

# Turning Point Scotland's Housing First Project Evaluation

## Final Report



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## Executive Summary

### Introduction to the Pilot

The Housing First pilot was developed by Turning Point Scotland (TPS) in response to high levels of repeat homelessness amongst people with active substance misuse problems in Glasgow. It has involved a three-year pilot running from October 2010 until September 2013, providing housing and support to 22 individuals who were homeless and actively involved in substance misuse (drugs, alcohol, or poly-substance misuse) at the point of recruitment. The pilot was funded by TPS, the Big Lottery Fund, and Greater Glasgow and Clyde Health Board.

The pilot was, as the name implies, modelled on the principles of the Housing First approach which was developed by Pathways to Housing in the United States. Housing First departs from orthodox 'linear' approaches to homelessness by placing homeless people with complex needs directly into independent tenancies without first insisting that they progress through transitional housing programmes and/or undergo treatment. Tenants are then provided with flexible, non-time-limited support in their homes and communities.

The TPS pilot in Glasgow was the first Housing First project to be developed in the UK, and one of the first internationally to explicitly target homeless people involved in active drug misuse. It accommodates service users in 'normal' independent self-contained housing association flats, on a scatter-site basis, with a rent contract and unlimited lease. The project is staffed by a team of six which includes three peer support workers who have histories of homelessness and substance misuse. Support plans are developed on a client-centred basis and assertive outreach and motivational techniques are employed. Staff members assist service users to access welfare entitlements and other support services, as appropriate to their support plan. The provision of support continues if service users disengage or spend extended periods in institutional care settings (e.g. prison or rehab).

Most of the pilot's service users are male, aged between 25 and 44, and all are White British. The adulthood of almost all have typified the 'revolving door' of repeat homelessness and institutional care, that is, cycling in and out of prison, rehabilitation facilities, hospital, and/or psychiatric wards. Substance misuse problems date back to teenage years for most, and addictions were severe at the point of recruitment in a number of cases (particularly in the case of those addicted to illicit drugs, less so alcohol).

This report presents the findings from an independent evaluation of the pilot conducted by Dr Sarah Johnsen with Prof Suzanne Fitzpatrick from Heriot-Watt University. The evaluation ran for the full three-year duration of the pilot period and was funded by TPS. It employed a longitudinal methodology and involved repeat interviews with TPS staff and representatives of key stakeholder agencies (total  $n=30$ ), repeat interviews with service users (total  $n=43$ ), and analysis of service users' case files.

### Project Outcomes

The project has been highly successful at retaining the involvement of service users, including several of those widely regarded as 'serial disengagers'. Its housing retention outcomes have also exceeded expectations. The vast majority of service users have retained their tenancies continuously since they were allocated their property; half of these individuals had in fact done so for more than two years by the end of the pilot period. No evictions were recorded, but one service

user 'lost' their tenancy due to serving a long prison sentence (and thereby losing Housing Benefit entitlement), and another 'gave up' theirs after being victimised by other members of the drug-using community.

The general direction of change in terms of health has been one of improvement, with a number experiencing vast improvements in physical health, which have generally been attributed to improvements in diet and reductions in drug or alcohol use. Some service users do however suffer from ongoing physical health issues and a number from periodic fluctuations in mental health. Deteriorations in mental health have often been reflected in increases in substance misuse or relapses of varying durations.

Outcomes as regards substance misuse have been mixed, but positive on balance. There has been an overall reduction in the severity of service users' dependence on illicit drugs, but little observable change as regards overall levels of alcohol dependency. Several service users have achieved abstinence from whatever their primary 'substance of choice' had been at the point they were recruited to the project. A minority (approximately one quarter) of service users still report high levels of drug dependence. Those who have 'slipped' on their journey toward recovery nevertheless report being closer to meeting their goals regarding substance misuse than they were before becoming involved with Housing First.

Involvement with the criminal justice system and levels of participation in street culture activities (e.g. begging or sex work) have declined overall in concert with reductions in levels of illicit drug use. Periods of incarceration – sometimes (but not always) for offences committed prior to being housed by the pilot – have been very disruptive to service delivery and led to the loss of one (of the total two) tenancies ended to date.

Service users' financial wellbeing has improved overall, largely due to reductions in the amount of income spent on illicit drugs, but most continue to struggle to cope financially on low incomes. Outcomes as regards participation in 'formal' meaningful activities have exceeded expectations, with several service users now involved in either education, training or voluntary work. Participation in paid work nevertheless remains a long-term goal for most.

A number of service users have benefited from family support, but feelings of social isolation have been a common experience for others, especially those who have deliberately cut ties with former drug- or alcohol-related peer networks. Involvement with meaningful activities in the community has gone some way to mitigating the loneliness experienced by a few service users, but Housing First staff continue to play a critical role as sources of social and emotional support for many.

Instances of neighbourhood disturbance, where service users have been either the perpetrators or victims of anti-social behaviour, have been relatively rare, and certainly far less prevalent or severe than had been anticipated by most stakeholders. The extent to which service users have interacted with other people or activities in their local community has varied, in part reflecting their differing levels of confidence and social skills.

Levels of service user satisfaction with the project have been very high. Key contributors to these high satisfaction levels have included: the positive relationships developed between staff and service users, the flexibility and 'stickability' of support, and the project's 'realistic' approach to substance misuse which encourages service users to be honest about where they are on their journey toward recovery.



The inclusion of peer support workers in the staff team has been universally welcomed by service users. Their shared histories break down perceived barriers about the risk of being judged and enhance service users' faith in their own ability to recover from addiction.

Any dissatisfaction expressed by service users has related predominantly to substantial delays in the allocation of flats, reflective of current high demand for housing association tenancies in Glasgow. These delays have been a source of great frustration for all those involved in service delivery and have had a detrimental impact on the motivation of a number of service users.

### Trajectories of Experience

The pilot's service users have tended to follow one of three general trajectories with regard to the overall direction and/or extent of behaviour change; so too 'distance travelled' on their journey toward recovery from substance misuse. These may be described as follows:

1. *'Sustained positive change'*. For half of all service users ( $n=11$ ), outcomes have been largely or uniformly positive overall and have, on the whole, been sustained to date. Generally speaking, their substance misuse has stabilised or reduced (and in some cases ceased), their physical and mental health has improved, and any prior involvement in criminal or street-culture activity has terminated. In most instances their social support networks have strengthened, and they have become increasingly involved with meaningful activities within their community. Some of these individuals report having experienced 'difficult' periods – experiencing a 'dip in mood' for example – but the general trajectory of their experience has been one of positive lifestyle change and enhanced wellbeing.
2. *'Fluctuating experiences'*. For a further quarter of service users ( $n=6$ ), 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 and intermittent periods of disengagement with support. Staff have often increased the intensity of support provided at such times to help service users 'get back on track'.
3. *'Little observable change'*. For the remaining quarter of service users ( $n=5$ ), there has (as yet) been little evidence of change with regard to most of the outcomes measured<sup>1</sup>. These cases 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) or low-level criminality (e.g. shoplifting). Managing their home (e.g. budgeting, cleaning) continues to present an ongoing challenge. Engagement is often 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).

The small size of the pilot dictates that the relative proportions of service users following each of the trajectories identified above should be regarded as indicative rather than definitive; that is, it should

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<sup>1</sup> It should be noted that two of these individuals had not been housed by the end of the pilot period, as a result of repeat periods spent in institutional care settings (i.e. prison or psychiatric wards) and/or because they kept changing their mind about which area they wanted to live in.

not be assumed that these would necessarily be replicated in other Housing First projects. The small number of service users also means that it has not been possible to identify any demographic characteristics that might influence the likelihood of individuals being classified in each group. Staff do however note that the existence of family support (and particularly the prospect of (re)establishing contact with children) acts as a motivating factor for positive behaviour change, as does service users' active involvement in meaningful activities within the community.

### Conclusions and Recommendations

The project is widely heralded as a 'success' by the service users, staff, and stakeholders in Glasgow – in large part because of the very positive housing outcomes recorded, but also because the staff team has successfully maintained positive relationships with and continued to support service users who were previously regarded as highly challenging 'serial disengagers'. It is of course impossible to predict at this stage whether or not service users will retain their housing in the long-term, but the evidence collated to date looks very promising.

The evaluation contributes to a burgeoning evidence base that the Housing First approach is effective when implemented outside its 'home' country of the United States. It also goes some way to redressing the gap in evidence regarding the model's effectiveness with homeless people with active substance misuse problems, by providing compelling evidence that it can and does 'work' for this ostensibly 'hard to reach' client group.

Difficulties accessing housing, which lie outwith the control of the Housing First project, have been a source of great frustration for service users and staff alike. These do, however, serve to indicate that the effectiveness of the Housing First approach lies as much (if not more) in the provision of high quality, flexible and non-time-limited support as it does the allocation of stable independent housing *per se*.

Recommendations deriving from the lessons learned during pilot implementation, which should be borne in mind if/as the Housing First project is expanded or replicated, are as follows:

- It is worth investing significant time engaging stakeholders at *all* levels of seniority before and during project set-up, as it cannot be assumed that the support of senior managers will automatically 'trickle down' to frontline practitioners. Engaging frontline staff at an early stage will alleviate their anxieties about making referrals and improve communication between stakeholders involved in the delivery of support.
- Effective interagency working is critical to successful project operation. Liaison with the police is invaluable for the development of drug-use policies which alleviate housing providers' concerns about the legalities of housing active drug users. Moreover, open communication with housing officers enables Housing First staff to respond to any problems quickly and constructively, particularly in situations involving neighbour disturbance.
- The recruitment of high quality staff is a critical factor influencing the experiences of and outcomes for service users. It is imperative that all members of the staff team fully understand and support the principles of Housing First, particularly its expectations as regards service user engagement. They must be respectful, compassionate, non-judgemental, and have the ability to 'not take it personally' if a service user disengages.

- Peer support workers should be included in staff teams wherever possible, given the significant added value they bring. Ongoing training and support must be offered, tailored to the needs of the individual worker. Consideration should be given to potential ways of reducing the current high levels of sickness absence amongst peer support staff; so too the time that those without driving licences spend travelling to and from appointments with service users.
- Housing First providers should expect that some service users may potentially experience a 'dip in mood' and associated relapse or increase in substance misuse after being housed independently and be prepared to respond as appropriate. Strategies for expediting the acquisition of furniture and furnishings should be prioritised given the role that 'making a house a home' appears to play in mitigating dips in mood.
- There remains a need to develop innovative ways to combat social isolation, especially where service users' family support networks are weak and/or they have cut ties with former peer networks. On a related note, Housing First providers might valuably consider whether and if so how to respond to changes in service users' relationship status by supporting partners whilst continuing to safeguard the health and safety of staff and service users.
- Expectations regarding participation in formal/structured meaningful activity and employment should be ambitious, yet remain realistic. The value of supporting service users to engage in 'normal' recreational activities (e.g. going to the gym or cinema) should be recognised going forward. These not only act as useful 'diversions' from the cultures and practices associated with substance misuse, but also act as 'small steps' increasing service users' confidence in utilising mainstream facilities within their local community.
- Finally, this and future Housing First projects should work toward devising ways to improve outcomes for the minority of service users following the third trajectory of experience described above, that is, those for whom there has to date been little observable change as regards health, levels and patterns of substance misuse, and involvement in street culture.



## 1. Introduction

### 1.1 Background to the pilot

A scoping exercise conducted in Glasgow by Turning Point Scotland (TPS) in 2009 revealed high levels of repeat homelessness amongst homeless drug users and identified a number of particular barriers faced by this client group when they tried to access support services. The exercise prompted TPS to pilot a Housing First project with the aim of more effectively meeting the needs of homeless people with active substance misuse problems.

The pilot is, as the name implies, modelled on the Housing First approach which was developed by Pathways to Housing in the United States (Tsemberis, 2010). Housing First departs from orthodox 'linear' approaches to homelessness by placing homeless people with complex needs directly into independent tenancies without first insisting that they progress through transitional housing programmes and/or undergo treatment (Johnsen and Teixeira, 2010).

The model has been replicated in a number of European countries in recent years given robust evidence regarding its effectiveness accommodating chronically homeless people with severe mental health problems in the United States (Busch-Geertsema, 2013). The TPS pilot was the first Housing First project to be developed in the UK, and one of the first internationally to explicitly target homeless people involved in active drug misuse (Johnsen and Teixeira, 2012).

The project has involved a three-year pilot, in Glasgow, running from October 2010 until September 2013. It has provided housing and support to 22 individuals who were homeless and actively involved in substance misuse (drugs, alcohol, or poly-substance misuse) at the point of recruitment. The pilot was funded by TPS, the Big Lottery Fund (for one year), and Greater Glasgow and Clyde Health Board.

This report presents the findings from an independent evaluation of the pilot conducted by Dr Sarah Johnsen with Prof Suzanne Fitzpatrick from the Institute of Housing, Urban and Real Estate Research (IHURER) at Heriot-Watt University. The evaluation ran for the full three-year duration of the pilot period and was funded by TPS.

The Glasgow Housing First pilot has also acted as the UK 'test site' for the European-Commission funded Housing First Europe 'social experimentation' project which concluded in May 2013. This initiative drew together evidence regarding the implementation and effectiveness of the Housing First approach in ten European countries (see Busch-Geertsema, 2013; Johnsen with Fitzpatrick, 2013)<sup>2</sup>.

### 1.2 The evaluation

The evaluation aimed to assess the effectiveness of the pilot in achieving the intended outcomes for service users, including (amongst others): improvement in personal living situation; reduction or no increase in substance misuse; improved physical health and psychological wellbeing; reduction in criminal activity; and improved capacity to participate in and be valued by society (see Chapter 2 for full details).

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<sup>2</sup> See <http://www.socialstyrelsen.dk/housingfirsteurope> for full details of the Housing First Europe programme and all evaluation reports.

The evaluation was longitudinal and involved three main methods:

1. *Interviews with TPS staff and representatives of key stakeholder agencies.* These were conducted on two occasions: initially when the pilot had become fully operational and ‘bedded down’ in order to explore views on the process of setting up the project (wave one); and again toward the end of the pilot period to explore staff and stakeholder assessments of the project’s strengths, weaknesses and overall effectiveness (wave two).
2. *Interviews with pilot service users.* These were also conducted twice: initially after being recruited to the project to gather baseline data about participants’ characteristics, support needs and aspirations (wave one), and again one year later to examine specific pilot outcomes and the overall impact that the project has had on their lives (wave two)<sup>3</sup>. All service users participated in both waves of the evaluation<sup>4</sup>.
3. *Case file analysis.* All service users granted the research team permission to access the contents of their case files, held by TPS. These files – containing records of support needs, services received, and issues raised during quarterly review meetings – were analysed toward the end of the evaluation period.

