

01:2012 WORKING PAPER

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INTERMEDIARY REPORT – AUGUST 2012

RESEARCH DEPARTMENT OF SOCIAL POLICY AND WELFARE SERVICES

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# Experiences from an ACT-program in Copenhagen

Intermediary Report – August 2012<sup>1</sup>

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## Summary

This working paper presents intermediary results<sup>2</sup> of a study of an ACT-program (Assertive Community Treatment) in Copenhagen, Denmark. The ACT-program 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 individuals who have 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 not only of social support workers but also of a psychiatrist, a nurse and 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.

This study is based on quantitative outcome measurement in an intervention group of about 60 homeless individuals who through the program has 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 ten citizens receiving the support and eight staff members of the team.

The study shows that a very high part – 95 pct. – of the individuals participating in the program remains housed throughout the study period. About half of the individuals have been housed in independent apartments in ordinary public housing. Amongst this group – all participants have remained housed. The other half has been housed in different forms of communal housing<sup>3</sup> – two group homes, and one large communal housing unit with independent flats. Amongst the individuals in communal housing 90 pct. have remained housed. It has not been possible to control for selection of participants to the different forms of housing.

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<sup>1</sup> This study is part of the research project 'Housing First Europe' which has been financed by the European Commission under the PROGRESS-programme. The study is also part of the evaluation of the national Danish Homelessness Strategy.

<sup>2</sup> A final report is expected in January 2013.

<sup>3</sup> Communal housing (or 'category' housing) is a term for housing units where all residents belong to the same or similar categories such as housing aimed at rehousing the homeless, or housing for mentally ill etc.

The qualitative interviews show that the possibility to attend different dimensions of support needs - social support needs, health needs and administrative support needs is crucial to the success of the ACT-method. Especially 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 communal housing units there are mixed experiences – most are satisfied with their apartments but there are also signs that gathering many people with complex problems at the same place creates negative synergy effects especially by maintaining an environment marked by substance abuse. Such unintended negative effects of congregating individuals with social problems in the same housing units are well described in the research literature.

All in all 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. Though no conclusive evidence can be given on the relative effectiveness on the different housing forms, due to possible selection effects to the different housing types, the experiences from the project point towards housing in independent, scattered housing as the preferable form of housing. The results also suggest that communal housing should be reserved for individuals who are not able to live in ordinary housing even with the intensive support of an ACT-team.

## **Introduction**

In 2010 an 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. About half of the citizens in the program have been assigned to independent scattered apartments in ordinary public housing and the other half have been assigned to three different communal housing units attached to the program. This paper presents and discusses experiences from the ACT-program based on quantitative data for the whole group of citizens attached to the program, and qualitative interviews with eight staff members and ten citizens.

## **Assertive Community Treatment – an evidence based method**

ACT is a method which originated in the field of psychiatric services. Following the de-institutionalization of psychiatric treatment in the 1960 and 1970 outreach psychosis teams were established in many countries to provide treatment and support for the mentally ill in a community setting.

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 programs 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 Pathways-to-housing program set up in New York City by Sam Tsemberis has become one of the most well-known examples of the housing first approach and the use of the ACT-method. In a manual for Housing First, Tsemberis (2010) describes how the Pathways program 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 program – 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.

An ACT-team is a multidisciplinary team of professional specialists such as social workers, a psychiatrist, an addiction counselor, 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, so that the individual does not need to access support from mainstream services. 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 the 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 treatment or a particular treatment outcome, such as 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 program is based on independent, scattered housing in the ordinary housing sector, instead of communal housing units where all residents have complex support needs (also known under labels such as congregate housing, integrated housing, category housing or group homes). 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 category 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. Most well-known is probably a study by Tsemberis et. al. (2004) where ACT in combination with independent scattered housing was tested against 'usual care'. With a follow-up period of 24 months the study shows that amongst the intervention group receiving ACT in combination with independent scattered housing about 80-85 per cent exits homelessness 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 study 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 program.

