support workers (most of whom have a social work degree), a nurse, a psychiatrist (part-time, two days a week), two part-time addiction councillors, a social office worker and a job centre worker (both with discretional powers over support and benefits). In January 2013 this team served 76 service users, which was seen as a maximum amount.

In **Amsterdam** provision of housing support and mental-health support were divided, but both teams worked in close cooperation with each other. The support-team of the organisation in charge of the Housing First project (Discus) consisted of 19 workers with very different background including social workers, an anthropologist, a nurse, a sports teacher, and a peer expert (a staff member with lived experience of homelessness). Some workers have qualifications in psy-

[7] In Copenhagen the team leader had a mobile phone number for emergency calls, but other staff were only available during daytime.

chiatry, psychology, or child services. While they provided social support across different dimensions, based on a client-centred and strength-based approach, following a rehabilitation methodology with an eight phases model they cooperated closely with community psychiatric nurses who were responsible for mental health support and treatment, but were not employed by the NGO in charge of the project. Support provided by Discus was relatively intensive with a ratio of staff to service users of 1:6-8. According to the evaluation report, Discus provides 4.5 – 10 hours of services per client per week, of which about 3.5 hours on average are provided as face-to-face contact (varying to a great extent between individual clients). The rest of the time is used for organising the work and also for availability during office hours and the 24/7 hours emergency service (Wewerinke *et al.*, 2013: 10-11).

In **Glasgow** the Housing First support team consisted of a service co-ordinator, two assistant service co-ordinators and four peer support workers (all employed full-time). The Glasgow project therefore stands out for the important role it gave to the peer support workers who have experience of homelessness and substance abuse and deliver most of the day to day support of support to service users (although the other staff members are also actively involved in frontline service delivery). Each peer support worker had four to five clients at the time of evaluation. If we include the three other staff members we even have a staff service user ratio of about 1:3. If service users are in need of more specialised services (such as health care, drug or alcohol treatment, welfare benefits, education/training), the Housing First support workers assist them to get access to these services.

In **Lisbon** the support team had six staff members and a ratio of one support worker for 11 service users in 2011. Because of massive reduction of funding and a reduction of the number of clients (from 60 to 50) the team was reduced to four staff members in 2012. One staff member had mental health problems and experience of being homeless for many years. In contrast to three of the other test sites support in Lisbon also included – in addition to home visits and individual meetings with clients in neighbourhoods and other community contexts – a weekly group meeting, in the headquarters of the NGO operating the project, "*where the participants have the opportunity to raise and discuss, with their peers and staff team, issues of their concern, share experiences and contribute to program development and improvement*" (Ornelas, 2013: 4). It might be of interest, that for example in Glasgow such a group meeting was offered as an option to service users, most of whom have rejected this option, while it was first conducted on a monthly basis in Lisbon and was requested to be every week by some of the service users. Group meetings and group activities are also offered in Amsterdam.

In **Budapest** re-housing support was provided by seven organisations which had all been active in outreach work in Budapest for a long time. However the Pilisi Forest project was the first project for the organisations to move rough sleepers directly into housing (or the other types accommodation mentioned already). Client numbers per organisation varied between 10 and 45. For each client they were helping out of the forest the organisations received an amount of 200 Euro (in addition to the 800 Euro for covering housing costs) which was planned to cover the costs of support for a whole year. Given that a minimal annual salary for one support worker with a degree in social work or that of a social assistant was about 5,000 Euro in 2009, an organisation would have needed to support at least 24 homeless people to be able to pay for one full time staff to do that work (see Fehér and Balogi, 2013: 38). Accordingly we can assess the intensity of support as a staff client ratio of 1:24. However, most organisations did not hire extra staff at all, but gave the task to their existing outreach workers, who provided support in their free time in addition to their regular working hours. In any case the time for supporting clients after they have found their accommodation and moved out of the forest was restricted and much more limited than that in any of the other projects.

Summing up we may distinguish different ways of organising support for Housing First participants while the common features of (almost) all projects were regular home visits, a client centred approach with individual support plans and 24/7 availability of support staff for crisis

interventions. What differed considerably was the integration of mental health, physical health and addiction specialists in the teams (only fully achieved in the ACT team of Copenhagen, close cooperation in Amsterdam, less integrated in the other peer sites) and the role of peer support (very high with four peer workers in Glasgow, so far non-existent in Budapest and Copenhagen, but under consideration for future development of the team in Copenhagen). In Amsterdam and Lisbon one member of each team had "lived experiences" of homelessness.

Group meetings were only used in Lisbon, while in all other projects the support was highly individualised and in at least one of them group meetings were even actively rejected by the majority of project participants.

While the integration of a multitude of disciplines was emphasised as very positive in the evaluation of the Copenhagen project it was not seen as a particular problem to cooperate with existing specialist services in other peer sites (except for the Budapest project). It has also to be taken in account that ACT is quite an expensive approach, and if close cooperation with specialists in pre-existing teams works well the integration of all specialists in the Housing First team may not be essential (though it might still hold some advantages, as is claimed for the Copenhagen project). Nevertheless this will always depend to a high extent on the concrete local conditions.

We have mentioned already that if we followed the classification of Pleace (2010: 5) we would have to classify all projects under review in the HFE test sites, with the exception of Copenhagen, as "Housing First Light", as none of the others directly provides drug and alcohol services and psychiatric and medical services.[8] But it is important to emphasise that the projects in Amsterdam, Glasgow and Lisbon do *not* target people with low needs nor do they provide support of a relatively low intensity. The ratio of support workers to service users in Amsterdam (1:6-8), Glasgow (1:3-5) and Lisbon (1:11) rather demonstrate a rather high intensity of support;[9] only in Budapest is it much lower at 1: 24. Finally, given the severity of needs of the target groups in all projects we would not want to use the term "Housing First Light" in any of them. Perhaps it would be most appropriate for the Budapest project, but even there we should probably refrain from speaking of a Housing First project at all, as a number of necessary conditions were not fulfilled.

2.5 Target groups

From the brief project description above one can see that the target groups for HFE projects were similar but not always the same. All projects aimed at re-housing homeless people with severe and complex support needs and in all projects the target group included long-term homeless people with experiences of sleeping rough. But only the Lisbon project followed the pioneer in New York by making access dependent on service users having a diagnosis of mental illness. In Amsterdam either/or psychiatric and addiction problems were inclusion criteria. In Copenhagen homeless people with a mental illness diagnosis would usually be supported by the mental health authorities directly, so that typically those who participated in the Housing First project were people who were excluded or excluded themselves from this sector.

[8] As noted already even in Pathways to Housing the ACT approach with direct integration of health experts and addiction specialists is not the only approach applied and Intensive Case Management is used for service users with "moderate psychiatric disorders".

[9] The „Manual" of Pathways to Housing mentions staff-client ratios of 1:10 for ACT-Teams and for Intensive Case Management staff-client ratios range between 1:10 and 1:20, depending on the severity of clients' needs (see Tsemberis 2010b: 93 and 130).

In Glasgow active addiction was the main access criterion, which is of particular interest because – as mentioned above - some researchers in the US have raised doubts whether the Housing First approach is well suited to people with severe and active addiction (see Kertesz *et al.*, 2009, and Tsai et al, 2010; but see more positive results regarding substance abuse in Padgett et al, 2011 and Edens *et al*., 2011). While the extent of use of hard drugs (heroin) was a particular feature in Glasgow we can also find high proportions of alcohol abuse in Amsterdam, Copenhagen and Budapest.

In Budapest the main criterion for being a member of the target group was to have lived in the the forest owned by the Pilisi Forest Company. On the one hand most of the people were long-term homeless people with complex support needs, living in shacks, tents or sleeping rough, on the other hand they differed from the other target groups – as we will see – in terms of household structure, income and other features.

Apart from the Budapest project all other projects targeted people without children living with them and mainly single men and women. In Lisbon preference was given to people living on the streets, to those who are the longest in the situation of homelessness and to women.

2.6 Conclusion

The HFE test sites were located in five countries representing different welfare regimes and in big cities with quite a variety of local contextual conditions, regarding the accessibility of affordable housing and social and housing benefits etc. The structural conditions and the level of general welfare and social protection were more difficult in Lisbon and especially in Budapest with low minimum benefits and housing allowances and barriers for vulnerable people in taking up the limited financial support available. But previous research has shown that targeted interventions on homelessness are possible even in difficult structural contexts.

In all test sites the Housing First project was one of the first pioneering attempts to test this approach in an environment dominated either by staircase systems or by emergency provision for homeless people with no or very weak links to the regular housing market. Only the project in Copenhagen was part of a national (and local) strategy to promote and implement the Housing First approach on a wider scale.

None of the HFE test sites was an exact replica of the pioneer project Pathways to Housing in New York although – except for the Budapest project – they have followed this example in many aspects and have broadly followed most of the principles of Housing First as laid down by the "manual" of this project. Some caveats apply: We have not conducted a proper fidelity test and for some of the principles we have insufficient information to confirm that they have been followed in practice. While all HFE projects served homeless people with complex and severe support needs, there might have been at least some selection of clients in the beginning, based on their willingness and motivation to hold a tenancy. In one of the projects (Copenhagen) congregate housing was used for a majority of service users at the outset, but during the evaluation period increased use was made of scattered housing as a result of negative experiences with the congregate units.

Other ways in which the HFE test sites diverted from the Pathways to Housing pioneer project included:

- Only one of the projects (in Lisbon) made it a condition that project participants have a diagnosed mental illness, but in all projects people with mental health problems comprised a considerable part of the target group. One of the projects (in Glasgow) stood out as supporting exclusively homeless people with active addiction, most of them addicted to heroin. But all projects saw active substance abusers as part of their target group.
- Only one project (Copenhagen) worked with an ACT team including a psychiatrist, a nurse and addiction specialists as integral parts of the team. But in all test sites – again with some excep-

tion in Budapest – close cooperation with other specialist and mainstream services was sought and seemed to work. Peer experts with "lived experience" – highly recommended as part of the team by Pathways to Housing – were not part of the support team in two of the five HFE projects, but played a very prominent role (forming the majority of staff members) in one of them (Glasgow).

- Only one of the projects (Lisbon) followed the pioneer in New York by renting dwellings from the private rental market and sub-letting them to the service users. A second project (Amsterdam) followed the model of renting and subletting, but used social housing from a number of housing associations. Social housing was used in two other test sites (Copenhagen and Glasgow), where national and local regulations facilitated priority access for homeless. In three of the five projects service users had a direct rental contract with the landlord, thereby following the principle of separation of housing and support to an even greater extent than in the pioneer model. Most of them followed this principle also in the sense that a transitional stay in hospital or prison did not automatically lead to a loss of their dwelling and if that was the case (because rental costs were not covered any more) services kept in contact and clients got another chance to be rehoused by the programme after release from prison or hospital.

With the exception of Budapest, all of the HFE test sites worked to at least some extent with a client-centred approach and individual support plans, had regular home visits as a rule (and an obligation for clients to accept them), worked with a high staff-client ratios (ranging between 1:3-5 and 1:11) and availability of staff for emergency cases 24 hours a day, seven days a week.

The deviations from the pioneer "model" in terms of organising housing and support confirm reflections that a certain degree of "programme drift" and adjustment is inevitable if an approach is transferred to different local conditions (see Johnson *et al*., 2010; Johnson, 2012; Hansen Löfstrand, 2012). If social housing is an important source for housing vulnerable people and instruments are available to provide priority access to social housing – as is the case in Copenhagen and Glasgow – it seems obvious to use this resource. If there is a lack of social housing and it is not accessible for homeless people – as in Budapest – or residualised and of very bad quality – as in Lisbon – private rental housing may be the preferred option. If access to other specialised and mainstream services is relatively easy, the ACT approach might not be necessary (though it might still have some advantages as is claimed for the Copenhagen project, see further below).

The Budapest project was different from the other projects in many respects. It was included as a test site because it was one of the very few programmes in Central and Eastern Europe which was trying to bring rough sleepers directly into mainstream housing with support, sharing some of the basic principles of the Housing First approach. However, some important elements were also missing: support in Budapest was time limited from the beginning, and with a (theoretical) ratio of support workers to clients of 1:24, far less intensive than in all of the other test sites. In addition, as this support was provided by outreach workers from different services on top of their full-time job, there was no Housing First team working exclusively with re-housed homeless people. Support capacities were not only limited in intensity but also in duration (to one year), service users had to basically search for housing by themselves (with some support from staff), and support with housing costs was also minimal and time-limited. In contrast to all other projects, long-term housing retention was not an explicit target of the Budapest project (the main target being to clear the forest of homeless people). We therefore need to keep in mind for what follows that the test site in Budapest was not really practising the Housing First approach, but rather some elements of it – and in a relatively weak welfare context where housing costs and the costs of living are not covered to any reasonable extent by basic benefits for those who are without income from work. But the project may also helpfully demonstrate the serious challenges for implementing the Housing First approach in such welfare contexts.

3 Evaluation Results

3.1 Service user profile

In Table 2 we give a broad overview of the profile of service users who were provided with services in our five Housing First test sites. As we can see, only a minority of between 18% and 35% of the users were women, the majority were men. Given the gender distribution among rough sleepers and marginalised homeless people in most cities, this might mean that women are still overrepresented rather than underrepresented in some of the projects. The Lisbon project for example gave priority "*to those who are the longest in the situation of homelessness and to women*" (Ornelas 2013: 3).

The highest proportion of women (35%) was reported from Budapest and was certainly also due to the fact that in this project the household structure differed from the dominant structure in all other projects. While in four of the five projects the service users were predominantly single and living alone in their apartments (with some exceptions, especially in Lisbon), only 22% of service users in Budapest were living alone, almost two thirds were living with a partner or family member and 12% shared their accommodation with a friend.

Table 2: Service User Profile

	Sex	Age	Household structure	Nationality / Place of birth
Amsterdam	78% male 22% female	Average: 45 years	Almost all single	91% Dutch, more than half ethnic minority background
Copenhagen	68% male 32% female	36-45: 37% Younger: 17% Older: 46%	Almost all single	89% Danes (including 30% Danes from Greenland) 11% other nationality
Glasgow	82% male 18% female	36-45: 45% Younger: 50% Older: 4%	All single, one participant now living with baby	Most from Glasgow and (White) British
Lisbon	73% male 27% female	36-45: 43% Younger: 18% Older: 38%	Most single; 4 couples and mother with adult son; 2 friends live together	91% Portuguese
Budapest	65% male 35% female	36-45: 30% Younger: 19% Older: 51%	Only 22% single 64% living with partner/family 12% with friend	All born in Hungary and Hungarians; "significant proportion" of Roma origin, but no exact data

Regarding the age of service users, between one third and almost half were in the age group between 36 and 45 years in the four projects for which these data are available. In Amsterdam the average age of service users was 45 years. It is noteworthy that around half of the service users were older than 45 in Budapest (51%) and Copenhagen (46%) whereas the project in Glasgow stands out with 50% of the service users being younger than 36 and only one person being older than 45.

The overwhelming majority (between 89 and 100%) of service users had the nationality of the country where the Housing First project was located. Ethnic minorities and persons with a migrant background played a significant role in the projects in Amsterdam (where one or both parents of more than half of the interviewees were born outside the Netherlands, most often in Surinam or Morocco, but also in a number of other southern, eastern and western countries), in Copenhagen (where 30% of the participants were Danes with a Greenland origin) and in Budapest (where a "significant" proportion were of Roma origin, but national legislation does not allow for the identification of ethnicity).

Concerning the employment status and the income situation we can assume that most of the participants were unemployed and had very low incomes (if at all) at the point of entering the projects. For participants in Amsterdam we have no baseline data for this period, but we know from registration data of the NGO running the project that about 80% of their customers had incomes at the net social assistance level. The other 20% of customers had incomes from youth or adult incapacity or unemployment benefits. For the project in Copenhagen the proportions are very similar (all service users being in receipt of some sort of transfer benefits, the majority of them of social assistance). In Glasgow approximately half (10 out of 22) of service users had never had long-term (i.e. non-casual) paid employment. Although the others had had paid jobs in the past, they were all unemployed at the point of entry in the project and had been reliant on welfare benefits since they had developed more serious addictions. Equally all participants in Lisbon were unemployed or inactive, but less than half of them (39%) had an income (from transfer benefits) at all, 30% from social minimum benefit, 8% from a disability pension and one person from unemployment benefit. Thus it was a priority task for the project in Lisbon to support those service users with no regular income at all to register and realise existing entitlements for subsistence benefits, pensions etc.

As for many other aspects data on employment and income for the participants of the project in Budapest at the point of entry into the project show a slightly different picture, as the structural conditions for welfare provision in Hungary are quite different as well. Very few service users in Budapest received unemployment benefit (2%) or social benefits from local government (3%) as for obtaining any of these benefits a previous legal income or a registered address is required in Hungary. However, almost a fifth (19%) lived from a pension (old age or disability). The remaining participants had to make their living by different kinds of activities: More than a third (37%) lived from temporary jobs including street paper vending, almost a quarter (24%) lived from collecting garbage or begging, and 15% even had some regular income from work (Fehér and Balogi, 2013: 24).

Regarding the homelessness/housing history of project participants the information of some of the local evaluations is limited. There is no information about this from the Copenhagen project. In Amsterdam 78% of the participants interviewed claim that they have been without any housing in the past and the average duration of homelessness given by those who answered the question was eight years, but ranging between a minimum of three weeks and a maximum of 24 years (the median being 5.3 years). Among those who were homeless directly before they entered the project the most frequent type of place they were staying at were families or friends or on the street. Other places were emergency shelters and low threshold facilities, hostels or hotels, a boat, Salvation Army accommodation, etc. Some of the Amsterdam Participants also came directly from prison or a clinic (Wewerinke *et al*., 2013: 16-17). In Glasgow more than half of the service users joined the project from a hostel or other temporary accommodation for homeless people, three of the 22 participants were staying temporarily with friends or relatives, two were sleeping rough and four were in an addiction rehabilitation facility before entering the project. Many of the Glasgow participants found it difficult to calculate an exact duration of homelessness as many had fluctuated between sofa surfing, sleeping rough, stays in hostels and other types of temporary accommodation and times spent in prison. But almost all of the service users in Glasgow had long-standing histories of homelessness and insecure housing and only twelve of the 22 had ever had

independent tenancy at some point (Johnsen with Fitzpatrick, 2013: 9-10). In Lisbon almost half of the participants (48.6%) were homeless for more than six years, 38.6% for three to five years and only 17.6% for less than two years (Ornelas, 2013: 16). In Budapest the average duration of sleeping rough or staying in the forest was almost 6.5 years, but information was only available for about a third of project participants (Fehér and Balogi, 2013: 23).

Summing up the participants of the projects in the five test sites were predominantly men and nationals of the countries where the projects were located. A significant proportion of ethnic minorities participated in the projects in Amsterdam, Copenhagen and Budapest. Participants were in their majority middle aged (36-45) or older, only in Glasgow half of the participants were younger than 36. A large majority of the participants in all test site projects had no regular employment at time of entry into the projects and with the exception of participants in Budapest they were living either on some sort of transfer benefits or had no income at all. The overwhelming majority of participants of all projects were long-term homeless people.