In almost all cases interviews were conducted face-to-face; the exception being two follow-up (wave two) interviews with service users which were conducted via the telephone because this was more convenient for interviewees. The number of interviews conducted is outlined in Table 1, indicating that 35 interviews were conducted in wave one and a further 38 in wave two (thus 73 in total). Some of the wave one interview numbers portrayed differ marginally from those in the earlier interim report, as a small number of service users were recruited to the study after that was published and have been included in the data presented here.

**Table 1: Number of interviews conducted during evaluation**

<i>Fieldwork phase</i>	<i>Type of interviewee</i>	<i>No. of interviews<sup>5</sup></i>
Wave 1	Stakeholder	9
	Staff	4
	Service user	22
Wave 2	Stakeholder	12
	Staff	5
	Service user	21*
Total		73

\* One service user was deceased.

<sup>3</sup> Not all service users involved in the evaluation were recruited when the pilot was first set up; rather, some were recruited more than one year later. The time points at which the service user interviews were conducted thus varied, and was determined by the length of time each had been involved with the project.

<sup>4</sup> That is, all with the exception of one who tragically died during the pilot period (see Chapter 4).

### 1.3 Report outline

This report comprises seven chapters. The next, Chapter 2, provides an overview of the pilot's aims and operational features. Chapter 3 profiles the service users' demographic characteristics and support needs at the point of their recruitment to the project. Chapter 4 discusses project outcomes, that is, the extent to which pilot objectives were met. This is followed, in Chapter 5, by an overview of individual service users' different trajectories of experience and levels of satisfaction with the project. Chapter 6 reviews the operational challenges and 'lessons learned' during project implementation. The report concludes in Chapter 7 with a summary of the key findings and recommendations emerging from the evaluation.





## 2. Project Description

This chapter provides an overview of the Housing First pilot's operational features. It thus describes its: aims and underlying philosophy; target group; referral, assessment and recruitment protocols; staffing and support arrangements; housing and tenancy type; governance, and degree of 'fit' with government policy.

### 2.1 Project aims and principles

The project's overall aim, as noted in Chapter 1, has been to reduce re-occurring homelessness by accommodating and supporting individuals who are in active addiction. This is underpinned by a number of specific objectives regarding intended service user outcomes, which TPS define as follows:

- improvement in personal living situation (e.g. move away from street homelessness, sustainment of tenancy etc.);
- reduction, or no increase, in substance misuse (as appropriate to service users' personal goals);
- reduction, or no deterioration, in injecting and associated risk behaviours;
- reduction in involvement with criminal activity;
- improved psychological wellbeing;
- improvement in overall physical health; and
- improved capacity to participate in and be valued by society.

The project is underpinned by the philosophy that if homeless people are provided with the security of their own home, along with adequate support, they will be better positioned to begin a journey toward recovery from addiction.

It is founded on seven key principles. First, service users are provided with *independent accommodation in scatter site housing*, in this case standard housing association (HA) tenancies. Second, the pilot has *no requirements regarding 'housing readiness'*, that is, there are no admission criteria regarding independent living skills, sobriety, or readiness to address an addiction. Third, the project operates a *harm reduction approach* to substance misuse. Fourth, there are *no time limits* on either the length of tenancy or the duration of support provided.

The fifth key principle relates to *respect for consumer choice* regarding levels of engagement with support. Service users are assertively encouraged to meet with a member of staff at least once per week, but the intensity of support is determined on a client-centred basis. Service users are offered a (limited) degree of choice as regards the flat they are allocated, but only insofar as is usually the case for HA lets in Glasgow.

Sixth, *holistic support is available 24/7*. The office is staffed 8am-8pm Monday to Friday and 9am-5:30pm Saturday; a member of staff is on call to deal with emergencies outside these hours. Finally, TPS aims to target some of the *most vulnerable* members of the homeless population, these being individuals actively involved in substance misuse – a group whom often have difficulty coping with traditional services and/or are resistant to service interventions.

The principles described above accord closely with those endorsed by Pathways to Housing, the organisation that first developed the Housing First model in the United States (see for example

Tsemberis and Eisenberg (2000) and Tsemberis et al. (2004)). Some operational features have necessarily been adapted given the UK's very different housing market, service network and welfare regime. The use of social rather than private rented sector housing is an obvious case in point; so too the fact that members of the staff team facilitate service users' access to existing services rather than deliver specialist care in-house.

### 2.2 Target group

As noted above, the project targets homeless people in Glasgow who are in active addiction and are poorly served by existing service arrangements. Specific eligibility criteria include:

- being aged 18 or older;
- being homeless, that is, 'statutorily homeless' and qualified for a 'Section 5 referral'<sup>6</sup>;
- having a current drug, alcohol or poly-substance misuse problem;
- needs are not being met by current services; and
- holding a desire to sustain a tenancy.

The pilot had initially targeted people with drug problems only, but eligibility criteria were expanded to include addicts whose primary 'substance of choice' is alcohol. This was done, in part, in recognition of the complexity of substance misuse patterns of many addicts; also to make it easier to recruit the target number of people under the age of 25, as per the Big Lottery Fund's requirements, given that many young homeless people in the city are reported to have a greater problem with alcohol than drugs.

### 2.3 Referral, assessment and recruitment

Referrals for the project can be made from a number of homelessness, addiction and allied support agencies, or via self-referral. A significant number of the referrals received, particularly when the pilot was first developed, were considered 'inappropriate' (e.g. the clients were abstinent, were already being accommodated, wanted supported accommodation or were not willing to engage with support), thus did not progress to the full assessment stage.

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<sup>6</sup> The UK, including Scotland, has a 'statutory homelessness system' whereby specific households 'accepted' by local authorities as homeless are entitled to be rehoused in 'settled' accommodation. While in most instances these households are rehoused in the local authority's own accommodation, in Scotland only there is also a duty on housing associations to rehouse statutorily homeless households referred to them by local authorities (this duty was enacted under Section 5 of the Housing (Scotland) Act 2001, hence the term 'Section 5 referral'). Housing associations are only permitted to refuse these referrals in very limited circumstances and the expectation is that they will normally rehouse referred households within six weeks. In Glasgow's case these Section 5 provisions are especially important because, in March 2003, all of the City Council's housing stock was transferred to the Glasgow Housing Association (GHA). This means that the local authority relies entirely on housing associations in the city to rehouse those households to whom it has a statutory homelessness duty.

All potential service users then underwent a period of assessment wherein their support needs were assessed (with a view to developing a client-centred support plan), as was their motivation to maintain a tenancy (as per the eligibility criteria specified above).

Referrals were then evaluated by an 'allocations group', comprising TPS staff, an occupational therapist from Greater Glasgow and Clyde NHS Trust Homelessness team, and representatives of the Glasgow City Council housing casework team. Once service users are formally recruited to the project, Section 5 referrals are forwarded to housing providers. Only a few referrals assessed fully were not recruited to the project, in all cases because they were not motivated to sustain a tenancy.

### 2.4 Staffing and support

The project's staff team consists of a service co-ordinator, two assistant service co-ordinators, and three peer support workers<sup>7</sup>. All are employed full-time. The service coordinators carry out service user assessments and visits, and line manage the peer support workers. The staff team also has a formal link with an occupational therapist, employed by the National Health Homelessness Services, who plays a role in allocation and support needs assessments.

The peer support workers, whom have histories of homelessness and substance misuse, deliver most of the day-to-day support to service users (although the service coordinator and assistant service co-ordinators are also actively involved in frontline support delivery). A member of staff is on-call to deal with emergencies outside office hours.

Support plans are developed on a client-centred basis, and staff assist service users to access any other services they need (e.g. health care, drug/alcohol treatment, welfare benefits, education/training etc.) Assertive outreach and motivational interviewing techniques are employed, and staff are highly flexible in terms of when, where and how they engage with service users. They may, for example, meet service users in their home, in a local cafe, or at the Housing First office.

Staff members typically aim to meet with service users once or twice per week, depending on their needs at the time. They may, however, meet them more often if required, which may be the case, for example in the lead-up and during the move into their new home, or if a service user experiences a 'dip in mood' (see Chapter 4).

Staff endeavour to 'stick with' service users during periods of disengagement, that is, do not sign service users off the project if they persistently fail to attend scheduled appointments or respond to communications. Similarly, support from the Housing First team continues if a service user spends extended periods in institutional care settings such as hospital, prison, or rehab.

### 2.5 Housing type and tenure

The project was designed in such a way that all service users would be allocated independent scatter-site housing provided by housing associations. Initially, the housing was provided by two housing associations, these being Glasgow Housing Association and Queens Cross Housing Association. Since then a number of other housing providers have allocated tenancies to the

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<sup>7</sup> The staff team initially included four peer support workers, but one subsequently resigned and was not replaced (see Chapter 5).

project, including: Southside Housing Association, Thenue Housing Association, North Glasgow Housing Association and New Gorbals Housing Association.

All such housing is located in the areas of Glasgow in which each of the six participating housing associations operate, these being the North, West and Southern regions. Each property is an 'ordinary' self-contained flat, typical of social housing within the city. Service users are given the same (very limited) degree of choice of housing that other housing association tenants are subject to. Service users are provided with a Scottish Secure Tenancy (SST), with rent contract and unlimited lease.

It had been intended that flats would be allocated relatively quickly (and ideally 'immediately') after service users were recruited to the project, but shortages in social housing have dictated that it has typically taken much longer (see Chapters 4-6).

### 2.6 Leadership, governance and interagency relationships

The commitment of senior management within TPS was a critical ingredient in the successful development and ongoing operation of the pilot. Further to this, the project benefited from the expertise and ongoing support of staff in other TPS projects working with similar target groups.

A number of multi-agency groups have been involved in the project's development and oversight. Initially, a steering group consisted of 32 individuals representing 13 agencies working in homelessness, housing, health, social care and the criminal justice sectors was developed. This was subsequently reconfigured to a much smaller and more focussed 'advisory group' comprising ten members representing six key stakeholder agencies<sup>8</sup>.

At the outset an 'implementation' subgroup of the initial steering group drew upon a range of stakeholders' expertise in the development of appropriate working protocols, policies and procedures. This was re-launched later on with all housing providers involved. In addition, an allocations subgroup comprising Housing First staff and representatives of two partner agencies have continued to assess individual referrals to the project.

Day-to-day communication and joint working between the project and other stakeholder agencies in Glasgow is also fostered by inviting relevant representatives (e.g. drug/alcohol treatment care managers or day service key workers) to service users' review meetings, held quarterly, to discuss any barriers or challenges encountered in the delivery of their support plan.

### 2.7 Policy fit

There is clear consonance between the objectives of the pilot and the current direction of both homelessness and substance misuse policies at the national level. The Scottish Government has publicly expressed its support for the principles underpinning the project, given the way it dovetails with key strategic priorities (Johnsen with Fitzpatrick, 2012). Most notably, the model accords with Scottish Government aims regarding homelessness prevention and the recent legislative emphasis on the assessment of vulnerable peoples' housing support needs. Furthermore, the pilot

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<sup>8</sup> Membership includes: an independent chairperson, GHA, Glasgow Social Services Homelessness Services, Scottish Government Homelessness Services, Greater Glasgow and Clyde National Health Service Homelessness Services, Strathclyde Police, TPS board member, and TPS operational manager.

complements the Scottish Government's most recent drugs strategy, which, whilst focussing less on harm reduction than previous strategies, is firmly premised on the broader notion of 'recovery' from addiction (Scottish Government, 2008).

### 2.8 Conclusion

In summary, the Glasgow Housing First project aims to reduce re-occurring homelessness by accommodating and supporting individuals who are in active addiction. It is strongly underpinned by the principles endorsed by Pathways to Housing, the agency that first developed the Housing First approach in the United States. Its objectives are strongly consonant with the current direction and emphases of homelessness and substance misuse policies at the national level.

The pilot supports 22 homeless people aged 18 or over who are involved in active substance misuse, be that drug misuse, alcohol misuse or a combination thereof. It accommodates service users in 'normal' independent self-contained housing association flats, on a scatter-site basis, with a rent contract and unlimited lease.

The project is staffed by a team of six which includes three peer support workers who have histories of homelessness and substance misuse. Support plans are developed on a client-centred basis and assertive outreach and motivational techniques are employed. Staff members assist service users to access welfare entitlements and other support services, as appropriate to their support plan. The provision of support continues if service users disengage or spend extended periods in institutional care settings.



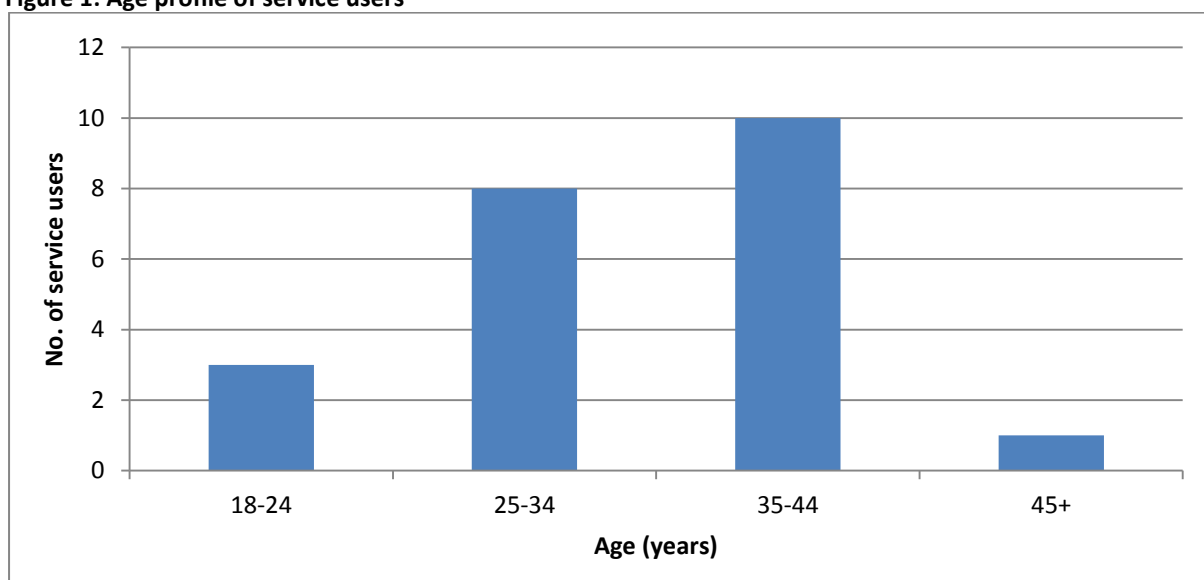
### 3. Service User Profile

This chapter provides a profile of the service users' characteristics and support needs at the point of recruitment to the pilot. It draws upon wave one ('baseline') interviews conducted with all 22 service users and their case file records (see Chapter 1). It begins by describing service users' demographic characteristics, housing circumstances and accommodation histories. It then provides details regarding their health, type and severity of substance misuse, involvement with the criminal justice system, and economic status at the point of recruitment.

