

Lars Benjaminsen

07:2013 WORKING PAPER

REHOUSING HOMELESS CITIZENS WITH ASSERTIVE  
COMMUNITY TREATMENT.  
EXPERIENCES FROM AN ACT-PROGRAMME IN COPENHAGEN

SFI – THE DANISH NATIONAL CENTRE FOR SOCIAL RESEARCH

REHOUSING HOMELESS CITIZENS  
WITH ASSERTIVE COMMUNITY  
TREATMENT.  
EXPERIENCES FROM AN ACT-  
PROGRAMME IN COPENHAGEN

Lars Benjaminsen

THE DANISH NATIONAL CENTRE FOR SOCIAL RESEARCH, COPENHAGEN,  
DENMARK;

Working Paper 07:2013

The Working Paper Series of The Danish National Centre for Social Research contain interim results of research and preparatory studies. The Working Paper Series provide a basis for professional discussion as part of the research process. Readers should note that results and interpretations in the final report or article may differ from the present Working Paper. All rights reserved. Short sections of text, not to exceed two paragraphs, may be quoted without explicit permission provided that full credit, including ©-notice, is given to the source.

# **Rehousing Homeless Citizens with Assertive Community Treatment**

## **Experiences from an ACT-programme in Copenhagen**

**Lars Benjaminsen**

June 2013

SFI – The Danish National Centre of Social Research  
Herluf Trolles Gade 11, DK-1052 Copenhagen K, Denmark.

Contact details: Lars Benjaminsen, [lab@sfi.dk](mailto:lab@sfi.dk), +45 33480910

## Content

Summary .....	3
1. Introduction.....	5
2. Assertive Community Treatment – an evidence based method.....	6
3. Method of the study .....	9
4. The ACT-programme and the national homelessness strategy.....	12
5. The context of the Danish welfare system .....	14
6. The citizens .....	16
7. The housing.....	18
8. The support provided .....	22
9. Housing outcomes.....	31
10. Independent housing versus communal housing .....	36
11. Other outcomes .....	48
12. Conclusion .....	54
References.....	56

## Summary

This report presents the results of a study of an ACT-programme (Assertive Community Treatment) in Copenhagen, Denmark, which has been part of the Danish national homelessness strategy.

The ACT-programme is aimed at rehousing homeless individuals and providing floating support in the citizens own home from a multidisciplinary support team. The target groups of ACT are homeless individuals with complex support needs due to for instance mental illness and/or substance abuse and for whom it is difficult to use mainstream support systems. The team consists of both social support workers and other professionals including a psychiatrist, a nurse, an addiction counselor, and social workers with administrative authority from the social office and the job center. In the international research literature ACT has been shown in randomized controlled trials to be a very effective method in bringing individuals out of homelessness and into a stable housing situation.

The study is based on quantitative outcome measurement on about 80 citizens who have been assigned to the programme and who have received both a housing solution and support from the ACT-team. The study is not a randomized controlled trial as there is no control group. Furthermore qualitative interviews have been carried out with fifteen citizens receiving the support and eight staff members of the team.

The study shows that a very high part – more than 90 pct. – of the citizens who have been assigned to housing and support remains housed throughout the observation period. About two fifths of the citizens have been housed in independent apartments in ordinary public housing and the rest have been housed in four different congregate housing units – places where all residents are formerly homeless or otherwise socially vulnerable individuals. In both housing types more than 90 pct. remain housed throughout the observation period. However, a considerable part of the citizens in congregate housing has been relocated to other forms of housing – mainly to independent public housing during the observation period. It has not been possible to control for initial selection of participants to the different forms of housing.

The qualitative interviews show that the possibility to meet different dimensions of support needs - social support needs, health needs and administrative support needs is crucial to the success of the ACT-method. The incorporation of both specialist health professions and staff with administrative authority into the team gives a high degree of flexibility of giving tailor-made and coherent support to the citizens.

The individuals who have been housed in independent, scattered housing are very satisfied with both their housing situation and the support from the team. Amongst the individuals in the congregate housing units there are mixed experiences – most are satisfied with their apartments but there are also indications that gathering many people with complex problems at the same place creates negative synergy effects especially by maintaining an environment characterized by substance abuse. The relocation of citizens from congregate housing units to independent housing during the programme period follows both the wishes of the citizens and the negative experiences of congregating many individuals with the similar problems in the same housing units.

The study shows that ACT is a very effective method of supporting homeless individuals with complex needs to move into own housing and to remain housed. Especially, the study shows that with the support from an ACT-team it is possible to live in independent, scattered apartments in ordinary housing even for individuals with complex support needs. The experiences from the project point towards housing in independent, scattered housing as the preferable and optimal form of housing, though no conclusive evidence can be given on the relative effectiveness on the different housing forms, due to possible selection of citizens to the different housing types. The results also suggest that congregate housing should be reserved for individuals who are not able to live in ordinary housing even with the intensive support of an ACT-team and only after housing in independent housing has been tried, as it is not possible in advance to predict who will succeed.

## 1. Introduction

In 2010 an Assertive Community Treatment (ACT) team was established by the municipality of Copenhagen as part of the Danish national homelessness strategy. The multidisciplinary team provides floating support to a group of formerly homeless individuals who at the same time are assigned to permanent housing through either the municipal priority allocation system or in congregate housing facilities attached to the programme.

This report presents and discusses experiences from the ACT-programme based on quantitative data for all citizens attached to the programme, and qualitative interviews with eight staff members and fifteen citizens. The study is part of the study Housing First Europe, which has been financed by the European Commission by the PROGRESS programme. The empirical data will also be used for the evaluation of the national homelessness strategy.

Section two gives an overview of the ACT-method. Section three describes the methodology of the study. Section four gives an overview of the context of the national homelessness strategy, and section five contextualizes the programme within the Danish welfare system. Section six describes the citizens enrolled in the programme. Section seven describes the housing used in the programme, and section eight describes the support involved. Section nine describes the housing outcomes, and section ten describes the experiences with independent housing versus congregate housing. Section eleven describes outcomes on other parameters and section twelve gives concluding remarks.

## 2. Assertive Community Treatment – an evidence based method

The ACT-method originated in the field of psychiatry. Following the de-institutionalization of psychiatric treatment in the 1960 and 1970 outpatient care was established on a local level typically in community mental health centers. However, the community based care often turned out to be less effective than anticipated and the ACT-method was developed as a more intensive method of providing support to individuals with complex support needs (Thompson et al., 1990)

During the 1990s the ACT-method increasingly found its way into homelessness services as a way to provide floating support for homeless individuals being rehoused. ACT is aimed at individuals with complex support needs for whom it is difficult to use existing services such as treatment for mental illness, addiction treatment and other social services. ACT is based on a multidisciplinary support team providing floating support in the individuals own home.

In particular the ACT-method has become associated with the turn away from ‘treatment first’/continuum-of-care programmes towards the ‘housing-first’ approach. The key idea of the housing first approach is to establish a permanent housing solution as early as possible in the course of an intervention, and to provide sufficient floating support which enables the individual to stay housed. The pioneer of this approach was the Pathways-to-Housing programme in New York City led by Dr. Sam Tsemberis. In a manual for Housing First, Tsemberis (2010) describes how the Pathways programme is based on the combination of two elements – independent scattered housing and floating support in the form of either ACT – assertive community treatment – or ICM – intensive case management – depending on the degree of support needs.

By independent scattered housing is meant independent flats in ordinary residential areas. In the Pathways programme – housing is obtained in private rented housing – as public housing options in the US are scarce and waiting lists long. However, independent housing might as well be provided through public housing. An important aspect of the Housing first approach is that no conditions of adherence to treatment or ‘behavioral progress’ such as abstinence is set as a condition for obtaining housing. The individuals have the same lease conditions as any other residents regarding for instance noise and no drug dealing. However, a condition is that the individual must accept to receive support from the team in the form of a home visit at least once a week.

An ACT-team is a multidisciplinary team of professional specialists such as social workers, a psychiatrist, an addiction councilor, a housing specialist and a job consultant. Also peer specialists – individuals with own former experience of homelessness may be included in the team. Support is given directly to the individual in his or her own home. However, for individuals with less complex



support needs, and who are capable of using mainstream services, support from an individual case manager (ICM) may be sufficient. The individual case manager provides both practical support at home and supports the individual in using mainstream support services such as psychiatric services and addiction treatment.

An important aspect of housing first is the separation of the housing solution and the social support, in the sense that access to housing should not be conditioned upon following treatment. Except for the initial agreement to accept regular visits from the support team, obtaining a housing contract and the conditions of eviction should not be conditioned upon a requirement to follow addiction treatment or of abstinence. In case of an eviction the social support follows the individual and the ACT-support should not be interrupted due to a loss of housing. The housing intervention in the Pathways programme is based on independent, scattered housing in the ordinary housing sector, instead of congregate/communal housing units where all residents have complex support needs (in Scandinavia known as 'category housing' – housing for individuals of the same 'category'). In the literature communal housing has been criticized for the risk of negative synergy effects (see e.g. Blid 2008). By bringing together many individuals with strong support needs, mental illness and/or addiction problems, there is a risk of maintaining the individual in an environment marked by addiction, social problems, and conflicts amongst the residents. Contrary to congregate/communal housing, scattered housing in the community may involve positive community effects from the interactions in everyday life with other residents in the community. On the other hand the independent scattered housing model may pose a risk of loneliness as many individuals with complex support needs have weak or no social relations.

The effectiveness of ACT as a method to stabilize the housing situation of formerly homeless individuals has been tested in randomized effect studies. A study by Tsemberis et al. (2004) where ACT in combination with independent scattered housing was tested against 'usual care' and with a follow-up period of 24 months shows that amongst the intervention group receiving ACT in combination with independent scattered housing about 80-85 per cent are in a stable housing situation whereas in the control group only about 30 per cent were in a stable housing situation at the two-year follow up.

Other studies have pointed to the effectiveness of the ACT-method as well. In a meta-analysis of six randomized studies of ACT-support Coldwell and Bendner (2007) find an average effect difference on homelessness outcome measures of 37 per cent in favor of ACT compared to a control condition of standard care. In most of the studies the control group received some form of ordinary

case management. In the same meta-analysis a 26 per cent greater improvement was found in psychiatric symptom severity for the ACT-intervention group compared with standard care. However, no significant difference was found between the two groups in hospitalization outcomes. A further review (Nelson et al. 2007) suggests that the effect of both ACT and ICM is enhanced when combined with a housing programme.