The social profile of service users in Budapest differs from the profile of participants in other projects in at least two important dimensions: Only a minority of them were single and the majority lived with family members, partners or friends while the majority in all other projects were single households. Furthermore, only a very small minority of them could receive subsistence or unemployment benefits as this required previous legal employment and an official address. While together about one third either received a pension or had a regular income from work, the majority relied on precarious and irregular jobs or activities like collecting garbage, begging and vending street newspapers.

3.2 Support needs

As mentioned above it was a condition of HFE that the Housing First projects evaluated would be targeting homeless people "with mental illness/drug or alcohol problems or other complex support needs (i.e. who could not access housing without support)". So it is no surprise that the overwhelming majority of service users showed such complex support needs.

For the project in **Amsterdam** detailed data on the support needs of service users at the time of joining the project are not available but we know that service users are selected by a group of professionals under supervision of the municipal health services of Amsterdam and that Discus services are reserved exclusively for persons with complex and multiple problems. Both psychiatric and addiction problems are inclusion criteria for Discus.

Service users in Amsterdam have only been interviewed once after they have already used the services for some time. No baseline data are available for the time when the participants had entered the programme. At the time of the interview they were asked about their present needs of care in different life areas. The results can be seen in the order of frequency in Chart 3.

Finances was the life area which was most often mentioned (by 77% of the interviewees), followed by housing (53%), physical health (46%) and mental health (44%). Between a quarter and more than a third of interviewees mentioned a need for support with finding a job (37%), daily activities (30%), help for their children (30%), relations with their children (29%) and regarding the use of drugs (26%). For the other life areas support needs were mentioned by less than 20% of interviewees: resilience (19%), use of alcohol (18%), nutrition (16%), basic skills (16%), housekeeping issues (13%), relations with family (8%), protection of their own safety (6%), teeth (7%) and transportation (2%)(see Wewerinke *et al.*, 2013: 18).

While the respondents didn't mention this very frequently as an area of support need, problematic use of substances in the past and during the last month before the interview was high among the programme participants in Amsterdam. Of 64 people interviewed for the evaluation, 57 had at some point in the past used cannabis, 47 had consumed more than five glasses of alcohol a

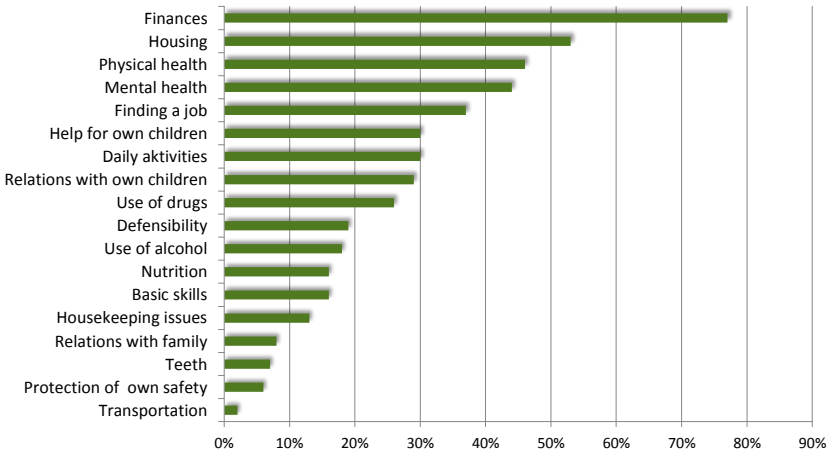
day, 47 had used narcotics, 46 crack and 45 cocaine. More than half of the clients had used heroine and/or ecstasy at some point in the past and almost half methadone and other drug-substitutes, hallucinogens and/or amphetamines.

Those who had used the substances at some point in their life were asked if they also had used them in the month before the interview and the answer was "yes" for 71% of those who had used cannabis, 66% of those who had snorted cocaine, 63% of those who used methadone and other drug-substitutes, 57% of those who had consumed more than five glasses of alcohol, 51% of those who had used crack, 44% of those who had used sedatives, hypnotics and/or hallocinogens, 38% of those who had used other opiates and analgesics and 34% of those who had used heroin (Wewerinke *et al*., 2013: 17).

Cross-referring back to the numbers given above, we can conclude that, for example, 63% of all 64 clients interviewed in 2011 still had consumed cannabis in the month before the interview, 47% had snorted cocaine and 42% had more than five glasses of alcohol per day once or several times during the preceding month.

Chart 3

Support needs of service-users in Amsterdam at time of evaluation interview



Source: Wewerinke et al. (2013): 18

For the **Copenhagen** project a detailed assessment of support needs has been entered into an electronic monitoring system by case workers of the ACT-team every third month. If we look at the first report for each service user who agreed to have their data monitored we get a good overview how their problems were assessed by their case workers (see Table 3 and Table 4).

Focusing on those service users who had problems "to a certain extent" or "very much" in the opinion of their case workers we can conclude that more than two thirds (69%) had a problematic use of alcohol and a majority of service users had mental health problems or a mental illness (60%). Abuse of hard drugs was less common (27%), but problematic consumption of hashish was reported for more than half of the service users (56%). Problems with physical health were reported "to a certain extent" or "very much" for 47% of service users, problems with maintaining daily practical activities such as doing the dishes, cleaning or grocery shopping for 42% (with a high proportion of 20% of all persons for whom this was unknown in the first assessment). Slightly more than half of all service users (51%) were assessed to have financial problems which made it difficult for them to pay rent, electricity and heating and 62% were reported to have problems with a lack of or a weak social network.

Table 3: Mental health and substance abuse problems of service users of Housing First project in Copenhagen reported by their case workers in first assessment

	Alcohol abuse	Abuse of hard drugs	Abuse of hashish	Mental health problems
Not at all	18%	65%	24%	7%
To a minor extent	11%	5%	13%	27%
To a certain extent	27%	11%	29%	38%
Very much	42%	16%	27%	22%
Don't know	2%	2%	7%	5%
N	55	51	51	51

Source: Benjaminsen (2013): 48-50

Table 4: Other problems of service users of Housing First project in Copenhagen reported by their case workers in first assessment

	Physical health	Daily practical activities	Financial problems	Weak social network
Not at all	13%	20%	22%	7%
To a minor extent	35%	18%	15%	27%
To a certain extent	29%	29%	40%	31%
Very much	18%	13%	11%	31%
Don't know	5%	20%	13%	4%
N	51	51	51	51

Source: Benjaminsen (2013): 50-52

For the project in **Glasgow** we have to keep in mind that this is the project with the lowest number of participants among the five test sites and that there is limited scope for any quantitative analysis. Some of the data further relate to all 22 users of the programme (or the 21 of them who were interviewed at baseline) including six persons who had not yet been allocated a tenancy by the end of 2012. All of these persons had alcohol or drug related problems as this was a condition for eligibility for the project. Two thirds (14 out of 21) had used heroin in the month before recruitment (twelve of them had injected it) and 15 out of 21 had used methadone (on prescription as a heroin substitute). Twelve had used cannabis, and smaller numbers other substances including valium, cocaine, diazepam, crack, speed and ecstasy. Validated measures of dependency showed relatively high scores for most of the drug users. The scores regarding alcohol dependency were lower, but for a minority of service users they indicated (also) relatively severe levels of alcohol dependency (Johnsen with Fitzpatrick 2013: 10-11). It is worth noting that all but one of the service users with drug problems aspire to be completely drug free in the medium-to-long term while in regard to alcohol, those dependent on it aspire to get their consumption under control and drink 'in moderation' or become a "sociable drinker".

14 of the 21 service users in Glasgow reported problems relating to mental health (anxiety, depression or bad nerves) and of these twelve reported that they had ever been prescribed medication for mental health problems (five of them had been hospitalized for mental health problems). Other frequent health problems included digestive or liver problems (incl. hepatitis; reported by ten out of 21), and blood circulation problems (reported by seven; ibid.: 10).

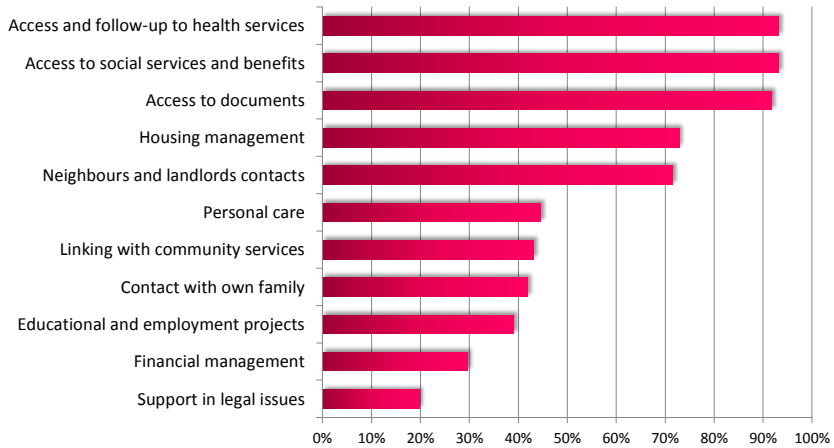
All but two (19 of 21) of the service users in Glasgow had a direct involvement with the criminal justice system in the past and most had served multiple sentences. A majority (twelve out of 21) had been arrested or fined for an offence in the twelve months prior to recruitment to the Housing First project.

Most users of the Housing First service in Glasgow found it impossible to manage the limited funds they had. For quite a number of them financial difficulties were exacerbated by deductions from welfare payments for outstanding loans or fines but also by `debts` owed to drug dealers or fellow users. Other people with drug and/or alcohol related problems were most often the only people constituting the social network of the service users and thus these networks were described as superficial and shaped by co-dependency. However, some of the Glasgow service users could still count on emotional and instrumental support of family members (such as parents, siblings or children) and most of those who had no contact to their family members were optimistic in their first interview that having a settled home with support would help them to re-establish such contacts. A lack of meaningful activity was reported by most of the service users at the time of recruitment to the Housing First project when their life was dominated entirely by the acquisition and consumption of drugs or alcohol. "*Virtually all aimed to (re)gain employment or participate in training/education, but these were considered very long-term goals by most. The acquisition of housing and stabilisation of substance misuse problems were consistently accorded higher priority in short- to medium-term goals*." (ibid.: 14)

As reported above the **Lisbon** project was the only test-site where a psychiatric diagnosis was an exclusive eligibility criterion for becoming a user of the service. Psychiatric records show that 80% of the 74 users of the Lisbon project have a diagnosis of schizophrenia. The rest have other mental health problems like bipolar disorder or major depressive disorder. While this indicates that the Lisbon project was probably the HFE test site with the highest proportion of mentally ill service users,[10] data also show that it was probably the reverse in relation to substance use. A comparatively small proportion of only 29.7% of the 74 service users in Lisbon were abusing drugs and/or alcohol (14.8% drugs, 12.2% alcohol and 2.7% alcohol and drugs) at point of entry, a proportion which reduced during their stay in the project (see Ornelas 2013: 14 and 33).

Chart 4

Support requested and provided in the Lisbon project



Source: Ornelas (2013): 18

Support needs in Lisbon were measured by the support requested and provided by the service provider. The chart shows that this was for the large majority the case in relation to access to

[10] We have no psychiatric diagnosis data of service users in the other projects, but the fact that Lisbon was the only test site where a psychiatric diagnosis was a condition for eligibility and all other projects were also open to persons who had another type of complex support need (for example an addiction without another mental illness diagnosis) makes such a conclusion highly probable.

social services and benefits as well as to access and follow-up to health services (in both cases support was provided to 93.2% of all participants). Help with access to documents (citizen card, taxpayer card, residence licenses for non-nationals etc) was given to 91.8% and support with housing management and with contacting neighbours and landlords was provided to 72.9% and 71.6% of the service users respectively. Less than half of them requested personal care (44.6%), support to link up with community services (43.2%) such as the local City Hall offices, neighbourhood organisations and the Food Bank, or support for contacting family members (41.9%). Support in educational and employment projects was provided to 39.1% of the participants, 29.7% were helped with managing their finances, and 19.8% with legal issues.

In the project in **Budapest** the participants were slightly more mixed than in the other projects as it was open to all homeless people living in the forest areas of the Pilisi Forest Company. However according to the records held by service providers more than two thirds of the project participants (69%) suffered from addiction and in 95% of cases the substance they were addicted to was alcohol (only in 5% of cases were they addicted to drugs, see Fehér and Balogi, 2013: 23). At the time of entry into the project 37 service users took part in some kind of regular treatment or psychiatric therapy. The physical state of service users was reported by service providers as being generally very poor as a result of several years of sleeping rough and living in the forest. Most were excluded from receiving medication and proper medical treatment as they had no health insurance and prices for medicine exceeded their scarce resources.

While more participants of the Budapest project were working at the time of recruitment than in any other HFE test site, the lack of a sufficient income was one of the main problems of the Budapest project. As soon as the time-limited financial support of the project for the housing costs ran out many could not afford to keep their accommodation. Most people had no stable income nor were they capable of working full time due to their physical or mental state. The level of welfare payments – if accessible at all for people without a history of legal employment – is very low in Hungary and jobs like collecting or sorting through waste, temporary employment on construction sites or on a market did not secure sufficient income to pay rent and utility bills. Re-learning housekeeping skills was reported as a problem for service users who moved into rented apartments and obviously support resources to help with these issues were insufficient (ibid.: 31). For the Budapest project only limited data are available on social contacts and loneliness of the service users and on problems with the criminal justice system as these items had not been part of the needs assessments and the different service providers involved in the Budapest project worked with a variety of different documentation systems. However it should be remembered that a majority (64%) of the service users in Budapest lived together with a partner, spouse or other family member, 14% lived with a friend and only 22% lived alone (see above).

Summing up most of the data on service users' needs show that the projects have reached their target groups but that these groups differ to a considerable extent. While the Lisbon project has probably the highest share of clients with a psychiatric diagnosis it has the lowest proportion of people with an addiction to alcohol and drugs. While more than two thirds of the service users in Copenhagen and Budapest exhibited a problematic consumption of alcohol, and abuse of a variety of substances was also frequent among the service users in Amsterdam, the project in Glasgow targets and reached a particularly challenging group of heroin users. Apart from addiction problems and mental health problems a considerable number of the project participants reported support needs relating to poor physical health.

Support needed for getting access to housing and for sustaining the tenancy (including contacts with the landlord and neighbours) played a major role in all projects. Making the flat into a home is an obvious need in the period after moving into the flat which can require quite intensive support of a very practical nature (organizing furniture and household items, payment of bills etc.).

The evaluations also show that financial problems and unemployment were common problems among project participants. Partly these problems were exacerbated by the financial requirements of substance abuse and by the problems faced by project participants in accessing their subsistence benefit entitlements, but we should also bear in mind that unemployment and poverty are structural problems which cannot be "solved" by the Housing First projects, particularly in welfare system contexts which allow for only a very low standard of living (if at all) at the level of subsistence benefits. However, the projects could help with getting personal documents organised and claiming existing rights to subsistence benefits, housing benefits, pensions etc. and this played a very important role in some of the projects.

In Amsterdam, Copenhagen and Glasgow a lack of social networks was reported as a problem, not for all, but for a significant proportion of the service users. To a certain extent loneliness and social isolation might be an initial "price" to be paid for moving into scattered housing, especially if the new tenants want to cut ties with their former peer networks which might put their tenancy at risk by using the new homes to sleep there or continue abusing alcohol or drugs. It is therefore important for support services to consider how to overcome such problems of social isolation.

3.3 Support provided

In **Amsterdam** the evaluation included a detailed analysis as to what extent the desired support matched with the support received. The majority (55%) of service users reported a match between demand and supply in at least four out of 21 potential areas of life and again a majority (59%) did neither demand nor receive support in at least 14 areas of life listed. The areas where the best match between support and received was perceived were finances (73%), dental problems (53%), housing and living space (44%) and emotional health (42%). A rather large group (44% of all service users interviewed) reported unfulfilled support needs in one or two areas of life, most frequently finding a job (14%), physical health (14%), dental problems (14%), and support for own children (13%).

According to the evaluation report the NGO Discus in the Amsterdam project provide 4.5 to 10 hours service per client per week. On average 3.5 hours consist of face-to-face contact, and the remaining time is spent on organisation, coordination of care, registration etc. Part of the time is also needed for the guaranteed 24-hours-care and guaranteed opening hours of the office. The intensity of support varies with the needs of service users. While some of them have daily contact with the NGO others are only visited once a week.

Regarding the use of mainstream services no difficulties are reported: "*Customers of Discus can make use of various mainstream services in the fields of physical health, mental health, employment and training, debt counselling and other areas of support needs. Discus merely provides housing counselling, and if customers have service needs in other areas of life – such as treatment and social support – the workers of Discus connect them to the necessary services. They closely work together with these service providers, especially with providers of mental health care in Amsterdam. No difficulties have been experienced in the collaboration with mainstream services*" (Wewerinke *et al*., 2013: 20).

Support in **Copenhagen** is provided by various members of the ACT team, usually at the home of the service users. The monitoring system provides information on the frequency and length of support visits. In November 2012 such data were available for 55 service providers and showed that within the three preceding months 18% of them had received daily support (mainly from onsite support services in one of the group homes), 13% about twice a week, 36% about once a week, 20% every second week and 13% about once a month or less. While in about a quarter of all cases (26%) visits took no longer than 30 minutes, a third of all visits took more than an hour and in 42% of cases the visit took between half an hour and an hour (Benjaminsen, 2013: 22).

The author of the Copenhagen evaluation report distinguishes three important dimensions of support, namely social support (mainly provided by the social support workers and related to challenges in everyday life, housekeeping issues, social problems, social relations etc.), health support (provided by a full-time nurse, a part-time psychiatrist and two part-time addiction councillors and supporting the participants with physical as well as with mental health problems and addiction) and administrative support (provided by staff with administrative authority from the social office and the job centre). As we have seen, the Copenhagen team is the only one of our five test sites where these three dimensions of support are integrated in one team. The evaluation report emphasizes the positive aspects of this integrated provision of support: The nurse has seen almost all service users shortly after their acceptance by the project, to assess their needs for health support. She is in regular contact with about 20 to 30 of them; in times of acute sores she visits service users almost daily. She helps to make contact with general practitioners and provides assistance if hospitalization becomes necessary. The psychiatrist has been in contact with about half of the service users, with about 15 more regularly. The two addiction councillors, in contact with about 20 service users, offer the possibility of counselling in the citizens own home using a harm reduction approach. The social office worker and the job centre worker can make many administrative procedures easier and reduce the number of appointments to be made, they may prevent sanctions from occurring when service users are not fit enough for activation programs and facilitate access to activation projects for those who are capable of participating in it (though in November 2012 only about ten of the ACT-users participated in such activities). While the social support workers regularly meet almost all of the participants we know from the monitoring system that in November 2012 about two thirds of them had also been in contact with the nurse (64%) and the social office worker (69%) during the three preceding month, while only less than a third had been in contact with the psychiatrist (29%) or one of the addiction councillors (18%).

