Acknowledgements

The authors would like to express their sincere thanks to the staff and service users of the Housing First pilot, and stakeholder agency representatives, for taking the time to share their experiences and thoughts with us. We are particularly indebted to the project’s frontline staff for their support of the evaluation, most notably for facilitating the organisation of service user interviews.
Contents

Acknowledgements ............................................................................................................................ i
Contents ............................................................................................................................................ ii
Executive Summary .......................................................................................................................... iii
1. Introduction .................................................................................................................................. 1
   1.1 Background to the pilot ......................................................................................................... 1
   1.2 The evaluation....................................................................................................................... 1
   1.3 The report ............................................................................................................................ 2
2. Pilot Description and Early Operation ......................................................................................... 3
   2.1 Project aims and principles .................................................................................................. 3
   2.2 Target group ........................................................................................................................ 4
   2.3 Referral, assessment and recruitment ................................................................................ 5
   2.4 Staffing and support ............................................................................................................ 6
   2.5 Housing and tenancy type .................................................................................................. 7
   2.6 Policies re drug use ............................................................................................................. 8
   2.7 Governance and interagency relationships ....................................................................... 9
   2.8 Degree of fit with government policy ............................................................................... 10
   2.9 Early implementation challenges ..................................................................................... 10
   2.10 Conclusion ........................................................................................................................ 12
3. Profile and Experiences of Service Users .................................................................................. 14
   3.1 Demographic characteristics .............................................................................................. 14
   3.2 Housing histories ............................................................................................................... 15
   3.3 Health and substance misuse ............................................................................................ 16
   3.4 Criminal activity ............................................................................................................... 19
   3.5 Financial wellbeing ............................................................................................................ 19
   3.6 Social relationships ............................................................................................................ 20
   3.7 Employment and meaningful activity ............................................................................... 21
   3.8 Reasons for participating in the pilot ............................................................................... 22
   3.9 Early experiences of the pilot .......................................................................................... 23
   3.10 Conclusion ....................................................................................................................... 25
4. Conclusion .................................................................................................................................. 27
References ...................................................................................................................................... 29
Executive Summary

Turning Point Scotland’s Housing First project is a three-year pilot, in Glasgow, providing housing and support to 18 individuals who are homeless and actively involved in substance misuse. It is modelled on the ‘Housing First’ approach which was developed in the United States, and was the first project of its kind to be developed in the UK. The pilot is funded by Turning Point Scotland, the Big Lottery Fund, and Greater Glasgow and Clyde Health Board. It began in October 2010, will run until September 2013, and is being independently evaluated by Heriot-Watt University. This interim report provides an overview of the project’s operational features, service user characteristics, and ‘lessons learned’ during early stages of operation. It draws upon data from the first (of two) ‘waves’ in the longitudinal evaluation, which involved interviews with frontline staff (n=4), representatives of stakeholder agencies (n=9), and service users (n=18). The final evaluation report, which will draw upon wave two data and provide full details regarding outcomes, will be produced in autumn 2013.

Project and service user profile

The Housing First project’s overall aim is 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 service user outcomes, including: improvement in personal living situation (e.g. sustainment of tenancy); 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, including: provision of independent accommodation in scatter-site housing; no requirements regarding ‘housing readiness’; a harm reduction approach to substance misuse; respect for consumer choice; provision of holistic support 24/7; and targeting the most vulnerable members of the homeless population. These accord with the original ‘Pathways’ Housing First approach; the pilot’s fidelity to the Pathways model will be assessed after publication of Pathways’ forthcoming fidelity scale.

Eligibility criteria for the project include: being aged 18 or older; being homeless; 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. Referrals were received from a wide range of agencies. Potential service users 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, before being recruited to the project.

The staff team consists of a service co-ordinator, two assistant service co-ordinators, and four
peer support workers (the latter of whom have histories of homelessness and substance misuse). All are employed full-time. A member of staff is on call to deal with emergencies outside office hours. Assertive outreach and motivational interviewing techniques are used and staff are highly flexible in terms of when, where and how they engage with service users. 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.

All service users will be allocated independent scatter-site housing in ‘ordinary’ self-contained flats, provided by three Housing Associations. Each will have a Scottish Secure Tenancy (SST) with rent contract and unlimited lease, thus having security of tenure. A working protocol has been developed between Turning Point Scotland, housing providers and the Strathclyde Police to clarify responsibilities and develop policies regarding any illicit drug use in service users’ properties.

The majority of service users are male (15 are male, 3 female), most are aged between 25 and 44, and all are White British. The backgrounds of almost all typify the ‘revolving door’ of repeat homelessness and institutional care (e.g. prison, rehabilitation, hospital, psychiatric wards etc.). Substance misuse problems dated back to teenage years for most, and addictions were severe in a number of cases (particularly in the case of drugs, less so alcohol) at the point of recruitment to the pilot.

At the point of recruitment to the pilot, the majority of service users were struggling to cope financially. Most had weak or fragile (and often potentially damaging) social support networks, 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 time. Virtually all aimed to (re)gain employment or participate in training/education, but these were considered very long-term goals by most. The acquisition of housing and stabilisation of substance misuse problems were consistently accorded higher priority in short- to medium-term goals.

**Early experiences and lessons learned**

A substantial amount of work was needed to ‘sell’ the idea of Housing First to local stakeholders before the project was set up, given widespread concerns about the risks involved in working with people actively involved in drug misuse. Levels of buy-in to the project are nevertheless now generally high, especially at senior managerial level, but this has not always ‘trickled down’ to frontline staff of some agencies. Notably, the Scottish Government has publicly expressed its support for the principles underpinning the project, given the way it dovetails with key national strategic priorities in addressing homelessness.

Stakeholders were generally optimistic as regards the potential effectiveness of the project, albeit that some had reservations about how well it is likely to work with young people. The staff received consistently high praise from stakeholders, particularly as regards the flexibility with which they worked, and the positive relationships they had developed with service users. The involvement of peer support workers was especially welcomed. Early stages of project operation were, however, marred by severe delays in the allocation of properties to a number of service users and in the acquisition of furniture. These delays had been de-motivating for a
number of service users.

Yet, despite such operational problems, service users’ early experiences of the pilot were very positive overall. All had developed excellent relationships with the frontline staff and greatly valued the flexibility and intensity of support that the project provided. They particularly appreciated being able to be ‘honest’ about their substance misuse, without fear of being ‘judged’, or of losing their accommodation and support should they ‘slip’ during their journey toward recovery.

A number of individuals who had already moved into their Housing First flat at the point of interview had found the adjustment to independent living very difficult, experiencing what staff described as a ‘dip in mood’; the substance misuse of some service users had increased as a consequence. This experience was generally attributed to feelings of isolation, which sometimes coincided with delays in acquiring furniture in order to turn the flat into a ‘home’. It is not yet clear how common, or long-standing, such experiences may be.