However, still relatively few effect studies have been made, and certain questions can be raised. Kertesz et. al. (2009) has argued (p. 522) that the housing first programmes reported in the literature mainly includes individuals with a non-addiction psychiatric disorder, whereas the severity of substance abuse has been moderate. This raises the question whether the 'residual' group who do not succeed in maintaining housing in these studies is likely to include a higher number of individuals with severe and active substance abuse, and whether other housing solutions – such as communal housing may be needed for this group?

Furthermore it should be noticed that almost all effect studies so far has been conducted in the US. This might especially affect the control condition, as the content of 'usual care' might vary according to the welfare regime.

In this study of the Danish ACT-team there is no control group but only an intervention group receiving ACT-support and housing. However, the study gives an estimation of how many amongst the participants who maintain a stable housing situation during the follow-up period. At the same time the Danish ACT-programme involves different types of housing. Some participants have been assigned to independent scattered housing and others have been assigned to communal housing. This gives an opportunity to compare outcomes and experiences between the different types of housing, though there may be an element of selection to the different housing types through the assignment process.

### 3. Method of the study

The study of the ACT-programme in Copenhagen is based on both quantitative and qualitative data. Since the beginning of the ACT-project, a quantitative monitoring system measuring outcome for each individual receiving support has been in place. This monitoring system is part of an evaluation of all projects financed under the national homelessness strategy. Data from the monitoring system is used in the study.<sup>1</sup> Every third month data on each participant is entered into the system by case workers. Besides basic demographics of the citizens receiving support, information is given about housing status, extent of the support received and which type of professions in the team whom the individual have received support from. There is also information on a range of other measures such as an assessment of the extent of addiction problems, mental problems, ability to maintain daily activities, social network etc. The quantitative measurement is based on the assessment by support workers and not on self-reporting of the citizens. In addition to the quantitative data from the monitoring system of the national homelessness strategy, specific information on housing status and reasons for changes in housing status for all citizens has been collected from the ACT-team specifically for this study.

Besides the quantitative data, qualitative interviews have been conducted with team staff and with citizens who receive support from the team. Most qualitative interviews were carried out during May and June 2012 and some were carried out in a second round of interviewing in January and February 2013.

At the time of interviewing the team had 14 staff members including the team leader. Some staff members work only part time in the team. Qualitative interviews were carried out with the team leader and seven staff members. A second interview was conducted with the team leader in January 2013. In the selection of staff members for interviews the priority has been to cover the variety of professional disciplines represented in the team. The interviewed staff members are a psychiatrist, an addiction councilor, a nurse, a job consultant, a social welfare officer, and two social support workers. One of the interviewed support workers is an on-site support worker in one of the group homes and this support worker is not formally part of the ACT-team. This arrangement of attaching the ACT-team to communal housing/group homes with on-site support staff will be explained in a further section. Thematized interviewguides were made for each interview with a

---

<sup>1</sup> The monitoring system for the Danish Homelessness Strategy has been set up and is administered by Rambøll and quantitative data from the monitoring system has been provided for this study through Rambøll Results.

special focus on the treatment and support given by each particular professional. Each interview lasted about 1-1½ hour.

Fifteen qualitative interviews were carried out with citizens receiving support from the team. Contact to the interviewees was facilitated by staff members of the team who undertook a great effort to engage citizens for interview. Most citizens who receive support from the team were approached about whether they would participate in an interview. A few citizens were not approached due to the severity of their condition. Initially the ambition was to carry out interviews with 20 citizens, but it turned out not to be possible to engage this number of citizens for interviews. The staff members who have facilitated the contact point to the fact that most of the citizens receiving support from the team obviously have very complex support needs, and most have severe addiction problems, which is of course a barrier for committing to an interview. There is a risk that it is the more resourceful among the citizens who have committed to an interview. However, it should be recognized that complex support needs is a general condition for being assigned to support from the team and that all the interviewees can be characterized as having complex support needs.

The interviewed citizens were eleven men and four women, four were in 30-39 years old, five were 40-49 years old and six were 50-59 years old. Six lived in independent housing, two lived in a group home, four lived in a large communal housing unit and three lived in another communal housing unit consisting of row houses. Fourteen of the interviewees were Danes, of whom three had Greenlandic background. One had a different nationality than Danish.

Thematised open-end interview guides were used. Priority was given to the interviewees view of their housing situation, and the support they receive from the team and whether this support covers their needs. A decision was taken by the researcher not to emphasize questions about the interviewees' life history, homelessness trajectory and personal problems such as addiction history and mental illness unless these subjects came up naturally during the interviews as these themes might strain the interviewees unnecessarily. The focus on the housing situation and the support received from the team, was also communicated to potential interviewees in the process of engaging citizens for interviews. However, in most cases it turned out to be a natural part of the conversation to ask where the interviewees stayed before they moved into their current home, and in most cases also the issue of addiction problems came up. It was the general impression from the interviews that all interviewees were keen on expressing viewpoints on both their housing situation and the support they received. All interviews were carried out in the homes of the citizens. The names of both staff

and citizens have been changed in the report. Also the names of the communal housing units have been anonymized to 'communal housing unit I, communal housing unit II (row houses), group home I and group home II.

#### **4. The ACT-programme and the national homelessness strategy**

In 2008 the Danish government adopted a national homelessness strategy. Four overall goals were set: That rough sleeping should be reduced, that young homelessness individuals should have alternatives to a stay in a homeless shelter, that the length of stays in a shelter should be reduced for individuals capable to move on, and that homelessness following institutional release from prison or hospitals should be reduced. A pool of 500 million DKK (66 million €) were allocated to the strategy over a four year period. Eight municipalities, primarily the largest cities and town, with the highest level of homelessness were invited to participate in the strategy. At a later stage additionally nine – mainly medium sized – municipalities received funding from the strategy, particularly aimed at strengthening floating support services.

The eight municipalities were asked to set local goals and to initiate specific interventions to fulfill these goals. The initiatives were to be agreed upon between the municipalities and the Social Ministry. Priority was given to developing social methods effective in bringing individuals out of homelessness. Existing knowledge on such methods was consulted. In particular priority was given to set up projects based on three support methods which had already shown to be effective in the international research literature – Assertive Community Treatment, Intensive Case Management, and Critical Time intervention. Another priority was given to provide new housing for the homeless and part of the funding was allocated to projects providing new housing units for the homeless.

The first national count of homelessness in week 6, 2007 had shown that the highest number of homeless was found in the municipality of Copenhagen with 1,884 homeless individuals registered in the count week, out of a national total of 5,253 homeless individuals, thus corresponding to 36 per cent of the national total (Benjaminsen & Christensen, 2007). The definition of homelessness used in the count was based on an adapted version of the European Typology of Homelessness and Housing Exclusion (ETHOS), and had as main categories rough sleepers, individuals in emergency night shelters, homeless shelters, and individuals staying temporarily with family or friends (couch surfers).

The municipality of Copenhagen received 200 million DKK (27 million €) to set up new initiatives and a variety of new initiatives was agreed upon. One initiative was to establish an ACT-team to provide support to homeless individuals with complex support needs who should be assigned to housing as part of the programme. The ACT-team became anchored under the existing homelessness unit in the Social Department of the municipal administration.

As mentioned earlier the distinctive feature of the ACT-method compared to other forms of floating support such as ordinary case management, is that multiple professional disciplines are integrated into the team, and all provide outgoing floating support in the home environment of the citizen. Not all of the professional disciplines were part of the team from the beginning, as some were attached to the team after a while. At the time of interviewing in summer 2012, the team consisted of a team leader, 7 full time social support workers, a full time nurse, a part time psychiatrist who also specializes in addiction problems and works two days a week for the team, two part-time addiction councilors (each working one day a week for the team), one full time and one half time social office case worker, and one part-time job center case worker. According to the team leader the average yearly cost per citizen is about 88,000 DKK (about 11,500 €). This excludes housing costs. The citizens pay rent for their housing out of their transfer income (mostly cash benefit or early retirement benefit).

## 5. The context of the Danish welfare system

The assignment of a citizen to receive support from the ACT-team means that he or she can receive the specialized professional support from the team at home. Besides the possibility to get floating social support from the social support workers this also means that the citizen does not need to attend meetings at the job center concerning social benefits as this can be taken care of directly by the job office worker in the team, or to go a addiction treatment center for substance addiction treatment, as such treatment can be given directly from the addiction councilor in the team.

However, the assignment to the ACT-team does not as such exclude the citizen from receiving support from other welfare services. Especially in the field of health care (both somatic and psychiatric) Denmark has universal coverage which means that the ACT-citizens have the same rights as all other citizens to receive public health care. However, by incorporating a nurse and a psychiatrist (who also has general medical competence) into the team additional treatment can be given directly in the citizens own home. The nurse can also assist the citizen in contact with the general health system and thus facilitate the citizen's use of the general health system when necessary.

The possibility to receive addiction treatment directly from the addiction councilor in the team does not as such exclude the possibility of receiving treatment in the general addiction treatment as assignment is considered in each individual case. While some of the ACT-citizens receive medical substitution treatment for opioid addiction, only a few receive psychosocial addiction treatment in the regular treatment system, whereas most who receive psychosocial addiction treatment do so from the addiction councilor in the team.

All of the citizens attached to the team receive some form of transfer benefit. Of those attached to the team in January 2013 the majority (69 out of 77) received cash benefit. 7 received disability pension and one received old age pension. The level of cash benefits is approximately the equivalent of 1100 €pr. month after tax, the early retirement pension is about 1,600 €after tax and the old age pension is about 1200 €after tax.

Both in independent housing and communal housing the rent must be paid out of transfer benefits. In addition there is a housing benefit (calculated on the basis of rent and income) which gives a supplement to cover part of the housing cost.

Cash benefit receivers can be required to follow labour market activation programs or other kinds of social activity programs but individuals can be exempted due to social problems. Most of



the cash benefit receivers amongst the ACT-citizens are not required to follow activation programmes due to the severity of their support needs, but depending on individual capabilities it is possible to follow such activity programs.

## 6. The citizens

In January 2013 a total of 92 individuals had been assigned to the programme. 80 had been assigned to housing through the project so far, while 12 were waiting to be assigned to housing, most of whom had been assigned to the team very recently.