In **Glasgow** support staff have typically met users twice per week in the initial phase (in some cases however much more often and exceeding five times a week directly after moving in and in times of crisis). In a number of cases the frequency of visits was reduced to once per week when service users felt confident enough to cope more independently. Over the course of time "*in many instances the level of support has not changed at all (in terms of the number of meetings with staff per week), but the nature or focus of support has tended to evolve as service users' goals have altered. Intensive support was often provided with 'making a house a home' via the acquisition of furniture and decorating immediately after moving into a flat. This was often followed by a period supporting individuals to stabilise or reduce their substance misuse. For many, attention was then able to focus on accessing training or other meaningful activities once individuals felt settled in their new home and were successfully 'managing' their addictions. The provision of support has not always followed this pattern, however, given the non-linear nature of the cycle of addiction recovery.*" (Johnsen with Fitzpatrick, 2013: 15-16).

In Glasgow the cooperation with mainstream service providers was fostered by including them in a steering group for the project but also by inviting relevant representatives to service users' review meetings, which were held quarterly. The involvement in such meetings was universally welcomed by other support agencies.

Concerning changes of support needs over time and the frequency of provision of support the authors of the **Lisbon** evaluation state: "*The frequency and type of support provided depends on participants length of housing, since the needs in the beginning are more related with domestic management, shopping, and acquiring social benefits. As the time goes by, the participants' needs change to other levels, like achieving goals in employment, and education or contact with families. Sometimes participants needed a greater amount of support in terms of crisis management or problem solving*." (Ornelas, 2013: 21). It is a particularity of the Lisbon project that in addition to weekly visits of individual participants at their homes they organise group meetings for all participants and staff members of the project, "*for ongoing evaluation of the program, discussion of*

issues of general interest and suggestions for the future. This has also been a moment of conviviality and peer support, registering a growing attendance of participants over time. In the beginning, these meetings were organized once a moth, but by participants' request, they now take place once a week." (ibid.: 20-21).

For Lisbon, access to mainstream mental and physical health care is not reported as problematic. Local health centres and hospitals are reported as being easily accessible to all people enrolled.

Service provision in the **Budapest** project was far from ideal, given the very limited resources available. As mentioned already most support workers who provided help for rehoused former residents of the forest did this during extra hours in addition to a full time job as outreach worker or day center helper. Per client a flat amount of 200 Euro for one year was available for providing the support needed. Such the support was focusing on the issues directly related to the rehousing process, like making a decision on the preferred sort of accommodation, searching for accommodation, contacting the landlord (or the owner of the trailer park, where some people were accommodated), helping with moving into the accommodation and organizing home equipment and mediation between landlords and tenants when necessary (ibid.: 31). "*Frequency of visits or meetings with clients varied by organizations: generally they met clients once a week in the beginning of the project, until they moved. After a while, support workers visited clients in their new home on a monthly basis when they handed the rent to the landlords. More frequent visits were organized when some issues or conflicts arose. In the case of those who moved to the countryside, visits took place less than once a month. Generally speaking it can be stated that visits became significantly less frequent after the client moved to the new accommodation. Due to the shortage of time these visits were restricted to handing the rent to the landlord and quickly asking the client how s/he was feeling*" (ibid: 32). As one of the support workers put it in an interview, meetings with clients in later stages were "*driven by problems*". Because of the limited time available any more intensive support could only be provided in a few cases. However, all the seven organizations involved in the support work of the Budapest project also tried to assist their clients in finding work or employment as this seemed often the only chance to sustain a tenancy after financial support for housing costs provided by the project would have run out. Service staff accompanied their clients to the job centre or let them make phone calls and search for job adverts in the day centre. Some also helped with preparing CVs etc. No attempt was made to organize peer support or group sessions.

Summing up we can conclude that in all projects support is most intensive in the time around moving into the apartments and diminishes after some time, but for some of the service users and in time of crisis quite intensive support has to remain available. Generally the dominating areas of support change after a period of turning the flat into a home and dealing with public administration, not least to secure subsistence benefits, towards issues of addiction and physical health, overcoming social isolation and finding something meaningful to do.

All evaluations emphasised that support was adjusted to individual needs and individual intensities differed substantially between participants. It is also important to emphasise that there is a group of service users whose needs are not diminishing over time, but may rather go up and down in waves or remain on a relatively high level.

3.4 Service user satisfaction

Data about service user satisfaction are available from the projects in Amsterdam, Glasgow and Lisbon. The number of interviews with service users in Copenhagen was too low to provide any representative results and in Budapest satisfaction was not measured during or after the project.

In **Amsterdam** the majority of 52 service users who answered an open question asking whether their expectations (about their future life when they entered the project) were met by the project responded in the affirmative and stated that they felt positive about it. Six persons (11%) said that their expectations have not been met or the results were disappointing. The expectations most

frequently mentioned were a private dwelling or house and living as independent as possible and/or participating again in society. A more stable and calm life and getting over things from the past (including resolving debts and having less or no contact with the criminal justice systems) was also mentioned several times.

Expectations concerning independent living and support in the homes were also met for the majority (72%), and the current living situation at the time of interview was rated as reasonable, good or very good by 78% of the interviewees. Some of the more negative judgements of the current life situations related to the quality of dwellings the respondents lived in.

Satisfaction with the support by the NGO operating the Housing First project in Amsterdam was analysed with a detailed list of questions and for almost all very high ratings were achieved. Almost all of the interviewees (between 87 and 97%) agreed that

- they can reach support workers most of the time or always, if necessary;
- they receive the information they need most of the time or always;
- they get information on the right moment;
- support workers explain things in an understandable way.

A slightly smaller group, but still between 79 and 82% of the interviewees agreed that they were able to make better decisions for their life, had more faith in the future because of the support and knew what to do in case they had a complaint against the service provider. All in all the support provided by the NGO Discus was rated at 8.2 on a scale from 0-10 for its performance during the six months preceding the interview (Wewerinke *et al*., 2013: 23-24).

In **Glasgow** preliminary results equally showed "*that the support provided by the project has, almost without exception, met the needs and preferences of service users. All have developed positive relationships with frontline staff who are widely regarded as being non-judgemental, 'easy to talk to' and trustworthy*" (Johnsen with Fitzpatrick, 2013: 16). Service users were particularly positive about the inclusion of peer supporters in the staff team, who were seen as non-judgemental and gave a positive example of recovery. They also appreciated the flexibility of support delivery, knowing that they can ask for more or less support when their individual circumstances change. The fact that there was no set time-limit for the support and that it was available around the clock were other positive aspects emphasised by service users interviewed.

More negative experiences related to substantial delays (and limited choice) in the allocation of housing. Waiting times were particularly high for those who had a specific area preference, had changed their area preference or had to reapply when they were admitted into psychiatric care institutions for sustained periods. These problems are all related to the pressure on social housing stock and the administrative procedures to access housing under the homelessness legislation. On the other hand satisfaction of those who were interviewed in the second wave of interviews with the type, size and quality of their flat was high and most were also satisfied with their neighbourhood.

As a result of the harm reduction approach service users in Glasgow as indeed elsewhere emphasised that this enabled them to be "honest" about their addiction and the use of drug and alcohol and that they don't have to "lie" when they experience a relapse to avoid losing their flat.

In **Lisbon** 45 interviewees were asked in 2012 about their satisfaction with the Housing First programme in terms of support provided and in terms of the level of choice. Results can be seen in Table 5 and Table 6. 80 per cent and more per item were satisfied or very satisfied with the support services provided, with how easy it was to contact support staff and with the way services helped to reduce and address problems and to get and stay well. Only the amount of help received met with a little more dissatisfaction. While still almost two thirds of the interviewees (64.5%) were satisfied or very satisfied, 17.8% were dissatisfied or very dissatisfied, mainly because they felt it was not enough.

Table 5: Lisbon project: User satisfaction with the support provided in % (N = 45)

Satisfaction	Very dissatisfied	Dissatisfied	Mixed	Satisfied	Very satisfied
With the support services provided	2.2	2.2	6.7	33.3	55.6
How easy is to contact program team	2.2	6.7	4.4	37.8	48.9
Way services help reduce and address problems	6.7	2.2	11.1	44.4	35.6
Way services help to get and stay well	4.4	4.4	11.1	40.0	40.0
With the amount of help received	6.7	11.1	17.8	46.7	17.8

Source: Ornelas, 2013: 36

Regarding the level of choice results were a little less positive overall. Still around three quarters of the interviewees or more saw contacts with the programme team (82.3%), visitors (75.5%) and whether or not taking medication (73.4%) as mostly or completely their choice. But almost 39% stated that they had no or not much choice about the place to live and almost a quarter (24.5%) felt that they had little or no choice about decorating and furnishing. In fact most of the flats in Lisbon were let to the participants with furniture already in place, although they were free to decorate their homes with personal things. Regarding visitors, there is no programme rule and according to the evaluation report participants can invite who they like and when they want. If visitors stay on a long-term basis they have to contribute to the rent (Ornelas, 2013: 37).

Table 6: Lisbon project: User satisfaction with the level of choice in % (N = 45)

Choice	Not choice at all	Not much choice	Some choice	Mostly my choice	Completely my choice
About the place to live	15.6	13.3	11.1	26.7	33.3
About decorating and furnishing	8.9	15.6	20.0	24.4	31.1
About visitors	2.2	4.4	17.7	31.1	44.4
About contacts with the program team	4.4	6.7	6.7	46.7	35.6
About whether or not take medication	4.4	4.4	17.7	35.6	37.8

Source: Ornelas, 2013: 37

Asked about their satisfaction with the Housing First programme as a whole, more than 90% of the interviewees in Lisbon were satisfied or very satisfied. "*When asked to identify what they like best about their experience in the programme, the main reasons reported were the opportunity to have a house ("It was the first organization that provides a solution for such a serious problem"); the support provided by the team; the tolerance, respect, honesty and cordiality in staff participants relations; and the opportunity to meet and talk with people that share a homeless experience. Some participants also reported vocational training and educational activities they were involved. Others reported the sense of wellbeing, recovery and empowerment ("Staff believe in me; that I can have a future and move on with my life.").*"

Summing up we can report a high level of service user satisfaction for the three projects where this was evaluated (Amsterdam, Glasgow and Lisbon). The overwhelming majority of service users were positive about the support provided and how it was provided, and about the accessibility of staff. With very few exceptions support provided met the needs of service users.

Some of the basic ingredients of the Housing First approach let to high satisfaction on the side of users: That they lived in their own self-contained flats and could remain there, that support is delivered as long as they need it, that they are accepted as they are and treated with respect and empathy, and that they can be open and honest about the use of drugs and alcohol without fears of being evicted as a consequence (harm reduction approach). Especially in Glasgow the inclusion of peer supporters in the support staff was highly appreciated by service users, because they were seen as real experts with relevant lived experiences, non-judgemental and easy to communicate with.

Dissatisfaction – which was rare overall – related in some cases to the support provided (asking for more support, e.g. in Lisbon), but more often to the choice of housing and in some cases long-waiting times before being allocated permanent housing. Such problems reflected structural problems like a shortage of (affordable and accessible) housing of good quality in preferred locations.

3.5 Housing retention

Housing retention was measured in different ways at local levels. We have tried for the European synthesis to apply similar rules as to what should be understood as housing retention, how it should be calculated and which cases should be excluded from the calculation. In general we have measured housing retention by the proportion of people who have been assigned housing by the Housing First project and have managed to sustain a tenancy (or to move to another tenancy) with the support of the project. If people have left the local programme in order to live in another apartment this was generally seen as a positive case of housing retention. If people have died during their stay in the HFE project we have excluded such cases from the calculation of housing retention. It was more difficult to decide about those cases when people have moved from the Housing First project into a more institutionalized form of accommodation, like a long-term nursing home. In some cases this was seen by service providers as the adequate form of accommodation given the support needs of the individual, but it cannot be seen as a success in relation to sustaining a tenancy and in most cases we do not know as to what extent it was a desired solution by the person him- or herself. We have therefore opted for excluding those persons from the calculation of housing retention rates. [11]

Another discussion related to persons who were imprisoned for a longer time and could no longer pay their rent but stayed in close contact with the Housing First project. While these persons still were in the programme they nevertheless had lost their tenancy and the prospect for being re-housed after release were not always entirely clear. In one of the projects (Glasgow), the offences two tenants were imprisoned for had been committed before they had joined the Housing First project and the contact between project staff and the person remained active during their prison sentence. Neither the persons concerned nor the programme staff had a chance to prevent a loss of the tenancies during programme participation given the structural conditions (ending of housing benefit after 13 weeks of incarceration) and both persons had a high chance of being re-

[11] Housing retention rates are not direct comparable with results from the US, where different methods have been used. For example Tsemberis *et al*. (2004) measured "*residential stability*" by the number of days "*stably housed*": stably housed was defined as "*residing in one's own apartment; or having a room or studio apartment in a supportive housing program, a group home, a boarding home, or a long-term transitional housing program; or living with parents, friends, or other family members*" (ibid.: 653). In Tsemberis *et al*. (2012) the calculation of "*housing stability after 2 years in housing first program*" was measured in a more similar way to our study, but "*discharge to long-term care facility*" was regarded as a positive example for housing retention and only those deceased were excluded from the housing retention rate (ibid.: 14). Excluding moves to long-term care facilities from the calculation of the housing retention rate, as done in our calculation, leads to a stricter definition of housing retention than used in the US.

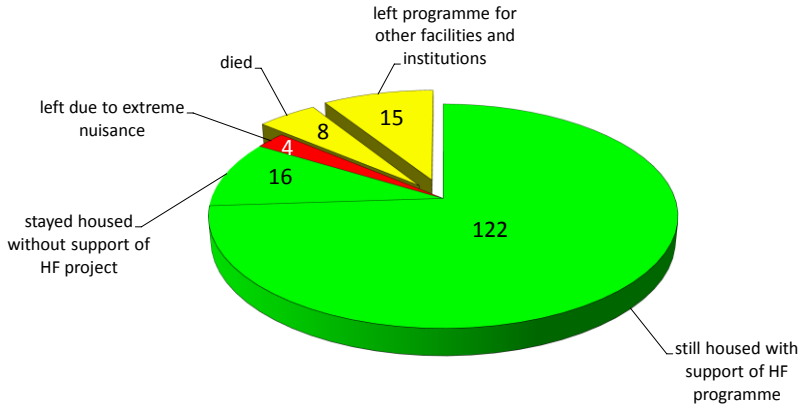
housed after release (though one of them in fact died tragically of an overdose upon release from prison). We have taken these two persons out of the calculation of housing retention.

In addition to the housing retention rates we have also calculated rates of programme retention for the individual projects, which is the rate of persons who were housed by the programme and have remained participants of the programme whether still housed by it or not. Here we have also included in the calculation persons who have remained in the programme until they died.

While most of the evaluation data for **Amsterdam** relate to April 2011 when the evaluation phase had ended, data for the housing retention rates were updated for the period from starting the project until November 2012. Until this month a total of 165 service users have made regular use of the Housing First project run by the NGO Discus since the start of the project in 2006. By the end of 2012, 138 were still housed. 16 of these had taken over the lease contract and did not receive support from Discus any longer. Of the others who left the project, eight people had died, and 15 customers went to live in institutions or less independent facilities for homeless people. They should not be included in the housing retention rate, so our basis for calculation is reduced to a total of 142.[12] Only four persons had to leave the project due to extreme nuisance. A few people who had to serve a prison sentence could return to their apartments and still received support by the NGO. So we can conclude that for 138 out of 142 service users for whom such a judgment is possible the programme was successful in terms of housing retention, and that the housing retention rate was as high as 97.2% for the Amsterdam project.

Chart 5

Housing retention in Amsterdam project



165 service users. Housing retention rate calculated for 142: 97.2%

It is important to add that the average duration of participation in the programme of the 64 service users interviewed in Amsterdam in 2011 was 1.5 years and that a third of the customers interviewed there had lived in a Discus dwelling for at least two years. The majority of those interviewed (86%) had stayed in the same apartment, while 12.5% lived in the second dwelling provided by the NGO and one person in the third (Wewerinke *et al*., 2013: 21, 22).

138 of the 157 persons who have participated in the programme (excluding the persons who have died) were still in the programme in 2012, so the programme retention rate was 87.9%.

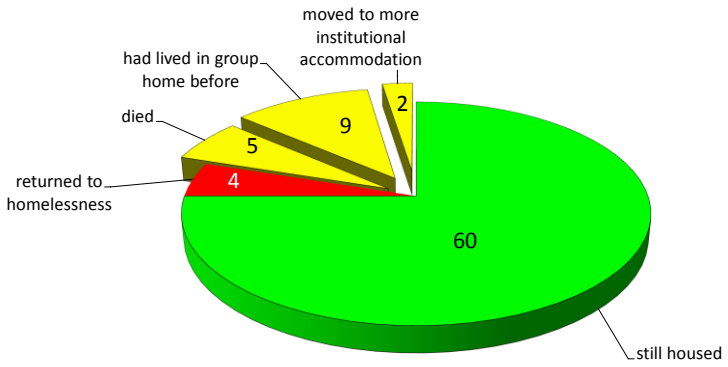
[12] It is not entirely clear from the evaluation what the move to "a different housing facility or institution" meant for the 15 persons taken out of the calculation here. Even if we would have classified all of them as a "negative" outcome, the housing retention rate in Amsterdam would still be at almost 88%.

In **Copenhagen** 80 service users had been housed by the project by January 2013. One of the particularities of the Copenhagen project is that only a minority of the service users (27 or 33.8%) were first housed in independent housing (including one person in an alternative type of housing, of the skaeve huse program). 29 (36.3%) were housed in two group homes, eleven (13.8%) concentrated in a tower block and 14 (17.5%) in another form of communal housing in row houses. We will come back to a comparison of experiences in the different types of housing further below.

16 people have been excluded from the calculation of the housing retention rate. Nine persons in one of the group homes had been living there for quite some time and were assigned to the ACT-team because of the need to strengthen the provision of support at this group home. In this case it is hardly fair to speak of a rehousing process. Five people had died during the period of ACT-support (but all had remained housed until their death). And finally two persons are excluded from the calculation as they have moved from the initial type of housing into long-term nursing homes, due to extensive physical care needs. Accordingly the housing retention rate is calculated for 64 service users. By January 2013 60 of these (94%) were still housed while four had returned to be homeless. About a third of those living in one of the communal housing units had moved either to another such unit or (more frequently) to independent housing.

Chart 6

Housing retention in Copenhagen project



80 service users. Housing retention rate calculated for 64: 94%

As a number of the Copenhagen service users had moved into their homes only some months before the housing retention rate was calculated in January 2013 another calculation was done for those service users who have been rehoused by the project in the years 2010 or 2011 and thus had joined the programme at least one year ago. Of these 44 people 40 (90.9%) had remained housed for a period of more than a year and were still housed in January 2013 (Benjaminsen, 2013: 34).