#### 3.1 Demographic details

Of the total 22 service users, 18 are male and 4 female. The majority were aged between 25 and 44 years at the point of recruitment, as shown in Figure 1. All are of White British ethnic origin.

Figure 1: Age profile of service users



Source: wave one service user interviews. Base: 22.

All were single person households at the point of recruitment to the pilot. One female service user has since had a baby and continued to care for her child with the support of Housing First staff and social workers. Several others have children who are in the care of an ex-partner, other relatives, or in the statutory care system.

#### 3.2 Housing histories

At the point of referral to the project, the majority of service users (n=13) were living in a hostel or other form of temporary accommodation for homeless people (e.g. a temporary furnished flat). Of the others, 5 were in an addiction rehabilitation facility, 2 were sleeping rough, 1 was staying temporarily with friends or family because they had no home of their own, and 1 was in prison.

Almost all service users have had long-standing histories of homelessness and insecure housing. For the majority, these experiences began in their mid/late teenage years. Their adult lives have been punctuated by repeated periods of rough sleeping, sofa-surfing, stays in hostels or other temporary

accommodation (such as bed and breakfast hotels), and time spent in prison. As a consequence, many found it impossible to calculate with any degree of accuracy the total number of homelessness episodes experienced or total length of time they had been homeless.

*I've been sleeping rough and in jail off and on for 20-odd year. (Service user)*

*It's been a revolving door: prison, sleeping rough, hostels, since I was 19. (Service user)*

Service users' experiences of hostels had been overwhelmingly negative. Many described them as depressing and chaotic environments which were not conducive to addressing substance misuse problems:

*There was one [hostel] I stayed in was so bad that I nearly turned around and walked right back out again. There was people smoking heroin on the stair and drinking and I'm like: 'I'm trying to get better but you're putting me into a place like this?' (Service user)*

Several had been evicted on multiple occasions for failing to adhere to the rules and regulations of hostels. A few also expressed frustration with having to 'start over' in the city's (linear) response to homelessness after 'making silly mistakes', most of which were directly related to their addiction:

*They [the council] would put you in a temporary furnished house while you were waiting for your own place, but then I would go to jail and lose it, and then have to start again. (Service user)*

As noted above, some of the service users were staying with friends and family on a temporary basis (i.e. 'sofa-surfing'). Some of these arrangements were very fragile, and as one service user explained, risked exacerbating substance misuse problems:

*A lot of time I'm worrying about where I'll be staying. If I'm staying with someone who takes heroin, I'll buy them heroin. Or I'll do the same with alcohol if they're drinkers, so I can live in their house. Whatever their preference is, I'll buy for them and end up taking with them just so that I can live there for the night. (Service user)*

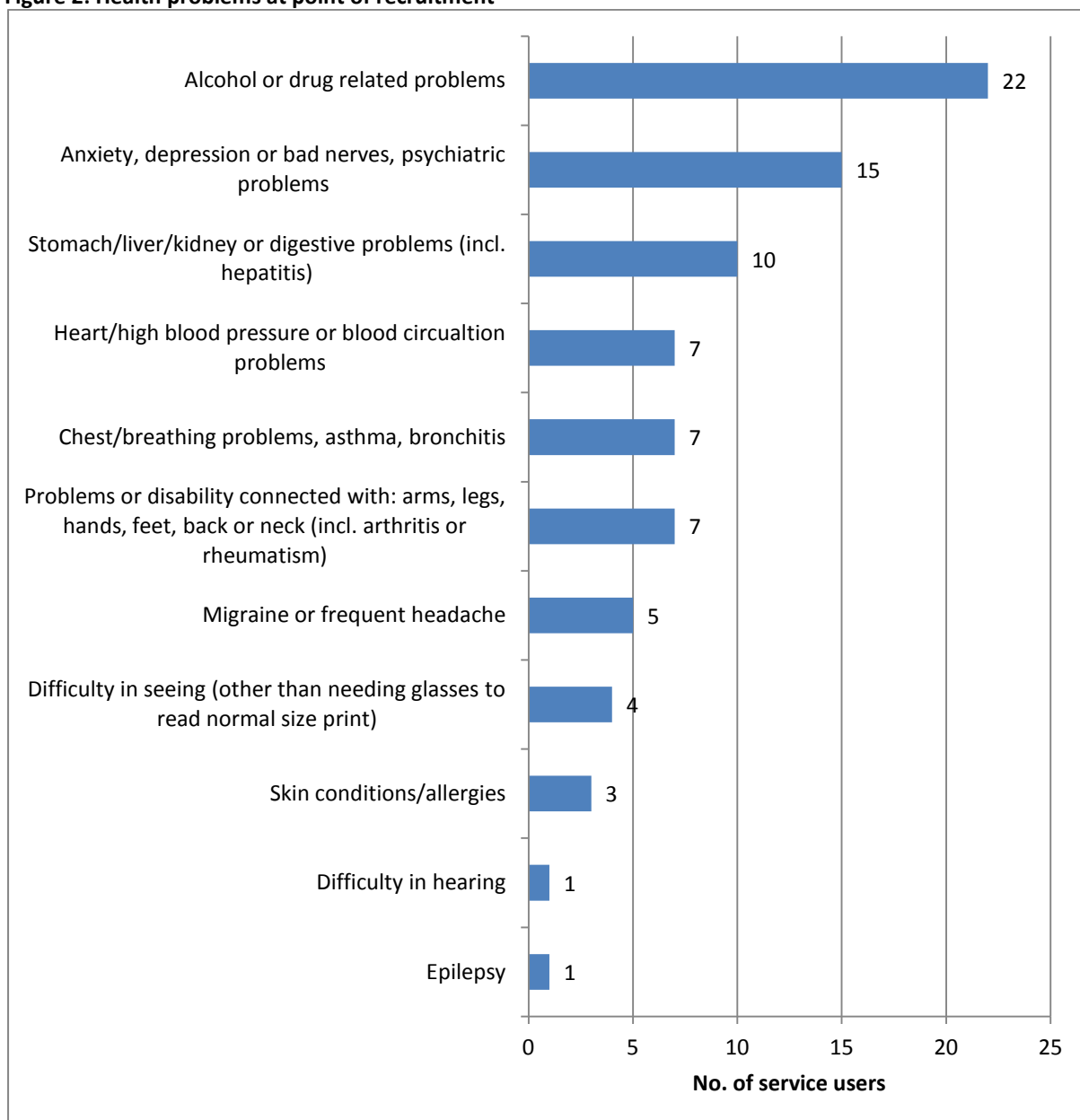
A total of 13 service users had had their own independent tenancy at some point, the majority of which had been in the social rented sector. The length of time that they had maintained these tenancies varied (from a few weeks to a few years). Reasons for loss of tenancy included: rent arrears, prison sentences, or having been the victim of anti-social behaviour from neighbours or drug-users/dealers.

### 3.3 Health

When asked to assess their overall health at the point of recruitment, 4 service users described it as 'good', 13 as 'fair', 4 as 'bad', and 1 as 'very bad' (none as 'very good'). Figure 2 portrays the (current) health problems service users (self)-reported at point of recruitment. Notably, 14 reported problems relating to mental health. Of these, 13 reported that they had ever been prescribed medication for mental health problems, and 6 that they had been hospitalised for mental health problems (in some instances on multiple occasions).



**Figure 2: Health problems at point of recruitment**



Source: wave one service user interviews. Base: 22. More than one response possible.

Other health problems affecting a notable proportion of service users at the point of recruitment included digestive or liver problems (typically hepatitis) (n=10), and blood circulation problems (often deep vein thrombosis caused by intravenous needle use) (n=7) (Figure 2). All service users reported having an active drug and/or alcohol problem (an eligibility criterion for recruitment to the pilot).

### 3.4 Substance misuse

The severity of service users’ addictions to drugs and/or alcohol at the point of recruitment was assessed with the aid of the Severity of Dependence Scale (SDS)<sup>9</sup>. This confirmed that drug addictions were very severe in a number of cases: scores (for those using drugs in the past month) ranged from 3 to 14, with an average (mean) of 9 (notably above the score of 3 which is generally considered to indicate dependency).

SDS scores calculated regarding alcohol dependency were lower, ranging between 0 and 11 (average 3), but indicate that a minority of service users (also) experienced relatively severe levels of alcohol dependency. For virtually all, substance misuse problems had begun early in life, in many cases in their early teens.

Table 2 lists the drugs that service users reported having used in the month prior to recruitment to the project. Two thirds (n=14) had used heroin, and 15 had used methadone (on prescription) as a heroin substitute. More than half (n=12) had used cannabis, and smaller numbers other substances including valium, cocaine, diazepam, crack, speed and ecstasy. A total of 12 service users had injected drugs (in all instances heroin) in the month before recruitment.

**Table 2: Substances consumed in the month prior to recruitment**

<b>Substance</b>	<b>No. of service users</b>
Methadone	15
Heroin	14
Cannabis	12
Valium	9
Cocaine	6
Diazepam	5
Crack	3
Speed	1
Ecstasy	1

Source: wave one service user interviews. Base: 22.  
More than one response possible.

Many service users emphasised that the frequency and quantity of their drug and/or alcohol consumption fluctuated significantly, sometimes daily, depending on factors such as their state of income and/or mental health:

*I would be a binge drinker if I had enough money! [Laughs] I drink now and then, but how often and how much depends on how much money I have. (Service user)*

*I binge but that has a lot to do with how I’m feeling at the time. Sometimes my depression gets a bit much. I just think ‘fuck it, fuck everything’. (Service user)*

All had had treatment for substance misuse in the past, often including residential rehabilitation (and in a few cases numerous times). Whilst they had typically found this to be effective at the time,

<sup>9</sup> The SDS is a validated measure assessing the severity of an individual’s addiction to drugs or alcohol. Scores may range from 0 to 15: a score of 3 or higher is generally considered to be indicative of dependence, with higher scores indicating greater severity of dependency (Kaye and Darke, 2002; Lawrinson et al., 2007).

most had nevertheless returned to homelessness and substance misuse shortly afterward. Periods of being 'clean' and/or 'dry' were thus generally short-lived.

At the point of recruitment all but one of the service users with a drug problem aspired to be completely drug free in the medium-to-long term (the one exception has the more limited aim of stabilising drug consumption in the long term). With regard to alcohol, a few aimed to be teetotal but a greater number aspire to become 'sociable drinkers', that is, able to drink 'in moderation'. The following comments were illustrative of widely held aims regarding substance misuse:

*When it comes to drugs I would like to be abstinent. And when it comes to alcohol I would like to have it under control. When I do drink I would like to be able to say 'that's me, I've had enough, I'll just have four cans and that's it. I'd like to be able to take me da [father] or me brother to the pub and be sociable. (Service user)*

*I wish I could just drink socially, like at the weekends or something like that ... If I can't become a sociable drinker I'll just need to try and come off the drink ... I just need to settle down man. I just need to stop going from house to house to house to house and getting mad w'it. (Service user)*

### 3.5 Criminal activity

All but two (n=20) service users had had direct involvement with the criminal justice system at some point in the past. Most of their offences had been acquisitive (e.g. shoplifting or car crime), explicitly drug-related (e.g. possession or dealing), breaches of the peace, and/or related to street culture activities (e.g. sex work). A small number had also committed serious violent offences such as serious assault, assault and robbery, and police assault. Most had served multiple sentences:

*I've been in and out of prison from the age of 21. My biggest gap without going to prison has been three year, but apart from that I was in at least once a year. Always drugs related, for thieving or selling drugs. Never any assaults or anything like that, it's always been to make money for drugs. (Service user)*

More than half (n=13) had been arrested or fined for an offence in the twelve months prior to pilot recruitment. They consistently emphasised that their involvement in criminal activity was directly related to their substance misuse problems, and almost without exception believed the only way to reduce involvement in criminality was to address their addiction.

### 3.6 Financial wellbeing

Service users were asked to self-assess their financial wellbeing at the point of recruitment according to a five-point scale. At the time, no service users reported that they were 'doing well financially', one that they were 'doing alright', 4 that they were 'just about getting by', 7 that they were 'finding it quite difficult' and 7 that they were 'finding it very difficult' (3 did not specify).

At the point of recruitment most service users reported that they found it virtually impossible to budget the limited funds they had given their active substance misuse problems. A minority reported supplementing their income via (illegal) street culture activities at the time. The financial difficulties of a number were exacerbated by automatic deductions from welfare payments for outstanding loans or fines and/or informal payment of 'debts' owed to drug dealers or fellow users.

Furthermore, a fragile, and damaging, financial co-dependence on fellow drug users/ drinkers was a significant feature in the lives of several service users:

*A lot of time I'm worrying about where I'll be staying. If I'm staying with someone who takes heroin, I'll buy them heroin. Or I'll do the same with alcohol if they're drinkers, so I can live in their house. Whatever their preference is, I'll buy for them and end up taking with them just so that I can stay there for the night. (Service user)*

### 3.7 Social relationships

On a related note, many service users reported that their social networks at the time of recruitment to the pilot consisted almost entirely of other people with drug and/or alcohol problems. 'Friendships' were thus described as superficial, and shaped by the co-dependency described above. All acknowledged that their peer networks would need to change profoundly if they are to become, and remain, free from addiction:

*Sometimes I sit in people's company that I'd rather not. People that are mean, or violent. I'd rather avoid people like that, but sometimes they are the only ones that'll give me a couch to sleep on. So, you just need to put up with it, which is not very pleasant, because these people can be quite volatile. I've got the scars to prove it, you know what I mean? (Service user)*

Several explained that their addiction exacerbated feelings of loneliness and isolation. For example:

*I don't really see my family when I'm on drugs and that. I just seem to block myself off ... I don't socialise when I am on drugs, I don't want to do nothing. (Service user)*

Family did however provide valuable instrumental and/or emotional support for a number of service users. These individuals all had immediate family (such as parents, siblings or children) living locally, whom they visited regularly (in some instances more than once a week). Others, however, could or would not maintain contact with family members because of estranged relationships, the vulnerabilities of other family members (e.g. addiction or mental health problems), or feelings of shame regarding their own current circumstances:

*At the moment I've lost contact with them [sons] because I am here there and everywhere. And it'd be embarrassing. I mean, my son's doing a lot better in life than me, you know what I mean? And I don't want to bring them down and they worry a lot about me. (Male service user in 30s)*

Most were however optimistic that gaining a settled home, with support, would help them develop the stability and confidence required to re-establish relationships with family, especially children.