At the time of the last interview in January 2013 the ACT-project was closed for new participants as the number of citizens receiving support had reached maximum capacity. New participants are only accepted when somebody leaves the programme. There were a total of 76 citizens actively receiving support from the team. The remaining citizens did no longer receive ACT-support for various reasons. Five citizens died throughout the programme period, at the average age of only 41 years, reflecting a high mortality amongst long-time substance abusers.

The assignment to the ACT-team is made by an assignment team in the municipality's homelessness unit. The assignment team has the possibility to assign individuals to different forms of housing and support where the ACT-team is one amongst several options. The ACT-team is aimed at individuals with complex support needs, for whom support from a regular social support worker is assessed not to be sufficient.

The team leader explains that there are individuals who have so severe support needs that these needs cannot be met by ACT-support and whom it is therefore not possible to assign to the programme. These are for instance individuals with intensive care needs, such as a need for intensive daily support, and who are the target group for so-called § 108 accommodation which is institutional accommodation with full-time on-site support. There are also some substance abusers who have been assessed not to be possible to house and support through the ACT-programme, due to a very chaotic behavior.

The citizens who are assessed to be within the target group of the ACT-team are asked about their housing preferences and particularly whether they wish to live in independent accommodation or if they want to live together with other formerly homeless individuals in which case referral to one of the communal housing units is possible. The assignment team widely follows the citizens' own housing preferences but the assignment team may consider that some individuals cannot be offered a certain type of housing due to behavioral issues. Amongst the interviewed citizens there are two who were initially offered a place in the communal housing units but declined this offer, and both these individuals were instead offered to move into independent housing.

In table 1, demographics are shown for 87 citizens who have been assigned to the project in total, excluding five citizens who have died during the programme period.

Table 1: Gender of the ACT-citizens

	Per cent (count)
Female	32 (28)
Male	68 (59)
Total	100 (87)

Table 2: Age of the ACT-citizens

	Per cent (count)
18-24	0 (0)
25-29	8 (7)
30-39	22 (19)
40-49	37 (32)
50-59	31 (27)
60+	2 (2)
Total	100 (87)

Table 3: Ethnic background of the ACT-citizens

	Per cent (count)
Danish	59 (51)
Danish from Greenland	30 (26)
Other nationality	12 (10)
Total	100 (87)

About two thirds of the ACT-citizens are males, and only one third females. A few are younger than 30 years old, but most are from 30 years and upwards, with 40-49 year olds being the largest group. 89 per cent (77 individuals) are Danish including 26 individuals with Greenlandic background. 12 pct. (10 individuals) have another nationality than Danish.

## **7. The housing**

At the onset of the ACT-programme a decision was taken by the municipality mainly to assign citizens in the ACT-programme to communal housing units. There was a perception among municipal decision makers and administration that many of the individuals with complex support needs would not be able to live on their own in independent housing, and that specialized housing would be needed for this group. There was also a concern of providing enough housing units for the project, as there is a general shortage of affordable, independent public housing for allocation under the municipal priority access scheme (explained below). A decision was taken, to provide housing in three separate communal housing units in the city. A further fourth unit has later come into use. However, some individuals were also housed in ordinary public housing, and as the experiences with housing some of the ACT-citizens in ordinary public housing were very positive it was decided to assign more of the ACT-citizens to ordinary housing. At the same time experience from the communal housing units began to show signs of negative effects from congregating many individuals with similar problems at the same place, and a number of residents at the communal housing units have during the observation period moved from communal housing and into independent housing in ordinary public housing.

### **Independent housing**

The municipality of Copenhagen can assign one third of all housing units which become vacant in public housing in the municipality to households in priority need of housing. Many groups 'compete' for such assignment such as single mothers, individuals with physical handicaps, mentally ill individuals with a housing need, and homeless individuals with social problems. Demand generally exceeds supply and there is a waiting time to get an apartment through this priority access scheme. The team leader assess that average waiting time is about 4-6 months for assignment to independent housing. However, for individuals with a dog, the waiting time is about one year, as a number of housing organizations do not allow pets. For individuals under 25 years the waiting time is generally longer, as cash benefits are lower for individuals under 25 years, and therefore fewer of vacant apartments are affordable for this group. The apartments which have been allocated to ACT-residents are generally scattered all over the city. All individuals who are allocated to public housing get a permanent ordinary rental contract. The residents pay rent out of their cash benefit or early retirement allowance.

## **Communal housing I**

One of the communal housing units that have been attached to the project as ‘ACT-housing’ is a large 10-storey housing block with a total of 70 apartments. The house is owned by a public housing company and all residents have their own rental contract. The municipality provides support for the residents, and previously the place was a residential unit only for individuals with mental illness. As demand for this particular form of housing for the mentally ill declined, the municipality decided that 20 of the apartments should instead be converted into housing for the homeless, and be attached to the ACT-programme. At the same time the administrative responsibility for the support was moved from the municipality’s health department to the social department. The 20 apartments should over-go to the ACT-programme as they become vacant.

Each apartment consist of one room with own kitchen and a bathroom and with separate entrance from a regular stairway. In the ground floor there are common rooms and on-site staff facilities. Until April 2012 a model of divided support between on-site staff and the ACT-team was used in this housing unit. It was the same staff that used to service the mentally ill residents in the rest of the complex who should also deliver on-site social support to the formerly homeless residents. The ACT-staff should then provide additional support from the professions represented in the team. However, the on-site staff did not have any particular experience with homeless individuals with complex support needs. From April 2012 the ACT-team took over the full support for the residents housed through the ACT-programme.

At the summer 2012 11 apartments had become available for the ACT-programme. As will be discussed later, conflicts have occurred in this communal housing unit about access to the common facilities for the formerly homeless residents, and at the time of the first interviews in summer 2012 it had been decided by staff in the house that the ACT-citizens cannot use the common facilities in the ground floor. Furthermore there was a general experience of negative effects of congregating many individuals with addiction problems in this facility. During autumn 2012 the municipality has decided to offer the ACT-citizens in this communal housing unit relocation into other housing and mainly into independent public housing if the citizen wants such relocation.

## **Group home I**

In the case of one of the communal housing units, it was decided by the municipality that support from the ACT-team should be assigned to a group of residents already living at this place. The unit is a group home with 20 rooms dispersed in six separate apartments in the same stairway in an

ordinary apartment building in the inner city. In each flat the residents share bath and kitchen. 14 of the rooms are reserved for individuals with Greenlandic minority background. In the group home there is tolerance of use of alcohol and hashish. Users of hard drugs are generally not assigned to the place but eventual use of hard drugs is not sanctioned with eviction as the residents have their own rental contract. Only 15 of the rooms were occupied at the time of the first interview round in summer 2012. According to the staff interviews one reason why there are empty rooms at the place is that many potential residents do not want to live at the place and many would rather prefer to live in an independent flat. Another reason is that individuals with use of hard drugs are not assigned to the place.

A reason why it was decided that the group home should be included in the ACT-project was that a strengthening of the support given at the place was needed. Before the ACT-team was attached only one social worker and a part-time nurse were attached to the place. However, it was decided that two on-site support workers with a base in a homelessness shelter should be attached to the place and provide daily social support to the residents whereas the ACT-team should provide additional support by the professions in the team. In this way the ACT-team does not provide full floating support to the residents, as the on-site social support workers are not as such part of the ACT-team.

Nine residents lived at the place at the time the ACT-team and the support workers were attached to the place. According to the staff interviews, the residents already living at the place all became attached to ACT-support without any extensive assignment procedure. A staff member assesses that almost all of the residents belong to the target group for ACT by having complex support needs, but that a few might not fall under this category. However, all residents were attached to ACT-support as nobody should need to change their place of residence.

## **Group home II**

Another communal housing unit which has been attached to the ACT-project is a small group home where there is room for 10 residents. Two of the housing units are flats with own kitchen and bath whereas 8 rooms share facilities. Only 7 rooms were occupied in May 2012. As was the case for the first group home, there is a lack of demand to live in the place. Also in this place, daily social support is given by on-site support workers, not part of the ACT-team, whereas the team provides additional support. Like in the second communal housing unit described above, the interviews point

to certain challenges in this facility. The existing staff of the place did not have previous experience with the ACT target group. During 2012 a decision has been taken by the team and the municipality to end the attachment of this place to the ACT-programme and to offer the ACT-citizens in this place to move to other accommodation. At the time of the second interview round all ACT-citizens but one, in this facility, has accepted this offer.

### **Communal housing II**

During summer 2012 a new unit of communal housing was attached to the ACT-programme. The new housing unit consists of 18 small rowhouses – 1 or 1½ room each with own kitchen and bath. The place used to house mentally handicapped individuals. All interior of the houses has been rebuilt. Based on the experiences from the existing group homes there is no on-site staff and all support will be supplied from the ACT-team.

## 8. The support provided

The ACT-team consists of staff with different professional backgrounds. Besides social support workers (most of whom have a social pedagogical degree) the team includes a nurse, a psychiatrist, an addiction councilor and a social office worker and a job center worker, both with discretionary authority over support and benefits. All support is given as floating support in the citizens own home.

The monitoring system provides information on the extent of support given to the citizens. Table 4 shows how often support is given for citizens receiving support. Only data from the last measurement period in November 2012 is included. Only citizens attached to the team at the time of measurement (for each period) are included. A few citizens have not allowed for data to be collected.

18 per cent of the ACT-citizens receive daily support. This mainly reflects the availability of on-site support in one of the group homes. The majority of the citizens receive support from about two times a week to about every second week. 13 per cent (7 persons) have received support only once a month or less in November 2013. This probably reflects cases where it is difficult for the team to deliver support to the citizen for instance if the citizen resists support visits or it is difficult to make an appointment if the citizen is not at home or responding to phone calls.

Table 4: How often has support been provided (citizens receiving support in November 2012, on average within last three months)

Frequency of support	Per cent (count)
Daily	18 (10)
About two times a week	13 (7)
About once a week	36 (20)
Every second week	20 (11)
About once a month or less	13 (7)
Total	100 (55)

Also the duration of support visits is recorded in the monitoring system. Briefer and more frequent contacts in the group homes probably explain why some visits are relatively short. However, two thirds of support visits last longer than 45 minutes and one out of four visits even last more than 1½



hours. This underlines how the individual support provided from the ACT-team is relatively intensive.