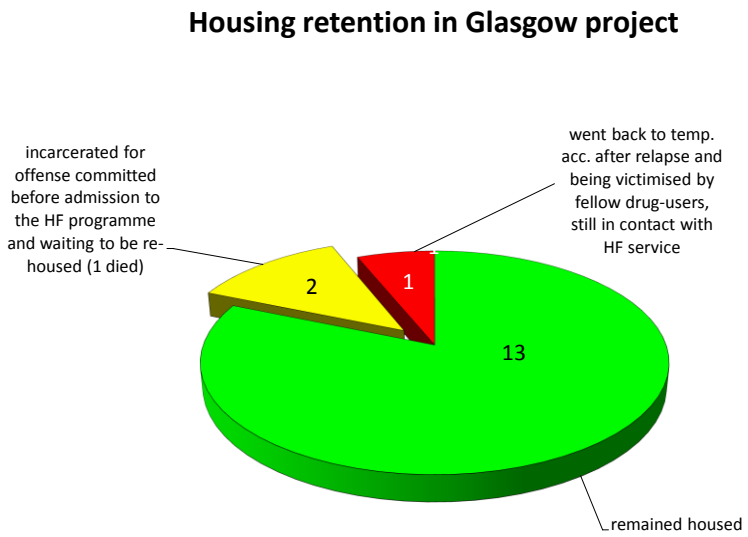
The rate of programme retention in Copenhagen, calculated on the basis of the 71 persons who had been housed (without the long-term residents of one of the group homes), was 91.5%.

In **Glasgow** 16, service users had been housed by the project by January 2013. While none of them had been evicted, two had lost their tenancy because they were imprisoned for longer than 13 weeks, thereby also losing their entitlement to Housing Benefit for covering their rent. We have already noted that both persons remained in contact with the Housing First project after imprisonment and that the prison sentences were given for offences happening before their admission to the Housing First project. Both participants had a good chance of being rehoused after release (though one of the persons tragically died of an overdose upon release from prison). We have tak-

en these persons out of the calculation of housing retention. A third person became victimized by fellow drug users after relapsing in his/her home and moved back to temporary accommodation with support by the Housing First team. While this was a clear case of tenancy failure, the person achieved abstinence from illicit drugs with the support of treatment services, kept in touch with the Housing First-Team, and was hoping to be reallocated to a flat in a different area.

Accordingly 13 of 14 rehoused service users in Glasgow (92.9%) remained housed by January 2013[13] and again 13 have maintained their tenancy for at least one year. Of those who have been housed by the project all persons stayed with the programme, so the Glasgow project can claim a programme retention rate of 100%.

Chart 7



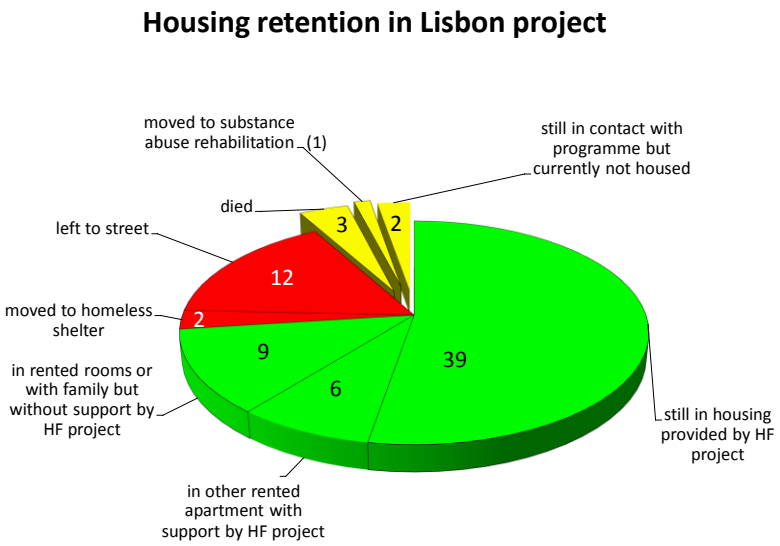
16 service users housed. Housing retention rate calculated for 14: 92.9%

The project in **Lisbon** has housed 74 service users since its start in September 2009. Three of these are deceased due to severe physical health problems, one had moved to a detox and substance abuse treatment programme and two were still in contact with the Housing First team but not in regular housing in early February 2013, so they were excluded from the calculation of the housing retention rate, leaving a basis of 68 persons. Of these 68 persons 54 (79.4%) were still housed at the end of the evaluation period (including a person who had just been rehoused again after a period of "temporary departure"). 39 of these persons were still living in apartments provided by the service provider, six had rented apartments with financial support of their families but still received support by the Housing First programme while nine persons lived in rented rooms or in the house of their family or had moved with a family to another country without support by the Housing First service. Almost two thirds of those who still remained in the project (61.7%) were housed for more than two years, and almost all the others for one to two years. Only one person was housed for less than one year.

Twelve service users in Lisbon "*left to the street*" and a further two persons returned to a shelter. Reasons given for these drop outs of the programme were financial reasons for some (the obligation to pay 30% of their income on rent) and seven participants were reported to have been "*unable to remain in the programme due to difficulties in meeting the basic rules of the condominium and good neighbourhood.*" (Ornelas, 2013: 24).

[13] Even if we had included these cases in the calculation and classified them as "negative outcomes", the housing retention for the Glasgow project would still be higher than 80% (81.3%).

Chart 8



74 service users. Housing retention rate calculated for 68: 79.4%

It has to be taken into account that the project in Lisbon had suffered from a considerable reduction of funding in 2012, so the project had to find ways to increase the rent contributions of service users and "*to explore different housing options that promote autonomy from the program*" (ibid.: 46). The programme retention rate was therefore also lower than in other projects (68.9%).

For the **Budapest** project it is virtually impossible to calculate a housing retention rate, but we have to assume that it was much lower than in the other test-sites. First of all we have to take into account that the aim of the project was to help rough sleepers in a forest to move out of this forest into any other type of accommodation. "*It is necessary to highlight that comparing to consciously Housing First-type projects, the Pilisi Forest Project was different in many aspects. The main goal of the project was to clean the territory of the Pilisi Forest Company (illegally) inhabited by homeless people. The deadlines set by the Forest Company imposed a permanent pressure on clients and staff as well. Staff of implementing organizations could support their clients mainly in helping them move from the forest and find proper accommodation. A secondary aim of the project was to prevent people from becoming rough sleepers or homeless again. The latter also meant preventing them from moving into homeless shelters in a large number. Long-term housing stability was not an explicit goal of the project and several characteristics of the project made it difficult (e.g.: support worker – client rate, shortage of working hours of staff, lack of professional guidance, lack of a stable and high enough income of clients, etc.).*"(Fehér and Balogi, 2013: 33).

It was a relatively new step for a project in Budapest that a direct move of rough sleepers into rented rooms, rented dwellings or even into owner occupation were considered as options in addition to other solutions like workers' hostels or homeless hostels. It might be debated if we can see the move to a trailer in any sense as "housing" as understood in the Housing First approach. We have decided to exclude this type of accommodation from the calculation and focus on rental rooms and apartments and on the few cases (six in total) in which rough sleepers acquired owner occupied housing (usually somewhere in the countryside far from any bigger cities and of very low quality). Of the total of 152 participants of the Budapest programme 90 persons (59%) were helped to acquire one of these three options, most of them a rental apartment. The problem for doing any serious calculation is that at the end of the project data were only available for 58% of the participants, and only 29 (33%) of the remaining clients, whose housing situation is known, have remained housed. It is assumed by the evaluation that much of the missing data is due to the fact that support workers lost contact with tenants once they moved out of their housing.

The Budapest programme was the only one which was time-limited. It was carried out in two phases of one year each, so that some of the participants could receive support for longer than a year, but the rule was a planned support period of one year. However, the proportion of drop outs from the programme before the agreed support period was finished was as high as 60%, and 63 of the total number of 152 clients (41.4%) stayed only for six months or less. If we take the programme retention rate for the Budapest programme as the proportion of people who joined the programme and stayed for the whole time agreed, it was only 40% (Fehér and Balogi, 2013: 19).

Summing up we can report that very high housing retention rates have been achieved by four of the five projects and the only project where the results were less positive was the project in Budapest, which in many respects departed from the principles of the Housing First approach (housing costs were not covered over a longer period, social support diminished quickly and was not available as long as it was needed, etc.), but is very helpful in teaching us more about the basic elements needed for a successful process of rehousing homeless people.

Housing retention rates in Amsterdam and Copenhagen were extraordinarily high (over 90%, even when we focus exclusively on those persons who had been rehoused in the project more than a year ago). In Glasgow, for a smaller project with a group of homeless people generally seen as particularly difficult to house (users of illegal drugs, mainly heroin), an extraordinarily high retention rate of 92.2% was reported, and for the project in Lisbon the retention rate was still very near to 80% after running the project for more than three years and despite severe cuts of funding in 2012.

Table 7: Housing retention rates in Housing First Europe test sites

	Amsterdam	Copenhagen	Glasgow	Lisbon	Budapest
Total number of service users housed	165	80	16	74	90
Unclear cases (death, left to more institutional accommodation, left with no information if housed or not etc.)	23	16	2	6	na
Basis for calculation of housing retention	142	64	14	68	na
Positive outcome (still housed)	138 *(97.2%)*	60 *(93.8%)*	13 *(92.9%)*	54 *(79.4%)*	29 *(< 50%)*
Still housed with support from HF programme	*122 (85.9%)*	*57 (89.1%)*	*13 (92.9%)*	*45 (66.2%)*	*0*
Housed without support from HF programme	*16 (11.3%)*	*3 (4.7%)*	*0*	*9 (13.8%)*	*29 (<50%)*
Negative outcome (lost housing by imprisonment, eviction, "voluntary" leave into homelessness etc.)	4 *(2.8%)*	4 *(6.3%)*	1 *(7.1%)*	14 *(20.6%)*	na

Source: Local final reports, own calculations

A note of caution is needed for assessing these overall very positive results. First we know that certain requirements were applied for accepting homeless persons into the projects. One of these requirements was the motivation of homeless applicants to be housed and remain housed, which might have excluded some more chaotic homeless people who have not shown such a motivation. Furthermore we have excluded some people from the housing retention calculation, when they have moved – often with support of the Housing First team – to more institutional provision with on-site support which was seen as more adequate for them. Obviously this is a small group but it should not be forgotten in any discussions about "scaling up" the Housing First approach. And of course the few persons who have entered the Housing First project and became homeless again despite the efforts to support them in sustaining their tenancy are an indication that there might still be a small group of homeless people with complex needs who might not benefit from the approach.

We also have to keep in mind that the projects in Copenhagen and Glasgow are still at a relatively early stage and given the remaining problems of many service users concerning their mental health situation and addiction problems the potential for losing their tenancy at some stage remains. Finally data of the local evaluations included in our HFE-project are not as robust as in other evaluation projects working with randomized controlled trials and no data are available for control groups of homeless people receiving "treatment as usual".

Nevertheless the data reinforce the findings of a number of studies in the US and elsewhere that the Housing First approach facilitates high rates of housing retention and that it is possible to house homeless persons with complex support needs in independent, scattered housing. This is even more remarkable as the four successful test sites evaluated in the framework of HFE show notable differences concerning the target group, the type of housing and the provision of services, but share most of the principles of the Housing First approach.

3.6 Experiences with different types of housing provision

The founders of the "model" of Pathways to Housing in New York recommend housing homeless people in scattered site housing in "*a regular building in the community*" in order to increase the chances for social integration. As a principle it has been recommended that not more than 20% of any housing block should be provided to service users of Housing First projects (Tsemberis, 2010b: 53/54). However, as mentioned above, in the US and elsewhere a number of Housing First projects also use congregate housing with on-site support. These projects have been called "Project-Based Housing First" or "Communal Housing First" (see Pearson *et al*., 2007; Pleace, 2012). In the HFE social experimentation project we can find examples of these approaches in the peer sites of Helsinki and Gothenburg and in the test site in Copenhagen. In Finland – in the framework of the national strategy to end long-term homelessness – quite a number of new dwellings for achieving this ambitious goal were created by reconverting old shelter buildings in condominiums with self-contained flats so that congregate housing with on-site support are relatively wide-spread and seen as an important basis for the Finnish version of the Housing First approach (Tainio and Fredriksson, 2009; Luomanen, 2010; Busch-Geertsema, 2011).

Arguments in favour of congregate housing with on-site support refer to opportunities for informal contact between staff and tenants of the building. In some cases being housed closely together might also create a sense of community and encourage peer support. When converting shelters like in Finland, or using motels and similar buildings as in some cases in the US, it is also easier to secure rather quickly a considerable number of apartments (or rooms). It has also been argued that risk management and supervision is facilitated by using this approach (Pleace, 2012).

On the other hand the housing offered in congregate settings with on-site support is usually not "normal" housing (and in some instances has more similarities with hostel provision than with what is generally understood as mainstream housing). In most cases it is not what homeless people prefer. Sometimes the housing provided is not even self-contained, but tenants have to share kitchens and sanitary facilities (which make it questionable if we can speak of "Housing First" in this case at all). Privacy is often restricted and important elements of the Housing First approach like choice and community integration are limited in such approaches. Furthermore there is a high risk of stigma and conflicts created by the spatial association of many people with complex support needs. Last but not least the specific requirements for the buildings (often with communal premises, specific technical equipment for safety and supervision and a "concierge" at the front door) bear high costs.

In Sweden there has been some sharp criticism against congregate housing for homeless people: "*In transforming the special-housing units into a permanent living arrangement, the new model fails to provide a mechanism by which homeless clients can re-establish themselves on the* regular *housing market, offering no real pathway out of homelessness.*" (Hansen-Löfstrand, 2010: 12).

The HFE test-site in Copenhagen provided us with an opportunity to compare experiences with congregate housing and scattered site housing in the same programme and with support provided by the same ACT-Team. While in the beginning the bulk of housing in the Housing First project in Copenhagen was provided in "category housing" a range of problems with this type of housing and the preference of homeless people for scattered housing – supported by positive results of those living there – led to increasing use of scattered housing during the project. "*In the qualitative interviews there are many reflections on the different housing types. There are indications that the independent housing has worked out better. The interviewed citizens living in independent flats are generally very satisfied with living in their own flat. Amongst the residents in the communal housing units there are mixed opinions. Some are happy about living in the category housing units, whereas some dislikes living there and would prefer their own flat. Some residents in the communal housing unit criticize conflicts which have occurred in the house about the use of common facilities, but at the same time appreciate their apartments and the social contacts they have in the house."* (Benjaminsen, 2013: 37). Especially in one of the group homes, the atmosphere was far from positive, described by the evaluation as "*an environment of heavy drinking, and (..) many guests of the residents hang around at the place most of the time*." Service users criticized this environment when they were interviewed:

"Interviewer:	*"How do you feel about living here?"*
Interviewee:	*"It is not good. It is not."*
Interviewer:	*"How?"*
Interviewee:	*"Because then visitors come here in the morning. They drink. They make noice. I cannot be healthy here, not really. So, I would like to move."*
Interviewer:	*"Where would you like to move to?"*
Interviewee:	*"I would like to move to a flat."*
(…)	
Interviewer:	*"So, there is a lot of drinking going on?"*
Interviewee:	*"Yes, there is. I get weak, you know, from drinking. Then the guests come. They drink. It is better to control that yourself…".*
Interviewer:	*"Yeah?"*
Interviewee:	*"It gets all full and then they argue, and…[the interviewee makes a deep sigh]…" Interviewer: "So living here is not what you would like – you would like to come out and live in your own flat?"*
Interviewee:	*"Yes. Or I go crazy.*
Interviewer:	*"Have you talked to the staff about this. Is this something they know?"*
Interviewee:	*"Yes, I did not want the keys and move in here. But where else could I go?"*

(Benjaminsen, 2013: 38-39)

The Copenhagen evaluation showed a clear preference for scattered housing: While there was a waiting list for this type of housing and greater housing stability of those who had moved there, no waiting list existed for congregate housing and a number of tenants expressed their wish to move out of there. Residents who had been first rehoused into congregate housing showed similar high housing retention rates as those in scattered housing (i.e. were still housed in January 2013) but more of them had moved from the place they were first rehoused to either another congregate setting or to scattered housing.[14]

[14] Focussing on tenants who were rehoused at least a year before measuring the retention rates, 93% of those initially housed in independent, public housing and 90% of those initially housed in communal housing re-

The team leader of the Copenhagen project – while seeing scattered housing as the best option for most homeless people – also emphasized that for a small group of residents the congregate type of housing was a suitable option, if it is well located and organised: ""*We have the best results in our individual dwellings. No doubt about that. When the citizen moves into an ordinary stairway with ordinary people then you also change your behavior. It becomes a place you return to, to have peace and quiet, and pull oneself together, you have to be more normal, you cannot just scream and shout. Actually, there is a double effect – they both can have peace and quiet, and there is also some need to behave different, otherwise you get kicked out, or somebody comes and says something to you. (…) I will not say that the category housing is generally bad. It depends on how the citizens are met, and if it is citizens who prefer to live in communal housing (…) some of them need to live close to others who are like themselves. To be able to knock at a neighbours' door and ask if they should have a beer and watch a movie in TV. I will not say that such housing is bad, it depends a lot on where and how they are located and what is expected."*

All other test-sites of HFE have followed the recommendations of the "model" of Pathways to Housing to use exclusively independent scattered housing for re-housing, though in Amsterdam and Glasgow (as well as in Copenhagen) it was social housing, not private rental housing, which was used. For the debate on which type of housing serves best the needs of homeless people with complex needs it is also worth noting that even for the founder of Pathways to Housing, Sam Tsemberis this is rather a question of dimensions than of 'dogmas'. While he recommends scattered-site housing as the best way to reintegrate homeless people in the community for the majority, he also points to the fact that the housing retention rate of projects using this approach is less than 100% and that there are always some people who have not managed to retain their tenancy and who may not benefit from the support provided as it was hoped for: "*Anticipating that a small percentage of clients will be unable to maintain an independent apartment, or would prefer more congregate living, single site programs with on-site services offer a useful and effective alternative*." (Tsemberis, 2012: 170).

In this context it should also be mentioned that elsewhere (but not in our test sites) there is experience of other types of congregate and scattered housing, aimed at finding a balance of "mixed communities" and spatial concentration of people with support needs. One example is to be found in the "Common Ground" projects offering permanent housing and on-site social support for vulnerable homeless people concentrated in larger blocks but still aiming at a mix of tenants with and without a homeless past inside the same building.[15] Another example are "core and cluster" projects which can be found in the sector of housing for elderly people: Flats are scattered around in a certain area but still in relative proximity to each other and a support office with facilities for meetings and common activities is located nearby.

3.6 Changes of quality of life and recovery

A number of recent articles and comments have noted that, while producing high housing retention rates, the outcomes of Housing First projects in relation to other dimensions of social inclusion and recovery (reduction of addiction, improvement of mental health, integration into employment or something meaningful to do, overcoming social isolation etc.) are *"underwhelming"* (McNaughton and Atherton, 2011; see also Pleace, 2011 and Johnson *et al*., 2012).

On the other hand there is very little evidence that staircase or continuum of care services produce any more promising results for homeless people with complex support needs in overcoming social isolation, long-term unemployment, and poverty. Given these complex needs of most of the users of Housing First services, it might be unrealistic to expect any quick and widespread pro-

mained housed in any housing. 80% of the first group remained housed in the initial housing whereas this applied only for 52% of the second group (Benjaminsen, 2013: 34).