### 3.8 Employment and meaningful activity

Almost half (n=10) of the service users had never had long-term (i.e. non-casual) paid employment. The others had had paid jobs in the past, but had not worked and had been reliant on welfare benefits since developing drug and/or alcohol problems.

*I've always had a drug problem with spells of depression and not wanted to go anywhere or do anything. I was not mentally or physically able to work. (Service user)*

A few found it virtually impossible to think about long term goals regarding employment or training. Of those that felt able to think about the future, all aspired to be involved with paid work in the long term. Most did however consider this to be a very distant goal, given their current state of homelessness, addiction and/or lack of qualifications. Service users' aspirations in this area were often tempered by concerns about their employability given their disabilities, poor health, and/or criminal records.

All service users noted that at the point of recruitment their daily lives lacked meaningful activity. For many (with the obvious exception of those in rehab at the time), daily life revolved around the acquisition and consumption of drugs or alcohol:

*My day involves getting up, getting ready, going out and shoplifting to fund my bags of heroin. Then just shoplifting all day to buy drugs 'cause of my drug habit and that. It's not what I want to be but that's the way it is, you know? (Service user)*

### 3.9 Conclusion

This chapter has described the characteristics of the pilot service users at the point of recruitment to the pilot. Most are male, aged between 25 and 44, and all White British. The adulthoods of almost all have typified the 'revolving door' of repeat homelessness and institutional care, that is, cycling in and out of prison, rehabilitation facilities, hospital, and/or psychiatric wards. Substance misuse problems dated back to teenage years for most, and addictions were severe in a number of cases (particularly in the case of those addicted to illicit drugs, less so alcohol).

The majority of service users were struggling to cope financially at the point of recruitment. Most had weak or fragile (and often potentially damaging) social support networks at the time, although some benefited from support from family. Boredom and a lack of meaningful activity were significant features of the daily lives of almost all at the point of recruitment. 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 service users' short- to medium-term goals.



## 4. Project Outcomes

This chapter documents project outcomes as regards service users': project retention; housing stability; health; substance misuse; involvement with the criminal justice system and street culture; financial wellbeing; social support networks; participation in employment and meaningful activity; and community integration. It draws upon all wave two data, including interviews with service users, staff and stakeholders, together with material recorded in service users' case files (see Chapter 1). Variations in experiences at the individual level and issues relating to service user satisfaction are addressed in the next chapter (Chapter 5).

### 4.1 Project retention

At the end of the pilot period (end September 2013) the majority ( $n=17$ ) of the total 22 service users continued to utilise the services of the Housing First project. Of those whose involvement had ended, one had left to go into a residential rehabilitation facility and no longer wanted support from the project, two felt that they no longer required support from Housing First because they were moving in with or near to their partner (in one case in a different city), the involvement of one was terminated prior to him being allocated a house due to suspected drug dealing, and one tragically died as a result of a drug overdose (occurring after release from prison). An additional service user asked to be signed off the project after more than one year because he felt he was coping well in his tenancy, but has since requested that the support from staff be reinstated.

A number of stakeholders commented that the project's ability to retain the involvement of the vast majority of service users was in itself a very positive outcome, especially given that several of these individuals are widely regarded by service providers in the city to be 'serial disengagers' with long histories of service resistance and/or chaotic patterns of engagement with supportive interventions.

*I'd definitely say it's been a success. We've known some of these individuals [service users] for a very long time. They've been turning up at our door for years. And we're just not seeing them anymore, because they're still engaging with Housing First, they're maintaining their tenancies. (Stakeholder)*

*I think that it's really effective. I think the team really do go the extra mile in terms of what extent they will go to to try to engage people and particularly when people are spinning out of control and they're proactively seeking them out in situations where a lot of other supports would have totally shied away from. (Stakeholder)*

Looking forward, service user interviews indicate that the majority do foresee a time in the future when they will no longer require the support of Housing First staff. They do however find it very difficult (if not impossible) to anticipate when this is likely to be, in large part due to the unpredictability of the recovery process.

*Probably I'll not need them at some point. But I don't think that far ahead ... Even when I'm clean, which I will be shortly, I think I'd probably need the support more. I mean, I need support often like to get there, but staying clean can be harder. (Service user)*

## 4.2 Housing stability

The majority ( $n=18$ ), but not all, of the 22 service users recruited to the project had been allocated an independent tenancy by the end of the pilot period. Of those that were, half ( $n=9$ ) had by the end of the pilot period sustained their tenancy for more than two years, a further two had been in their home for between one and two years, and four for less than one year (see Table 3)<sup>10</sup>.

**Table 3: Housing outcomes and tenancy sustainment as at end of pilot period**

<b>Outcome</b>	<b>No. of service users</b>
Housed and retained tenancy:	<b>15</b>
(...of whom housed for 24 months or longer)	(9)
(... of whom housed for 12-23 months)	(2)
(... of whom housed for 6-11 months)	(3)
(... of whom housed for less than 6 months)	(1)
Housed but subsequently lost/gave up tenancy	<b>2</b>
Not housed	<b>4</b>
Deceased	<b>1</b>
<b>Total</b>	<b>22</b>

Source: Case file records.

Significantly, no service users were evicted. Two tenancies were however terminated for other reasons (Table 2). Of these, one tenancy was 'lost' because the service user was imprisoned for longer than 13 weeks (for an offence committed after being housed) which meant that their rent was no longer able to be covered by Housing Benefit). The other service user relapsed after being housed and was victimised in their home by other members of the drug-using community and thus 'gave up' their tenancy, requesting that they be moved back into supported accommodation. Both of these individuals had been housed for more than one year before their tenancy was terminated.

Of the four service users that had not been housed, one was actually allocated a property but was unable to take it up due to receiving a lengthy prison sentence at approximately the same time, and another was asked to leave the project for suspected drug dealing activity (see above); attempts to house the remaining two were repeatedly thwarted by periods spent in institutional care settings (i.e. prison, rehabilitation facilities and/or psychiatric wards) and/or because they kept changing their minds about which area of the city they wanted to live in (see Chapter 6).

The project is widely regarded as a 'success' by other stakeholders in Glasgow given the rate of tenancy sustainment achieved. Several service providers in the city emphasised that they had not anticipated such positive housing outcomes, particularly given the histories and vulnerability of many of the service users recruited.

*I would say it [the pilot] was a success on the basis that the tenancies succeeded ... None of the tenancies ended quickly, none of them ended acrimoniously in terms of our relationship, we didn't evict anyone and there is no one who has even gone down the route of anything that vaguely looked like eviction ... I would say it was more successful than I had expected. I thought we would have a couple of spectacular crash and burns fairly early on because I was kind of geared up to get that from Housing Officers "you put these people in and look what happened", and [there was] absolutely none of that. (Housing provider)*

<sup>10</sup> The individual who died had retained their tenancy for six months.



*I had anticipated that housing officers would be calling me on a daily basis with problems ... but I was more than pleasantly surprised ... Our housing officers have felt that the support has been very robust and the ability to continue to engage during difficult times and so on was all very much there. That was something that housing officers would ordinarily say didn't exist, that housing support usually tends to fall away fairly quickly if there are issues ... but that clearly wasn't the case. (Housing provider)*

### 4.3 Health

For the majority of service users, general health has improved, in some cases dramatically. As Table 4 shows, the number reporting their health to be 'good' or 'very good' in wave two ( $n=12$ ) was notably higher than those doing so in wave one ( $n=4$ ), and far fewer described their health as merely 'fair' (5 in wave two as opposed to 13 in wave one).

**Table 4: Self-reported health at point of recruitment and one year later**

Health status	No. of service users	
	Wave one (recruitment)	Wave two (one year later)
Very good	0	3
Good	4	9
Fair	13	5
Bad	4	4
Very bad	1	0
Total	22	21

Source: wave one and wave two service user interviews.

Improvements in physical health are generally attributed to the reduction or cessation in illicit substance use and/or reduced alcohol consumption (see below), but also to improvements in diet.

*Its [my health is] a lot better. I've done a lot of things since then, like going to hospitals and doctors and got things sorted, my DVT and my blood clots in my leg and all that. It's just I've got a bad chest, that's the only thing that I'm saying for now, apart from that I'm fine. (Service user)*

*I think it's a big improvement because, obviously, I wasn't really taking care of myself, I wasn't eating the way that I should have. If it hadn't been for [name of support workers] checking up on me I would probably have been a skeleton. I wasn't looking after my health, because I was smoking a lot of crack and I had a really bad chest. But, yes, I think there's been a big improvement. (Service user)*

*I would say my health is good now. I've put on weight and all that as well, which I couldn't do with the drink ... I don't get any aches or pains in the stomach, which I used to do with the cider. So I don't know whether my liver's healed itself or not because I've got cirrhosis and I've got Hepatitis C as well. But because I'm not drinking it's not been flaring up. (Service user)*

That said, and as Table 4 indicates, a few individuals remain in poor health, typically because they suffer from ailments associated with long-term substance misuse such as hepatitis, deep vein thrombosis and/or cirrhosis. Some thus require substantial ongoing health care interventions from mainstream services such as general practitioners, dentists and/or hospitals. In one case, poor levels of hygiene had been a cause of significant concern for support staff, prompting an escalation of

support (with the service user's permission) to ensure that the individual's health was not compromised.

The overall direction of change with regard to mental health has also been one of improvement. Staff observe that the mental health of service users who have been housed in an independent tenancy is generally better than those who are still in temporary accommodation. Service users report that the security of having stable housing and 'stickability' of Housing First support – which does not terminate should they relapse and/or disengage temporarily (see Chapter 5) – has contributed to enhanced feelings of psychological wellbeing and self-confidence. Reductions in drug misuse have also contributed to overall improvements in psychological wellbeing.

*My mental health is actually a bit better, a little bit better ... because I'm not using as much drugs and that. Because I'm not using cocaine and that all the time and that, you know what I mean? (Service user)*

That said, a minority of service users experienced what staff describe as a 'dip in mood' after being housed. This was often attributed to feelings of isolation and/or anxieties about the responsibilities involved in managing a home. For some individuals, periods of 'low mood' were relatively short-lived as they adjusted to independent living. For others, they were recurrent, triggered by stressors such as welfare benefit payment problems, anxieties about finances, or arguments with friends or family. Deteriorations in mental health often coincided with an increase in (or relapse into) substance misuse (see below).

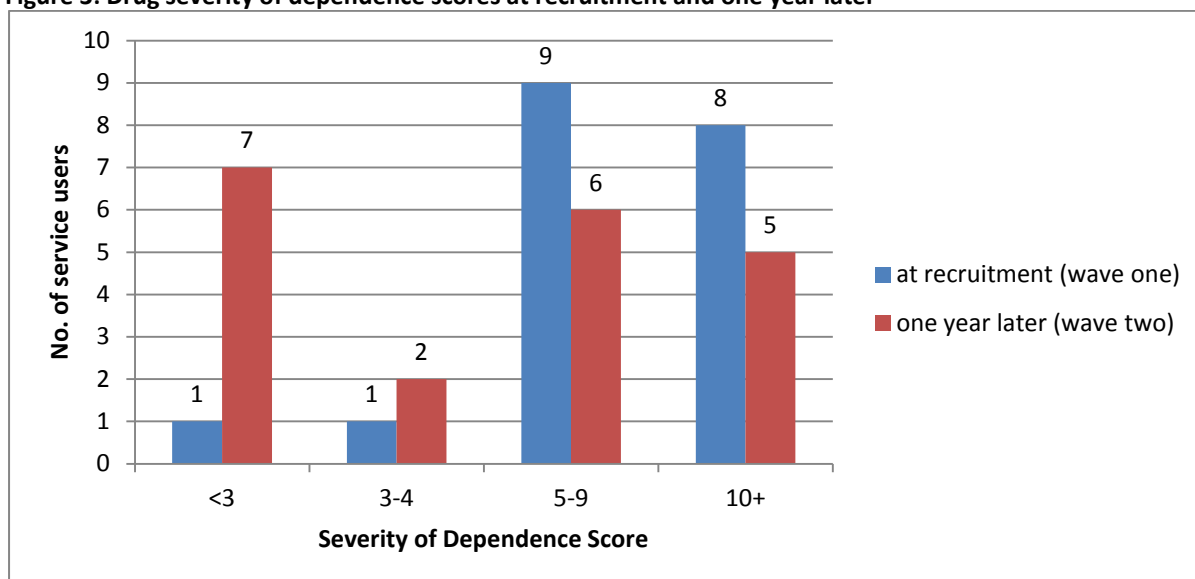
*The first year was just a constant struggle, constant. I felt as if I was getting nowhere and my mental health was suffering and I was getting depressed ... Being a drug addict is like a full-time job, but it's a bit of a cop-out because you've got no worries. Your only worry is where your next fix is coming. There's absolutely nothing else to worry about. But then I got this place and all the worries about money and things. (Service user).*

*When I started drinking, when I got the flat, I just felt so low all the time. I tried to hurt myself and all that ... My confidence was out of the window, just couldn't, just depressing. But I've been taking my anti-depressants, they've been helping us. I've got a more better outlook on life now. (Service user)*

#### 4.4 Substance misuse

Substance misuse outcomes have been mixed, but positive on balance. As Figure 3 shows, the majority of service users experienced a reduction in the severity of their dependence on illicit drugs as measured by the SDS (see Chapter 3), with seven of those who had been active users at the point of recruitment no longer reaching the threshold (value three) to be considered dependent one year later (Kaye and Darke, 2002; Lawrinson et al., 2007). That said, almost one quarter ( $n=5$ ) continued to report high levels of dependence, scoring 10 or higher on the 15-point scale at wave two.