Staff reported that maintaining levels of engagement with support was an ongoing challenge with some service users, particularly after they had been allocated a flat. Staff had found the relaxation of expectations about the frequency of meetings, but ‘being there’ and maintaining frequent contact via telephone calls and text messages etc., an effective strategy to prevent total disengagement.

All but one service user has maintained their tenancy to date. The exception lost their tenancy due to rent arrears accrued during an extended prison sentence (for an offence committed prior to pilot recruitment). All service users believed that Housing First offered them the greatest possible chance of maintaining their tenancy and meeting their other aspirations, but few were entirely confident about the likelihood of doing so given previous experience of tenancy failure and/or relapse.

Concluding reflections
The early experiences of the project give grounds for optimism regarding its potential effectiveness, at this stage, especially as regards the main aim of reducing repeat homelessness. Key issues for Turning Point Scotland and partner agencies to reflect or act upon looking forward include:

- the effectiveness of existing referral and assessment processes, particularly the appropriateness of the current referral route and length of time taken to assess service users;
- potential means of assuring frontline staff in partner agencies, most notably housing case workers, that they will not be targeted for ‘blame’ should difficulties arise after Housing First service users are re-housed;
- how to expedite the allocation of flats and acquisition of furniture;
- how to promote meaningful activity so as to overcome the boredom commonly reported by service users, whilst bearing in mind that paid employment is a very long-term goal for most;
• strategies to maximise service user engagement, especially after clients have been housed;
• a need to assess how widespread and enduring the ‘dip in mood’ experienced by some service users after being housed is, and identification of means of avoid / respond to it;
• ongoing assessment of the implications of service user imprisonment, especially where sentences are long, for project operation and tenancy sustainment.

The findings of the evaluation, particularly results from wave two of the evaluation to be reported in autumn 2013, will contribute directly to the growing evidence base regarding the effectiveness of the Housing First approach outside the United States. They will be especially valuable in light of the current gap in the evidence base regarding outcomes for people with active addictions.
1. Introduction

1.1 Background to the pilot

Turning Point Scotland’s Housing First project is a three-year pilot, in Glasgow, providing housing and support to 18 individuals who are homeless and actively involved in substance misuse. As the name implies, it is modelled on the ‘Housing First’ approach which was developed in the United States. Housing First departs from orthodox ‘linear’ approaches to homelessness, dominant in most developed nations, 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). It is being widely replicated throughout Europe given evidence, drawn from robust evaluations in the US, that it is effective in accommodating chronically homeless people with complex support needs.

Turning Point Scotland (TPS) is the first provider to implement a Housing First approach in the UK. The pilot was developed after a scoping exercise, conducted in Glasgow by TPS in 2009, which revealed high levels of repeat homelessness amongst homeless drug users and identified a number of barriers faced by this client group when accessing services. The Glasgow Housing First pilot was thus developed with a view to reducing recurrent homelessness by accommodating and supporting individuals who are in active addiction.

The pilot is funded by TPS, the Big Lottery Fund, and Greater Glasgow and Clyde Health Board. It began in October 2010 and will run until September 2013.

1.2 The evaluation

The pilot is being independently evaluated by researchers at Heriot-Watt University. The evaluation aims to assess the effectiveness of the project 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).

The evaluation is longitudinal and involves two main methods:

1. Interviews with TPS staff and representatives of key stakeholder agencies. These are being 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

---

1 A number of other providers operate programmes that contain elements of Housing First – and some of these claim to be ‘doing it already’ – but these projects depart significantly from the core principles of the Housing First approach (Johnsen and Teixeira, 2012). That said, another Housing First pilot, established after the Turning Point Scotland project, has recently been set up in London by Single Homeless Project (SHP). Others are under development, or planned, elsewhere in England and in Wales.
stakeholder assessments of the project’s strengths, weaknesses and overall effectiveness (wave two).

2. **Interviews with pilot service users.** These will also be 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). Provisions have been made for follow-up interviews with service users should they exit the programme prior to the end of the pilot period.

This interim report outlines the findings of wave one data, that is, the initial interviews with staff and stakeholders (held between June and December 2011), and ‘baseline’ interviews with service users (held between February 2011 and January 2012). A total of four frontline staff members were interviewed, as were nine stakeholders, and all 18 service users. All interviews were conducted face-to-face and recorded with participants’ permission. Findings from wave two data, including details of service user outcomes and an assessment of overall programme effectiveness, will be provided in the final evaluation report, to be produced in autumn 2013.

The evaluation will contribute directly to the emergent international evidence base regarding the effectiveness of Housing First, most notably via the pilot’s involvement as a test site in the Housing First Europe (HFE) social experimentation project funded by the European Commission (Busch-Geertsema, 2011)\(^2\). Two contributions are especially noteworthy. First, the evaluation will help to re-balance the evidence base on Housing First geographically, which at presents consists almost entirely of evaluations conducted in the US. Second, the evaluation will redress a gap in the evidence base regarding the model’s effectiveness with homeless people with active drug problems (Johnsen and Teixeira, 2012).

### 1.3 The report

The next chapter (Chapter 2) provides an overview of the pilot’s aims and characteristics, the challenges encountered during project set-up, and ways in which these have been responded to. This is followed, in Chapter 3, by a detailed account of service user characteristics at the point of recruitment to the pilot and their early experiences of the project. The interim report concludes, in Chapter 4, with a summary of the ‘lessons learned’ to date, and an outline of issues the pilot project faces going forward.

\(^2\) For further details of the HFE project see [http://www.servicestyrelsen.dk/housingfirsteurope](http://www.servicestyrelsen.dk/housingfirsteurope)
2. Pilot Description and Early Operation

This chapter provides an overview of the Housing First pilot’s operational features, including details of its: aims and underlying philosophy; target group; referral, assessment ad recruitment protocols; staffing and support arrangements; housing and tenancy type; policies regarding drug misuse; governance and inter-agency relationships; and degree of ‘fit’ with wider government strategies. The chapter ends with an overview of the challenges encountered during project establishment and early operation, and the means by which these have been responded to.

2.1 Project aims and principles

The project’s overall aim, as noted in Chapter 1, is 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. a 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 with those endorsed by Pathways to Housing, the organisation that first developed the Housing First model in the US (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 being an obvious case in point. The extent of the TPS pilot’s fidelity to the Pathways to Housing model, in terms of both philosophy and operation, will be assessed fully in the final evaluation report with the aid of the Housing First ‘fidelity scale’, which is currently being developed by Pathways to Housing (Tsemberis, 2010).