Table 5: Duration of a support visit (citizens receiving support in November 2012)

Frequency of support	Per cent (count)
1-5 minutes	0 (0)
6-15 minutes	4 (2)
16-30 minutes	22 (12)
31-45 minutes	15 (8)
46-60 minutes	27 (15)
61-90 minutes	13 (7)
More than 90 minutes	20 (11)
Total	100 (55)

The monitoring system also provides information on which of the professions represented in the team has been in contact with the citizens.

84 per cent of the ACT-citizens receiving support in November 2012 have had contact with a social support worker within the last 3 months. The team leader explains that the reason why not all citizens have been in contact with a social support worker at that time is changes in the staff group as a social support worker had a new job and until replacement was found other team staff – for instance the nurse had the primary contact to the citizens who were attached to this support worker. 64 per cent has been in contact with the nurse, reflecting that many of the ACT-citizens also have health problems, and furthermore that the nurse generally aims at meeting with all ACT-citizens at some point in time after their assignment to the team. Almost one out of three has been in contact with the psychiatrist. 18 per cent has been in contact with the addiction councilor. 69 per cent has been in contact with the social office worker. A third of the citizens have been in contact with other staff which may be the case worker from the job center who has authority over cash benefits, and assignment to activation projects. The results clearly illustrate how the support which the citizens receive is multidisciplinary. This is where the ACT-method differs from ‘brokered’ case management, where the case manager facilitates access to mainstream support services.

Table 6: Which type of staff has had contact with the citizen during the last 3 months (citizens receiving support in November 2012).

Staff category	Per cent (count)
Social support worker	84 (46)
Social office worker	69 (38)
Social assistant	4 (2)
Nurse	64 (35)
Psychiatrist	29 (16)
Addiction councilor	18 (10)
Other	22 (12)
Total	100 (55)

### *8.1 Three dimensions of support*

There are three main dimensions in the support provided from the ACT-team. First, there is the social and practical support delivered mainly by the social support workers. Second, there is health related support – physical and mental – provided by the nurse, the psychiatrist and the addiction councilor. Third, there is ‘administrative’ support where the inclusion of the social office case worker and job center case worker as members of the team means that decisions regarding cash benefits and other kinds of social services can be dealt with in a flexible manner.

#### **Social support**

The social support covers many aspects of daily life – having somebody to talk to about challenges in everyday life, social relations etc. There is also a considerable element of practical support such as helping to keep order in the apartment, helping with doing the dishes now and then, and support to paying bills, and assistance to access other kinds of services not covered by team, such as going to the hospital, to the doctor or to the dentist.

Especially there is an intensive period of support when moving in, where the support worker both helps with practical things such as getting furnished, and the social and emotional adjustment to the new life in the apartment.

In the interviews the citizens generally describe their relation to their social support very positively. Several of the interviewees emphasize the crucial importance of the support they receive from the team. Some explicitly states that without this support they would not be able to live on their own. Asked about what he thinks about the support he receives, an interviewee says:

Interviewee: “It has been good. She [his support worker] comes once a week, and we start by opening my mail, and take care of my bills, and she follows me to the tax office to fix it. I am in activation [a job activation programme], but I have not been there for a month, because a friend of mine is living here, and he goes on my nerves. ‘Nothing will happen with your money, don’t worry, we will make sure there will be no sanctions’...She is....I call her, and then she calls me up in the morning and makes sure I will go to the activation...”

Interviewer: “And do you feel you can get in touch with her when you need to?”

Interviewee: “Yes I can, I call her, and if she is off, she calls me back in the morning.”

Interviewer: “What if you imagine that you did not have Else [support worker] to help you with your bills and..?”

Interviewee: “Then I would not have had this [apartment].”

Interviewer: “Then you would have lost it again?”

Interviewee: “Yes I would, then I would not have had this.”

Interviewer: “So you feel that it is what makes you being able to live here?”

Interviewee: “Yes, I get a lot of help, when I need it”.

Another interviewee says that previously he had often felt let down by the social system, but has had a very different experience with the ACT-team. He explains about his initial contact with the social system when he was assigned to the project that he was offered help by ‘the system’, and that he felt he was recognized as being somebody, and that he was asked ‘what can we do for you’. The interviewee is a non-native Danish speaker, his wording is:

“Before I got my apartment my motivation was high. I often had an overdose. Then the system comes and says we can help you, so I am happy. I had many times an overdose, in hospital, it was enough. The contact with the system, the authorities, the confirmation that you are here, what can we do for you.”

Asked what he thinks about the support he gets from the team he says:

“It gives confidence. If I don’t feel well, then Jane [the nurse] comes...hi...and Jens [social support worker]...how are you. It gives.....ah...not acknowledgement [he is looking for the wording]...but that I exist.”

### **Health support**

The team includes a full time nurse, a part-time psychiatrist (two days a week), and two part-time addiction councilors each working one day a week for the team. The psychiatrist also specializes in addiction problems, and consults on physical/medical problems of the citizens.

The nurse describes how she sees all citizens shortly after their enrollment, to assess their need for health related support. She estimates that at the time of the interview she regularly sees about 20-30 of the citizens. Most of them she sees every second or third week, but at times there are citizens she visits almost on a daily basis, especially if they have acute sores. The psychiatrist assesses that he has been in contact with about half the citizens attached to the team, and that at a given time he is in contact with about 15 citizens. The addiction councilor estimates that she currently has contact with 10 citizens, and so we may assume that the two addiction councilors altogether are in contact with about 20 citizens. However, as mentioned the number of citizens with contact with the addiction councilor has fallen toward the end of the observation period.

There are many kinds of physical problems among the citizens. Many have lung problems, sores or heart problems. Some have stomach ulcers, and some have HIV or hepatitis. The nurse describes how she assists the citizens both in case of hospitalization and in their contact with general practitioners. Especially the contact with general practitioners can be a challenge as some doctors are not very sensitive to the needs of these citizens.

Another issue concerns the coverage of costs for pharmaceuticals. In the Danish health system there is a partial user fee up to a certain level of expenditure for pharmaceuticals. For some of the citizens it can be difficult to pay for such expenditure. According to the health staff it could be a help if there was a budget to cover smaller expenditure for pharmaceuticals. Very recently the team has established a small medicine budget on a trial basis for a few of the citizens.

The nurse describes how some of the ACT-citizens begin to have a need for more intensive nursing care, and especially how such needs may further develop in the future as the citizens get older. Hidden care needs may also appear as citizens leave the life on the streets behind, where such

needs have not been attended to, or repressed. A general challenge is whether staff to attend such care needs should be integrated into the team, or whether care services should be provided by the specialized care unit in the municipality which provides such support. For a few of the citizens contact with the municipal nursing care and/or the municipal home care support (help with cleaning, grocery shopping) has already been established.

Almost all the ACT-citizens have addiction problems, either alcohol or hashish abuse or abuse of hard drugs. About 14 of the citizens are receiving substitution treatment for heroine addiction. 10 of these follow treatment in ordinary addiction treatment centers and four receive such treatment through the team, through an arrangement with addiction treatment centers which covers the expenditure of the substitution medicine. A practical challenge is that the team does not have resources to deliver substitution medicine daily or more times a week in the citizens own home for more than a few individuals, as this will otherwise be too time consuming. At the same time the team can only deliver non-methadone substitution medicine, as there are not adequate storage and safe-keeping facilities available. This has set a limit on the number of citizens in substitution treatment who can be assigned to the ACT-programme and who are not capable of following substitution treatment at ordinary addiction treatment centres.

Besides the receivers of substitution medicine, many of the citizens have an alcohol and/or hashish addiction. The addiction councilors offer the possibility of counseling in the citizens own home. The interviewed addiction councilor explains how the treatment she gives to the ACT-citizens, is similar to the treatment she gives to clients in the addiction treatment center where she works the rest of the week. She talks to the citizen about how things have been since the last visit, if anything has been different, if substance consumption has gone up or down, and about strategies to change addiction patterns. She also has the possibility to draw up recommendations for assignment to more intensive treatment such as full-time treatment at a treatment facility.

Asked what she thinks about this form of floating addiction counseling provided through the ACT-team she says:

“I think it is a really good solution for this group. As I work at an intake unit [of an addiction treatment center] the other days, I see all the new clients – how many schedule an assignment meeting but then never show up. This is the group whom this solution helps. I could imagine that this could become a permanent solution for all the addicts who live in the street. If a reduction of substance abuse in Copenhagen should be achieved, this would be my recommendation.”

However, no requirement to follow addiction treatment is placed upon the citizens – it is an offer for those who want this option. One of the interviewed citizens with an alcohol abuse explicitly states that he does not want any addiction treatment. He describes how previously, when he was still homeless, he was met by a requirement from the job center to start alcohol treatment, and as he refused, he lost his cash benefit. Asked about whether the ACT-team has set any requirements about treatment he says:

Interviewee: “No, they know that as soon they start doing so – then fuck – then I don’t want the apartment or anything else”

Interviewer: “So that is none of their business?”

Interviewee: “No neither the municipality nor the job center. They know. Otherwise I will return to the street. It was the only requirement I stated - I will not receive any kind of treatment. I don’t smoke hashish, I don’t do drugs or pills, but I will drink my booze as I want to, and nobody should interfere with that.”

According to the psychiatrist few amongst the ACT-citizens have severe, psychotic disorders. There are a few with paranoid symptoms who may have schizophrenia, but who refuse psychiatric treatment. He also assess that a substantial part have personality disorders, and others have post-traumatic stress disorders. There are also some with depression and anxiety disorders, and some who are in treatment with anti-depressives. Here it should be taken into consideration that individuals who are already in treatment in the psychiatric system, are generally not assigned to the ACT-team, and that the ACT-citizens with psychiatric problems are therefore typically also substance abusers, for whom it has been difficult to follow treatment in the ordinary psychiatric treatment system.

### **Administrative authority in the team**

There is also staff with administrative authority from the social office and the job center in the ACT-team. Job centers have authority over cash benefit payments and the assignment to social activation programmes which are required to attend to receive cash benefits if the citizens is capable to attend such activities. Accordingly, the jobcenters also administer the sanctions imposed on the citizen if he or she does not participate in the required activation programmes. Such sanctions first of all consist of withdrawal of cash benefits, which can lead to rent arrears, and eventually an

eviction may be a consequence. The social office has authority over all other kinds of social support the citizen may receive, such as the ACT-support in itself, other forms of support in the home – nursing care, home care – and also one-off cash support for unforeseen expenditure.