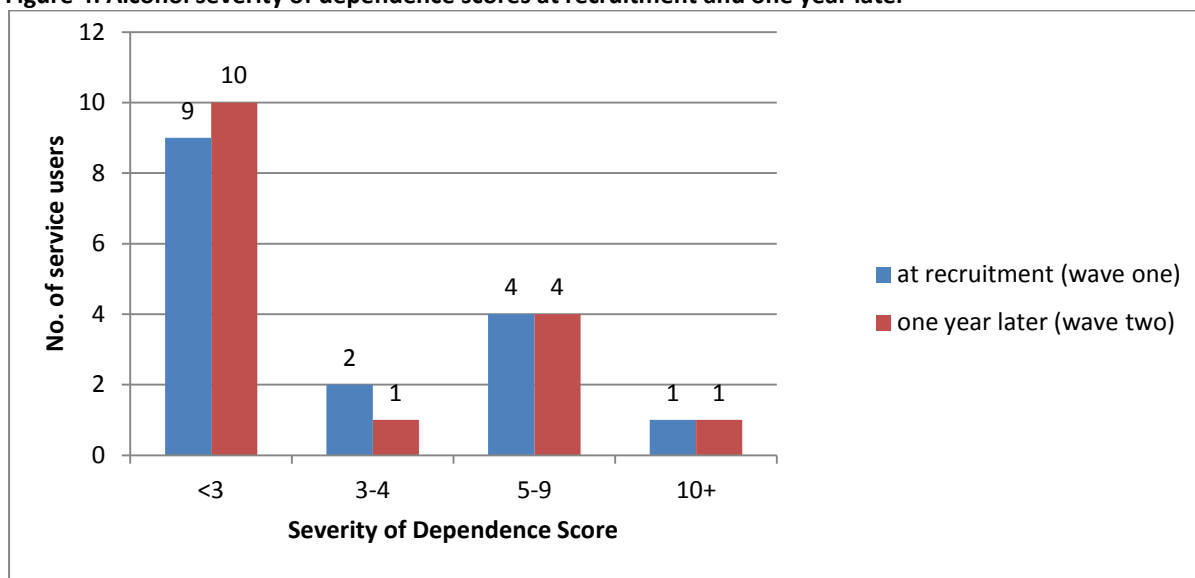
**Figure 3: Drug severity of dependence scores at recruitment and one year later**



Source: wave one and wave two service user interviews. Base: wave one 22, wave two 21 (no data provided in 3 and 1 case(s) respectively).

The equivalent SDS scores measuring alcohol dependency showed that there was little observable impact on overall levels of alcohol dependence, with nearly half of service users in both waves one and two scoring greater than three on the scale (that is, the threshold indicating dependence) (see Figure 4).

**Figure 4: Alcohol severity of dependence scores at recruitment and one year later**



Source: wave one and wave two service user interviews. Base: wave one 22, wave two 21 (no data provided in 6 and 5 case(s) respectively).

Staff records indicate that by the end of the pilot period, 10 of the service users whom had had a problem with drug misuse at the point of recruitment were abstinent from illicit drugs. Furthermore, two service users who were involved in problematic alcohol use at the point of recruitment were abstinent from alcohol by the end of the pilot period. It is of course not possible to predict whether or not these levels of abstinence will be sustained given the fragility and

unpredictability of the recovery process for many individuals, but these figures must be considered a significant achievement given the severity of addictions recorded at the beginning of the pilot.

*I haven't used kit [heroin] for almost a year now. I smoke cannabis. It's just puffing that stuff ... Whenever the motivation levels drop and you can't be bothered doing stuff ... the thing that gets with me round the heroin is when I meet up with people that I used to use with and then they start telling you, 'Oh yes', just the way you used to talk and it's putting yourself into that mode. I could easily fall back into it, easily. (Service user)*

A number of the other service users have however continued to misuse drugs or alcohol, albeit often to a lesser degree than before and/or have substituted one substance for another. A number substituted alcohol for illicit drugs, and several continue to smoke cannabis regularly.

*I'd stopped using illicit drugs all together, illegal drugs basically, and alcohol at the beginning started escalating... I just didn't know how to get up and sat about and being normal during the day and ... drinking and that helped us a bit just dealing with it. (Service user)*

*I didn't touch drink for a long while and I ended up starting drinking again, because I came off drugs. And drink doesn't agree with me ... I sometimes smash things up when I'm silly on the drink. But I've calmed down and that now. (Service user)*

*I used a bit of heroin last year but I stopped that and it's just been amphetamine basically and cannabis. I usually smoke cannabis at night time to relax me but it's affecting my mood. (Service user)*

In such cases, service users often report that boredom is a contributing factor to their ongoing drug use and/or alcohol consumption.

*I've not relapsed for about two weeks now, I'm feeling a lot better but I can't really say why. Certain days it can just pop up ... It can be boredom that triggers it, boredom's a big one. (Service user)*

As noted above, some service users relapsed after a period of abstinence or stabilisation. A few have noted that relapses have in large part been caused by 'unwise' decisions regarding who to allow to stay in their flat. Issues relating to difficulties of 'managing the door' are reported to have been far less problematic than had been anticipated by staff and stakeholders, however (see below).

*I let a friend stay and it was only supposed to be for a couple of days and it ended up longer and because they were using I ended up using. (Service user)*

*At first I found myself bringing homeless people home because they were homeless and then they did help me in the past and I thought I still owed them something [but] they were just out to use what they could get ... It got to the point where I found enough confidence to open the door and go, 'I don't want these in my...', and shutting the door on them. (Service user)*

The majority of service users, including those who have experienced one or more relapses, feel that they are closer to meeting their goals regarding substance misuse than they were at the point of recruitment to the project.

*I wouldn't say I'd met all of them [goals re substance misuse] but I've met most of them ... To stop using heroin, stop using crack cocaine and sure I've achieved both of them ... Stop using diazepam, I achieved that ... and to managing my drink ... I've achieved them all and my next one will be to start cutting down on my methadone. So, I'm just I'm stable at the moment, so I can start looking at reducing that and that will be the next thing. (Service user)*

They note that secure housing and ongoing support provides them with stability to maximise their chances of 'getting back on track' on their journey toward recovery. Returning to street homelessness or hostels, they argue, would make it very difficult to do so in the short term.

*When I was living in [name of hostel] I was always glad to be out of the hostel, so I would always be like getting money and getting mad with it ... Having my flat stopped me feeling as if I had to go out all the time, and run about getting mad with it. (Service user)*

#### 4.5 Involvement with the criminal justice system and street culture

Service users' involvement in criminal activity – particularly in relation to acquisitive crime and offences such as drug possession and/or dealing – has reduced overall in concert with reductions in levels of illicit drug use.

*I've been arrested once in the past year but I've never been convicted with anything. That was my first Christmas and New Year out of prison since 2008. (Service user)*

*I don't get into anything that's illegal. Because I've got this, a stable environment to live in, you know what I mean? I've been able to do that because I'm not sleeping rough and that and getting drugs and all that, to kind of block out what was going on round about me. (Service user)*

Some did nevertheless continue to be engaged in criminal activity and the imprisonment of service users proved a significant ongoing challenge to project operation (see Chapter 6). As Table 5 shows, more than half ( $n=5$ ) of the service users who served prison sentences did so for offences committed before being recruited to or housed by the Housing First project, the remainder ( $n=3$ ) for offences committed after being housed.

**Table 5: Criminal offences leading to prison sentences served after recruitment**

<i>Time of offence</i>	<i>No. of service users</i>
Before recruitment to the pilot	2
Between recruitment and being housed by the pilot	3
After being housed by the pilot	3

Source: staff records. Base: 22.

A small minority of service users ( $n=3$ ) were imprisoned for more than one offence since being recruited to the pilot (in one case after being housed, in the others before being housed). A number of service users noted that incidents of criminal activity were often alcohol-fuelled:

*The boredom leads to the drink, and the drink leads to the arguments and the arguments lead to the jail. (Service user)*

Levels of participation in street culture activities have undergone similar reductions, again in concert with reduced levels of drug misuse. Whilst five of the total 22 service users were known to beg regularly at the point of recruitment to the project, staff records indicate that this figure had by the end of the pilot period reduced to three. In a similar vein, whilst two service users had been involved in street-based sex work at the point of recruitment, none were by the end of the pilot period. All cessations in street culture activity were attributed by the individuals concerned to the cessation of illicit drug misuse.

## 4.6 Financial wellbeing

Most service users reported that their level of financial wellbeing had improved since becoming involved with the pilot, as shown in Table 6.

**Table 6: Self-reported financial wellbeing at point of recruitment and one year later**

<b>Financial wellbeing</b>	<b>No. of service users</b>	
	<b>Wave one (recruitment)</b>	<b>Wave two (one year later)</b>
Doing well financially	0	1
Doing alright	1	5
Just about getting by	4	8
Finding it quite difficult	7	4
Finding it very difficult	7	3
Not specified	3	0
<b>Total</b>	<b>22</b>	<b>21</b>

Source: wave one and wave two service user interviews.

This overall improvement is, for the most part, attributed to the fact that much less (or none) of their income is now expended on illicit drugs.

*I'm doing all right ... Because I stopped doing drugs. I was spending a stupid amount a week on heroin and crack cocaine before. (Service user)*

That said, the majority are still finding it relatively difficult to cope financially on their low incomes (see Table 6), given the need to pay for utilities (e.g. gas and/or electricity) and food. Some are also paying off previous rent arrears or other debts, thus placing an additional strain on already limited financial resources.

*Now you have to pay for the electricity, TV license, council tax and everything else, so I'd say [my financial situation has] not improved. (Service user)*

*I only get £80 [on benefits] and like I'll spend £40 on food and £20 on electricity and £10 on gas ... and I smoke, so that's quite bad, if you know what I mean? (Service user)*

Assistance with budgeting has been an aspect of support that many service users particularly value. Some have elected to have pre-pay gas or electric meters installed, so that they do not accrue utility bills which they are then unable to pay. Staff confirm that money management has been a significant challenge for most service users, but that most are 'managing' on the whole.

*On the main people are managing. They may have a little blip there, go off track slightly regarding keeping on top of bills and whatever. But they catch up at their own pace ...*

*We've only had maybe two that's stuck for a couple of days without electricity, but then they have learnt from that ... Other people are doing phenomenally well. (Staff member)*

#### 4.7 Social support networks

As noted in Chapter 3, a number of service users have regular contact with relatives living in Glasgow, and these family members have generally provided important sources of emotional and instrumental support. Several had begun the (sometimes difficult and lengthy) process of 'rebuilding bridges' with estranged family members, albeit that the receptivity of their relatives to this process varied.

*Family members obviously have got their own issues with dealing with their son and daughter, father, whoever it may be, and I think they like to take their time, which can maybe be a little bit frustrating for the person who's wanting to build the bridges. But we have to say "well, that bridge didn't get broken overnight and it's not going to get mended overnight" ... Some of it has worked out really well and others not so well. (Staff member)*

Three service users have re-established contact with estranged children, or established contact with them for the first time, since being recruited to the pilot. The prospect of (re)developing such relationships has been an important factor motivating positive behaviour change for the individuals involved.

*I've got everything I want. A house in an area I like. Contact with my family, my kids. It might not be the life everyone would want, but it's my life and I couldn't ask for more (Service user)*

Some service users have effectively cut ties with former friendship networks since being housed, as they felt this was necessary for them to become and/or remain free of addiction (see Chapter 3). Many of these individuals had requested to be housed a long distance from the areas they used to spend most of their time. They have been particularly vulnerable to feelings of social isolation and/or loneliness since being housed, especially if they do not benefit from the support of family. In such cases, Housing First staff are regarded crucial members of their social support network, most notably as sources of emotional support.

*Most of my pals I've got now take drugs, so I'll just end up back in to it. So I just keep away. Say 'hiya' if I see them, yes, but don't hang about with them. (Service user)*

*Nobody knows where I stay [live], so nobody comes to my door. Anybody that does come to my door it's usually just Housing First, or my missus, basically ... Sometimes I do find that boring a bit ... but if I was still doing that I'd probably be back in the jail. Because I was doing all sorts of drugs, so that's why I wanted to get away from them. (Service user)*

A number of service users are however still in contact with former drug-using peers. They are less likely to report being lonely than the individuals described above, but are more susceptible to relapse. A few of these individuals have found 'managing their door' very difficult, especially where they have felt obliged to 'return favours' to acquaintances who had previously allowed them to stay when they were homeless. Staff report that this particular issue has not been as prevalent as they



had anticipated, but that it was nevertheless a challenge for a minority of service users. The support of staff has been crucial in helping those affected respond, especially where damaging forms of co-dependency are involved.

*The trouble is the only people I've really bothered with were acquaintances that all had habits at the time and I've left that behind because of trying to get myself clean ... That's kind of the difficulty when it's a friend and they're still using to try and distance yourself from them at times. (Service user)*

*Managing the door has not been a problem for as many as I actually thought it was going to be. I think the majority of people want to remove themselves and want to have that safe security, because they have said they don't tell people where they're staying ... There have been a few issues with one individual who liked to have people round about him and he made the mistake of telling certain individuals ... because then he started to feel a little bit intimidated by people who were coming to his door and he didn't know how to deal with it. So it was just reinforcing, you know, "you don't have to let these people in, don't let them in. If you've got any concerns phone us, we will come over"... (Staff member)*

Meaningful activities such as community rehabilitation programmes and training courses have been positive influences expanding the social support networks of a number of service users (see below).

*I've got my girlfriend that I met in the community rehab and I've got another friend but yes, everything is fine. The people that I'm actually seeing now are positive people so yes, I'm quite happy and we do a lot together, we go out and do things ... They're trying to do the same as I'm doing and everybody supporting each other. (Service user)*

#### 4.8 Employment and meaningful activity

Outcomes as regards levels of participation in 'formal' or 'structured' meaningful activity surpassed staff and stakeholder expectations, which had been modest at best given the severity of addiction and low levels of self-confidence affecting the majority of service users at the point of recruitment (see Chapter 3). Service user case files indicate that by the end of the pilot period: seven service users had been involved in education or training (e.g. part-time confidence-building or employability preparation courses); five were regularly attending day services (e.g. Narcotics Anonymous or other community-based addiction programmes); and two were involved in voluntary work.

Other service users reported that whilst they still aspired to become involved in such activities, they felt that they were not 'ready' and/or feared they would not be welcome because of their involvement in substance misuse (see Chapter 6). Levels of boredom reported by such individuals generally remained high.

*My relapses are to do with boredom and things ... It's dangerous for me, sitting about too much because that's when I start thinking deep into things and I just go, 'oh bugger this, that's it, I'm off [to buy drugs] today'; but I don't want to do that ... I tried college in September, I stuck at it five weeks, I just couldn't get into it at all. (Service user)*

Wave two interviews indicate that the majority of service users continued to regard the acquisition of paid employment as a long-term goal: something they aspire to but feel they will not be equipped



to cope with for a long time (see Chapter 3). Furthermore, most are aware that their paid employment prospects will be restricted given their criminal records.

*In the future I would hope to work. But I don't think I could hold a job down the way things are at the minute. I just don't think I could. I don't trust myself, you know what I mean? (Service user)*

*I'd like a job, right enough, I really would ... But because of my charge from probation I don't know what I would get. I don't know if [name of charge] will still show up on my disclosure. And I've got other previous convictions for assault and all that, so, drugs and all that, so I don't know. (Service user)*

## 4.9 Community integration

Staff report that the extent to which service users have interacted with neighbours or activities within their local community has varied. Wave two service user interviews indicate that many know at least some of their neighbours 'well enough to say hello to'. A few have befriended neighbours, and meet with them fairly regularly to watch television or share meals, for example. The greater majority however report that they do not know their neighbours and/or tend to 'keep themselves to themselves' (as would be true for many members of the British public generally).