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’;\(^3\)
- 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, 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.

Stakeholders generally agreed that the target group was appropriately defined, although a small

---

\(^3\) 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 GHA and other housing associations in the city to rehouse those households to whom it has a statutory homelessness duty.
minority expressed some reservations about its potential effectiveness with young people:

*I don’t think young people are kinda burnt out enough of the kind of chaos, you know? And I’m not saying that people have to go through the mill before they’re able to break away from homelessness, I don’t mean that. But, I do think that for some of the older guys, you know, they’ve been around homelessness for years ... Whereas I don’t know whether younger people are experienced enough to maybe appreciate the value of a permanent tenancy...* (Stakeholder)

*I think a tenancy for any twenty year old is quite a lot, never mind somebody who’s got drug misuse problems ... I don’t know, but my feeling has always been that the young people are quite a big gamble in terms of the likelihood of success.* (Stakeholder)

### 2.3 Referral, assessment and recruitment

Referrals for the project could be made from a number of agencies including, amongst others, homelessness services, the Glasgow Drug Crisis centre, Homeless Addiction Team, Base 75, the Glasgow Street Team, or via self-referral. A total of 54 referrals had been made to the project by the time the total 18 service users were recruited. Of these, 20 were considered ‘inappropriate’ referrals (e.g. 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.

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). They were then evaluated by an ‘allocations group’, comprising TPS staff, an Occupational Therapist, and representatives of the Glasgow City Council housing casework team. Once service users were formally recruited to the project, Section 5 referrals were forwarded to housing providers. Only a few referrals assessed fully were not recruited to the project, in each case because they were not motivated to sustain a tenancy:

*I think there’s been three assessments, like full assessments completed, maybe four, of individuals that haven’t come on board, and they haven’t come on board because they haven’t really shown a motivation in wanting to keep a tenancy, and that’s pretty much the only reason that somebody would get through the full assessment without being accepted for the pilot.* (Staff member)

The processes of referral, assessment and recruitment raised a number of issues in the early stages of the pilot, some of which led to changes in practice. Firstly, a few stakeholders questioned whether the Section 5 referral route was the most appropriate one to use and/or noted that it presented a barrier to attempts to involve the most ‘chaotic’ individuals:

*If they’re coming through a Section 5 route, why are we giving them a different priority almost to someone who’s got the same level of homeless need? So ... is the Section 5 referral route the right route? I’m not sure it is ... I have a sense that if someone needs that service, they need that service, whether they’ve actually come
in through the homeless route or not. (Stakeholder)

A few [rough sleepers] are ... on our books but they’re not on the council’s books, so. We can still work with them as in introducing the [Housing First] concept and try and explain what it’s about, but in order to then trigger the process ... they need to be formally on the council’s books ... That can be very challenging ... if you’re using, quite heavily using heroin every day ... you’re not going to prioritise going and sitting for a homeless assessment which can take a really long time. (Stakeholder)

Second, the assessment process was initially anticipated to be up to six weeks in duration, but was often taking much longer given the frequency of missed appointments. Attempts were made to expedite this process given concerns about the risks of disengagement and/or compromises to the Housing First principle regarding rapid provision of permanent housing. A degree of flexibility was however deemed necessary given the challenges involved in engaging individuals who are disconnected from the ‘services world’. In this vein, a few stakeholders highlighted the potential value of an extended assessment process, which they believed enabled staff to develop valuable rapport with service users:

I can’t imagine them working without that pre work getting done and that whole, you know, really focusing on engagement and classic stuff about building a relationship and the trust that comes out of that ... All that preparatory work and that relationship building, it just, it pays dividends down the road when things really get serious and keys are getting talked about ... At least they’ve got a relationship and, you know, they’re not facing these things on their own. (Stakeholder)

Third, in the early stages of the pilot an Occupational Therapist (OT) from the NHS Homeless Health Services assessed potential candidates separately from the TPS staff. It was however decided that this process created unnecessary duplication of assessment and the OT’s role was reviewed. The OT’s involvement now includes: attendance at both the allocation and weekly coordination meetings and an assessment of service user needs (particularly their levels of functioning and daily living skills) after recruitment to the project.

2.4 Staffing and support

The project’s staff team consists of a service co-ordinator, two assistant service co-ordinators, and four peer support workers. All are employed full-time. The service coordinators carry out service user assessments and visits, and line manage the peer support workers. 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).

The recruitment of peer support workers represented something of a culture change in TPS, particularly regarding the traditional means of dealing with professional ‘boundaries’ in conversations about personal experiences. In recognition of the potential challenges that peer support workers face (working daily with people in active addiction) these members of staff
receive additional (fortnightly) supervision sessions over and above that that other TPS staff receive.

Staff and stakeholders agreed unanimously that the inclusion of peer support workers in the staff team was highly beneficial. Other staff members had developed equally positive relationships with service users, but had had to ‘work a little harder’ in order to do so given some service users’ fears about the risks of being ‘judged’ by professionals without shared experiences (see Chapter 3).

The service users have taken to the peer support massively and I think it is because ... if somebody perceives you of never having a drug issue there’s a barrier there straightaway. But because of that peer element, people seem to be able to really engage at a different level ... Even just being out on a visit with a peer support worker you can see that. (Staff member)

Assertive outreach and motivational interviewing techniques are used, and staff are highly flexible in terms of when, where and how they engage with service users. Stakeholders frequently commented in the positive relationships that Housing First staff had built with service users and the significant value of their flexibility in service delivery:

They [staff] have been really tenacious and they’ve had a brilliant relationship with them [service users] ... In fact one guy today said ‘By God, that lassie never gives up’, and that’s great. She never gives up on him, do you know what I mean? And they understand the client group. (Stakeholder)

They’ve [staff have] been going out to meet them [service users] on the street instead of making them come into an office which, when if you’re begging out in the street or when you’re all over the place, you’re not gonna make every appointment. So they’ve had a good relationship before they got in their tenancy. (Stakeholder)

2.5 Housing and tenancy type

As noted above, all service users will be allocated independent scatter-site housing. This is being provided by three HAs – Glasgow Housing Association (GHA), Queens Cross Housing and South Side Housing – and located within the North, West and Southern geographic regions in Glasgow (i.e. in the areas those HAs operate). Each property is an ‘ordinary’ self-contained flat, typical of social housing within the city.