The interviewed staff generally expresses that it is a great strength of the ACT-team that the staff members with administrative authority are part of the team, so that no other appointments need to be made with social office or job center staff. The interviewed citizens generally express that they get a lot of help from the team with administrative issues. One of the interviewees says that besides having got a place to live, one of the best things is that the support worker can easily help him to take care of administrative issues, which he has previously had very difficult to deal with.

The case worker from the job center describes that besides the administration of cash benefits, an important aspect of her work is to facilitate access for the ACT-citizens to various forms of activation projects. She describes how her presence in the team strengthens the sensitivity of the system to the capabilities of the citizens. For instance in the critical period of moving into own housing where the citizens must start to pay rent, she helps to ensure that they are not met by sanctions which could lead to failing the rent payment. She facilitates access to activity projects for those citizens who are capable to participate in such activities, and which gives a possibility for meaningful activities and social contact in everyday life. About 10 of the ACT-citizens participate in such activities. One of the interviewees describes how he participates in such an activation project working in a forest outside the city three days a week, and how he appreciates this work.

Though the presence of the social office worker and the job center worker in the team has made many administrative procedures easier, there are still challenges which some of the citizens find difficult. A particular challenge is old debts. When a citizen gets an address, creditors start sending claims for repayment. One interviewee describes how as soon as he got a regular address he started receiving claims of repayment of personal debt of various kinds. For instance he has debts to the public transportation authorities for unpaid train fines. He feels stressed by these claims which cause a lack of clarity about his financial situation. Some of the interviewed staff also raises this problem but there is no immediate solution to this issue.

Table 7 shows how many of the ACT-citizens have an action plan at first and last report for citizens who received support in November 2012. As mentioned earlier a few citizens have declined to have registrations made about them. A social action plan (a so-called §141 action plan) is an overall social plan for the citizen about support needs, interventions and how to improve the citizens life situation. The citizen can decline an offer to make an action plan. The lack of social action plans

for vulnerable groups has often been pointed to. The national homelessness count from 2011 showed that only 21 per cent of the homeless had a social action plan (Lauritzen et al., 2011). From the first recording to the last the number of ACT-citizens with a social action plan increase from only 22 per cent to 65 per cent and with further 15 pct. having a social action plan underway. This shows how the ACT-support also facilitates for social action plans to be made.

Table 7: Does the citizen have a social action plan. Per cent.

	First report	Last report
The citizen has a social action plan	22	65
A social action plan is in preparation	15	15
The citizen has no social action plan, but has been offered one within the last 3 months and declined the offer	2	4
No, the citizen has no social action plan and has not been offered one within the last three months.	51	13
Don't know	11	4

N=55



## 9. Housing outcomes

A fundamental element in the housing first approach is that a permanent housing solution should be provided early in the course of an intervention process together with floating support to enable the formerly homeless individuals to live on their own. As mentioned earlier, both ACT and ICM have proven to be effective methods of social support (Coldwell & Bendner, 2007, Nelson et al., 2007).

A first question is how we should measure the housing chances of participating in the ACT-programme? When individuals are assigned to the ACT-team, they are typically still in a homelessness situation. Being assigned to the project in practice also involves an assignment to housing. Depending on the type of housing the individual is assigned for, there may be a waiting time before housing is available. In Tsemberis' study (Tsemberis et al. 2004), housing stability is measured as the proportion of total intake, who is housed at different times of follow-up. This means that in the beginning relatively few are housed, then in the period where housing is obtained the share who are housed increase steeply. Eventually some lose their housing again and the rate who are housed may therefore decline again. The long term housing stability rates (at one and two year follow up) in Tsemberis' study are around 80-85 per cent. However, there is no report on whether those not in a stable housing situation were housed at some point, and lost the housing again, or whether they were never housed in the first place.

Thus, a question is whether housing stability/exit from homelessness should be measured as the proportion of all individuals assigned to the project at a given time, who are housed, or if it should be measured as the proportion of individuals assigned to housing, who maintain their housing, with the support from the ACT-team. In this study we will measure housing stability (chance of exiting homelessness) as the proportion amongst those who are actually housed through the project and who maintain their housing throughout the observation period. Thereby individuals still waiting to be housed through the project are excluded from the measurement. A reason for this is that including individuals waiting to be housed into the measurement of housing chances, would mean that the waiting time to obtain housing and the practices of assigning individuals to the programme in relation to this waiting time would influence the measure of housing chances. By measuring housing outcome as the proportion, who remains housed amongst those who were housed through the programme we get a clearer measure of the effectiveness of the ACT-support on chances to exit homelessness and staying housed.

Due to the set up of the monitoring system, it is not possible to determine the housing situation at specific follow-up intervals for each participant individually. It is only possible to extract whether

a participant is still housed at each measurement time independent of individual start-up time. Therefore, the outcome measure of housing stability is calculated as the share of participants who were initially housed through the project and who are still housed. Additional information has been provided from the team about the housing status of the citizens.

Of the 92 citizens who have been assigned to the programme until January 2013, 80 have been housed, while 12 are waiting to be housed. Most of those waiting to be housed have been assigned to the team very recently.

Of the 80 citizens who have been housed so far, 26 were at first housed in independent housing, 28 in the two group homes, 11 in the first communal housing unit (tower block), and 14 in the newest communal housing unit (row houses), and 1 person was housed in alternative housing ('skaeve huse').

9 of the housed citizens were already living in one of the two groups homes at the start-up of the ACT-programme. These citizens were assigned to the ACT-team because of a need to strengthen the provision of support at this group home. We exclude this group from calculating housing outcomes in the following as these nine individuals were not as such homeless immediately before their attachment to ACT-support.

In the analysis of housing outcome we also exclude 5 individuals who have died during the period. According to the team leader these five individuals all remained housed until their death.

Furthermore we exclude from the calculations of housing outcomes two citizens who have moved from the initial form of housing (independent housing and group home) and into long-term nursing homes, due to extensive physical care needs. Here it shall be taken into consideration that individuals who have experienced homelessness and substance abuse for many years often develop physical care needs relatively early – often when they are in their fifties.

We include into the calculation of housing retention rates two citizens who during the project period have decided to move to another town and thus to leave the project. According to the team leader both individuals voluntarily terminated their tenancies and both individuals are now housed in their new municipality.

In the following we analyze the housing outcomes for 64 citizens who have been housed through the project, excluding the 16 citizens mentioned above. Of these 64 citizens 20 were initially housed in independent public housing while 44 were housed in one of the communal housing units or group homes.

Table 8 shows housing outcomes by initial housing type in terms of the rate who are still out of homelessness (housed in any housing) in January 2013, and the rate of housing stability, defined as those still living in the same place they were initially housed.

Table 8: Housing outcomes in January 2013 by initial housing type

Type of initial housing	Housing outcome, January 2013		Total
	Housed in any housing	Housed in initial housing	
Independent, public housing	95 % (19)	85 % (17)	100 % (20)
Communal housing	93 % (41)	68 % (30)	100 % (44)
Total	94 % (60)	73 % (47)	100 % (64)

Four citizens have returned to homelessness during the observation period. Three of the four were evicted. Three of the four also no longer receive support from the ACT-team, due to individual reasons. One of the citizens who have returned to homelessness had been housed in independent housing and the rate who remains out of homelessness for those initially housed in independent housing is 95 per cent (19 out of 20 individuals). Three of the citizens who have returned to homelessness were initially housed in communal housing and the rate who remain out of homelessness for those initially housed in communal housing is 93 per cent (41 out of 44).

The disparity between the number who are still housed and those who have remained housed in the same housing over the whole period is explained by a number of replacements from the initial housing to another kind of housing.

Amongst those initially housed in independent, public housing 85 per cent (17 out of 20) remained housed at the same place during the observation period. Amongst those initially housed in communal housing, 68 per cent have remained housed at the same place throughout the observation period (30 out of 44). Seven persons have moved from communal housing or group homes into independent public housing. Three persons have moved from one place of communal housing to another. One citizen has moved from independent housing into communal housing. And as mentioned two persons have moved to other towns, one of these persons lived in independent housing and the other in communal housing.

It should be noticed that the citizens have different start-up times. Especially the citizens in the row houses all moved in during 2012, and most in autumn 2012, and so they have only been housed for a short time at the time of measurement in January 2013.

In table 9 we include only citizens who started in the programme during 2010 and 2011 and thus have been in the programme for more than one year at the end of the observation period. We still exclude five citizens who died over the observation period, the two who had moved to care homes, and the nine who lived in one of the group homes already at the onset of the ACT-support.

Table 9: Housing outcomes in January 2013 by initial housing type for citizens with start-up in 2010 or 2011

Type of initial housing	Housing outcome, January 2013		Total
	Housed in any housing	Housed in initial housing	
Independent, public housing	93 % (14)	80 % (12)	100 % (15)
Communal housing	90 % (26)	52 % (15)	100 % (29)
Total	91 % (40)	61 % (27)	100 % (44)

Amongst those initially housed in independent housing (during 2010 and 2011) 93 per cent (14 out of 15) remained housed in January 2013, and 80 per cent (12 out of 15) were still housed in the same flat in which they were originally housed.

Amongst those initially housed in communal housing (during 2010 and 2011) 90 per cent (26 out of 29) were still housed in January 2013, but only 52 per cent (15 out of 29) were housed in the same flat/room.

While the percentage staying out of homelessness is almost the same for those initially housed in independent housing as compared to those housed in communal housing, the percentage staying housed in the initial place of housing is clearly lower for those initially placed in communal housing, mainly reflecting a considerable number of relocations to other places of accommodation in the latter group, of which most have been relocations from communal housing into independent housing.

Another dimension is whether the citizens still receive the support from the ACT-team. A total of six citizens are still housed, but do no longer receive support from the ACT-team. One citizen does no longer receive ACT-support as support was no longer needed. Two persons no longer

needed the intensive support from the ACT-team and now they receive support from another municipal unit. Two persons have been moved to nursing homes with full time support and no longer receive ACT-support. One person receives on-site support in a group home which is no longer attached to the ACT-team.

As individuals waiting to be housed are excluded from the outcome measure above, and as it is not possible to measure follow-up time on individual level, the housing outcomes cannot directly be compared with housing outcomes in effect studies such as the study by Tsemberis et al. (2004). We also cannot compare the housing chances for the ACT-programme to a control group. However, a rate of about 90 per cent remaining housed (including internal replacements) so far, is very high. In this way the results show that the ACT-programme is highly effective in bringing homeless individuals out of homelessness and keeping them housed.