*Most people keep their selves to their selves quite, so you don't see much of people. You don't see neighbours very much. It's quiet. Nobody bothers anybody ... I know a couple [of neighbours] just to say hello to and different things. I've never taken it any further than that. (Service user)*

*Well I know them [neighbours] well enough to say 'hello, how are you doing?' and things like that but don't really talk a lot. Some neighbours I don't know, a couple I do but it's just passing, 'how you are?' and that's it. (Service user)*

Over the three year duration of the pilot period, a total of 11 instances of neighbourhood disturbance or complaints from neighbours were reported to Housing First staff; these relating to the residences of six individual service users<sup>11</sup>. Stakeholder interviewees, most notably housing providers, emphasised that instances of neighbourhood disturbance had been far less prevalent, and less severe, than they had anticipated. In the vast majority of cases, complaints related to noise disturbance – in some cases caused by people visiting flats rather than the tenant themselves – but those regarding one service user were associated with the unsanitary condition of their flat. None of these instances has led to eviction, in large part due to the critical intermediary role played by Housing First staff in responding to neighbour complaints (see Chapter 6).

*I thought we would get an element of antisocial behaviour with most of the cases ... There was certainly one case where the guy continued to live a kind of street lifestyle, so the neighbours had issues with that, I think it was things like bags of rubbish left in the landing but all relatively basic stuff. It has certainly not been the volume of that or the severity of it that I would have anticipated. (Housing provider)*

<sup>11</sup> It should be noted, however, that it is not entirely certain that Housing First service users were in fact the perpetrators of disturbance in all such cases. Staff and stakeholders alike emphasised that they had due reason to suspect that in at least some of these instances Housing First service users may have been 'blamed' for the antisocial behaviour of other people.

*There has been minimal problems with the tenancies because Turning Point are there at the end of the phone if there is a problem ... If there's been any issues they've dealt with them and assisted the person ... We had initially one of tenant we had some issues with noise of anti-social behaviour and that was dealt with and we've never had a complaint since ... I think our staff have been quite surprised how few problems there have been. (Housing provider)*

#### 4.10 Conclusion

The project has been highly successful at retaining the involvement of service users, including several of those widely regarded as 'serial disengagers'. Its housing retention outcomes have also exceeded expectations, as the vast majority of service users allocated houses have retained their tenancies since being accommodated. Half of those housed had in fact sustained their tenancies for more than two years by the end of the pilot period. No evictions were recorded, but one service user 'lost' their tenancy due to serving a lengthy prison sentence, and another 'gave up' theirs because they were victimised by other members of the drug-using population.

The general direction of change in terms of health has been one of improvement, with a number experiencing vast improvements in physical health, which have generally been attributed to improvements in diet and reductions in drug or alcohol use. Some service users do however suffer from ongoing physical health issues and a number from periodic fluctuations in mental health. Deteriorations in mental health have often been reflected in increases in substance misuse or relapses of varying durations.

There has been an overall reduction in the severity of service users' dependence on illicit drugs, but little observable change as regards their overall levels of alcohol dependency. Several service users have achieved abstinence from whatever their primary 'substance of choice' had been at the point they were recruited to the project. A minority (approximately one quarter) of service users still report high levels of drug dependence. Those who have slipped on their journey toward recovery nevertheless report being closer to meeting their goals regarding substance misuse than they were before becoming involved with Housing First.

Involvement with the criminal justice system and levels of participation in street culture activities (e.g. begging or sex work) have declined overall in concert with reductions in levels of illicit drug use. Periods of incarceration – sometimes (but not always) for offences committed prior to being housed by the pilot – have been very disruptive to service delivery and led to the loss of one (of the total two) tenancies terminated to date.

Service users' financial wellbeing has improved overall, largely due to reductions in the amount of income spent on illicit drugs, but most continue to struggle to cope financially on low incomes. Outcomes as regards participation in 'formal' meaningful activities have exceeded expectations, with several service users now involved in either education, training or voluntary work. Participation in paid work nevertheless remains a long-term goal for most.

A number of service users have benefited from family support, but feelings of social isolation have been a common experience for others, especially those who have deliberately cut ties with former drug- or alcohol-related peer networks. Involvement with meaningful activities in the community

has gone some way to mitigating the loneliness experienced by a few service users, but Housing First staff continue to play a critical role as sources of social and emotional support for many.

Instances of neighbourhood disturbance, where service users have been either the perpetrators or victims of anti-social behaviour, have been relatively rare. The extent to which service users have interacted with other people or activities in their local community has varied, in part reflecting their differing levels of confidence and social skills. Details regarding these and other differences in service user experiences and outcomes are discussed in the next chapter.



## 5. Service User Experiences and Satisfaction Levels

This chapter provides an account of the differences in the experiences of individual service users and the implications of these for project operation and outcomes, together with an overview of service users' views regarding the strengths and weaknesses of the project. It draws upon data from both waves one and two of fieldwork, most notably service user and staff interviews (see Chapter 1).

### 5.1 Trajectories of experience

Since being recruited to the project, service users have tended to follow one of three general trajectories with regard to the overall direction and/or extent of behaviour change; so too 'distance travelled' on their journey toward recovery from substance misuse. These are described in turn below. It should be noted that given the small size of the pilot, the proportions of service user following each should be regarded as indicative rather than definitive; that is, it should not be assumed that such proportions would necessarily be replicated in other Housing First projects. Vignettes outlining the experiences of illustrative case examples are provided in Boxes 1-3, each of which presents an 'amalgam' of the experiences of relevant individuals so as to preserve their anonymity<sup>12</sup>.

1. *'Sustained positive change'*. For half of all service users ( $n=11$ ), outcomes have been largely or uniformly positive overall and have, on the whole, been sustained to date. Generally speaking, their substance misuse has stabilised or reduced (and in some cases ceased), their physical and mental health has improved, and any prior involvement in criminal or street-culture activity has terminated. In most instances their social support networks have strengthened, and they have become increasingly involved with meaningful activities within their community. Some of these individuals report having experienced 'difficult' periods – experiencing the dip in mood described in Chapter 5 for example – but the general trajectory of their experience has been one of positive lifestyle change and enhanced wellbeing.
2. *'Fluctuating experiences'*. For a further quarter of service users ( $n=6$ ), 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 and intermittent periods of disengagement with support. Staff have often increased the intensity of support provided at such times to help service users 'get back on track'.
3. *'Little observable change'*. For the remaining quarter of service users ( $n=5$ ), there has (as yet) been little evidence of change with regard to most of the outcomes measured, albeit that it must be borne in mind that two of these individuals had not been housed independently by the end of the pilot period<sup>13</sup>. These cases are generally still misusing substances at or near to the same level they were before being recruited to the project

<sup>12</sup> Each of these vignettes contains elements of the 'stories' of three or more individuals classified within that group. Identifying details such as demographic characteristics and/or substance misuse histories (amongst other attributes) have also been altered so as to further preserve anonymity.

<sup>13</sup> The individual who is deceased (who retained their tenancy for six months) is also included in this group.

and/or continue to be actively involved in street-culture activities (e.g. begging) or low-level criminality (e.g. shoplifting). Managing their home (e.g. budgeting, cleaning) continues to present an ongoing challenge. Engagement is often 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).

**Box 1: Group 1 'sustained positive change' case example – George**

George had been homeless since losing a tenancy several years before being referred to the Housing First project. He explains that at the time he was using 'something' illicit most days, including any combination of heroin, cocaine, valium and/or cannabis. He has now been in his flat for nearly two years and has invested a significant amount of energy furnishing and decorating it. He has met some of his neighbours but generally likes to 'keep himself to himself'. George explains that his substance misuse has stabilised on a methadone script and he has not used heroin in "a good while" but that he "still takes a wee smoke [of cannabis] now and again". His physical health has improved, but is still relatively poor given pre-existing health conditions. He has a history of involvement with the criminal justice system but has not been charged with anything since moving into his flat. George notes that he can sometimes feel quite depressed or anxious and then has to fight a "temptation to rush out and get a bag [of heroin]" or to "drink a bit more than I should". He reports being quite lonely at times, but has found attending a community rehabilitation programme helpful to meet "positive people". He hopes to do some voluntary work "at some point in the not too distant". He is also delighted to have begun re-establishing a relationship with his children. George says that he is a lot happier and more confident than he was, and is very grateful for the ongoing support of his Housing First worker whom he describes as "a pal, a confidant and a worker all in one".

**Box 2: Group 2 'fluctuating experiences' case example – Joan**

Joan had been sleeping rough "off and on" for many years and spent extensive periods living in hostels and sofa surfing in between episodes of street homelessness. She had a tenancy once before, but lost it due to rent arrears because her drug use had "got out of control". When she first came into contact with Housing First Joan was using a range of illicit drugs including heroin, amphetamines and cannabis: "basically whatever I could get my hands on at the time", she explains. Joan has now successfully retained her Housing First tenancy for over a year. She succeeded in stabilising her drug misuse a few times with the aid of a methadone prescription, but has kept relapsing. The most recent relapse occurred when she allowed a friend who was still using to stay. Joan sees friends most days and notes that "it's difficult when your friends are still using to try and distance yourself from them at times". She has found managing the door quite difficult as a result. Joan explains that her mental health has "gone up and down quite a bit", in large part because she forgets to take her antidepressant medication when she relapses. She notes that the extent to which she has engaged with support from the project has varied, often because she is "out and about trying to get money together" to support her habit. She hopes to get stable again and believes that she will need the support of Housing First for some time yet, especially given her past track record with the lost tenancy.

**Box 3: Group 3 'little observable change' case example – James**

James had been “homeless off and on” for many years before being referred to the Housing First project. He is a heroin user and explains that his drug use has at times been “fucking outrageous”. He has an extensive history of involvement with the criminal justice system as a consequence. James had not had his own tenancy before and hoped that his Housing First flat would be his “first and last”. He has now retained his tenancy for over a year. He is happy with his flat and feels safe in his local neighbourhood. James is on a methadone script and did manage to stop using heroin for a little while, but relapsed, saying of his addiction that “it’s just in my head man, it’s constantly there, it never leaves”. He explains that “I tried not to beg but find myself doing it again”. He has been charged with a number of minor offences in the past year. James struggles with budgeting and keeping his flat tidy: “It’s a tip, everything just gets on top of me”. His health is poor and he believes that his life is “pretty much the same as it was before”, but adds that “it’s scary to think that the flat could be taken off me”. He is very grateful for the support he has received from the Housing First project, emphasising that “they’re the first ones that never gave up on me, even though I gave them plenty enough reason to”. He concludes that “It’s not them, it’s me. They try to steer me in the right direction, it’s a good thing. But I just, I don’t know... I’m still hoping to get stable”.

The characteristics of the individuals following each of the trajectories described above varied. Notably, there did not appear to be any observable differences between the outcomes of the project for male and female service users, nor those within younger (under 25) or older (over 25) age brackets. In any case, the numbers of women and young people within the project’s clientele are too small to allow for the robust comparison of outcomes for different demographic groups.

That said, staff note that the existence of family and/or other support networks did appear to act as a positive, and in some cases powerful, motivating (‘protective’) factor for some service users. As noted in Chapter 4, a few had begun to (re)establish relationships with estranged family members, including children; this was deemed an influential motivator in their journey toward recovery.

Similarly, staff reported that the service users ‘doing best’ in their flat tended to be those who were also engaged in activities in their community (e.g. community rehabilitation services, training courses, voluntary work etc.). Those whose social networks continued to consist predominantly (or entirely) of substance misusing peers and/or for whom daily activities revolved around the acquisition and use of substances typically found it far more difficult to progress in terms of their recovery.

Staff also noted that some (but not all) of the ‘highest risk’ individuals taken on at the project’s outset, notably those with especially long histories of ‘entrenched’ rough sleeping and involvement in street culture, remained the ‘highest risk’ at the pilot conclusion. These individuals were predominant amongst those following the third trajectory of experiences described above. The staff did nevertheless emphasise the benefit of stable housing, and flexible support, in improving their personal safety and facilitating their engagement with supportive interventions.

*I think people have to realise a success to us might not be seen as success to another organisation or whatever ... That person is in his tenancy, a year and half later, still to this day, getting on with it, maybe not to the lifestyle you and I would think is ideal. He's out and about doing what he does and whatever, but he's got the safety and security of having his own home. He's maintaining a tenancy, has food, and electricity... That's a vast change, especially for someone who's slept rough for years. (Staff member)*

## 5.2 Service user satisfaction

Levels of service user satisfaction with the project have, almost without exception, been very high overall. Virtually all service users were effusive in their praise of the project and reported that they would recommend Housing First to other homeless people actively involved in substance misuse (and indeed had often already done so).

*I've had more help from Housing First than I have from any other service I've used. They've been brilliant. I can't think of any ways to improve it. (Service user)*

*I've passed the phone number to many people, told them it's the best thing that ever happened to me ... Nothing stopped me from taking drugs. I was set to take them, to die, I didn't care ... [The turning point] was getting the house and getting people that were always there and they always showed up. (Service user)*

*They've done everything I needed them to do, and I wouldn't be where I was now if it wasn't for them. I'd probably be still sitting with a needle hanging out of my arm or something now. (Service user)*

A number of inter-related factors contributed to this high level of user satisfaction. Crucially, all service users had developed very positive relationships with frontline staff who were widely regarded as being non-judgemental, 'easy to talk to' and trustworthy:

*I feel comfortable talking to them [staff] and telling them about the problems I've got. Even asking for help, which sometimes is kind of tough for me ... The staff go above and beyond the call of duty. They've not got caseloads like that they are only just working with you to get another file off their desk. They don't get you somewhere and then just leave you. (Service user)*

*As I say they helped us out, no matter how many times I sat here, I cried in front of them and everything, feeling really emotional. I could tell them anything, do you know what I mean? I trust them, anything I could say to them. I've told them things that I haven't told anybody. I feel really comfortable with them. (Service user)*

On a related note, the inclusion of peer support workers in the staff team was widely regarded as a key strength of the project (see also Chapter 6). Their shared histories (of homelessness and substance misuse) served to break down perceived barriers regarding the potential risks of being 'judged' and enhanced service users' motivation toward recovery:

*They've [the staff have] been great. A few of them know where I'm coming from 'cause they've been users themselves. They're not bullshitting you. From my point of view that makes a difference. They've been there, they've done it all ... It gives that wee sense of saying like 'I could do that', you know what I mean? (Service user)*

Service users also particularly appreciated the flexibility with which the support was delivered, knowing that they could ask for more or less frequent meetings if/when their circumstances changed. Wave two interviews indicated that service users generally agreed that the default 'starting point' of holding two meetings per week was 'about right'. They were also greatly reassured by the fact that they can, in theory, get in contact with a member of the staff team 24/7, albeit that this facility had only been utilised a very small number of times in practice.