Service users will be provided with a Scottish Secure Tenancy (SST), with rent contract and unlimited lease. There was a great deal of debate when the pilot was being developed regarding the type of tenancy that should be offered. TPS rejected the offer from one housing provider to lease flats which could then be sublet to service users. The option of utilising Scottish Short Secure Tenancies (SSSTs) was also disregarded on grounds that it offered less security of tenure:

[On an] SST ... if something’s happening within a tenancy then the tenant has rights, pretty much, whereas with a SSST, which is the Scottish Short Secure Tenancy agreement it’s like a six month rolling lease. So it would be like a six month trial period where they could either extend your lease or they could make it a SST ... The
individual still has rights but it isn’t as secure as a SST, and that’s what we were aiming for for Housing First. (Staff member)

2.6 Policies re drug use

One of the key challenges the pilot has encountered has involved addressing concerns about the ‘risks’ involved in accommodating and supporting people involved in active drug misuse. Housing providers in particular reported having had a number of concerns about their obligations under Section 8 of The Misuse of Drugs Act 1971. It is widely believed that these concerns, together with anxieties about potential neighbourhood nuisance caused by Housing First service users, deterred other housing providers from being involved with the pilot.

Liaison between TPS and Strathclyde Police about such issues led to the development of a working protocol. This process was regarded as mutually beneficial by both parties. Importantly, it 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:

My approach to it was to be as supportive as possible within the legal constraints, and to keep them [TPS and housing providers] right ... particularly on their Section 8 obligations ... disabusing the notion that they have to go further than they actually do. You know, they are not Police deputies or anything like that ... they’re not required to take on that role. What they have to do is manage the offences effectively and stay within the confines of the law. (Stakeholder)

Key elements of TPS’s policy on drug misuse thus include the following stipulations: service users must not allow another person to use substances in their flat; drug paraphernalia should not be visible to staff when they visit service users in their home; staff must inform the police if they suspect service users are involved in dealing; and any illicit substances seen by staff should be surrendered by service users and taken straight to a Police station by staff.

Stakeholders and staff alike highlighted the value of what they considered to be the project’s ‘realistic’ approach to drug misuse. This, they consistently argued, allows service users to be ‘honest’ about the nature and severity of their substance misuse problems, thus overcoming a common barrier to therapeutic relationships:

There’s a reluctance to accept a Section 5 for somebody that’s still quite chaotic with their drug misuse ... So I think there is a real opportunity that people don’t have to pretend that they’re not using drugs cos, let’s face it, there’s plenty of people in Glasgow that have tenancies that use drugs ... I think that’s a big plus, that people could be honest... (Stakeholder)
2.7 Governance and interagency relationships

A number of multi-agency groups have been involved in the project’s development and oversight. The initial steering group consisted of 32 individuals representing 13 agencies working in homelessness, housing, health, social care and criminal justice sectors. The implementation (sub)group, which terminated once the project had become fully operational, drew upon a range of stakeholders’ expertise in the development of appropriate working protocols, policies and procedures. The allocations (sub)group comprising Housing First staff and representatives of two partner agencies assessed individual referrals to the project.

A number of stakeholders noted that there had been a lack of clarity regarding the purpose and remit of these groups in the early stages of the pilot. There was widespread agreement that whilst the original steering group achieved substantial buy-in from key stakeholders, it was too large and lacked clear purpose. Stakeholders also reported experiencing frustration at the lack of progress made between meetings and overall length of time it took for the project to become operational.

In recognition of such issues, the steering group was reconfigured to create an ‘advisory group’. This consists of ten members representing six stakeholder agencies. Whilst having no direct involvement in service management, the advisory group will play a crucial role in focusing on the strategic direction of the evolving Housing First project. Members are committed to the ethos of Housing First and bring both individual and organisational expertise to the group. They will also oversee the longitudinal evaluation of the pilot and other research links that might develop through relationships being forged with other Housing First services in Europe.

Levels of buy-in to the project by stakeholders within the homelessness and substance misuse sectors are generally high at management level, given stakeholders’ recognition that, should it prove to be effective, the project has the potential to meet the needs of a group that has, to date, been poorly served by existing services. This degree of buy-in had not always ‘trickled down’ to the frontline staff of other agencies, however:

*I think most [agencies] have been supportive ... I think the odd alarm bell’s been hit with the, the odd [housing] case worker who’s been in the mix ... I think there was, there’s still a wee bit of resistance there, and I think that that’s partly about not really fully understanding what it is.* (Stakeholder)

Stakeholders believed that the anxieties of frontline officers (housing case workers in particular) were 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 cause disturbances within their neighbourhood, for example.

---

4 Membership includes: an independent chairperson, GHA, Glasgow Social Services Homelessness Services, Greater Glasgow and Clyde National Health Service Homelessness Services, Strathclyde Police, a TPS board member, and TPS operational manager.
2.8 Degree of fit with government policy

The Scottish Government has publicly expressed its support of the general principles underlying Housing First, together with an interest in the findings of the pilot evaluation. A government representative explained that the Housing First approach dovetails with a number of the government’s strategic priorities:

*The general approach very much fits into a whole series of priorities that the Scottish Government are taking forward on homelessness. You know, from 2012 down to all of the prevention work and that general approach around supported accommodation, around housing options hubs and around all the other pieces of work we’re doing on Health and Homelessness ... The general principles are something that the Scottish Government’s supportive of.* (Stakeholder)

Furthermore, a number of stakeholders emphasised that the pilot complements the Scottish Government’s most recent drugs strategy (Scottish Government, 2008), which, whilst focusing less on harm reduction than previous strategies, is firmly based on the broader notion of ‘recovery’:

*If you put recovery as being abstinent at every juncture then they’re [Housing First service users are] a long way off it, but they’re certainly further up that ladder than where they were before getting into something like Housing First ... If recovery is really about, you know, engaging with someone and trying to allow them to make their own decisions in terms of engaging with their drug reality ... they’ll probably do better in their recovery journey than they would if they’d been unsupported ... So I think it [Housing First] actually fits with the broader recovery model...* (Stakeholder)

2.9 Early implementation challenges

Staff and stakeholders identified a number of challenges that have been encountered during the early stages of project operation. First, with regard to recruitment, staff and stakeholders involved in the referral process noted that many service users had initially not understood the potential differences between Housing First and other services, but that this was changing over time as the project became better known:

*I think initially people [potential service users] were just sort of saying, ‘Och, we’ve tried all this’, thinking it’s going to be a hostel like type thing ... So I think initially they were quite dubious about it. But now they know people that have done all right and the word, the word’s out there and they know it’s doing quite well, and that it supports.* (Stakeholder)

Secondly, staff reported encountering some difficulty recruiting young people to the project as per the Big Lottery Fund’s stipulations – partly because other service providers believed that young people prefer communal supported housing, and/or would not cope in independent accommodation. Some were also reluctant to refer young people with active, but less severe, substance misuse problems:

*A lot of the individuals that are in those sort of [young homeless person’s] services went through the whole care system and so are used to sort of communal living, and felt that*
having their own tenancy was maybe a step too much initially ... Even with support. And also that the drug use ... young people are more abusing alcohol. Yes, there will be intermittent Valium use or Ecstasy use or cannabis use, but it wouldn’t be at a level that would satisfy coming to a homelessness drug misuse project. (Staff member)

Third, one of the most significant problems encountered related to delays in accessing flats once service users had been formally recruited to the project. The co-incidence of this phase in the project with ‘second stage transfer’ of GHA stock meant that the availability of properties was lower than originally anticipated, and lengthy delays were encountered in the allocation of flats to service users. This was believed to have had a negative impact on service users’ levels of motivation:

We thought well, right ... we’ve got a guy [service user], you guaranteed a tenancy, what stock have you got? But it didnae work out anything like that, so ... we’ve got guys that have been sitting there for months. And they’re starting to say “If I put a Section 5 homeless referral in myself, I’d have probably had a house by now”. (Staff member)

Fourth, delays were also experienced in the acquisition of furniture. 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 need. Further, Community Care Grants are not accessible to all service users, and could not be applied for quickly enough to furnish flats before service users moved in:

The lack of furniture is a nightmare ... We’re getting dribs and drabs which hasn’t been ideal ... Somebody should have a comfortable environment and move into it straight away, but it hasn’t turned out like that unfortunately. (Staff member)

We can’t apply for a community care grant, to get them furniture and stuff, until they have an address. And sometimes it’s as quick as “There’s a flat” you’re in the next day and “There’s your keys” the next day ... and a community care grant takes up to two weeks. So sometimes people are moving into flats with nothing and that causes big problems. (Staff member)

Fifth, staff believed that problems such as those described above, when combined with feelings of isolation, contributed to a ‘dip in mood’ amongst some service users after being allocated their flat. In some cases this had led to an increase in substance misuse:

Individuals, when they first move into their tenancy, seem to dip with regards to mood, and drug use is increased slightly ... And I wonder how much of that is to do with isolation ... Because obviously when people are in a hostel environment they have support on like their doorstep, they also have friends and associates who they hang about with within that situation. Even when people are rough sleeping they may have a crowd that they will hang around with ... and when you move into your

---

5 ‘Second stage transfer’ relates to a process whereby GHA tenants can vote 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.
own tenancy you want to keep that tenancy safe so you don’t tell anybody where it is, invite anybody up to it. (Staff member)

Sixth, staff highlighted the challenges in maintaining some service users’ engagement with support, particularly once they have been allocated a flat. They had found the relaxation of expectations about the frequency of meetings, whilst persistently ‘being there’, an effective strategy. Frequent contact was maintained with service users insofar as possible during such periods, via telephone calls, text messages and so on:

*We changed how we worked, we became less, well we’d try and see somebody a couple of times a week, we, we’d just cut right back and were like ‘oh we’ll give you a phone then’ ... and people would then come to us for support... So I think it was just about changing our ideals and how we work ... because we all come from services where often, you know, we get charged on hours and different services. So it was just ... looking at how we can support individuals better ... just being more sensitive to the fact, and maybe somebody does just want a house, but you’ll still be there for them and offer that kind of informal support. (Staff member)*

*We’re kind of always there, and I think the service users see that. Cos there’s times when service users haven’t engaged and then one of them turned up at the door, at this office, asking for help. So they, they know we’re there but we’re not in their face, if you get what I mean. (Staff member)*

A further, seventh, challenge related to the imprisonment of service users after recruitment to the pilot. To date, four individuals have served sentences for offences committed prior to their involvement with the pilot, and one for an offence committed subsequently. The staff have continued to engage with service users throughout their incarceration. All but one of these cases involved short sentences. Housing Benefit rules enable individuals with sentences of less than 13 weeks to retain their tenancy; but those with longer sentences cannot. This issue had led to the single loss of tenancy recorded on the project to date: in this case an extended prison stay (for an offence committed prior to being recruited to the pilot) had led to rent arrears. The project continued to support the individual concerned with the aim of supporting him back into independent accommodation following his release. Tragically, however, this individual suffered a fatal overdose shortly after being liberated from prison.

The other 17 service users had successfully maintained their tenancy at the time of writing, and continued to be involved with the pilot, albeit that their levels of engagement with support varied.

### 2.10 Conclusion

Drawing upon wave one staff and stakeholder interviews, this chapter has provided an overview of the characteristics of the pilot project, and reflected upon some of the issues and challenges encountered in the early stages of its implementation. It has noted that the project is considered to be a potentially valuable complement to the service network, should it prove to be effective, given that it targets a group generally served poorly by existing services.

Many stakeholders in the homelessness, substance misuse and allied sectors within Glasgow
have invested resources, particularly in an advisory capacity, in the project’s set-up and operation. Levels of ‘buy-in’ to the project are high overall, especially at the senior managerial level. Stakeholders in the city are, overall, optimistic regarding its potential success, albeit that some have reservations about its likely effectiveness with young people.

The project staff received consistently high praise from stakeholders, particularly as regards the flexibility with which they worked, and the positive relationships they had developed with service users. The involvement of peer support workers was especially welcomed. Early stages of project operation were, however, marred by severe delays in the allocation of properties to a number of service users and in the acquisition of furniture.

Staff and stakeholder assessments of the early stages of project operation highlighted a number of challenges and issues that TPS and partners might valuably reflect upon as the project progresses. These include: determining whether Section 5 is the most appropriate referral route; gauging the ideal length and degree of flexibility needed for the service user assessment process; ascertaining how and when the OT involvement might be utilised most effectively; identifying means to expedite the allocation of flats and acquisition of furniture; determining how to most effectively maintain service user engagement; identifying ways to mitigate the ‘dip in mood’ experienced by some service users after being housed; and assessment of the implications of service user imprisonment for project operation and tenancy sustainment.
3. Profile and Experiences of Service Users

This chapter describes the characteristics and experiences of the pilot’s 18 service users. It begins by profiling their demographic characteristics and housing histories, as well as health and other support needs at the point of recruitment. It then outlines what their understandings of the Housing First model were at the point of recruitment, why they elected to participate in the pilot, what their initial experiences of the project have been, and what their priorities for the future are.

As noted in Chapter One, wave one service user interviews were conducted as soon as possible after they were recruited to the pilot in order to collate information about ‘baseline’ characteristics and support needs prior to the Housing First intervention. These will be used to measure ‘distance travelled’ by the time of follow-up interviews (see Chapter One). This interim report thus does not report on outcomes, but does comment on service users’ early experiences of the pilot insofar as wave one data allows.