However, the considerably lower housing stability rate in the communal housing units reflects an experience from the project that certain problems may arise from congregating many citizens with complex support needs, and especially substance abuse problems, at the same place. In the following section experiences regarding the different forms of housing are further explored.

## 10. Independent housing versus communal housing

A key question in the international research literature is whether housing should be independent, scattered housing in ordinary housing, or in collective housing such as communal housing and group homes, and whether the term 'Housing First' should be reserved to independent housing? This also involves the issue of the heterogeneity of the homeless group. Do different housing solutions apply to different subgroups amongst the homeless? Is independent housing possible for all, or is there a residual group for whom collective or institutionalized housing solutions are necessary – as the only alternatives for these groups are sleeping rough or staying in a homelessness shelter?

In the ACT-programme in Copenhagen both independent, scattered housing, and different forms of 'communal housing' are applied. The communal housing varies from the apartments with full individual facilities in the communal housing unit to the shared apartments in one group home and to a mix of both own flats and rooms with shared facilities in a second group home. During the second half of 2012 a new communal housing unit was taken into use consisting of small row houses with own facilities, but placed together at the same allotment.

Influenced by the experience that many citizens preferred independent housing, and the challenges that occurred in the different communal housing units, independent housing was increasingly used as a housing solution during the project.

At the second interview in January 2013, the leader of the project describes how it was decided during autumn 2012 to end the attachment of ACT-team to one of the group homes which is a private facility. The residents have been offered to move to other types of housing, and most have accepted this offer. However, one resident has decided to stay in the group home, and will receive on-site support instead of support from the ACT-team. The relatively low rate of housing stability (remaining housed in the same place throughout the observation period) in the group homes to a certain extent reflects this process of relocation of ACT-citizens from this group home to other forms of housing.

At one of the communal housing complex it has been decided by the municipality to offer the ACT-citizens to move to other accommodation if they wish. Most have accepted this offer and most will move to independent public housing offered through the prioritized municipal allocation system. A few have decided to stay in their flat in the complex. The flats which become vacant will instead be used to house citizens with mental illness under care in the psychiatric system and not part of the ACT-project.

In the qualitative interviews there are many reflections on the different housing types. There are indications that the independent housing has worked out better. The interviewed citizens living in independent flats are generally very satisfied with living in their own flat. Amongst the residents in the communal housing units there are mixed opinions. Some are happy about living in the communal housing units, whereas some dislikes living there and would prefer their own flat. Some residents in the communal housing unit criticize conflicts which have occurred in the house about the use of common facilities, but at the same time appreciate their apartments and the social contacts they have in the house.

The team leader reflects on the different housing forms:

“We have the best results in our individual dwellings. No doubt about that. When the citizen moves into an ordinary stairway with ordinary people then you also change your behavior. It becomes a place you return to, to have peace and quiet, and pull oneself together, you have to be more normal, you cannot just scream and shout. Actually, there is a double effect – they both can have peace and quiet, and there are also some need to behave different, otherwise you get kicked out, or somebody comes and says something to you.”

She further reflects on the challenges which have occurred in the communal housing units:

“The place where things have been most problematic is [Communal housing I] (...) where the psychiatric service has 50 apartments and the homelessness team should have 20 apartments. And the old staff should provide support for the new residents. With common living rooms in the ground floor. That could only give problems and so it did. It was stigmatizing for our citizens...excluding...then they could use the living room and then they could not. There is a lot of work ahead for those who are going to work out there now.”<sup>2</sup>

However, she also says that communal housing can be a solution for some individuals:

“I will not say that the category housing is generally bad. It depends on how the citizens are met, and if it is citizens who prefer to live in category housing (...) some of them need to live close to others who are like themselves. To be able to knock at a neighbour’s door and ask if they should

---

<sup>2</sup> The support workers from the ACT-team has recently taken over the provision of floating support for the citizens living in ‘Communal housing I’.

have a beer and watch a movie in TV. I will not say that such housing is bad, it depends a lot on where and how they are located and what is expected.”

In one of the group homes the residents already lived in the place before the ACT-team was attached to the place. The support has been split between the ACT-team and two on-site support workers who were attached to the place at the same time as the ACT-team. The interviewed on-site support workers describe that before that time the place was utterly chaos. Windows at the ground floor were open at all times of the day. Mattresses and blankets were dispersed everywhere and up to 50 or 100 people – many of whom guests of the residents – regularly slept at the place.

The on-site support worker explains how contact to other services, such as the social office, job centre or addiction counseling is often very difficult for the residents and they need a lot of assistance in such contacts. He states that with the ACT-team providing these services directly to the residents, things have become much easier.

He reflects upon whether an alternative support model could be preferable where also regular social support would be provided by the ACT team instead of being delivered by the two on-site workers. He thinks that the current model works quite well, as there is a need for daily presence and support and that the residents know the two support workers very well. This view is generally shared by other staff members of the ACT-team. They state that due to the anchoring at the nearby shelter the two on-site support workers know the group of socially vulnerable homeless individuals with Greenlandic background very well, and have extensive experience in working with the group. However, some of the challenges in this group home is that there is an environment of heavy drinking, and that many guests of the residents hang around at the place most of the time.

A resident of this group home explains that she would prefer to live in independent housing and that she is not happy about living in the group home:

Interviewer: “How do you feel about living here?”

Interviewee: “It is not good. It is not.”

Interviewer: “How?”

Interviewee: “Because then visitors come here in the morning. They drink. They make noise. I cannot be healthy here, not really. So, I would like to move.”

Interviewer: “Where would you like to move to?”



Interviewee: "I would like to move to a flat."

(...)

Interviewer: "So, there is a lot of drinking going on?"

Interviewee: "Yes, there is. I get weak, you know, from drinking. Then the guests come. They drink. It is better to control that yourself...".

Interviewer: "Yeah?"

Interviewee: "It gets all full and then they argue, and...[the interviewee makes a deep sigh]..."

Interviewer: "So living here is not what you would like - you would like to come out and live in your own flat?"

Interviewee: "Yes. Or I go crazy.

Interviewer: "Have you talked to the staff about this. Is this something they know?"

Interviewee: Yes, I did not want the keys and move in here. But where else could I go?

She also describes how it is difficult for her to have her family visiting her in the group home, especially her (adult) children.

Another resident in this group home also describes how the environment at the place is marked by the extensive alcohol consumption of the residents:

Interviewer: "What do you think about living here?"

Interviewee: "I don't know [...] there is a lot of drunk people."

Interviewer: "Is there often drunk people, you think?"

Interviewee: "Yes, every day."

Interviewer: "What do you think about that?"

Interviewee: "I am tired of drunk people. I have had a break for a month now."

Interviewer: "Yes, where you have not been drinking or...?"

Interviewee: "Yes. I am having a break."

Interviewer: "Besides the drunk people, what do you think of being here?"

Interviewee: "When it is quiet, it is okay".

Interviewer: "And how often is it quiet?"

Interviewee: "When I say so! (laughs)"

Interviewer: "Okay, when you say so. How much do you talk with the other people here?"

Interviewee: "When I want to. I just don't like watching people drinking."

Interviewer: “Yes, and you think people are drunk much of the time?”

Interviewee: “Yes! You have to yell at them to get them out. Otherwise I can’t.”

Interviewer: “Is it also people from the other floors and so?”

Interviewee: “It is all kinds of people. Homeless, and some living at other places. Everybody.”

Amongst the residents in another of the communal housing units (Communal housing I) with a mix of ACT-citizens and mentally ill residents, there are mixed opinions about living at the places. The residents live in independent apartments with full facilities (kitchen and bathroom) and the interviewees at this place generally express satisfaction with their apartments.

One interviewee in the communal housing unit describes how at first she wanted to live in an independent flat. However, then she got second thoughts as she had previously been evicted following a period of turmoil and heavy substance abuse after her boyfriend died. At the same time she has severe health problems, and she describes how she expressed a preference to move into the communal housing unit. She says:

Interviewee: “I actually think it would be best for me to move into a communal house, where there is staff and so, so that I can get some help. I am very ill, I have an inflamed pancreas, and I have colitis, stomach ulcer, cirrhosis of the liver, a weak heart, and reduced lung function and so on. I was afraid the same would happen again, that I would sit cooped up in my apartment. I was not a dry alcoholic back then, so I knew that if I moved into an apartment it would all be the same again. So I said it would be best if I moved into a common house, and explained to them, what I have just told you. They could see that, so we agreed...and I asked about how it worked, because I did not want to move into a communal house if it was something with sitting and eating together, or if you did not have your own kitchen or room, or if they could just come and lock themselves into my apartment, or if I just got a small room as it is in some group homes, where you get a tiny room. So I asked how it was, and it all sounded fair, I would have my own toilet and bath, and my own kitchen and should do my own cooking, and they could not just lock themselves in – just in case it smelled like death and they got a suspicion that I lay dead in here, or they had not seen me for a long time and did not know where I was. I thought that sounded fair enough. It was also one of the reasons why I wanted to live in a group home. Not that I am afraid of dying, but I don’t want to die, but I am not afraid of dying. I am not afraid of dying, but I am afraid of the pain, and all which comes along. I would also like to stop drinking, and I knew I could never do that alone in an

apartment, and sitting alone. I would also like to learn to know new people, people who were not drinking, and I was told that many out here have had the same problem like me, and that many were dry now and stabilized the way I am too, now. So we ended up agreeing that to begin with I could move out here, and then we would see.”

She generally expresses that she appreciates her apartment, and she also describes how she has a good contact with some of the other residents. However, she reflects critically on the change of rules in house restricting the access to the common rooms for the formerly homeless residents:

Interviewee: “I must admit that when a new leader started in December, I went berserk and wanted to move out”

Interviewer: “You mean out here?”

Interviewee: ”Yes, here. When Jacob [leader in the house] started as a new leader, I don’t know if you know about that, but when I moved in, it was a ‘common’ house, but it isn’t now because the new leader started in December and he changed everything. Before we had a smoking room downstairs where we could sit and talk in the night, the day and the morning, and we could sit in the living rooms. Now us under ACT, we cannot sit in the living rooms, only if we get invited by somebody with a key (...) That is when I fell of the wagon again and started drinking, I drank for a few months, and then I started antabuse. (...) This is something that gets on my nerves, that it is no longer a common house. Then I start thinking of moving away, but then again...not...because I can still feel I need the support and help I get.