[15] http://www.commonground.org/

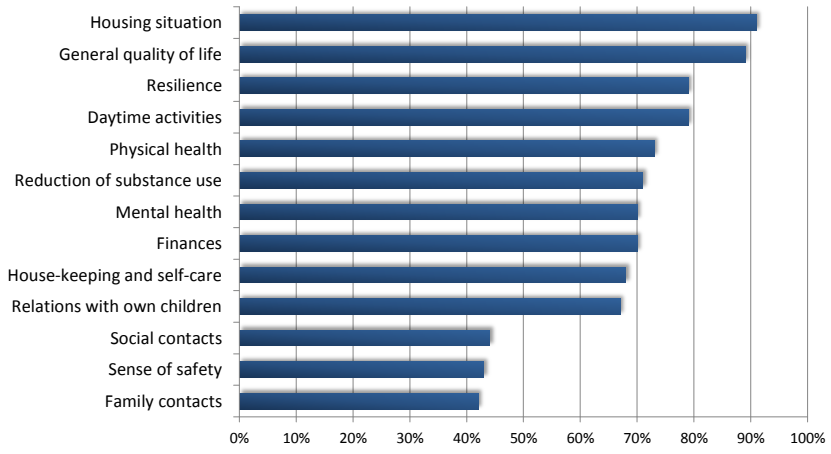
gress in respect of further social inclusion (see Busch-Geertsema, 2005 and 2012; Johnsen and Teixeira, 2012). Changes in quality of life might need much more time than covered by usual evaluations and for some people "relative integration" might be a more realistic goal. As Johnsen and Teixeira (2012: 190) note, "*Housing First proponents regard stable housing to be a platform from which the (often long and complex) process of recovery from mental illness, substance misuse and/or social isolation might* begin *(Tsemberis, 2010b; Henwood et al., 2011), not as a remedy to any or all of these problems* per se" (emphasis in original).

What are the results of the HFE evaluations regarding the changes of quality of life and recovery in the five test sites?

In **Amsterdam** participants of the Housing First project were asked if their quality of life improved, declined, or remained the same after entering the project. The overall results were quite positive in many respects: "*Almost all customers experience improvements in their living situation (91%), general quality of life (89%), daytime activities (79%), and resilience (79%). A majority also experiences an improvement of their physical condition (73%), mental condition (70%), substance abuse (reduction of substance abuse) (71%), finances (70%), house-keeping and self care (68%), and relation with own children (67%). Almost half of the customers find that family contacts (51%), (feeling of) safety (49%), and social contacts (44%) have not changed. Declines were experienced by customers mainly in their financial situation (16%), although, as mentioned before, a large group of customers mentioned an improvement in this area*" (Wewerinke *et al*., 2013: 22).

Chart 9

Perceived benefits from Housing First Project in Amsterdam: Improvements of quality of life



N = 61-63, 21 for relations with own children

Source: Wewerinke et al., 2013: 22

It is remarkable that at the time of interview 41% of the participants of the Amsterdam project were involved in either paid or voluntary work (13% had a job with a contract, and 28% did voluntary work; ibid.: 8).

A very detailed set of questions to measure feelings of loneliness confirmed that for about a third to over half of the service users this was still a problem: "*About a third of the customers claim not to be able to go to friends when they feel the need to (32%). More than a quarter often feels left alone (23%), and slightly more than a quarter misses people around them (27%). Almost half of the customers claims to have insufficient people they feel closely related to (48%), more than half of the customers does not have many people they can trust entirely (55%), and other customers-feel that their circle of acquaintances is too limited (41%). Almost a third of the customers misses*

sociability around them (30%) and thinks that there are insufficient people to rely on in case of need (31%). Over a quarter of the customers experiences emptiness around them (27), misses a real good friend (44%), or does not have many people in their surroundings to turn to with daily issues (30%)" (ibid.: 26). We should keep in mind here that the Amsterdam evaluation did not include a baseline interview to compare the results reported here with the situation of service users when entering the report. So the results do not tell us anything about possible improvements or deteriorations in individual cases.

Although the support provided by the NGO operating the project seems to have matched the support needs reported by clients, and although clients report very few unfulfilled support needs (see above), the evaluators asked, considering the problems clients face, whether they would not benefit from greater interventions. This mainly concerned relations with family and friends (considering that the social embedding of clients remains limited), but also the use of alcohol and drugs (considering the relatively high rates of substances abuse among clients).

The **Copenhagen** evaluation reported the changes in the assessment of social problems by ACT-professionals between the first registration of data and the last quarterly report for those individuals who agreed to have their data recorded and were still in the programme at the end of 2012.[16] It is clear that the methodological approach was a different one here than reported for other projects. It is not based on self-reported changes reported by the participants themselves nor on a status-quo analysis, but mainly refers to changes in the support needs of service users from the perspective of their case-workers. We can see that for about 40-47% of service users the assessment of their problems remained the same and that for hard drugs and hashish abuse even higher percentages of "unchanged" problem assessments were registered (but note that for 70 per cent or programme participants the use of hard drug was no problem or only to a minor extent in the first report and this percentage had increased to 76% in the last report; in the case of hashish abuse the percentage of service users who had no or only a minor problem in this respect increased from 37% in the first report to 49% in the last report).

Table 8: Copenhagen: Change in assessment of social problems from first to last report

	More positive	Unchanged	More negative	N
Alcohol abuse	32%	45%	23%	53
Hard drugs abuse	15%	75%	9%	53
Hashish abuse	29%	57%	14%	49
Mental illness	25%	45%	29%	51
Physical problems	28%	46%	26%	50
Problems with daily functions	29%	40%	31%	42
Financial problems	19%	45%	36%	47
Weak social network	25%	47%	27%	51

Benjaminsen (2013): 52

While in the field of substance abuse (illegal drugs as well as alcohol) more positive than negative changes were registered between first and last report considerably more negative changes were registered for financial problems. This may be mainly due to the fact that rent and utility costs are reducing the amount of benefits remaining for the daily subsistence. But a number of service users, once they had a fixed address, were also confronted with creditors claiming back old debts. For the other areas (physical problems, problems with daily functions and problems with a weak social network) a little more than a quarter of service users showed a positive change while an

[16] Differences of the number (N) of people between the different items are due to the exclusion of those cases when "Don't know" was recorded on one of the occasions.

almost equal proportion showed a more negative change. "*This picture is very consistent with what the citizens report in the qualitative interviews. Though some report to have reduced their substance use, only one of the interviewees reported to have totally quit an addiction, and most also reported on difficulties in other dimensions of their life, such as health problems, and the need of support to practical matters in daily life and to getting their bills paid. However, they all express that becoming housed and getting out of homelessness is a major improvement of their situation"* (Benjaminsen, 2013: 53).

The number of service users in Copenhagen who participated in activity projects remained relatively low (ten persons out of almost 80 participating in the programme), compared to some of the other HFE test sites.

The evaluation in **Glasgow** was not yet completed in May 2013 when the draft final report for HFE had to be provided. But interviews with a senior staff member, 11 Stakeholders and 13 service users had been conducted and preliminary outcomes were reported. General health of a majority of users has improved, mainly due to a reduction or cessation of substance use, but also to improvements in diet. But some service users were still in poor health and in receipt of substantial health care from mainstream services (e.g. hospitals, general practitioners).

A positive trend towards improvement is also reported for those with mental health problems and staff noted a significant difference with improved mental health for those who were already housed compared to those who were still waiting for a tenancy in temporary accommodation. Service users referred to the security of having stable housing and to the reliability of support even in times of relapse as important factors to improve their self-confidence and psychological stability. However, some of the service users had experienced a "*dip in mood"* after being rehoused and had temporarily increased the abuse of substances in reaction to feelings of isolation and loneliness, but also to problems in acquiring furniture and turning their dwellings into a 'home'. For some this was only a short period of "low mood" while for others it was a recurrent experience often triggered by additional problems such as welfare benefit payment delays, other financial problems, or conflicts with friends and relatives.

Regarding substance abuse the outcomes in Glasgow are "*mixed, but positive in balance*" (Johnsen with Fitzpatrick, 2013: 20). Staff reports that five out of the 22 who have joined the programme so far (including six people who were still waiting for rehousing) were abstinent from alcohol or drugs (i.e. of the substance which was their main substance of choice when they entered the program) and a further seven were abstinent from both substances early in 2013. "*A number of others have continued to misuse drugs or alcohol, albeit often to a lesser degree than before. Some, for example, are no longer using heroin, but smoke cannabis or drink fairly regularly. In such cases, they often report that boredom is a contributing factor to their ongoing drug use and/or alcohol consumption. Staff report that whilst the overall frequency of drinking and volume of alcohol consumed has reduced for some service users, a number are still drinking at problematic levels*." (ibid.: 20). In these cases as with those who continue to misuse hard drugs, a harm minimization approach is applied.

Like the participants of other test sites, most of the service users in Glasgow had to struggle with financial difficulties after paying the costs of utilities and some of them also with paying off debts related to previous rent arrears and other debts. A majority of interviewees report nevertheless an improved level of financial wellbeing mainly due to spending less (or even nothing any more) on drugs and alcohol. Regarding social contacts some of the service users could profit a lot from emotional and instrumental support of family members living in the same city. Five service users (re-)established contact with their children not living together with them and this was a motivation for them to make positive steps towards recovery. For those who were in close contact with former drug-using peers at times of entering the project a dilemma is apparent. Either they have cut ties with these peers and have opted to move to distant areas of the city where they have been vulnerable to feelings of social isolation and loneliness, or else they have remained in close

contact with the drug using community and have a much higher risk of relapse and difficulties in "managing their door". For one of the participants their relapse and use of the flat by other drug users led to giving up the tenancy and returning to temporary accommodation. This individual was planning – after having managed to stay abstinent for some time – to begin another attempt to sustain a tenancy with support of the Housing First team in another part of the city.

Given the scepticism of many service users at time of recruitment with respect to getting any form of paid employment in the short to medium term, and given the reported difficulties faced by staff in motivating service users to participate in meaningful activities, it is encouraging that in the second interview five service users in Glasgow were participating (part-time) in education and training activities, a further five were regularly attending day services (e.g. by Narcotics Anonymous or other addiction programmes in the community), two were involved in voluntary work and two were actively seeking paid employment. In the second interview for the final report most of the service users still saw integration into paid employment as a long-term goal, but quite a number of them had made important steps towards meaningful activities.

Support staff in Glasgow provided a useful distinction of three typical trajectories that can be found in the individual recovery processes of the service users addicted to drugs and/or alcohol:

1. *"*Sustained positive change. *For most service users, outcomes have been largely or uniformly positive overall and have, on the whole, been sustained thus far. Generally speaking, their substance misuse has stabilised or reduced (and in some cases ceased), their physical and mental health has improved, any prior involvement in criminal or street-culture activity has terminated, social support networks have strengthened, and they have become increasingly engaged in meaningful activities within the community. Some report having experienced 'difficult' periods (..) but the general trajectory of their experience has been one of positive lifestyle change and enhanced wellbeing.*
2. Fluctuating experiences*. For this (smaller) group, the overall pattern of experiences could be described as 'up and down', in that periods of relative stability or improvement have been punctuated by slips on their journey toward recovery. Symptomatic of such 'blips' have been increased levels of substance misuse (usually temporary) and/or deteriorations in mental health. These experiences have often had a knock-on effect on service users' ability to manage their home, particularly (dis)inclination to budget and/or 'manage the door'. It is sometimes also reflected in re-engagement with street culture activities. Staff support service users to get 'back on track' to meet their goals during such periods, often increasing the frequency of contact in so doing.*
3. Little observable change. *For a small minority of service users, the project has provided housing stability, which they greatly value, but there has (as yet) been little evidence of change with regard to most other outcomes. The individuals concerned are generally still misusing substances at or near to the same level they were before being recruited to the project and/or continue to be actively involved in street-culture activities (e.g. begging). Managing their home (e.g. budgeting, cleaning) continues to present an ongoing challenge. Engagement is sometimes intermittent, but staff report that the security provided by the project means that these individuals are now more receptive to supportive interventions (e.g. health care).*" (ibid.: 24)

As mentioned already the proportion of participants in the **Lisbon** project who were addicted to drugs and/or alcohol was rather low. After being rehoused numbers reduced further. Of the 21 participants who reported abuse of alcohol and/or drugs at time of entering the project, twelve stated that they had stopped using these substances after being rehoused and only nine said that their consumption had stayed the same. Although these are self-reported results, the fact that respondents did not have to fear any negative consequences when admitting their continued use of drugs and/or alcohol led the evaluators to consider the results as "*quite reliable*" (Ornelas, 2013: 33): "*Participants who stopped or decreased the use of alcohol or drugs said that the housing stability, the changes of daily routines, the access to health care and the support provided by*

the team, together with other specialized services, such as Alcoholics Anonymous or Narcotics Anonymous, were important factors to this change."

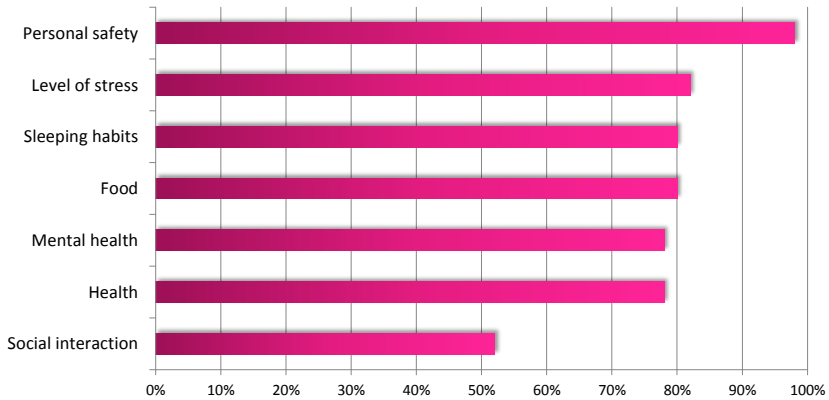
While about half of the interviewees in Lisbon had called the emergency number 112 during the last year of their homelessness, only 6% of them had done so after rehousing. 58% of the service users had been admitted to hospital in the last year of their homelessness and the percentage fell again to 6% after re-housing. Finally 20% had spent at least one night in a police cell when homeless and no one had done so after being re-housed.

One of the priorities after entering the programme in Lisbon was to secure a regular monthly income for all participants, either through employment or – more often – through obtaining a minimum social benefit or a disability pension. While at point of admission to the programme only 29 service users had a stable income it was achieved to secure some sort of income for all but one of the 74 participants of the project. More than two thirds (69%) of those 73 participants received a minimum social income or a provisional substitute until their benefit was approved and almost a quarter (24.3%) received a disability pension. Two persons each received a salary or a training grant (Ornelas, 2013: 28). While all participants had been unemployed before being rehoused, 26 of the 74 participants (35.1%) became involved in school, training, employment or other activities during the second and third year after rehousing. Nine of these service users participated in job site trainings in regular companies, across a wide range of jobs such as clerical work, library assistance, stock clerk in a supermarket, horse groom, baker, car wash worker, waiter and child care assistance. Two service users managed to become employed. Six participants engaged in educational projects to improve their qualifications and one was accepted onto a university course in community development. Five participants attended computer training courses, and two an art workshop.

The participants of the Lisbon project were asked to identify the areas of their life where housing had had an impact. As can be seen from the chart below, personal safety was mentioned by almost all participants (98%) and around 80% also agreed that it had had a (positive) impact on their stress levels, nutrition, sleeping habits and on health and mental health. The one area of life where only about half of the participants saw a (positive) impact of housing was the field of social interaction.

Chart 10

Impact of housing on different dimensions of quality of life according to participants of Casas Primeiro project in Lisbon



Source: Ornelas (2013): 30, N = 50

Data on changes in quality of life of the participants of the project in **Budapest** are scarce as staff did not have sufficient time to assess and provide adequate support for those clients with complex needs. Support workers emphasized that the involvement of specialized personnel (psychia-

trists, addiction specialists, etc.) would have been required to moderate the severe addiction of a considerable part of service users and to reach a higher success rate. But the time limited nature of the intervention probably also meant that not enough continuous support could be provided to reduce the harm and intensity of addiction to alcohol. Only a few examples were mentioned of people who took part in rehabilitation programs and managed to remain housed. There was also insufficient time available to help programme participants with housekeeping and integration into the community.

Given the lack of any sustainable welfare provision to cover the costs of living and housing (except for those who could receive an old age or disability pension), it was essential for participants in Budapest to find a job, but most of them had only a very low level of education and no formal qualifications. Moreover, in many case they were incapable of working full time due to their physical and mental state. Jobs were often of a casual nature, and many participants lost their jobs again after some time. But without regular income from work (or begging, garbage collecting etc.) it was impossible for them to pay their increasing share of rent and utility bills as the subsidy for these costs from the programme was time limited and regressive over time.

The evaluation report for the Budapest project again distinguishes three groups of trajectories of homeless people after being accepted in the programme, but on a rather different level than that reported for other projects:

The first (relatively small) group were those who were successfully integrated, and were mainly participants who did not suffer from any severe addiction and had some type of temporary work which allowed them to sustain the tenancy of a rented apartment or a workers hostel after financial subsidies by the project were gradually reduced.

A second group required much more support and counselling in different areas of life, many of them being severely addicted to alcohol, very poor and unemployed. But specialist support was not available from addiction or mental health specialists and the support provided was not broad and intensive enough to help with problems of keeping up a household, budgeting, regulate conflicts with the landlord etc.: "*This group probably considered the project as an opportunity to live in proper housing for a few months but did not make special efforts to maintain it in the long term. Usually everything went well in the first 2-3 months and then tenants started to get back to their alcohol addict lifestyle: lose their work, have loud fights, let other friends move in and in some cases cause damage in the apartment. In these cases support workers had to intervene and mediate between tenants and landlords if it was possible. Many of them had lived in the forest for 7-8 years before. Getting used to new forms of housing proved to be rather difficult for them. They had to get used to a regular lifestyle, maintaining a household. They found these expectations overwhelming. When some of them could not keep on maintaining an apartment, they experienced it as a great failure and could not cope with it psychologically. They had difficulties keeping their jobs or due to their physical and mental state could not even find one. Since they did not possess any savings, the loss of job meant that sustaining housing become impossible as well. Many of them moved back to the forest or the street, losing touch with the supporting organization*" (Fehér and Balogi, 2013: 34).

A (small) third group of participants of the Budapest project were a few people who tried to get the money (e.g. by a secret agreement with the landlord to share cash paid for the deposit) and leave the project as soon as they had achieved this (which – given the lack of sustainability of resettlement perspectives and the pressing need to make a living – might be seen as a comprehensible strategy).

Summing up the results from the five local evaluations on changes in quality of life and recovery is not easy, as measurement methods were different and we cannot compare the results directly. Interviews with programme participants provided a positive overall picture in four of the five projects. A varying proportion of those who were addicted to alcohol or drugs have made progress in reducing their abuse or even ceasing it. Especially for the projects in

Glasgow and Lisbon, some remarkably positive numbers are reported, and in Amsterdam fully 70% of all interviewees self-reported a reduction of substance abuse. There were also more positive than negative developments documented by staff in Copenhagen in this regard. But we need also to acknowledge that for some Housing First participants with problematic use of alcohol and drugs the level of addiction remained the same or even got worse, at least in specific phases after rehousing. The harm reduction approach applied in all projects means that we could not reasonably expect a different outcome. The harm reduction approach facilitates managing addiction and overcoming it gradually but abstinence is neither a requirement nor a primary goal. Obviously time and qualifications of the teams in Budapest were not sufficient to organize a successful harm reduction approach for most of the participants in need, so only very few positive outcomes can be reported from there regarding the management of severe addiction.