3.1 Demographic characteristics

Of the 18 service users, 15 are male and 3 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](image-url)

Source: wave one service user interviews. Base: 18.
3.2 Housing histories

At the point of recruitment, most (n=11) service users were living in a hostel or other form of temporary accommodation for homeless people (e.g. a temporary furnished flat). Of the others, three were in an addiction rehabilitation facility, two were staying temporarily with friends or family because they had no home of their own, and two were sleeping rough.

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. (Male service user, in 40s)

It’s been a revolving door: prison, sleeping rough, hostels, since I was 19. (Male service user, in 30s)

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:

Being homeless and trying to stay clean, it’s impossible really. The place I’m staying in right now, the drug use is rampant around about you every day. (Male service user, in 30s)

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?’ (Male service user, in 30s)

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. (Male service user, in 40s)

As noted above, some of the service users were staying with friends and family on a temporary basis (i.e. ‘sofa-surfing’) when recruited. 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. (Male service user, in 30s)
A total of 11 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-using peers/dealers:

*I let someone move in and they ended up selling drugs from the house. (Male service user, in 30s)*

A number noted that they had felt very unsupported when previously allocated their own social tenancy. Most had felt poorly equipped to access furnishing, set up utilities and pay bills, for example. The stress of attempting to live independently, combined with isolation and a lack of meaningful activity had, in a number of cases, led to worsening (or relapse into) substance misuse:

*I didn’t have any support at all, not even with getting furniture. It all got on top of me and I ended up back on the drugs because of it. (Male service user, in 30s)*

### 3.3 Health and substance misuse

When asked to assess their overall health at the point of recruitment, 3 service users described it as ‘good’, 11 as ‘fair’ and 4 as ‘bad’ (none as either ‘very good’ or ‘very bad’). Figure 2 portrays the (current) health problems service users (self)-reported at point of recruitment. Notably, 12 reported problems relating to mental health. Of these, ten reported that they had ever been prescribed medication for mental health problems, and five that they had been hospitalised for mental health problems (in some instances on multiple occasions).

Other health problems affecting a notable proportion of service users at the point of recruitment included digestive or liver problems (typically hepatitis) (n=8), and blood circulation problems (often deep vein thrombosis caused by intravenous needle use) (n=7) (Figure 2).

All 18 service users reported having an active drug and/or alcohol problem (an eligibility criterion for recruitment to the pilot). The severity of their addiction at the point of recruitment was assessed with the aid of the Severity of Dependence Scale (SDS). This confirmed that drug addictions were very severe in a number of cases: scores (for those using drugs in the past month) ranged from 5 to 14, with an average (mean) of 9 (i.e. well 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) experience relatively severe levels of alcohol dependency. For virtually all, substance misuse problems had begun early in life, in many cases in their early teens.

---

6 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).
Table 1 lists the drugs that service users reported having used in the month prior to recruitment to the project. Two thirds (n=12) had used heroin, and 13 had used methadone (on prescription) as a heroin substitute. Ten had used cannabis, and smaller numbers other substances including valium, cocaine, diazepam, crack, speed and ecstasy. Ten had injected drugs (in all instances heroin) in the month before recruitment.
Table 1: Substances consumed in the month prior to recruitment

<table>
<thead>
<tr>
<th>Substance</th>
<th>No. of service users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>13</td>
</tr>
<tr>
<td>Heroin</td>
<td>12</td>
</tr>
<tr>
<td>Cannabis</td>
<td>10</td>
</tr>
<tr>
<td>Valium</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>5</td>
</tr>
<tr>
<td>Diazepam</td>
<td>4</td>
</tr>
<tr>
<td>Crack</td>
<td>2</td>
</tr>
<tr>
<td>Speed</td>
<td>1</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: wave one service user interviews. Base: 18.

Note: 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.* (Male service user, in 40s)

- *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’. * (Male service user, in 20s)

All 18 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, most had nevertheless returned to homelessness and substance misuse shortly afterward. Periods of being ‘clean’ and/or ‘dry’ were thus generally short-lived.

All but one of the service users with a drug problem aspires 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 aim 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. (Male service user, in 30s)

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. (Male service user, in 20s)

3.4 Criminal activity

All but two (n=16) 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] since I was 16. It’s all been for shoplifting, to fund my drug habit. (Male service user, in 30s)

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. (Male service user, in 30s)

More than half (n=10) 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 believed the only way to reduce involvement in criminality was to address their addiction.

3.5 Financial wellbeing

Most service users reported that they found it virtually impossible to manage/budget the limited funds they had given their active substance misuse problems. Some were supplementing their income via (illegal) street culture activities at the point of recruitment:

I’m shoplifting and that kind of stuff to make ends meet basically. (Male service user, in 30s)

I’ve not been paid me social for four weeks, so I’ve been street working just to get myself by. (Female service user, in 20s)

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:

*My everyday thing is I’ll wake up and take a bucket, then I’ll start texting people ‘what’s happening, who’s got mad w’it funds, who’s got money?’ Everybody knows everybody’s giro [welfare benefit payment] day.* (Male service user, in 20s)

*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.* (Male service user, in 30s)

### 3.6 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:

*It’s been the story of my life. Go to people’s houses, drink in people’s houses. Have girlfriends who are drinkers. Falling out with them ‘cause it’s their house and then I’d be out on the street. Stuff like that. That’s all the people I knew, really, drinkers.* (Male service user, in 40s)

*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?* (Male service user, in 30s)

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.* (Female service user, in 20s)

*I don’t kind of get in touch with my family when I’m using drugs and that. I sort of stay away.* (Male service user, in 40s)

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.

3.7 Employment and meaningful activity

Nearly half (n=8) 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. (Male service user, in 30s)

A few found it virtually impossible to think about long term goals regarding employment or training:

I can’t think about things like that just now. I’m just kind of surviving day to day. I need to get me head together and get me house sorted first. (Female service user, in 20s)

Of those that felt able to think about the future, all aspired to 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:

I’d like to train to be a chef … it’s a wee bit far away the noo, but. (Male service user, in 40s)

Service users’ aspirations in this area were often tempered by concerns about their employability given their disabilities, poor health, and/or criminal records:

I’d like to think so [that will work in future], but you know, with my disabilities and drugs issues and all that, who would take me? (Male service user, in 40s)

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? (Male service user, in 30s)

I lie in, get up, if I’ve got money I’ll go and buy drugs, then I’ll go home and sit in the hostel and watch TV. (Male service user, in 30s)
Most spoke of being frequently bored and believed that having ‘something to do’ would be key to their recovery from addiction:

Boredom is a big thing with me. I need something to fill my time. (Female service user, in 20s)

If I’m doing other things and I spend my money on other things, then I’ll not buy drugs. If I’m just sitting about then I’ll go for a bit of this, and a bit of that, you know? (Male service user, in 40s)

If I had something to do to stay away from the drink it’d be easier. But when you’ve got nowhere to go you just kind of drink your sorrows, you know? If I had something to do, something that would keep me mind off it I could do without it. (Male service user, in 40s)

3.8 Reasons for participating in the pilot

Service users’ awareness of the differences between Housing First and other programmes for homeless people at the point of recruitment varied. A few were unaware that it was unique in any way and had merely elected to participate in the pilot because it presented a ‘new’, and in their understanding potentially ‘faster’, way to access social housing.