Another resident in ‘Communal housing I’ reflects on the restrictions in the access to the common facilities:

Interviewee: ”I think a lot has been changed since I moved in, I am thinking, I pay about 5400 DKK in rent a month and then I am thinking, what about those who live from the first to the fifth floor (the mentally ill, ed.), they must pay about the same rent. Why should they then have other and better possibilities?”

A third resident in ‘Communal housing I’ explains how he is very satisfied with his apartment, and that it is a great relief compared to living in a homeless shelter and on the street. However, he feels

he is a bit far away from old friends, and would like to move closer to a neighborhood where he has more friends from his life on the streets. He expresses satisfaction to live among other formerly homeless people, as they give him company. However, he also has some critical reflections about the house as he compares the building to a hospital:

Interviewer: What do you think about living here?

Interviewee: “It is awesome. It is a nice apartment, look at all these flowers everywhere.”

Interviewer: “So you are very happy about it?”

Interviewee: “mmm....it is nice to get you own apartment, instead of living at...such a...shelter...ahm....because there [at the shelter] is a lot of....what is it called....pee in the hallway, and you cannot have visitors and so. Here I can have visitors all day.”

Interviewer: “So you can decide on your own. Did you live in a shelter before you moved in here?”

Interviewee:”Yes, and on the street”.

Interviewer: “It must have been quite a change moving in here?”

Interviewee: “Yes I have started up activation and everything”.

Interviewer: “Yes? What kind?”

Interviewee:”It is down at the church, what is it... ‘Hus Forbi’ [name of homeless street paper]...no no the morning café for homeless.”

Interviewer: “In what church it is you say?”

Interviewee: “[name of church]”

Interviewer: “So you come there?”

Interviewee: “Yes, it goes very well.”

Interviewer:”That is great, you also look happy?”

Interviewee:”Yes” (smiles)

Interviewer: “What about the help you from Dorthé [support worker] and the others?”

Interviewee: Well....Now I live here in [Communal housing I], but I would like to move back to [name of another neighborhood] I spend most of my time in [name of another neighborhood]....so....I like the flat, but I would like to move back to [name of another neighborhood].”

Interviewer: “Because you are used to be there, and know people there, and it is a little far to go?”

Interviewee: “Yes”.

Interviewer: “What do you think about that there are many people with the same background in the house, that is, many others who have been homeless?”

Interviewee: “I think it is good, because we talk to each other every day.”

Interviewer: “So there is somebody to talk to?”

Interviewee: “When they come home, they knock on the door and ‘hi, hi’.

Interviewer: “Besides the distance to [name of another neighborhood], is there anything else you don’t like about living here?”

Interviewee: “It looks like a hospital everywhere, I think I get tagged as a mentally ill person, because they all look like mentally ill.”

The fourth interviewee in ‘Communal housing I’ express that he likes to live in the house and that he is very happy about his apartment. He also express that he doesn’t bother that the other residents in the house are also formerly homeless individuals, but it is also evident that he tries to keep the other residents a bit at a distance:

Interviewer: “What do you think about your flat?”

Interviewee: “For me it is paradise. I was afraid of contact with people, I shut myself away. But then I get contact and we talk [here he primarily refers to talking with the support worker] . I love to be here. I can cook”.

Interviewer: “What do you think about the house?”

Interviewee: I stick very much to myself. I have not had much contact with the staff. I can talk to Jens [support worker, name changed], and the nurse. It does not bother me who lives here. But it can be a little...if people know me from the street and wants to come here. Then I say I have guests. My family. I only want my family here. My son, who sometimes stay over.”

Interviewer:”Do you have any contact with the other residents?”

Interviewee:”Sometimes they ask if you have some money. The first times I gave a little money. But then suddenly it becomes a hundred crowns, and then a bottle of vodka. And then I get afraid of starting drinking again”.

Later in the interview asked about whether he prefers to live in the house with other formerly homeless, or he would like to live at another place, he says:

“For me it doesn’t matter. Sometimes friends ask, where do you live? Ah...in [Communal housing I]...ah that is where all the mentally ill live. But I don’t care. If you live with normal people you don’t know your neighbor, here I know everybody. Good morning. Good day. I don’t care what people talk about, what they say. It does not bother me. I am happy here, I don’t think of moving. Perhaps one day, but not now.”

During autumn 2012, yet another place of communal housing was attached to the ACT programme, consisting of 18 row houses with separate entrances and all with full facilities (kitchens and bathrooms).

Like in the large communal housing complex there are mixed opinions about living in this place amongst the interviewees. Besides some problems with building defects the interviewees express satisfaction with their apartments. A large group amongst the residents already have quite a lot of social interaction with each other but from the interviews it is also clear that much of this interaction centers around substance use.

One of the residents who has quit a long-lasting alcohol addiction expresses general satisfaction with his flat but also states that he has to stay outside the social community amongst the residents to avoid falling back into alcohol addiction:

Interviewee: “I don’t mix with anybody here. Because I have this with alcohol, I have to stay all away. It has nothing to do with the people. I have been part of such people for many years, and it has to end now. It is too easy to get carried along.”

Interviewer: “Then how is it here, as there are quite a few who drink here?”

Interviewee: “It is like all other places, but I guess I am surprised that it is actually quite peaceful. You can here when they have had ...aarhh....but that is the way it is.”

Interviewer: “And how is it, can you stay away from it or?”

Interviewee: “I hope, I can. I say hi to them and so, but I do not get involved with them. And it is only about me, it has nothing to do with them. But I do so, because otherwise – I could get into something, and I don’t want that anymore.”

In this way there are mixed experiences with housing amongst the ACT-citizens in the communal housing units. Some of the problems well-known in the research literature arising from gathering

many people with complex social problems – and especially citizens with addiction problems – at the same place have also occurred in the communal housing units attached to the ACT-programme. As there may be an element of selection to the different housing forms used in the programme, it is not possible to assess how the situation of these individuals would have been like, if they had been assigned to independent housing. However, as mentioned earlier, it has been decided to offer the residents in the large communal housing complex relocation into independent flats in public housing if they wish so.

The interviewed citizens who have been housed in independent housing in ordinary public housing, generally express, that they are very satisfied with living on their own. One of the interview persons who lives in independent housing at the time of interviewing, at first lived in the communal housing unit, from where he was then evicted. He was then rehoused in independent housing after a waiting time of three months, where he lived on the street, or stayed in shelters. He reflects on the experience:

Interviewer: “So you lived at [Communal housing I] first?”

Interviewee: “Yes, in the collective house, or what it is called. But it was...you don’t know me so well, but you see how I live now...I don’t need somebody to come and wake me up each morning and wipe my ass. They forgot to tell me it was an institution. – ‘Oh no, this is certainly not an institution. Some of the other apartments we got, is an institution, but this is something different’. But no, it was not. (...) It was all too institution like. We were hardly allowed to be there. It was like in the old days where it said: Tradespeople should use the kitchen stairs. We should too, or they would have liked us to do. Why should I pay for a common laundry room, when I am not allowed to use it?”.

He later in the interview reflects on his new apartment which is located in an ordinary block of flats in public housing:

“I am happy about this, I am fully happy about moving out here. What I was not happy about was that...they should not have put me at that other place before.” However, the interviewee has many acquaintances among the homeless and he also reflects that there might be other homeless individuals who might need to live in a place like the communal housing units. He says “I know many who might need that kind of apartment in [Communal housing I], with that kind of support”.

Another of the interviewees who lives in an independent apartment, describes that he would initially have preferred to live in a place with other formerly homeless individuals:

Interviewee: “At first I should have been in...what is it they call it...this homeless housing they make....but it kept getting postponed. Then they asked if I would like to have an apartment instead, and I said I would like too.

Interviewer: “Why would you have preferred the other [flat] to begin with?”

Interviewer: “To be with people I liked.”

Interviewer: “What then here when they [other homeless] are not here?”

Interviewee: “There are many former homeless people who live around here. I did not know that, but there is. It helped a lot.”

Interviewer: “So what do you think about moving in here?”

Interviewee: “At first it was difficult. I was more outside, I also slept outside. Also here sometimes, but in the beginning, I slept outside a lot.”

Interviewer: “Have you gotten more used to it now?”

Interviewee: “Yes I have, I think I am home everyday. I sleep here every night now. Unless I stay with some friends. I am home a lot, because here is peace and quiet. It is something which I have always liked, peace and quiet. No noise and not talking to people. I am much better at that. But to begin with it was difficult.”

Interviewer: “So what do you think of living here now?”

Interviewee: “I like it, and my dog loves it”.

Two of the interviewees who lives in independent apartments explain that at first they were offered a flat in [Communal housing I], which they both turned down. One of the interviewees explains that he turned down the offer, as he did not want an apartment with only one room. Instead he was then offered a two-room apartment in ordinary public housing, where he now lives. He expresses great satisfaction with his apartment and about living on his own. The other interviewee explains that he is trying to get out of his substance abuse, and that he did not want to live at a place with other substance abusers, but instead wanted an apartment of his own. He also expresses great satisfaction with his apartment and about living on his own.



Asked about whether he would like to live in on his own or in a communal house one interviewee in an independent apartment states that he prefers to live on his own:

Interviewer: Would you rather live here in your own flat, or would you have liked to live in a place with other formerly homeless people?

Interviewee: No, I would rather have my own, that's for sure, if I shall have anything.

Interviewer: Why is that so?

Interviewee: I want to be able to close my door and say – now I don't bother anymore, it is mine. I don't like the communal house. I talk with a lot of people on the street every day.

Another interviewee in an independent apartment reflects on what he is feeling about living on his own:

Interviewer: “How was this change suddenly to....?”

Interviewee: “It was wonderful, you can go in and be yourself and close the door.”

(...)

Interviewer: “How does it work out now, you think?”

Interviewee: “It works out very well. Better than it did elsewhere, here it works out very well.”

Interviewer: “What is it, that makes the difference?”

Interviewee: “I can go in and close the door, and be myself, and invite friends home, that is those whom I want and those whom I don't want.”

In this way, the experience amongst those living in independent flats is that they are very satisfied with living on their own, and prefer to live on their own and not in a group home or communal house. They also express that they get very good support from the ACT-team, and some explicitly states, that if it was not for this support they would not be able to live on their own. However, there are a few of the citizens living in independent flats who have issues with old debts that is being collected now that they have a fixed address, and they express how this is stressful and strains their economic situation.

All in all, it is an important result from the programme, that with the multidisciplinary support from the ACT-team it is possible for individuals with complex support needs to live on their own in independent housing in ordinary public housing.