Improvements in mental health problems were reported for a majority of participants who were struggling with such problems in Amsterdam, Glasgow and Lisbon where security of housing and reliability of support were held to be important factors in such improvements. It is quite obvious that stable housing has the potential to increase personal safety and reduce the level of stress compared to a life in homelessness (though experiences might also be quite different depending on local circumstances: note that in Lisbon almost all participants (98%) reported that housing has had an impact on their personal safety while in Amsterdam almost half (49%) stated that feelings of personal safety had remained unchanged; in Copenhagen staff reported positive changes in mental health for 25% of service users, but negative changes for 29%). These positive developments are often attributed to what Padgett (2007) and others have referred to as "*ontological security*" (see also Watson, 2012): Housing provides the basis for constancy, daily routines, privacy and identity construction. And as Padget (ibid: 1934) notes as well: "*Having a 'home' may not guarantee recovery in the future, but it does afford a stable platform for re-creating a less stigmatized, normalized life in the present.*"

The results were generally less positive in the areas of enagement in paid employment, managing financial problems and social contacts. Quite a significant proportion of participants had made progress in all three areas but the number of formerly homeless people who could find and hold paid employment remained rather low in Lisbon, Glasgow and Copenhagen. Again this might not be too surprising given the multiple support needs of most project participants, often combined with low educational attainment, poor mental and physical health and rather high unemployment rates in the respective countries. For many paid employment was a long-term aim and doubts might remain if it is a realistic aim at all for some of them. It is rather remarkable that quite high proportions of participants in Amsterdam, Lisbon and Glasgow were engaged in voluntary work or other meaningful activity. Numbers of people participating in any activity projects were lowest in the Copenhagen project.

While a majority of participants in Glasgow and Amsterdam report an improvement in their financial situation, financial problems were the only area for which staff in Copenhagen reported significantly more negative than positive changes. In Amsterdam it was one of the few areas in which a sizeable minority (16%) reported a decline in well-being and in Glasgow participants were still struggling with their modest financial resources (with some having to repay old debts, a problem which was also mentioned in Copenhagen). With the time-limited and decreasing nature of housing cost subsidies, and no access to subsistence benefits, finances were probably most precarious for the majority of the participants in the Budapest project.

When placed in scattered housing, many formerly homeless people experience feelings of loneliness and social isolation. If they remain in contact with the former peer group (which they do automatically if they are rehoused in congregate housing projects) they often continue to struggle with problems of co-dependence and of failing to reduce substance abuse. If they try to cut contacts with their former homeless peers – as many rehoused homeless peo-

ple do – it is not easy for them to create a new social network. For those with close family contacts these contacts might be helpful, others will need support by project staff to overcome social isolation. In Amsterdam this was one of the few areas that the evaluation found should receive greater attention. In Lisbon, social interaction was the area of life where participants reported the least positive impact of being rehoused, and feelings of loneliness and isolation are also reported from the projects in Glasgow and Copenhagen. However, for almost all projects there are also reports about progress made (by a minority) in reconnecting with family members and estranged children. We will come back to other aspects of building social networks and integration into the neighbourhood further below when analysing the degree of community integration. As in many other respects, the Budapest project was different in this regard. Data on social integration are scarce and it is clear that staff had little time to provide targeted support for overcoming social isolation. But many more participants than in any other project shared their housing with family members or other persons and it was reported that couples were generally more successful in sustaining a tenancy than single persons, and families with small children were the ones most motivated to get into and keeping accommodation.

The three different types of trajectories of recovery presented in the Glasgow evaluation - namely a majority experiencing sustained positive change, a group with fluctuating experiences ("ups and downs") and one with little observable change - might be a useful typology for all of the projects. It probably has to be complemented by a fourth type, a minority group whose situation deteriorated or who did not manage to sustain the tenancy and have returned to being homeless.

We had asked all evaluators to report about any differences regarding the gender of service users, but none of them could report any firm results, given the relatively low number of women participating. The evaluation report from Budapest emphasizes that, in accordance with all other reports, that stability of housing or motivations were not significantly influenced by the gender of project participants, but mentions the opinion of one of the social workers that "...*women participants were mostly more practical than men; and women provided a stable background and a drive within couples. It was also mentioned that women created less conflicts – with staff or with landlords*" (Fehér and Balogi, 2013: 34). However, this remains the opinion of a single support worker and no firm conclusions on the gender aspect can be drawn from any of the local evaluations.

3.7 Community integration and conflicts

Community integration is part of the recovery process and relates to social contacts as well as enabling persons in need to live, work, learn and participate in their communities (see Tsemberis, 2010b: 27). However, in modern society relations within the direct neighbourhood are often limited and we should not expect more from Housing First programme participants in this regard than we do from other members of society.

In all projects (except in Budapest) efforts were made to link participants with community resources such as visiting local cafes and restaurants, participating in sport or recreation facilities and in community events, visiting local libraries, attending community addiction treatment programmes, etc. Evaluations of the results of these efforts, of the degree of neighbourhood contacts, and of conflicts with neighbours, differ considerably.

Given the frequent fears of housing providers and the general public that homeless people might create "trouble" and conflicts in their neighbourhoods it is of course relevant to learn to what extent neighbourhood conflicts have occurred in our five test sites and how these were dealt with. Neighbourhood conflicts were reported to have been relatively rare in Copenhagen (for those in scattered housing), Glasgow and Lisbon. In Glasgow the most serious case related to a participant who was harassed by former drug-using peers and subsequently moved out of the

dwelling. Apart from this case "*housing providers report that their initial anxieties about the risk of service users being involved in antisocial behaviour (as either victims or perpetrators) had not been borne out in practice. A small number of specific incidents had led to neighbour complaints, but in each case a constructive resolution was found without resorting to eviction. In this process Housing First staff acted as intermediaries whom liaised with relevant parties – service users, neighbours, housing providers, and (where relevant) the police – to work toward a constructive resolution*" (Johnsen with Fitzpatrick, 2013: 22). From Lisbon it is also reported that the Housing First team, in the rare cases when neighbourhood conflicts occur, brings together all parts involved to discuss different perspectives and possible solutions and landlords have proved to be collaborative partners in that process.

However, nuisance reports were a more significant problem in Amsterdam, where they were also subject of detailed analysis. The NGO Discus rented 100 dwellings between 2006 and end of April 2011 from five different housing associations in Amsterdam. Over the period of five years, Discus received nuisance reports for 41 of these 100 addresses. 26 of these reports were forwarded to them from the housing associations. Complaints differ in character and gravity; most of them concern noise but there were also complaints about pollution, destruction of property, walking around naked, drunkenness and intimidation. Discus always takes action: usually the support worker talks to the project participant and the person who has reported the complaint. Possible solutions are discussed and fixed in written agreements with the service user. If nuisance caused by the same person continues a warning conversation follows and in the case of persistence nuisance an official warning letter, and in extreme cases eventually the termination of the lease contract (without intervention of a magistrate) may follow. The project participant is always involved in the conversations during the entire process. As a rule a period of nuisance should not exceed three months during which it should be clear – also for those who reported the nuisance – that the project participant is working towards a reduction of it.

Of the 41 nuisance reports registered by the NGO in Amsterdam (involving 39 of the overall 120 service users, i.e. a third of them), two fifths (41%) could be resolved within a month and one quarter (24%) was classified as serious (taking much more than a month to resolve).[17] While 15 of the 39 tenants who gave rise to a complaint stayed in their flat and resolved the problem, six got a second chance in another flat (were five of them could stay on while one eventually left to a different facility for homeless persons), 11 moved to another facility and three were evicted because of the nuisance (for four persons the procedure was still ongoing at the point nuisance data were analysed). The housing associations cooperating with the NGO were satisfied with the interventions by support workers and agreed that Discus always took immediate action when complaints were reported (Wewerinke *et al*., 2013: 27-28).

On the level of neighbourhood integration, we have no further information from the evaluations in Amsterdam, Copenhagen and Budapest.

Participants in **Glasgow** were asked in the second wave about their contacts with neighbours and many of them indicated that they know at least some of them "well enough to say hello to". While a few have become friends with neighbours and meet them regularly to watch TV or share meals, others hadn't formed such relationships and "*tend 'to keep themselves to themselves' (as would be true for many members of the British public generally)*" (Johnsen with Fitzpatrick, 2013: 23).

In **Lisbon,** 45 participants were asked in 2012 whether they had participated in a list of community activities over the past month: almost half of the interviewees (46.7%) reported having met people at a restaurant or coffee shop, and a little more than a quarter (26.7%) had gone to a place of worship or participated in a spiritual ceremony. 15.6% each had gone to a library or participated in outside sports or recreation activities. Less than one out of ten had participated in a com-

[17] No information is available from the evaluation report on the number of cases in which the nuisance reported was not caused by programme participants or the report turned out to be not justified.

munity event or attended a movie or concert. Participants in Lisbon were also asked if they know most of the people in their neighbourhood and if they interacted with them. In both cases the majority reported that they did not and only about a third (33.4%) agreed or strongly agreed that they know most of their neighbours, with 22.2% reporting some interaction with them. Understandably some participants emphasised a wish to maintain their privacy. However, 71.1% stated that they felt at home in their neighbourhood and a bit more than half (55.6%) reported a sense of belonging to their community (Ornelas, 2013: 41-43).

Summing up, the results concerning neighbourhood conflicts were mixed. While they played a minor role for the Housing First projects in Copenhagen, Glasgow and Lisbon, where constructive solutions could be found in most of the rare cases that arose, nuisance complaints were reported against a third of all service users in Amsterdam over a period of five years. While two fifth of these complaints could be resolved in relatively short time and with the tenants staying in their homes, some participants got a second chance and managed to sustain their tenancy in another flat, but some also moved out to other facilities and out of the programme, and three persons were evicted in the evaluation period because of nuisance. In all cities where this was analysed (including in Amsterdam, with a relatively high number of nuisance reports) housing providers gave very positive feedback on the way neighbourhood conflicts were handled by service providers. From the test sites where community integration was measured, the results were mixed too. While some of the project participants were engaging in activities in their community and met some of their neighbours regularly, many others "kept their privacy" and were less active.

Given the complex support needs of most of the programme participants further integration might take more time for some of them and structural constraints (lack of money for going out, having guests and participating in activities which require resources) play a role as well. One of the evaluation reports also mentions that the norms governing social interactions in facilities in the neighbourhood are not always familiar to service users and might be another barrier to participation.

3.8 Costs and financial effects

It has been claimed repeatedly that it costs less to provide homeless people with complex support needs with housing and adequate support than to meet all of the costs generated by prolonged homelessness, e.g. prolonged use of emergency shelters, repeated admission to emergency medical and psychiatric services, and multiple arrests and episodes of imprisonment.[18] On the homepage of Pathways to Housing a simple comparison shows that the daily costs in a Housing First programme are about 57 $ (appr. 43 Euro), while a night in an emergency shelter costs 73 $ (appr. 56 Euro), in jail 164 $ (125 Euro), in an emergency ward of a hospital 519 $ (appr. 396 Euro), and in a psychiatric hospital 1,185 $ (appr. 904 Euro).[19] However, we must take into account that the frequency and duration of use of any of these services may be very different individually so that more in-depth cost comparisons are much more difficult to conduct and may lead to different results, depending on how often and how long individual programme participants of a Housing First service have used the other facilities mentioned in the past.[20] Of course, the principle that

[18] Gulcur *et al.* (2003), Culhane (2008); Larimer *et al*. (2009); Tsemberis (2010a) with further examples

[19] See http://www.pathwaystohousing.org/content/our_model.html .

[20] Poulin *et al.* (2010), for example, using data from Philadelphia, argue that "*Supportive housing models for people with serious mental illness who experience chronic homelessness may be associated with substantial cost offsets, because the use of acute care services diminishes in an environment of housing stability and access to ongoing support services. However, because persons with substance use issues and no recent history of mental health treatment used relatively fewer and less costly services, cost neutrality for these persons may require*

Housing First services should be available as long as they are needed has important cost implications, as some of the service users might need the Housing First services for a very long time.

As Rosenheck (2000) has mentioned in an early analysis of programmes for homeless people with mental illness: even if more effective services for homeless persons will cost more than less effective provisions in some cases, "*their value ultimately depends on the moral and political value society places on caring for its least well-off members*".

In the HFE project some of the key questions of the evaluation at European level related to the costs and financial effects of Housing First projects implemented at the HFE test sites. Unfortunately the information provided by the local evaluation reports varied considerably and costs information (and information on the previous use of other services) was not available for all projects.[21] It was also agreed at one of the HFE meetings that a more detailed comparison of the costs of the local projects with each other would not make sense as these not only reflected the enormous variance of salary costs in different European locations but would also need a much more sophisticated frame of detailed information and analysis to make any sense.

However, calculations from Amsterdam and Lisbon indicate that the costs of the Housing First projects compare favourably with other existing services at local level.

In **Amsterdam** different types of financing mechanisms were practiced within the Discus Housing First project. In 2011 the organisation received for some participants (30 out of 101 clients served in June 2011) a contribution which was based on 2 hours of face-to-face contact per week and which amounted to 8,500 Euro per client and year on average (which is equivalent to 23.30 Euro per day). For the majority of participants (58 of the 101) a significantly higher annual amount is paid for, based on the calculation of "full-care-at-home-packages" in combination with a so-called "care weight". On this basis the average annual amount paid per client is 25,400 Euro per year (or 69.60 Euro per day). According to the evaluation report this is still less than the costs for hostels with 24 hours support for homeless people in Amsterdam (Wewerinke *et al.*, 2013: 30).

For the project in **Lisbon,** the costs of the whole project (including staff salaries, operation costs, rents, electricity, water supplies and property management) were calculated at 16.40 Euros per day and client. These calculations are based on the real costs in 2012 which were lower than in the years before, because in 2012 rent subsidies were reduced and the staff ratio per service users increased. A night in a night shelter in Lisbon costs 18.60 Euros, in a hostel with some support a night costs 30.77 Euro. The evaluation also points out that there was a drastic decrease in the number of psychiatric hospitalizations for Housing First clients. While 58% of the programme participants were admitted in a psychiatric hospital at least once during the year before joining the project, this happened only to 6% during their stay in the project. Psychiatric hospitalizations in acute wards have a one-time cost of 2,500 Euro per client, according to the evaluation report (Ornelas, 2013: 33 and 44).

For the project in **Budapest** the costs per participants were relatively low: A maximum of 1,000 Euro per person and year (2.70 Euro per day) were available to cover the costs for housing (with a maximum of 800 Euro for one year) and support (with a maximum of 200 Euro for one year). This amount was lower than state aid paid for a bed in a homeless shelter or hostel (which is 1,560 Euro per bed and year) and it would certainly have been more expensive for the state to provide 150 additional beds in shelters and hostels and pay for them on an ongoing basis while the costs

less service-intensive programs and smaller subsidies" (ibid.: 1093) See also Kertesz and Weiner (2009) with similar arguments re-analyzing studies on the cost-offsets of Housing First.

[21] There was no analysis of costs in the Glasgow evaluation. Annual costs of the ACT-team in Copenhagen were appr. 11,500 Euro per person and year (excluding housing costs which have to be paid from subsistence benefits or other incomes of the programme participants; see Benjaminsen, 2013: 13). Converted into costs per day this is 31.50 Euro per day and person.

for the Pilisi Forest project were time limited for one year per client. However, caution is needed before any quick conclusions are reached. On the one hand the state support for shelters and hostels does not fully cover their costs (additional funds have to be raised by service providers for financing them). On the other hand, as we have seen, that the amount available for the Pilisi Forest project was insufficient to cover the full housing costs for those who had no income and were not fit enough to work nor for providing support of the intensity and duration which would have been needed. The result was that a considerable number of participants have become homeless again even within the funding period of one year. The number of places in shelters and hostels in Budapest does not meet the demand and many of the former residents of the forest went back to sleep rough in the forest requiring even less public funds. There is no information available on the extent to which they have used hospitals or were in contact with the criminal justice system (generating additional costs on a much higher level while homeless).

Summing up we need to be cautious in coming to any firm conclusions on cost offsets and financial effects of the projects evaluated in the HFE test sites. We have indications from three of these projects that it would have been more expensive to provide the project participants with temporary accommodation for homeless people during the same time that they have used the Housing First project. But none of the projects has produced more robust data on previous service use (and a – probable – higher use of cost intensive institutions like hospitals and prison) and on the duration of support needed by the Housing First project.

While it is important to stress that rehousing people with complex support needs is not possible by providing "housing only", and that the support needed requires considerable funds in order to be successful, it is equally important to underline that these funds are well invested if we consider the high housing retention rates in four of our five HFE test sites. They indicate a high cost effectiveness of well-resourced Housing First projects, but further research with more robust and longitudinal data and direct comparison of different services will be needed in this field.

3.9 Challenges and lessons learned

One of the big challenges for any Housing First project is procuring quick access to affordable housing. No particular problems in this respect are reported from Amsterdam and Lisbon where the NGOs operating the project rented the dwellings from housing associations or private landlords and sublet them to the service users. From Glasgow[22] and Copenhagen considerable waiting times before getting access to (scattered) social housing were reported. In Budapest, where the homeless people had to search themselves for rental housing in the private market, they were confronted in some cases with strong prejudices against homeless people and Roma. In addition to that, the amount of money available in Budapest for securing the houses was not only time-limited (to a year) but was also too little, especially for single people to cover their costs even for that limited period.

When programme participants had moved into their flats the organisation of furniture was a problem in some of the test sites. In Glasgow, for example, delays were experienced in acquiring furniture because financial support for it was not available to all tenants, took too much time to be processed and because demand on the local furniture recycling scheme exceeded supply due to funding cuts. In Lisbon most flats were let with furniture in place which reduced choice on the part of service users in the process of making their flat into their home.

Another challenge mentioned for several test sites was imprisonment of service users after they had acquired a fixed address, often for offences committed prior to admission to the project.

[22] In Glasgow the allocation process was complicated by a one-off strategic level process concerning the transfer of former council housing stock in Glasgow to community-based housing associations.

Regulations for such situations varied considerably: for example in Glasgow, UK Housing Benefit rules enable service users with sentences of less than 13 weeks to retain their tenancy but those with longer sentences will lose it. In Amsterdam regulations are more generous: if participants are detained for more than nine months they lose their dwelling which they rent from the NGO operating the Housing First project. In both cases the service providers stay in contact with the person in prison and provide them with a "second chance" after being released from prison, but due to shortage of social housing the rehousing process might take some time.

Having a fixed address may also create a problem for people with high debts from the past, when creditors start to insist on the collection of outstanding payments. This was mentioned also as an example of why the financial situation of some of formerly homeless service users deteriorated after moving into their own flats in Copenhagen. In general, almost all project participants remained poor after being rehoused and most of them relied on transfer incomes (or irregular jobs) on the level of subsistence benefits. Making ends meet needs to be seen as a constant challenge for the formerly homeless people, even if they share this situation with a large number of other poor people in their city.