The majority, however, had been attracted to the project by one or more of its defining features. First amongst these was the fact that intensive support would be provided 24/7 and would not ‘automatically’ end at some pre-determined date. Virtually all service users acknowledged, sometimes on the basis of previous experience, that they would need support of this kind if they were to maintain a tenancy:

I’ve never had my own tenancy, so I liked the idea of there being help there. I was told that I would get help with paying bills and things like that. (Male service user, in 30s)

I want the support in case I lapse. That’s the thing with the drug taking, once you start getting heavier and heavier, everything goes, doesn’t it? Your responsibility goes, your care goes. (Male service user, in 30s)

I liked the fact that Housing First will always be there. There’s no cut-off. That’s important, obviously for an addict, because your life is chaotic as it is. You can phone up and say ‘I need help now’ and they’ll be there for you. (Male service user, in 30s)

Also of central importance to many service users was the assurance that they would not be ‘judged’ for using drugs, nor rejected by the service if they ‘slipped up’ on their journey toward recovery. Notably, service users felt that this would enable them to be honest about their substance misuse, without fear of becoming ineligible for the service:

I’m looking forward to the prospect that I don’t have to lie. The thing is that when you start lying, the whole deceit thing kicks in. You lie for a lie, then have to tell another lie ... Lies kind of roll off my tongue naturally, probably because I’ve been
Doing it for so long. But I’m just tired of doing it. The prospect that I can be honest, and just say ‘look, I’m too drunk today, or too full of it today’, and they won’t give up on me... It seems quite exciting. It’s going to help me a lot, just ‘cause I don’t need to lie anymore. (Male service user, in 30s)

Related to this, many service users found the inclusion of peer support workers within the staff team to be a highly attractive feature of the service.

They’ve [peer support workers have] been there and done it ... it’ll make a big difference to my life anyway, having people you can look up to who say ‘Well I done it this way’. (Male service user, in 30s)

3.9 Early experiences of the pilot
When asked about their overall impressions and experiences of the Housing First pilot up until the evaluation interview, service users’ overall assessments were uniformly positive. All commented on the very positive relationships they had developed with frontline staff, who they described as 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. (Male service user, in 30s)

They [staff] are just more helpful. You feel that at other agencies they just forget about you, it seems like ... I’ve had problems with companies in the past that don’t follow through, they make out as if they never said this time and date ... Whereas at Turning Point they’re here twice a week. They’re never late or cancel an appointment ... That makes a big difference. Now I have hope for getting a house. There’s a lot more positive stuff happening. (Male service user, in 20s)

Service users highlighted their appreciation of practical assistance with filling in official forms, dealing with authorities and so on. Importantly, they derived a significant amount of confidence from knowing that emotional support and practical assistance is always available:

I’m a lot more confident knowing that I’ve got the support there. I can pick up the phone at any time ... If I didn’t have that I’d probably end up with a drug problem again and would probably end up on the street again. (Male service user, in 30s)

For some service users, peer support workers’ ‘shared histories’ (of homelessness and substance misuse) served to break down (perceived) barriers regarding the potential risks of being ‘judged’ and enhanced 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? (Male service user, in 30s)
The only major criticism service users had of the project was the delay many were experiencing in the allocation of their flat. This had been de-motivating for some:

*I thought I’d get a house pretty fast, but it didn’t work out that way.* (Male service user, in 30s)

A small number had nevertheless recently moved, or were preparing for an imminent move, into their Housing First flat at the point of interview. All these individuals were satisfied with the quality and location of their flat, albeit that they had generally not completed turning it into a ‘home’ via the acquisition of soft furnishings etc. at the time of interview.

Most of those who had already been housed had found the adjustment to life in an independent tenancy much more difficult than they had anticipated, even with the support offered by Housing First. Feelings of loneliness appeared particularly acute for those who had been in rehab at the time of recruitment:

*I found it really hard going from a rehab with lots of people around to being by myself. Before I got out [of rehab] I thought ’Yes, it’ll be great, I’ll have my own place, my kids will be back, I’ll get a job, everything will be brilliant’. Soon as you are out... I still get this down feeling sometimes. It’s a lonely feeling.* (Male service user, in 30s)

As a consequence, some service users had experienced an increase in substance misuse:

*I don’t know why, really. Getting back into the wrong crowd, falling back into that whole thing... I ended up mad w’it again. I’d meet up with them and I’d got a habit again so I ended up jumping about with them again.* (Female service user, in 20s)

*I wasn’t planning on relapsing, but it’s happened ... I dunno why I done it. I ended up regretting it and then doing it again and regretting it ... It was coming out away from all that support [in rehab] ... and then it was just walking into my flat on my own. You’re all wrapped in cotton wool in them places. I think you get a wee bit scared. Fear kicked in and all. So basically you take to numb it.* (Male service user, in 30s)

A few noted that feelings of isolation, loneliness and/or fear – and therefore the risk of using/drinking – tended to be most acute at night. They were aware of the after-hours emergency number, and derived a degree of confidence from knowing the option of calling at night existed, but nevertheless had not utilised this facility:

*It’s alright during the day, when they [staff] come and see me about three times a week. But at night sometimes I do struggle. I know I can phone, but I don’t bother doing it ... I know I should pick up the phone because sometimes I sit here with my head bursting and it’s not right. Sometimes I think to myself I can do this myself, but it turns out I can’t!* (Male service user, in 30s)

When asked about their priorities for the future, all service users reported that their immediate aims included accessing a flat and stabilising their substance misuse with a view (in almost all cases, see above) to overcoming addiction in the longer term. Longer-term goals included
participation in training and/or (re)entry into paid employment, and the re-establishment of relationships with family (or in the case of one young person, having a family).

Ultimately, all aimed to do what one service user described as ‘normal everyday things’, free from addiction:

> My aim is just to get my independence, to have a place to call my own ... Not having to shoplift every day to buy drugs. Just to do normal everyday things. To do those things that other people take for granted, that’s what I want in my life now. (Male service user, in 30s)

Notably, for some this aim represents a return to a ‘normality’ that they have experienced in the past, that is, before developing an addiction. For others, however, such a goal is much more ambitious: for they have been actively involved in substance misuse and criminality since their teens, have few or no qualifications, have never had paid employment, and have never had an independent tenancy.