*Basically, it's up to me. If I want them to come out five days a week, they'll come out five days a week. As I say, you can pick up the phone and there's always somebody there. If you want somebody to come out and see you, they'll sort it. They've been great. (Service user)*

Equally if not more importantly, service users consistently emphasised the confidence they derive from knowing that the support of the staff team will not automatically end at some pre-determined date, and that they will not be 'written off' should they encounter a crisis and disengage temporarily or be imprisoned, for example.

*I've worked with a lot of agencies and not really got much with it and I've just thought 'oh I don't like working with these'. I used to miss appointments and visits. But Housing First have always, I don't know, stuck with me. They helped you more I think. (Service user)*

*They've stood by me. Even though I've not turned up for some appointments, they've still stuck behind me, you know what I mean? Definitely, they've been really good to me. Really good. ... They don't get me into a row or anything about it and, like, put me down or anything like that, you know what I mean? (Service user)*

*They're there when I need them. They never kind of fling it back in my face when I fall back into the gear ... They've stuck by me. (Service user)*

Service users understood that they would have very limited choice with regard to which flat they were provided, given pressure on social housing supply and the way it is allocated in Glasgow. Wave two interviews nevertheless indicate that they are generally satisfied with the type, size and quality of their flat. The majority were also satisfied with the neighbourhood, albeit that one experienced harassment and requested to be moved back into supported accommodation (see Chapter 4).

*I feel very safe here. I love my flat, yes, I feel so secure in it. I never really thought that I could stay on my own but now I'm doing it and I'm loving it, so more independent now. (Service user)*

Service users also commonly emphasised the significant value of the project's approach to substance misuse. This, they note, enables them to be 'honest' about their addiction, thereby aiding their journey toward recovery because they do not feel compelled to 'lie' in order to avoid losing their flat during periods of relapse, for example.

*The biggest, the best thing is the honesty ... Through any other agency to get somewhere you had to lie and basically we had, you had to lie to your drug counsellor and lie to your care manager and lie to this and that ... So, being able to just go, 'Oh... ' and tell the truth and say that you've been using and that you're had it and you're ready to fling in the towel ... that helped a lot. (Service user)*

They also consistently highlighted the value of being given an alternative to transitional accommodation for homeless people. This, many explained, offered a critical opportunity to break the self-perpetuating cycle of substance misuse and periods spent in institutional care settings, simply by ensuring that they were not forced to live amongst other users:

*I think the whole scheme of getting users into their own tenancy, I think that's brilliant ... because when you're stuck in the homeless scene in the hostels and all that, it's just a vicious circle, do you know what I mean? But, obviously, once you're taken out of that it's up to you, but you've got all the support there you need, and you've got your own little space, your own little hideaway... (Service user)*

*So I'm not abstinent, yeh, but I'm much more stable on me methadone than I was before. And I'm sure as hell doing a lot better than I would have been if I was stuck in a hostel, surrounded by other people using, running about mad w'it. (Service user)*

Any dissatisfaction with the project, where expressed, related almost exclusively to delays in the allocation of flats resulting from a lack of social housing supply (see Chapter 6 for further detail). Such delays had been very de-motivating for a number of service users.

*I've not get any further on. I'm going back in a way. I'm actually finding myself going back in a way now ... I was starting to ease off on the drugs and getting better, and now I'm just going right back to square one again because of the waiting [for a flat]. (Service user)*

One service user also expressed a degree of frustration that the project had been unable to support his partner when his relationship status changed. The project's health and safety protocols stipulated that she could not be in the premises when Housing First staff visited, which he and his partner found awkward and disruptive.

*At the end of the three years, not every, not all of their clients are going to be still single ... especially once they start getting themselves cleaned up and different things ... Then you move on in the relationships and there seems to be a sort of problem ... It can be frustrating on her and, at times, it can put stress on a relationship like ... So, when my life developed, can they not develop their programme to work with me? (Service user)*

### 5.3 Conclusion

This chapter has noted that the experiences of service users has tended to follow one of three different trajectories: one characterised by sustained positive change across a range of outcomes (experienced by half of all service users); a second defined by fluctuations in mental health and substance misuse in particular (true for approximately one quarter of service users); and a third wherein housing has been retained but there have as yet been few discernible changes with regard to other outcomes, improved personal safety and enhanced receptivity to support excepted (the case for the remaining quarter of service users).

The project is too small to allow for the identification of any demographic characteristics that might influence outcomes such as the likelihood of individuals following the each of the trajectories described above. Staff did however note that the existence of family support (and particularly the prospect of (re)establishing contact with children) acted as a motivating factor for positive behaviour change, as did service users' active involvement in meaningful activities within the community.

Levels of service user satisfaction with the project have been very high. Key contributors to these high satisfaction levels included: the positive relationships developed between staff and service users, the flexibility and 'stickability' of support, and the project's 'realistic' approach to substance

misuse which encourages service users to be honest about where they are on their journey toward recovery. Any dissatisfaction expressed has related predominantly to substantial delays in the allocation of flats. Details regarding these and other operational challenges encountered during project implementation are discussed in the following chapter.



## 6. Operational Challenges and Lessons Learned

This chapter provides an overview of the key operational challenges and ‘lessons learned’ during project implementation. It draws upon both wave one and wave two data, particularly the interviews with staff and stakeholders. It reflects on: stakeholder attitudes toward the project; the acquisition of flats and furnishings; the evolution of support needs; staffing; the role of the police and housing officers; the imprisonment of service users; issues relating to the promotion of meaningful activity; and challenges associated with geography and transport.

### 6.1 Stakeholder attitudes

One of the first challenges encountered during project set-up involved addressing stakeholders’ initial reservations regarding the risks involved in accommodating people involved in active substance misuse. Housing providers in particular reported having had a number of concerns about their obligations under Section 8 of the UK’s The Misuse of Drugs Act 1971. Such anxieties were alleviated, in large part, via liaison between TPS and Strathclyde Police. This process 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 (see Chapter 2).

Buy-in from a number of key stakeholders was established over time, given their recognition that, should it prove to be effective, the project had the potential to meet the needs of a group that has historically been poorly served by existing services. This endorsement did not ‘trickle down’ automatically or consistently to the frontline staff of stakeholder agencies, however. The anxieties of frontline staff of other agencies have been founded, in part, on a lack of understanding of the Housing First model’s key principles, but also fears that they might be considered ‘responsible’ should Housing First service users fail to sustain their tenancies or cause disturbances within their neighbourhood.

A number of frontline practitioners were thus reportedly reluctant to refer people they deemed “not ready” for independent housing. Such concerns have not been alleviated entirely, but diminished substantially as the pilot’s housing retention outcomes were witnessed first-hand by those working in the homelessness sector. Some practitioners report having undergone something of a ‘conversion’ in attitude toward Housing First as a result, from one of scepticism to endorsement.

*I was probably the most cynical of everyone to begin with. I thought ‘whose stupid idea was this?’ Now I’m telling everyone how great Housing First is! [laughs] We’re just not seeing the people that kept turning up on our doorstep time and time again, ‘cause they’re maintaining their tenancies. (Stakeholder)*

### 6.2 Acquisition of flats and furnishings

One of the most significant and sustained problems encountered has related to delays accessing flats once service users had been formally recruited to the project. The co-incidence of the inception of the pilot with the ‘Second Stage Transfer’<sup>14</sup> of Glasgow Housing Association stock meant that the

<sup>14</sup> ‘Second Stage Transfer’ relates to a process whereby Glasgow Housing Association (GHA) tenants can vote

availability of properties was lower than originally anticipated, and lengthy delays were encountered in the allocation of flats to many service users. The process took three months on average, sometimes much longer.

Delays were particularly acute if service users changed their minds about which area of the city they wanted to live in, or spent extended periods in institutional care settings such as prison, rehabilitation centres or psychiatric wards after recruitment to the project. Restrictions in the amount of time flats would be held for service users to view were also problematic:

*[Name of service user] got offered a flat, but they could only keep the offer open for that day and because he doesn't have a mobile, and because he has started drinking a lot, we couldn't contact him ... We like went out looking for him and by the time we got him it was the next day and they had given it away, so that was really frustrating... I wish they could have held it open another day then things might have been different for him. (Staff member)*

Significantly, delays in accessing flats had a very detrimental impact on some service users' levels of motivation:

*The length of time they're actually waiting to get their own tenancy can be a difficult time when you're working with individuals. That's when we can see them becoming a little bit disheartened and you start to maybe lose them a little bit ... It's difficult to keep the motivation going. We really do struggle. (Staff member)*

*It took ages [to get a flat]. I was getting pretty fed up to be honest. I know it's not their [staff members'] fault, but... It was really hard waiting. (Service user)*

The acquisition of furniture and furnishings also proved a significant challenge, and delays acquiring these goods negatively affected several service users' motivation levels. TPS had initially planned to get furniture from a local furniture recycling scheme, but a reduction in public donations to the scheme meant that supply was insufficient to meet demand. Further, Community Care Grants are not accessible to all service users, and in some instances could not be applied for quickly enough to furnish flats before service users moved in.

A notable 'lesson learned' during the pilot was that acquiring furniture and furnishings at a very early stage expedited the process of 'making a house a home' and that helped to mitigate the 'dip in mood' reported by some service users after being housed (see Chapter 4).

*I'm still battling with it [heroin addiction] ... I mean, I'm not using anywhere near what I've been using, but I'm still using until I get stable. Once I get stable that's when it'll stop ... Getting into the house and getting it decorated will help. I've got the tools there and I've got the paint, and I've got everything to go ... I got a small fireplace put in yesterday and everything as well ... [Those things] make a big difference. Even in your*

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on whether they want ownership of their homes to transfer from GHA to local community-based housing associations. The Second Stage Transfer programme was completed in summer 2011 and saw nearly 19,000 homes transfer in total, after tenant ballots. This complex process has proved challenging for many housing providers in the city and the partners who work with them.

*morale, even in your mood, do you know what I mean? Just, yes, it makes you feel better about yourself. (Service user)*

### 6.3 Evolution of support needs

The pilot provides clear evidence that the intensity and/or nature of support required by service users typically evolve over time. Staff typically meet with service users twice per week, but have in a number of cases reduced this to once per week at the request of service users when they have felt confident to live more independently. Levels of support have been a lot higher (sometimes exceeding five times per week) in a minority of cases, in most instances for short periods during and/or immediately after an individual has moved into their flat, but also if service users were experiencing a 'dip in mood' (see Chapter 4).

*I meet with them twice a week usually but at times when I've had a lapse and I'm feeling quite low they can step up their visits, it depends if I want to see them more. But it's usually twice a week I see them ... [That's] just about right I'd say, just at the moment anyway. (Service user)*

In some cases the intensity of support in terms of the number of meetings with staff per week has not altered, but the nature or focus of support changed as service users' goals have changed. 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 has typically been often followed by a period supporting individuals to stabilise or reduce their substance misuse. For several, 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.

Staff report that there have been times where they have 'backed off' and provided very 'light-touch' support when service user have disengaged. In such instances, the relaxation of expectations about the frequency of meetings, whilst persistently 'being there', has proved to be an effective strategy. Contact is maintained with service users insofar as possible during such periods, usually via telephone calls and/or text messages.

*With one individual we had concerns and we thought we need to bump his support up and it just put the person off. So we backed off, totally backed off and if we bumped into him there was no pressure. We'd phone him: "Hi there, haven't seen you for a little while. Are you okay? Do you want to go for a coffee?" We took all the pressure off him ... and he started to engage again. (Staff member)*

As noted in Chapter 4, most service users do foresee a time when they will be able to live completely independently without support from the Housing First team, yet none feels able to specify when this is likely to be. Significantly, a number note that the Housing First frontline staff are key to their social support network and fear that they would feel lonely, and thereby vulnerable to relapse, without regular contact from staff.

## 6.4 Staffing

A key message from the evaluation is that the success of the project hinged, in large part, on the quality of relationships established between frontline staff and service users (see Chapter 5). This highlights important lessons regarding staff recruitment, training and supervision. It is imperative that staff 'get' the philosophy of Housing First, especially its consumer choice approach as regards levels of engagement. They should be non-judgemental, compassionate, and have the ability to 'not take things personally' if a service user disengages. These attributes have a fundamental influence on the extent to which service users feel able to trust staff, especially if their relationships with professionals have not always been positive in the past.

*We will never walk away and we don't walk away. People initially would think "oh they'll be like everybody else, two strikes and I'm out and if I don't comply they'll walk away and leave me. Everyone else has walked away and left me before" ... People are now in a position where they actually do trust us. They do believe what we're saying, you know, we're not going to hang you up by the toes and make you apologise for using. (Staff member)*

*It's just being non-critical, non-judgemental and just being there for them at the time isn't it? ... We don't take it personally if we're called an asshole or a prick or whatever ... We see it as, it's a service user who's angry who's at a bad point in their life, who's whatever and that's why they behave towards us the way they have... (Staff member)*

The role of peer support workers was universally welcomed by staff, stakeholders and service users alike. Evidence indicates that their inclusion in the staff teams added value in three main ways. First, peer support workers' 'shared histories' of homelessness and substance misuse served to break down perceived barriers regarding the potential risks of being 'judged':

*You know they're not going to look down their noses at you, judge you, you know? 'Cause they've been there themselves and know how hard it is. (Service user)*

Second, the life experiences of peer support workers 'legitimised' their contribution such that service users were less likely to disregard their advice on grounds of them 'not understanding':

*The most I like about Housing First is because most of the people that works on Housing First has been through the same things I've been through, basically ... so you know that they're not talking rubbish... (Service user)*

*I can open up better with them, because they've been through it. But for somebody that's not been through it and they start picking at me about this and that ... I go "how the fuck do you know? You've never touched a drug in your life." (Service user)*

Third, peer support workers acted as positive role models, thereby enhancing many service users' faith in their own ability to recover from addiction:

*Some of the time ... they'll tell you about their experience and try and assure you that yes, you can make it, you can get yourself clean and back doing something in the community. (Service user)*



*A lot of them [staff members] have been through the same, so they know what it's like. It's just reassuring me really, that if they can do it I can do it. There's more to life than drugs or drink. (Service user)*

In recognition of the potential challenges that peer support workers face working daily with people in active addiction, and given the potential for them to have to deal with sensitive issues that may induce painful memories, these members of staff receive ongoing personal development support and additional (fortnightly) supervision sessions over and above that that other TPS staff receive. These and the associated training have been valued by peer support workers, as has the informal support provided by other members of the staff team.