As we have mentioned above loneliness and social isolation might pose a significant challenge especially for single people after moving into their own flat. In several projects the evaluation demonstrated less progress in the area of social contacts than in other areas of life. Especially the Amsterdam project showed that feelings of loneliness still persisted for quite a high proportion of people, though it didn't indicate that social relations have got worse or that the persons concerned felt lonelier than when they were homeless. However in some cases even that can be true, especially when they have tried to cut the ties to peer networks dominated by common substance abuse. Attention to an improvement of social contacts is therefore an important element of further inclusion.

It is interesting that only one of the evaluation reports (Johnsen with Fitzpatrick, 2013: 26) mentions the challenge for staff in maintaining service users' engagement with support once they had been allocated a dwelling and a "dip in mood" for some tenants during that period. In contrast to staircase services, the Housing First approach includes a change in the balance of power. The new tenants have their own key and might reject support offers which they don't feel necessary or useful. This increases the pressure on support staff to offer support which is really oriented towards the individual goals of service users and meets their needs and preferences. It also requires persistence and patience on the side of support staff who may use different ways of staying in contact (in addition to home visits) such as telephone calls, text messages etc.

Funding problems were a major challenge for the projects in Lisbon and in Budapest. In Lisbon it was a major problem to secure sustainability of the Housing First project in 2012. While it had received funding from Central Government (Institute of Social Security) during the first two years of its existence, funding was cut quite drastically in 2012. Even with additional support by the City Hall of Lisbon, local foundations and companies, the project had to manage a cut of 45% in 2012. A "strategic sustainability plan" was developed by the NGO in charge of the project which included negotiations with landlords to reduce the rent, additional financial support from a state funded local social organisation to increase the rent contribution of programme participants, as well as "*exploring different housing options that promote autonomy from the programme*" (Ornelas, 2013: 46). Some families with sufficient resources took over the lease for family members. As a result, the project costs for subsidizing the rent were reduced and the number of programme participants was reduced successively during the year 2012 from 60 in the first quarter to 52 in the last. Staff had to be reduced fron six to four. The organisation is confident that thanks to these measures they can now support 50 participants with the current funding.

In Budapest, the financial challenges mainly related to the individual rates available for housing and support which were far too low and time-limited to allow for sustainable outcomes for the majority of participants. This needs also to be seen in a context of a weak welfare system which

does not provide for any substantial housing allowances and where even benefits to secure a minimum for covering the costs of living for people unfit to work are extremely low (approx. 70 Euro per month) and do not allow for a decent life. In such a context, long-term funding on a higher level would have been needed for covering the housing costs as well as for providing more active and multidimensional support for the formerly homeless people from the forest.[23]

The harm reduction approach might pose a particular problem for projects working with users of hard and illegal drugs and in countries with strict legislation in this regard, as mentioned in the evaluation report for Glasgow. There the problem was overcome by an agreement with the local police, in which it was "*clarified that whilst it is an offence for service providers/managers to 'knowingly permit' drug misuse on their premises, they are not expected to 'police' them, but rather to respond to any incidents in an appropriate manner*" (Johnsen with Fitzpatrick, 2013: 25). The agreement with the police specified that service users must not allow another person to use substances in their flat, that any illicit substances seen by staff when they visit service users in their homes should be surrendered by service users and taken to the Police by staff, and that staff must inform the police if they suspect service users to be involved in dealing.

An important lesson learned from the Copenhagen project was that scattered housing was preferable to the different types of congregate housing for the large majority of formerly homeless people. The evaluation reports that "*...indications that gathering many people with complex problems at the same place creates negative synergy effects especially by maintaining an environment marked by substance abuse. The relocation of citizens from congregate housing units to independent housing during the programme period follows both the wishes of the citizens and the negative experiences of congregating many individuals with similar problems in the same housing units*", and recommends: "*The results also suggest that congregate housing should be reserved for individuals who are not able to live in ordinary housing even with the intensive support of an ACT-team and only after housing in independent housing has been tried, as it is not possible in advance to predict who will succeed*." (Benjaminsen, 2013: 3, 4).

Summing up one of the main challenges for most of the Housing First projects related to securing quick access to housing (and long waiting times especially in case of scattered social housing). Once housed with a fixed address some of the tenants may face prison sentences for offences committed earlier or get their small incomes reduced furtherby creditors claiming old debts. It may also be difficult for some of the rehoused persons to overcome loneliness and social isolation and a "dip in mood", especially if they live alone and have cut ties with former peer networks dominated by problematic substance use. If they don't do so "managing the door" might be a particular challenge for some of the project participants.

To prevent disengagement of programme participants once they have been allocated permanent housing, support staff needs to make support offers which are oriented towards individual goals of programme participants and meet their needs and preferences.

Problems in securing ongoing funding were a particular challenge for the sustainability of the project in Lisbon. In Budapest, one of the main challenges making it difficult to attain more sustainable results was the time-limited and the very limited amount of individual funding available for project participants who were not fit enough for employment, and a particularly weak provision of general welfare support for housing costs and the costs of living.

The harm reduction approach might pose a challenge for projects working with active consumers of illegal drugs in countries with strict legislation in this regard.

[23] The Budapest evaluation report mentions a lot of challenges and lessons learned which are focusing on the specific local circumstances. The reader may be referred to Fehér/Balogi (2013: 41 ff.) to learn more about the projects specific strengths, challenges and lessons learned.

One of the main lessons learned in the Copenhagen project was the preference of most homeless people to living in ordinary scattered housing and the negative consequences of congregating many homeless people – especially with addiction problems – in the same housing units. For a large majority of homeless people – even those with complex support needs – ordinary scattered housing is the better option.

3.10 Plans to upscale the Housing First approach

As it was mentioned above, the Housing First approach is an essential feature of the national homelessness strategy in Denmark where the implementation of different methods like Assertive Community Treatment, Intensive Case Management and Critical Time Intervention was planned in a number of cities. In none of the other peer site countries were there similar moves to scale up the Housing First approach as the dominant approach in homelessness policies for the whole city or even the whole country during the evaluation periods. But all test sites inspired new local initiatives.

The City of **Amsterdam** has decided, in association with the health insurance company Achmea, to increase the number of places for Housing First considerably: "*In collaboration with the city's housing associations, the City of Amsterdam aims to make 240 houses available for Housing First in the future, and possibly more*" (Wewerinke *et al.*, 2013:34).

In **Glasgow** the organisation operating the Housing First project (Turning Point Scotland) was planning to develop a Housing First project in another local authority area of Scotland, to apply the Housing First approach to other target groups (including people whose primary support needs are related to mental health), and to use a similar approach (same type and intensity of support) to help households at risk of homelessness with a prevention service. There was evidence of increased interest in the approach from England and Wales and the NGO is regularly approached by organisations interested in piloting new projects based on Housing First principles or a selection of it. One of these schemes is a small project in London.

The organisation AEIPS in charge of the **Lisbon** Housing First project has started in late 2012 another Housing First project in the city of Cascais funded by the local City Government. Organisations from other Portuguese cities such as Aveiro or Seixal have approached AEIPS because they have been interested in implementing a Housing First programme in their area.

In **Budapest** some new rehousing projects have been launched in 2012, including with Housing First elements, but no further information were available about the details of these projects.

Summing up the first positive evaluation results of our peer sites have attracted a lot of interest and plans for further piloting schemes in other places. In Copenhagen the ACT project was already one of several projects in a national strategy against homelessness actively promoting the Housing First approach, and in Amsterdam a considerable increase of Housing First places was planned after proving the successful results of the Discus project. From the other peer sites some plans and initiatives are reported. However, apart from Copenhagen we cannot report a significant tendency for scaling up the Housing First approach to homelessness services in general from our test sites.

Given that the evaluations are very recent date, and for example the evaluation in Glasgow has not even been completed when the HFE project was finalized, it would be very surprising if we had found another result. In many places using the Housing First approach on a broader scale would mean a substantial paradigm shift away from the staircase system (or approaches favouring a treatment-first approach and requiring homeless people to be "housing ready" before considering the allocation of ordinary housing to them) still dominating service delivery in the homelessness sector. In addition we should bear in mind that there are two opposing views on the potentials of the Housing First approach. For some, Housing First is one additional part of a whole menu of different approaches serving the needs of various subgroups

of homeless people, and the Housing First approach in this view is reserved for a particular (and usually quite small) group with severe and complex support needs which has not been served adequately by other existing services. For others, the Housing First approach has the potential for a more radical paradigm shift towards “housing led strategies” for all (or almost all) homeless people. In this view, the intensity and organisation of social support might vary according to the individual needs, but essential elements of the Housing First approach may apply for rehousing much larger groups of homeless people and even for the field of prevention of homelessness for households with support needs which are not covered by mainstream services. We will come back to that in our conclusions.

Finally we have reported already that before and during the funding period of the HFE project a number of new initiatives have been developed in other locations, including nation-wide experimentation and implementation projects of the Housing First approach in Finland, France and Belgium and smaller initiatives in a number of other countries. Even for the internal meetings of the HFE network we have always received a considerable number of external requests for information and the final conference of HFE in June 2013 (which was open to the public) was well attended by more than 230 participants.

Part III. Conclusions and Recommendations

1 Conclusions

The Housing First Europe (HFE) project was a social experimentation project, funded by the European Commission, DG for Employment, Social Affairs and Inclusion, under the PROGRESS programme from August 2011 to July 2013. HFEs aims included the evaluation of, and mutual learning between, local projects in ten European cities which provide homeless people with complex needs with immediate access to long-term, self-contained housing and intensive support. HFE involved five test sites where the approach was evaluated (Amsterdam, Budapest, Copenhagen, Glasgow and Lisbon), and facilitated the exchange of information and experiences with five additional peer sites (Dublin, Gent, Gothenburg, Helsinki and Vienna) where further Housing First projects were planned or elements of the approach were being implemented. The project was implemented through two principle strands, a research and evaluation strand, and a mutual learning strand. Five meetings, including a final conference open to the public and attended by more than 230 particpants, were used for exchange of information and experiences and for discussing a number of specific themes regarding the Housing First approach. A high profile steering group has contributed actively to the debates.

The main elements of the Housing First approach have to be seen in contrast to approaches requiring "treatment first" and/or moving homeless people through a series of stages (staircase system) before they are "housing ready". Housing First diverts radically from these approaches which have faced increasing criticism over the past few decades for being ineffective in ending homelessness for people with severe and complex needs and having unintentional negative effects. Housing First seeks to move homeless people into permanent housing as quickly as possible with on-going, flexible and individual support as long as it is needed, but on a voluntary basis, emphasising choice and self-determination of service users as an essential element and using a harm reduction approach. It has gained particular attention in the US, where robust longitudinal research has showed impressively high housing retention rates, especially for the pioneer model developed by Pathways to Housing in New York. The eight principles of this model, which focusses on homeless people with mental illness and co-occurring substance abuse, are: housing as a basic human right; respect, warmth, and compassion for all clients; a commitment to working with clients for as long as they need; scattered-site housing in independent apartments; separation of housing and services; consumer choice and self-determination; a recovery orientation and harm reduction.

Current debates about the Housing First approach have praised the potential, but also focused on the limits, of the approach and have highlighted a certain ambiguity of the term as it is used for a variety of projects and strategies for different target groups. Scepticism has been expressed about its effectiveness for certain groups, like homeless people with very severe drug and alcohol addiction, and in different national and local contexts. Some reservations have also been articulated about the non-housing outcomes of the approach (regarding substance abuse and overcoming social isolation and worklessness).

It was a condition for HFE test sites to target and re-house formerly homeless people with mental illness/drug/alcohol problems or other complex support needs. Broader local or national strategies and attempts to use the Housing First approach for homeless people with less severe support needs were not subject of evaluations in the HFE network.

Methodology: Based on local evaluations of test sites and collecting results on a number of guiding key questions

HFE builds on existing and on-going local evaluations in the five test sites, rather than attempting to devise a common evaluation methodology for all test sites, primarily due to funding con-

straints. With the budget given and the variety of projects included it was impossible to aim at randomized controlled trials or any other more robust research method for the European project. Furthermore none of the local evaluations included a control group, and local evaluations started and finished at different dates. As a result, diversity in the test sites is observable, in terms of scale and development, in terms of data collection and evaluation methods. This posed a challenge for analysis at a cross-national level, but also provided the opportunity to profit from different perspectives on a diversity of project practices.

At an EU level, a number of common key questions have been developed for all five test sites. The key questions were related to the following main topics:

- Numbers and profile of service users (age, sex, ethnicity/places of birth/nationality, household structure, employment status/income, housing/homelessness history)
- Support needs (and changes over time)
- Support provided/received
- User satisfaction
- Housing stability / housing retention rate
- Changes of quality of life/recovery
- Community integration/conflicts
- Costs and financial effects
- Specific positive effects, challenges and lessons learned

Questions on differences regarding gender and certain age groups could either not be answered by the local evaluation studies (as samples were too small to create any generalizable results) or it was stated in the reports that essential differences (regarding the gender of participants) were not found.

Five different test sites in five different welfare regimes, four of them broadly sharing main principles of Housing First as developed by Pathways to Housing, but still differing from the model in some respects. Budapest project special case.

The HFE test sites were located in five countries representing different welfare regimes, and in large cities with quite a variety of local contextual conditions with regard to the accessibility of affordable housing, and social and housing benefits, etc. The structural conditions and the level of general welfare and social protection were more difficult in Lisbon, and much more so in Budapest, with low levels of subsistence benefits and housing allowances and barriers for vulnerable people in taking up even this meagre financial support.

In all test sites the Housing First project was one of the first pioneering attempts to test this approach in an environment dominated either by staircase systems or by emergency provision for homeless people with no or very weak links to the regular housing market. Only the project in Copenhagen was part of a national (and local) strategy to promote and implement the Housing First approach on a wider scale.

None of the HFE test sites was an exact replica of the pioneer project Pathways to Housing in New York although – except for the Budapest project – they have followed this example in many aspects and have broadly followed most of the principles of Housing First as laid down by the "manual" of this project. Some caveats apply: we have not conducted a proper fidelity test and for some of the principles we have not enough information to confirm that they have been followed in practice. While all HFE projects served homeless people with complex and severe support needs, there might have been some selection of clients in the beginning, based on their willingness and motivation to hold a tenancy. In one of the projects (Copenhagen), congregate housing was used for a majority of service users in the beginning, but during the evaluation period and

based on negative experiences with this type of housing, increasing use was made of scattered housing.

Other aspects in which the HFE test sites diverted from the pioneer project regard the target group (only in Lisbon was this restricted exclusively to people with mental illness), the organisation of support (only in Copenhagen did the project work with an ACT team including medical experts and addiction specialists; other projects – except in Budapest – cooperated closely with such services if needed; peer experts were not employed in two of the five projects), and the use of social housing and direct contracts between landlords and service users.

With the exception of Budapest in some of the points, the HFE test sites all worked with a client-centred approach and individual support plans, having regular home visits as a rule (and with an obligation for clients to accept them), worked with relatively high staff-client ratios (ranging between 1:3-5 and 1:11), and offering the availability of staff (or at least a mobile phone contact) for emergency cases 24 hours a day, seven days a week.

The deviations from the pioneer "model" in terms of organising housing and support confirm arguments that a certain amount of "programme drift" and adjustment is inevitable if an approach is transferred to different local conditions. If social housing is an important source for housing vulnerable people and instruments are available to provide priority access to social housing – as it was the case in Copenhagen and Glasgow – it seems obvious to use this resource. If there is a lack of social housing and it is not accessible for homeless people – as in Budapest – or has long waiting lists and private rental housing can be acquired quicker and is seen as more flexible and better placed for community integration – as in Lisbon – private rental housing may be the preferred option. If access to other specialised and mainstream services is relatively easy, the ACT approach might not be necessary (though it might still hold some advantages for people with severe addiction and physical health problems, as is claimed for the Copenhagen project).

The Budapest project was different from the other projects in many respects. It was included as a test site because it was one of the very few programmes in Central and Eastern Europe which was trying to bring rough sleepers directly in mainstream housing with support, sharing some of the basic principles of the Housing First approach. However, some important elements are also missing: support in Budapest was time limited from the beginning, and with a (theoretical) ratio of support workers to clients of 1:24, support was far less intensive than in all of the other test sites. In addition the support was provided by social outreach workers from different services in addition to a full-time job, there was no Housing First team working exclusively with re-housed homeless people. Support capacities were not only limited in intensity but also in duration (to one year) and financial support for housing of the service users who had basically to search for their homes by themselves – with some support by staff- was also too little and time-limited. In contrast to all other projects, long-term housing retention was also not an explicit target of the Budapest project (the main target was to clear a forest area of homeless people).

Service user matched different target groups, high proportion of substance abuse in most projects, single long-term homeless men predominate

The data provided by the evaluation reports on the demographic and social profile of the projects demonstrate that they have reached their specific target groups, but that these groups differ to a considerable extent. While the Lisbon project had probably the highest share of clients with a psychiatric diagnosis, it had the lowest proportion of people with an addiction to alcohol and drugs. While more than two thirds of the service users in Copenhagen and Budapest indicated a problematic consumption of alcohol and abuse of a variety of substances was also frequent among the service users in Amsterdam, the project in Glasgow targets and reaches a particularly challenging group of heroin users. Apart from addiction problems and mental health problems, a considerable proportion of the project participants reported support needs because of poor physical health.

Demographic details show that the participants of the projects in the five test sites were predominantly men and nationals of the countries where the projects were located. A significant proportion of ethnic minorities participated in the projects in Amsterdam, Copenhagen and Budapest. Participants were mainly middle aged (36-45) or older; only in Glasgow were half of the participants younger than 36. A large majority of the participants in all test site projects had no regular employment at the time of entry into the projects and with the exception of participants in Budapest, they were living either on some sort of transfer benefits or had no income at all. The overwhelming majority of participants in all projects were long-term homeless people.

The social profile of service users in Budapest differed from the profile of participants in the other projects in at least two important respects: only a minority of them were single and the majority lived with family members, partners or friends, while the majority in all other projects were single person households. Only a very small minority of service users in Budapest could receive subsistence or unemployment benefits as this required previous legal employment and/or an official address. While altogether about a third of Budapest service users either received a pension or had a regular income from work, the majority relied on precarious and irregular jobs or activities like collecting garbage, begging and vending street newspapers.

Support needs: Housing, finances, mental and physical health, worklessness and social isolation

Support needed for gaining access to housing and for sustaining the tenancy (including contacts with the landlord and neighbours) played a major role in all projects. Making the flat into a home is an obvious need in the period after moving into the flat which can require quite intensive support of a very practical nature (organizing furniture and household items, payment of bills etc.).

The evaluations also show that financial problems and unemployment were common problems amongst project participants. Partly these problems were exacerbated by the financial requirements of substance abuse and by problems faced by project participants in realising their rights to subsistence benefit, but we should also keep in mind that unemployment and poverty are structural problems which cannot be “solved” by the Housing First projects and which are very difficult to overcome individually by service users who are among the most marginalised groups of society and in welfare system which allow only a very low standard of living (if at all) at the level of subsistence benefits (notwithstanding the country specific differences). However, the projects could help with getting personal documents organised and claiming existing rights to subsistence benefits, housing benefits, pensions etc. and this played a very important role in some of the projects.

From Amsterdam, Copenhagen and Glasgow a lack of social networks was reported as a problem, not for all, but for a significant proportion of service users. To a certain extent, loneliness and social isolation might be an initial “price” to be paid for moving into scattered housing, especially if the new tenants want to cut contact with their former peer networks.