Accordingly, very few service users were totally confident that they would achieve their short- and/or long-term goals, especially given their past experiences of relapse and tenancy breakdown. That said, all believed that the stable housing and ongoing support provided by Housing First maximised the likelihood of them succeeding:

> I’m not really confident. I’ll believe it [that will achieve goals] when I see it. If you expect the worst you’ll no be disappointed. I’ve been confident about things in the past but then it’s gone pear-shaped. You lose faith that way, I’m telling you. (Male service user, in 20s)

> I’m not 100 per cent confident but that’s just because of how many times I’ve kind of failed before. But I’m quite confident because I’ve got the right kind of people behind me. (Male service user, in 30s)

> I’m confident that Housing First will fulfil its side of the bargain. Will I? That’s another question! [laughs] I really hope so, but I’ve been slipping quite a bit with the drink, so... (Male service user, in 40s)

They emphasised the need for taking ‘small steps’, to avoid over-reaching and minimise the risks of worsening addiction, a return to a ‘chaotic’ lifestyles, and/or potential loss of tenancy.

### 3.10 Conclusion

This chapter has described the characteristics of the pilot’s 18 service users, as well as their initial experiences of the project, by the point of the wave one evaluation interview. Most were male, aged between 25 and 44, and all White British. The adulthoods of almost all typify the ‘revolving door’ of repeat homelessness and institutional care (e.g. prison, rehab, hospital etc.). Substance misuse problems dated back to teenage years for most, and addictions were severe in a number of cases (particularly in the case of 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 point of recruitment, 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 time. Virtually all aimed to (re)gain employment or participate in training/education, but these were considered very long-term goals by most. The acquisition of housing and stabilisation of substance misuse problems were consistently accorded higher priority in short- to medium-term goals.

Service users’ early experiences of the pilot were very positive overall. All had developed excellent relationships with the frontline staff and greatly valued the flexibility and intensity of support that the project provided. They particularly appreciated being able to be ‘honest’ about their substance misuse, without fear of being ‘judged’, or of losing their accommodation and support should they ‘slip’ in their journey toward recovery. Substantial delays in the allocation of flats to many service users were seen as problematic, and de-motivating, however.

A number of individuals who had already moved into their Housing First flat had found the adjustment to independent living very difficult; the substance misuse of some had increased as a consequence. Time will tell how prevalent and/or prolonged this experience is and, importantly, how it might be mitigated most effectively. All service users believed that Housing First offered them the greatest possible chance of maintaining their tenancy and meeting their other aspirations, but few were entirely confident about the likelihood of doing so given previous failed tenancies and/or relapses.
4. Conclusion

This interim report presents findings from the analysis of wave one evaluation data, that is, initial interviews with staff and stakeholders, and ‘baseline’ interviews with service users.

It notes that the Glasgow pilot is founded on Housing First principles, as endorsed by Pathways to Housing who developed the model in the US, but some of the operational features necessarily differ given the contrasting welfare regime and housing markets in the UK. The project’s (philosophical and operational) fidelity to the Pathways approach will be fully assessed in the final evaluation report, by which time the fidelity scale currently being developed by Pathways to Housing will be available.

A substantial amount of work was needed to ‘sell’ the idea of Housing First to stakeholders in the city before the project was set up, given widespread concerns about the risks involved in working with people actively involved in drug misuse. Levels of buy-in to the project are nevertheless now high. Notably, the Scottish Government has publicly expressed its support for the principles underpinning the project, given the way it dovetails with key national strategic priorities in addressing homelessness.

Almost all of the project’s service users have had long histories of repeat homelessness, institutional care and substance misuse problems (some of which were severe at the point of recruitment). Their early experiences of the project give grounds for optimism regarding its potential effectiveness, at this stage, especially as regards the main aim of reducing repeat homelessness. All but one service user has maintained their tenancy to date (the exception having resulted from an extended prison sentence for an offence committed prior to pilot recruitment).

All service users reported positive relationships with the support staff and emphasised the value of being able to be ‘honest’ about their substance misuse in aiding their journey toward recovery. They particularly appreciated the inclusion of peer support workers in the staff team, as their shared histories have broken down perceived barriers regarding the potential risks of being ‘judged’. Other staff members have developed equally positive relationships with service users, but have had to ‘work a little harder’ in order to do so.

Delays in the acquisition of properties and furniture following recruitment to the project have been de-motivating for some service users, however. Furthermore, a number of those who had moved into their flat experienced what staff described as a ‘dip in mood’ and increase in substance misuse. The imprisonment of some (for offences committed prior to pilot involvement in all but one case) presented an additional challenge to project operation. Whilst service user assessments of the project were very positive overall, they were less optimistic than stakeholders regarding the likelihood of them sustaining their tenancy long-term.
Given the above findings, key issues for TPS and partner agencies to reflect or act upon looking forward include:

- the effectiveness of existing referral and assessment processes, particularly the appropriateness of the Section 5 referral route and length of time taken to assess service users;
- means of assuring frontline staff in partner agencies, most notably housing case workers, that they will not be targeted for ‘blame’ should difficulties arise after Housing First service users are re-housed;
- ways to expedite the allocation of flats and acquisition of furniture;
- how to promote meaningful activity so as to overcome the boredom commonly reported by service users, whilst bearing in mind that engagement in paid employment is a very long-term goal for most;
- strategies to maximise service user engagement, especially after clients have been housed;
- a need to assess how widespread and enduring the ‘dip in mood’ experienced by some service users after being housed is, and identification of means of avoid / respond to it;
- ongoing assessment of the implications of service user imprisonment, especially where sentences are prolonged, for project operation and tenancy sustainment.

The evaluation will contribute to the evidence base regarding these and other challenges, as well as the identification of best practice as regards their mitigation and/or the minimisation of any potential negative outcomes. An account of ‘lessons learned’ during the pilot will be reported on fully in the final report, along with a detailed account of outcomes for service users. Drawing primarily upon qualitative data, this will assess the effectiveness of the pilot in achieving its objectives, these being: improvement in personal living situation (e.g. levels of tenancy sustainment and service user satisfaction with housing); reduction or no increase in substance misuse (e.g. changes in consumption patterns and severity of addiction, the extent to which personal goals regarding substance misuse are achieved); improved physical health (e.g. changes in self-assessed overall health); improved psychological wellbeing (e.g. changes in levels of self-esteem); reduction in criminal activity (e.g. whether charged for any criminal offences since recruitment); and improved capacity to participate in and be valued by society (e.g. changes in the composition and strength of positive social networks, participation in employment, education or training).
References