*It can be quite draining sometimes as well when the service users are disclosing something and then it flags up bad stuff for yourself so being able to come in and just share it with [names of other peer support workers] makes such a difference. (Staff member)*

Levels of sickness absence amongst peer support workers have nevertheless been much higher than is the case for other TPS staff and this has at times been problematic for service delivery. Such challenges may not be entirely avoidable when incorporating individuals with histories of homelessness and substance misuse into the staff team, but further consideration might valuably be given to finding ways to reduce the level of sickness absence and/or its impact on service delivery.

Feedback from staff and stakeholders indicates that the balance of senior practitioners and peer support workers on the project is appropriate. Some interviewees did nevertheless query whether having a formal link to a named practitioner working in the mental health sector, similar to the current relationship between the project team and the occupational therapist (see Chapter 2), might help to expedite service users' access to treatment for mental health issues where necessary.

### 6.5 Communication with housing officers

The pilot also highlighted the value of clear and open communication with housing officers. This enabled Housing First staff to respond immediately and constructively to problems which might potentially put a tenancy at risk.

*I think they really are proactive at just going up and really trying to keep people in tenancies, having a relationship with the housing officers, trying to prevent that kind of breakdown in communication between tenant and housing association, to the point that the housing associations want rid of them. (Stakeholder)*

*It's been a good project, open and honesty from both Housing First and myself. If I come across something I'll phone them and likewise they'll do the same and we do tend to have regular joint meetings with the client out at the tenancy, just to let them know everybody is working together on it. I think it's all positive. (Housing provider)*

These channels of communication proved particularly invaluable in situations where neighbourhood disturbance were involved. Rather than automatically resort to enforcement of threats thereof in the first instance, housing officers contacted Housing First staff who then played an intermediary role in attempting to resolve the situation constructively. By way of example, in one case it was ascertained that the source of disturbance was not in fact the Housing First service user but

members of their family. Liaison between the service user, Housing First staff and the housing officer determined that these individuals would be denied access to the building by the concierge, thus remedying the situation and aiding the service users' door management. A stakeholder commented of the process that:

*So whereas there had been issues where the police would ordinarily be involved like noise, that sort of thing, the Housing Officer rather than involving the mainstream police services, which the anticipation would be punitive had we involved these guys, was more to do with 'what can we do to resolve this'? ... In the past they would have probably got punitive action with a letter about 'you must address your behaviour' and all that kind of stuff ... And they may well have just jumped ship and abandoned the tenancy... (Housing provider)*

### 6.6 Imprisonment of service users

As noted in Chapter 4, the imprisonment of service users, sometimes (but not always) for offences committed prior to being housed by the project, has presented a significant challenge to project operation. Housing Benefit rules enable individuals with sentences of less than 13 weeks to retain their tenancy; but those with longer sentences lose it. The project continues to support individuals if they do receive a longer sentence, but staff must begin the (sometimes lengthy) application for housing once again when the service user is liberated from prison. Loss of a tenancy also dictates that service users must return to the hostel system and this had, in some cases, had a negative impact on service users' journey to recovery.

*There are people that have done well in prison and manage to stabilise themselves and stuff like that and they come back out and they get put in a hostel system ... Then straight away they'll use ... And of course while they're in prison their section five has to be withdrawn so their section five goes back in and the process has to start again. (Staff member)*

### 6.7 Meaningful activity

The promotion of meaningful activity has proved to be an additional challenge. As noted in Chapter 4, the staff supported more service users than had been anticipated to participate in 'formal' or 'structured' activities such as education, training or voluntary work. For many service users, however, their ability or willingness to engage in such activities was severely restricted by their ongoing substance misuse, a lack of self-confidence and/or fears that they would not be 'welcome'.

*Often they're unable to attend courses because their drug use is chaotic. It's just not possible at that point in their lives for them to be certain places at certain times because they don't know where they're going to be in two hours time never mind every Tuesday, Wednesday and Thursday for example. (Staff member)*

*We had somebody who wanted to start a new course and we'd identified one for him and he went along to it, but it was just too much for him and it actually ended up not being a good thing for him going to it at that point ... because of his self esteem and confidence at the time, he just didn't feel that he fitted in there... (Staff member)*

Furthermore, as noted in Chapter 3, many had never really thought about their long-term futures, and this made choosing courses or other formal/structured activities very difficult.

*It's difficult to get them to identify activities because they say "I don't know what I want to do, I know I want to get involved in something but I really don't know, I've never thought about that before" ... They've never had the ability or the safe surrounding or been able to know where they're going to be from one week to the next ... They've been surviving day to day, getting up, getting money, getting themselves sorted ... and never had that time to actually think "what else can I do in my life?" (Staff member)*

In such instances, staff have wherever possible supported service users to engage in 'normal' informal or unstructured recreational activities locally such as going out for coffee at a cafe, visiting the library, or attending a gymnasium. These activities were found to offer three major benefits: first, they provided an invaluable 'diversion' from the cultures and activities associated with substance misuse; second, they alleviated the boredom reported by many service users; and third, they increased service users' confidence in utilising facilities within their community. These comparatively informal/unstructured yet still 'meaningful' activities thus served as 'small steps' facilitating addiction recovery and community integration.

### 6.8 Geography and transport

The geographical spread of tenancies generated a number of challenges for Housing First staff, most notably the substantial amount of time taken to travel to and from appointments with service users when support was delivered in their home or neighbourhood. This problem was particularly acute for some of the peer support workers who did not have driving licences and were thus reliant on public transport. The time spent on buses restricted the amount of time they were able to devote to contact time with service users.

Efforts were made to ensure that meetings in proximate locations were scheduled on the same day wherever possible, but this was not always feasible given the need to take account of service users' other commitments and/or preferences regarding meeting times. Staff suggested that there may be some utility in allocating named workers to service users on a geographical basis insofar as possible, such that individual staff members' caseloads are concentrated in particular neighbourhoods.

### 6.9 Conclusion

In reflecting on lessons learned during pilot implementation, this chapter has noted that whilst buy-in was obtained from key stakeholders at senior management level, this did not automatically trickle down to frontline practitioners given their concerns about the risks involved in accommodating people they deemed 'not housing ready'. These reservations largely, but not totally, dissipated as the positive housing retention outcomes of the project were witnessed first-hand.

Delays in the acquisition of flats and furnishings have been highly problematic, and have had a detrimental impact on the motivation of a number of service users. The imprisonment of service users has also disrupted service delivery, especially where there has been a risk that tenancy sustainment could be jeopardised by long sentences and the associated termination of Housing Benefit entitlement. Time taken to travel to and from service users' homes has also restricted the amount of time available for face-to-face delivery of support.

The success of the project has hinged, in large part, on the quality of relationships between staff and service users, thus highlighting the importance of staff recruitment, training and supervision. Peer support workers' shared histories with service users add value by breaking down perceived barriers about the risk of being judged, 'legitimising' their contribution, and enhancing service users' faith in their own ability to recover from addiction. Clear communication between staff and housing officers has been critical in facilitating constructive resolutions to issues that might otherwise have jeopardised tenancy sustainment.

The intensity and/or nature of support required by service users evolved over time. The frequency of meetings often increased during and immediately after moving into a tenancy and/or if service users experienced a 'dip in mood'; but many users have requested an overall reduction in frequency of meetings over time. The primary purpose of meetings also evolved, often (but not always) shifting from a focus on furnishing/decorating to make their property 'home', to stabilising or reducing substance misuse, to the pursuit of meaningful activities.

Many service users have been reluctant to participate in formal or structured meaningful activities such as education/training or voluntary work due to their ongoing substance misuse, poor self-confidence and/or lack of long-term goals. These individuals have however responded positively to informal/unstructured recreational activities which divert them from the cultures and activities associated with substance misuse, alleviate boredom, and act as 'small steps' toward community integration.

## 7. Conclusion

This chapter draws together the key conclusions from the evaluation of the Turning Point Scotland Housing First pilot in Glasgow, before providing an overview of the key recommendations deriving from the study.

### 7.1 Key conclusions

The project is widely heralded as a ‘success’ by the service users, staff, and stakeholders in Glasgow – in large part because of the very positive housing outcomes recorded, but also because the staff team has successfully maintained positive relationships with and continued to support service users who were previously regarded as highly challenging ‘serial disengagers’. It is of course impossible to predict at this stage whether or not service users will retain their housing in the long-term, but the evidence collated to date looks very promising.

The vast majority of service users allocated houses retained their tenancies; half of these individuals had in fact done so for more than two years by the end of the pilot period. No evictions were recorded, but two tenancies were terminated for other reasons. Of these, one service user ‘lost’ their tenancy due to serving a long prison sentence (and thereby losing Housing Benefit entitlement), and another ‘gave up’ theirs after being victimised by other members of the drug-using community.

Incidences of neighbourhood disturbance have been relatively rare, and certainly far less prevalent and/or severe than had been anticipated by many service providers. To date no such cases have led to eviction due, in large part, to the valuable intermediary role Housing First staff have played in developing constructive resolutions in liaison with other stakeholders.

The health of most service users has improved, but some still experience physical health problems and/or fluctuations in mental health, these generally being associated with their past or ongoing substance misuse issues. Substance misuse outcomes are mixed, but positive on balance, particularly given that some service users have achieved abstinence from their former primary ‘substance of choice’. Overall reductions in involvement with the criminal justice system and/or street culture activities (particularly begging) largely reflect reductions in levels of substance misuse.

The financial wellbeing of service users has improved on the whole, but many still struggle to cope on low incomes. Some enjoy regular contact with family, but others report feeling socially isolated, especially if they have cut ties with former substance misusing peer networks. In such cases Housing First staff play a pivotal and ongoing role as sources of emotional support.

Several service users were engaging in ‘formal’ meaningful activities such as community rehabilitation programmes, education/training or voluntary work by the end of the pilot period, but involvement in paid work remained a long-term goal for most. Support to access ‘normal’ recreational activities such as going to the gym or cinema provided a valuable ‘diversion’ aiding some service users’ journey toward recovery and increasing their confidence in utilising facilities within their local community.

The extent and type of behaviour changes experienced by service users, especially regarding ‘distance travelled’ on their journey toward recovery, varied. Service users tended to follow one of

three different trajectories: one characterised by sustained positive change across a range of outcomes; a second defined by fluctuations in mental health and substance misuse in particular; and a third wherein housing was retained but there were few easily observable changes with regard to other outcomes, improved personal safety and enhanced receptivity to support excepted.

There are no clear patterns with regard to the demographic or other characteristics of the service users experiencing each of these trajectories. That said, staff noted that the existence of family support, especially the prospect of (re)establishing contact with children, acted as a positive motivating factor, as did active involvement in meaningful activities within the community.

It remains unclear how long service users are likely to require support from the Housing First programme, but existing evidence suggests that it may be for extensive periods of time in many cases, particularly where service users report feeling socially isolated and/or are unwilling or unable to participate in meaningful activities within the community.

Levels of service user satisfaction with the project have been very high overall. All service users have developed very positive relationships with frontline staff. The flexibility and 'stickability' of support is highly valued by service users, as is the 'realistic' approach to substance misuse which enables them to be 'honest' about their experiences on their journey toward recovery. The inclusion of peer support workers in the staff team has been universally welcomed. Their shared histories break down perceived barriers about the risk of being judged and enhance service users' faith in their own ability to recover from addiction.

Any dissatisfaction with the project expressed by service users has tended to relate to delays in accessing housing, reflective of current high demand for housing association tenancies in Glasgow. This issue, which is outwith the control of the Housing First project, has been a source of great frustration for service users and staff alike. It does, however, serve to indicate that the effectiveness of the Housing First approach lies as much (if not more) in the provision of high quality, flexible and non-time-limited support as it does the allocation of stable independent housing *per se*.

Importantly, the evaluation contributes to a burgeoning evidence base, spearheaded by the Housing First Europe programme (see Chapter 1), indicating that the approach is effective when implemented outside its 'home' country of the United States (Busch-Geertsema, 2013). It also goes some way to redressing the gap in evidence regarding the model's effectiveness with homeless people with active substance misuse problems (Johnsen and Teixeira, 2012), by providing compelling evidence that it can and does 'work' for this ostensibly 'hard to reach' client group.

## 7.2 Recommendations

Recommendations deriving from the lessons learned during pilot implementation, which should be borne in mind if/as the Housing First project is expanded or replicated, are as follows:

- It is worth investing significant time engaging stakeholders at *all* levels of seniority before and during project set-up, as it cannot be assumed that the support of senior managers will automatically 'trickle down' to frontline practitioners. Engaging frontline staff at an early stage will alleviate their anxieties about making referrals and improve communication between stakeholders involved in the delivery of support.

- Effective interagency working is critical to successful project operation. Liaison with the police is especially invaluable for the development of drug-use policies which alleviate housing providers' concerns about the legalities of housing active drug users. Moreover, open communication with housing officers enables Housing First staff to respond to any problems quickly and constructively, particularly in situations involving neighbour disturbance.
- The recruitment of high quality staff is a critical factor influencing the experiences of and outcomes for service users. It is imperative that all members of the staff team fully understand and support the key principles of Housing First, particularly its expectations as regards service user engagement. They must be respectful, compassionate, non-judgemental, and have the ability to 'not take it personally' if a service user disengages.
- Peer support workers should be included in staff teams wherever possible, given the significant added value they bring. Ongoing training and support must be offered, tailored to the needs of the individual worker. Consideration should be given to potential ways of reducing the current high levels of sickness absence amongst peer support staff; so too the time that those without driving licences spend travelling to and from appointments with service users.
- Housing First providers should expect that some service users may potentially experience a 'dip in mood' and associated relapse or increase in substance misuse after being housed independently and be prepared to respond as appropriate. Strategies for expediting the acquisition of furniture and furnishings should be prioritised given the role that 'making a house a home' appears to play in mitigating dips in mood.
- There remains a need to develop innovative ways to combat social isolation, especially where service users' family support networks are weak and/or they have cut ties with former peer networks. On a related note, Housing First providers might valuably consider whether and if so how to respond to changes in service users' relationship status by supporting partners whilst continuing to safeguard the health and safety of staff and service users.
- Expectations regarding participation in formal/structured meaningful activity and employment should be ambitious, yet remain realistic. The value of supporting service users to engage in 'normal' recreational activities (e.g. going to the gym or cinema) should be recognised going forward. These not only act as useful 'diversions' from the cultures and practices associated with substance misuse, but also act as 'small steps' increasing service users' confidence in utilising mainstream facilities within their local community.
- Finally, this and future Housing First projects should work toward devising ways to improve outcomes for the minority of service users following the third trajectory of experience described above, that is, those for whom there has to date been little observable change as regards health, levels and patterns of substance misuse, and involvement in street culture.





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