## 11. Other outcomes

The monitoring system also gives information on other outcomes than housing. For each period it is registered whether the citizen has an alcohol abuse, drug abuse, abuse of hashish, physical health problems, mental problems, difficulty in maintaining practical daily functions (such as cleaning, doing dishes, grocery shopping), financial problems that makes it difficult to pay rent and utility bills and whether the citizen has a weak social network.

In the design of the monitoring system priority was given to 'keep it simple'. This means that the assessment is made by the support staff, and does not involve interviews with the citizen. It also means that only one simple question is answered for each of the issues mentioned above, with four answer categories – 'not at all', 'to a minor extent', 'to a certain extent', and 'very much'. In this way priority was not given to use already tested batteries of items and questions to assess for instance mental illness or addiction. Instead the priority was for the citizens not to be burdened with reoccurring interviewing, and for the staff not to spend too much time on documentation and administration and instead use their working time mainly on providing support for the citizens.

The following tables display the results on these questions from the first and last recorded entry for each citizen available from the last registration period in November 2012. As there is no information in the system on whether citizens have moved internally between the different housing types the tables are calculated for all ACT-citizens.

Table 10: Does the citizen in your opinion have an alcohol abuse? Per cent.

	First report	Last report
Not at all	18	24
To a minor extent	11	15
To a certain extent	27	29
Very much	42	31
Don't know	2	2

N = 55

At the first recording 69 pct. of the ACT-citizens had an alcohol abuse to 'a certain extent' or 'very much'. This figure decreased to 60 pct. at the last report.

Table 11: Does the citizen in your opinion have an abuse of hard drugs? Per cent.

	First report	Last report
Not at all	65	65
To a minor extent	5	11
To a certain extent	11	15
Very much	16	7
Don't know	2	2

N = 51

The majority of the ACT-citizens are not abusers of hard drugs. At first report 27 per cent had an abuse of hard drugs to a certain extent or very much. This figure has fallen to 22 per cent in the last report.

Table 12: Does the citizen in your opinion have an abuse of hashish? Per cent.

	First report	Last report
Not at all	24	31
To a minor extent	13	18
To a certain extent	29	33
Very much	27	13
Don't know	7	5

N = 51

Contrary to hard drugs, many of the ACT-citizens are hashish abusers. 56 per cent had an abuse of hashish 'to a certain extent' 'or very much' at the first report, however decreasing to 46 per cent at last report.

Table 13: Does the citizen in your opinion have physical health problems which is a problem in his or her everyday life? Per cent.

	First report	Last report
Not at all	13	13
To a minor extent	35	36
To a certain extent	29	31
Very much	18	16
Don't know	5	4

N = 51

47 per cent at both first and last report was assessed to have physical health problems to a certain extent or very much.

Table 14: Does the citizen in your opinion have mental problems or mental illness? Per cent.

	First report	Last report
Not at all	7	4
To a minor extent	27	31
To a certain extent	38	40
Very much	22	24
Don't know	5	2

N = 51

A high number of the ACT-citizens are assessed to have mental problems or mental illness to a certain extent or very much with 60 per cent at first and 64 per cent at last reports.

Table 15: Does the citizen in your opinion have difficulties in maintaining daily practical activities such as doing the dishes, cleaning or grocery shopping? Per cent.

	First report	Last report
Not at all	20	20
To a minor extent	18	27
To a certain extent	29	25
Very much	13	24
Don't know	20	4

N = 51

42 per cent at first report and 49 per cent at last report had difficulties in maintaining daily practical activities, the increase probably due a better knowledge about capabilities, as the 'don't know' category dropped from 20 to 4 per cent. However, for almost half the citizens the answer is 'not at all' or 'to a minor extent' both at first and last report.

Table 16: Does the citizen in your opinion have financial problems which makes it difficult for the citizen to pay rent, electricity and heating? Per cent.

	First report	Last report
Not at all	22	4
To a minor extent	15	40
To a certain extent	40	40
Very much	11	15
Don't know	13	2

N = 51

51 per cent at first report and 55 per cent at last report are assessed 'to a certain extent' or 'very much' to have financial problems that make it difficult to pay the rent and utility bills.

Table 17: Does the citizen in your opinion have problems with a lack of or weak social network?  
Per cent.

	First report	Last report
Not at all	7	5
To a minor extent	27	25
To a certain extent	31	44
Very much	31	22
Don't know	4	4

N = 51

Finally, a large proportion of the ACT-citizens have problems with a weak social network. This is the case 'to a certain extent' or 'very much' for 62 per cent at first report and 66 per cent at last report.

In table 18 is shown for each item whether the assessment from the first to the last reporting has become more positive, unchanged or more negative. Cases with 'don't know' on either first or last report have been excluded.

Table 18: Change in assessment of social problems from first to last report.

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

For both alcohol, hash and drug abuse more citizens have had a positive than a negative change in assessment over the period. This may indicate that being housed and receiving support may help some citizens to stabilize or reduce their addiction problem.

However, for financial problems more citizens have a more negative assessment than a more positive assessment. This may reflect that with the housing comes also rent and utility payments and it may also reflect that with a fixed address creditors may begin to collect old debts putting a further strain on the citizen's financial situation.

For the other items the overall picture is that of status quo, rather than any progress. This picture is very consistent with what the citizens report in the qualitative interviews. Though some report to have reduced their substance use, only one of the interviewees reports to have totally quit an addiction, and most also report on difficulties in other dimensions of their life, such as health problems, and the need of support to practical matters in daily life and to getting their bills paid. However, they all express that becoming housed and getting out of homelessness is a major improvement of their situation.

These results raise the question of what is a realistic goal of housing first based interventions and ACT as an intensive kind of support given to individuals with complex support needs. Getting out of homelessness is an important success in itself whereas the reporting of no major changes in for instance addiction behavior or symptoms of mental illness should not be considered a failure of the intervention. On contrary, despite these complex problems, the ACT-support enables these individuals to get out of homelessness, become housed, and for the large majority to stay housed.

## 12. Conclusion

Almost all individuals who have been housed as part of the ACT-programme have remained housed until now. Of the citizens who have been in the programme for more than a year at the end of the observation period about 90 pct. have remained housed, with the support from the ACT-team, albeit a considerable number of citizens have been relocated to other forms of housing than the one they were initially assigned to.

The ACT-method is different from ordinary case management as specialized support is integrated into the team and also provides floating support in the citizens own home. Besides social support workers, a nurse, a part-time psychiatrist and a part-time addiction councilor are part of the team. Also case workers with administrative authority from the social office and the job center are integrated in the team. Thereby the team is capable of providing a very flexible support to individuals with complex support needs, who are not capable of using mainstream services.

The interviewed citizens express a very high degree of satisfaction with the support they have received from the team. Some explicitly says that if it was not for the help they get from the team, they would not have been able to live on their own. The citizens generally express that they get the help they need and that they easily can get in touch with their support worker if they have a problem and need help. They explain how they get both social support – having somebody to talk to about their life, and practical support such as help with getting bills paid, and help in the phase of moving in. Some have severe health problems and explain how they have received help from the health specialists in the team, including help when they need to go to hospital or to see a doctor.

Initially the programme was meant to be based mainly on communal housing. However, as there were very positive experiences with housing some of the ACT-citizens in ordinary public housing, it was decided to assign more citizens to ordinary housing.

The high number amongst the ACT-citizens who stay housed is found for both the citizens who live in independent housing, and for the citizens in the communal housing. However, especially for the citizens in communal housing quite a number of relocations to other forms of housing have taken place. This reflects that there have been certain problems attached to the use of communal housing units in the programme. In one of the communal housing units, which also houses a group of mentally ill citizens, the formerly homeless have been banned from using the common rooms in the house as conflicts have occurred. Some of the interviewees explain how these restrictions have felt offensive and stigmatizing. However, the residents in this communal housing unit at the same time express satisfaction with their apartments, and most of them appreciate the social contact with



other formerly homeless individuals in the house. In 2012 it was decided to end the attachment of the ACT-programme to one of the group homes, and offer residents relocation to other housing, and in autumn 2012 it was decided to offer the residents in another communal housing unit relocation mainly to independent public housing.

As randomization to the different housing forms has not been possible, no conclusive evidence can be given on the relative effectiveness of either independent public housing or communal housing from the study. However, the experience from the project points towards independent housing as the most optimal form of housing even for homeless individuals with complex support needs. From the interviews it seems that this is also the form of housing which most of the citizens prefer.

A very important result from the ACT-programme in Copenhagen is that with the intensive and multidisciplinary support from the ACT-team, it is possible to house even homeless individuals with complex support needs in independent, scattered housing in ordinary public housing.

## References

Benjaminsen L. & Christensen I., (2007) Hjemløshed I Danmark 2007. National kortlægning. [Homelessness in Denmark 2007. National survey]. København : SFI. 07 : 22.

Blid, M., (2008) *Ett folkhem for alla ? Kommunala insatser mot hemloshet* [A peoples home for everybody. Municipal interventions against homelessness] (Ostersund : Mid Sweden University).

Coldwell, C. and Bendner, W. (2007), The Effectiveness of Assertive Community Treatment for Homeless Populations with Severe Mental Illness: A Meta-Analysis, *American Journal of Psychiatry* 164(3).

Kertesz, S. G., Crouch, K., Milby, J. B., Cusimano, R. E., & Schumacher, J. E., (2009), Housing First for Homeless Persons with Active Addiction: Are We Overreaching? *The Milbank Quarterly*, 87(2), 495-534.

Lauritzen, H.H., Boje-Kovacs, B. & Benjaminsen, L. (2011), *Hjemløshed I Danmark 2011. National kortlægning*. [Homelessness in Denmark. National mapping, 2011], Copenhagen, SFI (11:45).

Nelson, G., Aubry, T., & Lafrance, A. (2007), A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless, *American Journal of Orthopsychiatry*, 77 (3), pp.350-361.

Thompson, K., Griffith, E., Leaf, P. (1990), A historical review of the Madison model of community care, *Hospital Community Psychiatry*, 41(6), 623-634.

Tsemberis, S., Gulcur, L. & Nakae, M. (2004), Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. *American Journal of Public Health*, 94(4), pp. 651-656.

Tsemberis, S. (2010), *Housing First. The Pathways Model to End Homelessness for People with Mental Illness and Addiction*. Center City, Minnesota: Hazelden.