Different patterns of support needed and provided over time, high service user satisfaction (where this was measured)

Support provided was generally most intensive in the time around moving into the apartments and diminished after some time, but for some of the service users and in time of crisis quite intensive support has to remain available. Generally the dominant areas of support change after a period of turning the flat into a home and dealing with public administration (not least to secure subsistence benefits), towards issues of addiction and physical health, overcoming social isolation and finding something meaningful to do. All evaluations emphasised that support was adjusted to individual needs and intensities, differing substantially between participants. It is also important to emphasise that there is a group of service users whose needs do not diminish over time, but may rather go up and down or remain on a relatively high level.

We can report a high level of service user satisfaction for the three projects were this was evaluated (Amsterdam, Glasgow and Lisbon). The overwhelming majority of service users were positive about the support provided and how it was provided, and about the accessibility of staff. With very few exceptions, the support provided met the needs of service users. Some of the basic ingredients of the Housing First approach let to high satisfaction on the side of users: that they lived in their own self-contained flats and had the security of being able to remain there, that support was delivered as long as they needed it, that they are accepted as they are and treated with respect and empathy, and that they can be open and honest about the use of drugs and alcohol without the fear of being evicted as a consequence (harm reduction approach). Especially in Glasgow, the inclusion of peer supporters in the support staff was highly appreciated by service users, because they were seen as real experts with relevant lived experiences, non-judgemental and easy to communicate with.

Dissatisfaction – which was rare overall – related in some cases to the support provided (asking for more support, e.g. in Lisbon), but more often to the choice of housing and in some cases long waiting times before being allocated permanent housing. Such problems reflected structural problems like a shortage of (affordable and accessible) housing of good quality.

High housing retention rates for four of the five test sites

High housing retention rates have been achieved by four of the five projects and the only project where the results were less positive was the project in Budapest, which in many respects departed from the principles of the Housing First approach (housing costs were not covered over a longer period, social support diminished quickly and was not available as long as it was needed, etc.).

Housing retention rates in Amsterdam and Copenhagen were extraordinarily high (over 90%, even when we focus exclusively at those persons who had been rehoused in the project more than a year ago). In Glasgow, for a smaller project with a group of homeless people generally seen as particularly difficult to house (users of illegal drugs, mainly heroin), the impressive retention rate of 92.2% was reported and for the project in Lisbon the retention rate was still very near to 80% after running the project for more than three years and despite severe cuts in funding in 2012.

Some caution is needed for assessing these overall very positive results. The two projects in Copenhagen and Glasgow were still at a relatively early stage and given the remaining problems of many service users concerning their mental health situation and addiction problems, a risk of losing their tenancy at some stage still remained. Some projects have required the motivation of homeless applicants to be housed and remain housed before accepting them as participants: this might have excluded some more chaotic homeless people who have not demonstrated such motivation. Furthermore we have excluded some people from the housing retention calculation, when they have moved – often with support of the Housing First team – to more institutional provision with on-site support which was seen as more suitable for them. Obviously this is a small group but it should not be forgotten in any discussions about “scaling up” the Housing First approach. The same applies to those few people who have “dropped out” or were evicted and could not benefit from the approach despite all the efforts of support services.

Finally, data from the local evaluations included in our HFE-project are not as robust as in other evaluation projects working with randomized controlled trials and no data is available for control groups of homeless people with the same profile receiving “treatment as usual”.

Nevertheless the data confirmed a number of studies in the US and elsewhere that the Housing First approach facilitates high rates of housing retention and that it is possible to house homeless persons even with the most complex support needs in independent, scattered housing. This is even more remarkable as the four successful test sites evaluated in the framework of HFE show some substantial differences concerning the target group, the type of housing and the organisation of services, but share most of the principles of the Housing First approach. As three of the four successful projects also had high proportions of substance abusers, the results add to the

evidence of positive housing retention outcomes of the Housing First approach for people with severe addiction, and even for those with active use of heroin and other hard drugs.

Scattered Housing preferable for bulk of homeless people with complex support needs, congregate housing with on-site support may be adequate for small subgroup

The HFE test site in Copenhagen gave us the opportunity to compare experiences with scattered site, independent housing (as provided in all other HFE test sites) and congregate housing in the same programme, with support provided by the same ACT team. It has shown high housing retention rates for both types of housing provision. But there were also strong indications that gathering many people with complex problems in the same buildings may create problematic environments (often dominated by substance abuse), conflicts and unintended negative consequences. The Copenhagen evaluation showed a clear preference of the bulk of homeless people for scattered housing and during the evaluation period many more people in congregate housing have moved to other addresses than those placed in scattered housing from the beginning. The results from Copenhagen suggest that congregate housing should be reserved for those few persons who do either display a strong wish to live in such an environment or have not succeeded to live in scattered housing with intensive Housing First support.

Mixed, but overall positive results on changing quality of life. Progress for the majority in terms of substance abuse and mental health, less positive results for overcoming worklessness, financial problems and loneliness

Interviews with programme participants provided an overall positive picture regarding changes of quality of life in four of the five projects. A varying part of those who were addicted to alcohol or drugs have made progress to reduce their abuse or even stop it. Especially for the projects in Glasgow and Lisbon, some remarkably positive numbers are reported, in Amsterdam even 70% of all interviewees self-reported a reduction of substance abuse and there are also more positive than negative developments documented by staff in Copenhagen. But we need also to acknowledge that for some Housing First participants with problematic use of alcohol and drugs the level of addiction remained the same or even got worse (sometimes only in specific phases) after rehousing. The harm reduction approach applied in all projects means that it would not be reasonable to expect a different outcome. The approach facilitates managing addiction and overcoming it gradually, but abstinence is neither a requirement nor a primary goal. Obviously time and qualifications of the teams in Budapest were not sufficient to organize a successful harm reduction approach for most of the participants in need, so only very few positive outcomes can be reported from there regarding the management of severe addiction.

Improvements of mental health problems were reported for a majority of participants who were struggling with such problems in Amsterdam, Glasgow and Lisbon where security of housing and reliability of support were held to be important factors in such improvements (though in Copenhagen staff reported positive changes of mental health for 25 % of service users, but negative changes for 29%). It is clear that stable housing has the potential to increase personal safety and to reduce the level of stress compared to a life in homelessness. The positive developments are often attributed to what is termed "*ontological security*" in the literature: housing provides the basis for constancy, daily routines, privacy and identity construction, and a stable platform for a less stigmatized and more normalised life.

The results were generally less positive with respect to the take-up of paid employment, managing financial problems, and social contacts. Quite a significant proportion of participants have made progress in all three areas but the number of formerly homeless people who could find and hold paid employment remained rather low in Amsterdam, Copenhagen, Glasgow and Lisbon. Again this might not be too surprising given the multiple support needs of most project participants, often combined with low educational attainment, poor mental and physical health, and high unemployment rates in the respective countries. For many, paid employment was a long-

term aim and doubts may remain as to whether it is a realistic aim at all for some formerly homeless people. It is rather remarkable that quite high proportions of participants in Amsterdam, Lisbon and Glasgow were engaged in voluntary work or other meaningful activity. Numbers of people participating in any activity projects were lowest in the Copenhagen project.

While a majority of participants in Glasgow and Amsterdam report an improvement of their financial situation, financial problems were the only area for which staff in Copenhagen reported significantly more negative than positive changes. In Amsterdam it was one of the few areas in which a significant minority (16%) reported a decline, and in Glasgow participants were still struggling with their scarce financial resources (and some with having to repay old debts, a problem which was also mentioned in Copenhagen). With the time-limited and reducing subsidy of housing costs, and no access to any substantial subsistence benefits, the financial prospects were probably most precarious for the participants in the Budapest project.

When placed in scattered housing many formerly homeless people experience feelings of loneliness and social isolation. If they remain in contact with the former peer group (which they do automatically if they are rehoused in congregate housing projects) and are struggling with addiction problems of co-dependence and of not managing to reduce substance abuse are reported. If they try to cut contacts with their former homeless peers – as many rehoused homeless people do – it is not easy for them to create a new social network. For those with close family contacts these contacts might be helpful, others will need support by project staff to overcome social isolation. In Amsterdam this was one of the few areas that the evaluation found should remain a point of attention. In Lisbon, social interaction was the area of life where participants reported the least impact of being rehoused and feelings of loneliness and isolation were also reported from the projects in Glasgow and Copenhagen. However, for almost all projects there are also reports about progress made (by a minority) in reconnecting with family members and estranged children. As in many other respects, the Budapest project was different also in this regard. Data on social integration are scarce and it is clear that staff had little time to provide targeted support for overcoming social isolation. But many more participants than in any other project shared their housing with family members or other persons, and it was reported that couples were generally more successful in sustaining a tenancy than single persons, and families with small children were the ones most motivated to get into and keeping accommodation.

Four types of trajectories of recovery

Four types of trajectories of recovery (adapted from the evaluation in Glasgow) are, we would postulate, probably to be found in all of the projects (again with patterns in Budapest probably quite different to the others): a majority experiencing sustained positive change; a group with fluctuating experiences (“ups and downs”); a group with relatively little observable change; and a (small) minority group whose situation deteriorated or who did not manage to sustain the tenancy and has returned to being homeless.

Mixed results concerning community integration and neighbourhood conflicts

Neighbourhood conflicts played a minor role for the Housing First projects in Copenhagen, Glasgow and Lisbon, where constructive solutions could be found in most of the rare cases that occurred. In Amsterdam, nuisance complaints were reported against a third of all service users over a period of five years. While two fifth of these complaints could be resolved in relatively short period of time and with the tenants staying in their homes, some participants got a second chance and managed to sustain their tenancy in another flat but some also moved to other facilities and out of the programme, and three persons were evicted during that period because of nuisance. In all cities where this was analysed (including in Amsterdam, with a relatively high number of nuisance reports) housing providers gave very positive feedback on the way neighbourhood conflicts were handled by service providers.

From the test sites where community integration was measured the results were mixed too. While some of the project participants were engaging in activities in their community, and met some of their neighbours regularly, others "kept their privacy" and were less active.

Given the complex support needs of most of the programme participants, further integration might take more time for some of them and structural constraints (lack of money for going out, having guests and participating in activities which require a fee) play a role as well.

Indications that HFE projects less expensive than providing temporary accommodation for the same period, but further cost effect-studies needed

We have indications from three of the five HFE test sites that it would have been more expensive to provide the project participants with temporary accommodation for homeless people during the same time that they have used the Housing First project evaluated. But none of the projects has produced more robust data on previous service use (and a – probable – higher use of cost-intensive institutions like hospitals and prison) and on the duration of support needed by the Housing First service. It is important to stress that intensive support such as that provided in Housing First projects requires considerable funding, and homelessness for people with complex support needs cannot be solved by providing "housing only" or with low level support. While our test sites with high housing retention rates indicate a high cost effectiveness of well-resourced Housing First projects further research with more robust and longitudinal data and direct comparison of different services will be needed in this field.

Challenges and lessons learned: securing quick access to housing, some risks for clients after settling with a fixed address, providing attractive and client centred support, securing continuous funding

One of the main challenges for most of the Housing First projects related to securing quick access to housing (and long waiting times especially in case of scattered social housing). The projects can help their clients to overcome barriers for access to housing but they are all working within structural constraints including the local shortage of affordable housing.

Once housed with a fixed address some of the tenants may face prison charges for offences committed earlier or find their low incomes further reduced by creditors claiming back old debts. It may also be difficult for some of the rehoused persons to overcome loneliness and social isolation and some may experience a "dip in mood", especially if they live alone and have cut ties with former peer networks dominated by problematic substance use. If they don't cut such ties they often find that "managing the door" might be a particular challenge.

The Housing First approach involves a change in the balance of power between service providers and service users, as compared with more institutional provision. To prevent disengagement of programme participants once they have been allocated permanent housing, support staff need to make support offers which are oriented towards the individual goals of programme participants and to meet their needs and preferences.

Problems in securing continued funding were particular challenging for the sustainability of the project in Lisbon. In Budapest, one of the main challenges making it difficult to reach more sustainable results was the time-limited and too limited amount of individual funding available for project participants who were not fit enough for employment and a particularly weak provision of general welfare support for housing costs and the costs of living.

Finally, the harm reduction approach might pose a challenge for projects working with active consumers of illegal drugs in countries with strict legislation in this regard, but strategies to overcome this problem may be found.

Test sites serve as example for other pilot projects and some scaling up on the local level

Only in Copenhagen, where the test site was already part of a wider (and nation-wide) strategy to implement the Housing First approach, and in Amsterdam (this time at local level), can we find plans for scaling up the Housing First approach. In the other test sites there was interest from other cities to work with the same approach in local pioneer projects or plans from the organisation to replicate their work in other locations and with other target groups. Plans and on-going projects to implement the approach on a wider scale (outside the HFE test sited and peer sites) are reported for example from France and Belgium, from Austria, Finland, Norway, Sweden and the Netherlands. It remains to be seen to what extent these plans go beyond single projects for a very strictly defined target group and how the positive results of the HFE project and positive experiences made in other projects will influence further development of the Housing First approach in Europe.

2 Recommendations

The positive results of four of the five Housing First test sites show that the Housing First approach is to be recommended as a highly successful way of ending homelessness for homeless people with severe support needs and helping them to sustain a permanent tenancy. They show that the majority of the target group, including people with severe addiction problems, is capable of living in ordinary housing if adequate support is provided. The eight principles developed by Pathways to Housing appear to be a useful device for developing Housing First projects, including the recommendation to use predominantly ordinary scattered housing and independent apartments not concentrated in a single building.

Important elements for success of the Housing First approach are:

- Quick access to housing: in countries where instruments to overcome access barriers for homeless people to social housing exist, social housing may be a useful resource. Elsewhere, private rented housing or even the use of owner occupied housing may dominate. Approaches as practised by social rental agencies (see De Decker, 2002, for Belgium) or by the Y-Foundation in Finland (see Busch-Geertsema, 2011) may be useful in getting access to housing in the private rented and owner occupied sector for use in Housing First projects.
- Housing costs and the costs of living must be covered long-term for those persons who cannot earn enough money by employment. This can be a particular problem in countries with a weak welfare system as we have seen in the test site in Budapest.
- Multidimensional support of high intensity must be available as long as it is needed. Our examples show that this can be organized in different ways and if close cooperation between medical experts and addiction specialists is possible they do not necessarily have to be integral part of the support team (as in the ACT approach). However ACT has proved to be a positive approach for people with severe mental and physical health problems and addiction.
- Housing First programmes should carefully consider how to deal with nuisance and neighbourhood conflicts and should make clear agreements about that with both the service users/tenants and the landlords. Our test sites show that successful management of such problems (if they occur at all) is possible in most cases under these conditions.

The risk of failure of schemes which do not procure long-term funding for housing costs and more intensive and specialized support is relatively high as we can see from the evaluation of the Budapest test site.

Housing First support staff have to meet particular requirements: they need to show respect, warmth and compassion for all service users and put service user preferences and choices at the very core of their support work. They have to be able to build up trusting relationships, and their

support offers have to be attractive and meet the individual needs of their clients, always based on the firm confidence that recovery is possible.

However, expectations of policy makers and service providers need to remain realistic. Ending homelessness provides a platform for further steps towards social inclusion, but is not a guarantee for it and for the most marginalised individuals relative integration might often be a more realistic goal. Nevertheless, for support workers the aim should always be to support clients in achieving the highest level of integration that is possible in their specific situation and further attempts to successfully overcome stigmatisation, social isolation, poverty and unemployment are needed, not only on the level of individual projects, but also on a structural level. The same applies to structural exclusion of vulnerable people from housing markets. The debate on Housing First should be used to (re-)place access to housing at the centre of the debate about homelessness while emphasising that housing alone is not enough for those with complex needs.

Promotion of the Housing First approach as an effective method to tackle homelessness is recommended at all levels, local, regional and national as well as at the European level. Mutual learning and transnational exchange should be continued on Housing First. Relevant policy frameworks for this include the European Programme for Social Change and Innovation, the European Platform against Poverty, and the Social OMC (Open Method of Coordination).

The Housing First approach is a perfect example for social investment. In February 2013, the European Commission published guidance to Member States on how to tackle homelessness in its Social Investment Package (SIP), a policy framework for (re)directing Member States' policies towards social investment. This guidance cites Housing First as an effective model.[24] Indeed, Laszlo Andor, European Commissioner responsible for Employment, Social Affairs and Inclusion has stated that "*Housing First approaches to homelessness can save people's lives from deteriorating further, and provide the best chances for reintegrating them into society*"[25]. Housing First should be further developed as a key element of integrated strategies to tackle homelessness at local, regional, national and European level.

The EU's structural funds in the period 2014-2020 should be used to support the development and scaling-up of Housing First to promote social inclusion and combat poverty, support the transition from institutional to community-based care and as a form of social innovation. The European Social Fund can be used to support services to promote the inclusion and empowerment of homeless people whilst the European Regional Development fund can support infrastructure/housing. A multi-fund approach is particularly relevant for Housing First implementation.

For the period 2014-2020, the EU Programme for Social Change and Innovation (EPSCI) should be used to further develop the Housing First approach in EU contexts. This new financial instrument will in particular support the testing and evaluating of innovative social policies. It would be useful to build upon the findings of Housing First Europe to further experiment and evaluate aspects of Housing First as an effective approach to tackling homelessness.

The Commission should support a network of European experts on the Housing First approach which could give useful advice for the development of local projects and continue the process of mutual learning.

Training of key players at different levels of homeless policy-making and service delivery is an important element of scaling-up the Housing First approach. The European Commission could support training on Housing First as part of its follow-up of the SIP programme.

[24] See http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52013DC0083:EN:NOT and http://ec.europa.eu/social/BlobServlet?docId=9770&langId=en

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At all the levels mentioned, the Housing First approach may at least comprise an element of (local, regional, national and European) homeless strategies, but might also be used for a more fundamental change of paradigm, departing from staircase systems and provision which primarily focuses on emergency measures.

The focus of HFE was on relatively small local projects for people with complex support needs. It is still a matter of debate whether the Housing First approach should be reserved exclusively for this relatively small subgroup of homeless people. It would be useful to test and evaluate the effectiveness of services following the same principles for people with less severe needs and for strategies implementing the Housing First philosophy in broader "housing led" strategies, and in strategies promoting de-institutionalisation on a broader level by combining ordinary housing with support. Several countries and cities have claimed to implement such strategies and it would be useful to promote information exchange and mutual learning between them and evaluate the effectiveness of such strategies.

In such a context, innovative methods of needs assessment and of methods of financing flexible support are needed to secure that floating support is sufficient and matching the individual needs but also doesn't overstrain the financial capacities of those responsible for funding it.

Further research is needed in the following areas:

- Cost effectiveness of the Housing First approach (taking into account previous service use and duration of support provided);
- Gender and age specific requirements and effects of the approach for example for young homeless people under 25 should be analysed in detail;
- More in-depth and comparative evaluation of the use of evidence based methods of social support, such as Assertive Community Treatment, Intensive Case Management and Critical Time Interventions and their applicability for different groups of homeless people and in the field of homelessness prevention.

Relevant authorities at different levels should move this research agenda forward. The Horizon 2020 programme could be a useful framework in this respect.

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