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 programs 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-program 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.

## **Method of the study**

The study of the ACT-program 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>4</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. No interviews are done with the citizens and the data is based on the assessment by support workers. 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 has been collected from the ACT-team.

Besides the quantitative data, the study is also based on qualitative interviews with team staff and interviews with citizens who receive support from the team. Qualitative interviews were carried out with the team leader and seven staff members. In total the team has 14 staff members including the team leader. Some staff members work only part time in the team. 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 counselor, 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 three category housing units and this support worker is not formally part of the ACT-team. This arrangement of attaching the ACT-team to category housing units with on-site support staff will be explained in a further section.

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<sup>4</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.

Thematized interview guides were made for each interview with a special focus on the treatment and support given by each particular profession. Each interview lasted about 1-1½ hour.

Ten 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 has been a general condition for being assigned to support from the team. The interviewees were eight men and two women, four were in 30-39 years old, four were 40-49 years old and two were 50-59 years old. Five lived in independent housing, four lived in a large communal housing unit, and one lived in a group home. Nine of the interviewees were Danes, of whom two had Greenlandic background. One had an other nationality than Danish.

Thematized 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 evaluator 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.



## **The ACT-project**

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 and 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 municipalities, mainly medium sized municipalities, received funding from the strategy, particularly aimed at strengthening floating support.

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 initiatives that developed social methods effective in bringing an end to individual 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 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 building 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. The definition of homelessness used in the count was based on an adapted version of the European ETHOS-definition, including main categories such as 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 program. 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 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 the full multidisciplinary character of the team had been achieved, and the team consists of a team leader, 7 full time social support workers, a full time nurse a part time psychiatrist who also specializes in addition 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. The annual budget is about 5 million Danish crowns (DKK) (about 650,000 €). According to the team leader the average yearly cost per citizen is about 85,000 DKK (about 11,300 €). This excludes housing costs. The citizens pay rent for their housing out of their transfer income.

## The citizens

In June 2012 a total of 76 individuals had been assigned to the program. 64 had been assigned to housing through the project so far. 12 of these were waiting to be assigned to housing and most of these had been assigned to the team very recently.

The assignment to the ACT-team is made by a general 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 support worker from the team is assessed not to be sufficient.

However, 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 program. These are for instance individuals with intensive care needs, or needs 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. Another group who in certain cases have been assessed not to be possible to house and support through the ACT-program are some active substance abusers with 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 three units of communal housing 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 a 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.

As mentioned earlier quantitative information on the ACT-citizens and the support they receive is reported in a monitoring system that covers all citizens receiving support under the national homelessness strategy. Two of the citizens receiving ACT-support have not allowed information to be reported to the system. Information to the system is entered four times a year and the latest available information is from February-March 2012. Additional information has been made available by the team for this study.

In the following demographics is shown for the 74 individuals who have been assigned to the project in total. For two citizens there is missing information on ethnicity.

Table 1: Gender of the ACT-citizens

	Count	Per cent
Female	22	30
Male	52	70
Total	74	100

Table 2: Age of the ACT-citizens

	Count	Percent
18-24	0	0
25-29	6	8
30-39	14	19
40-49	32	43
50-59	20	27
60+	2	3
Total	74	100

Table 3: Ethnic background of the ACT-citizens

	Count	Percent
Danish	41	57
Danish from Greenland	23	32
Other nationality	8	11
Total	72	100

Two individuals have missing information on ethnic background.

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 and upwards, with 40-49 year olds being the largest group.

89 pct. (64 individuals) are Danish including 23 individuals with Greenlandic background. 11 pct. (8 individuals) have another nationality than Danish.

The monitoring system also give information on the extend of various social problems among the citizens such as abuse of alcohol, hash and hard drugs, mental problems, and physical illness. A more specific account of these profiles in given in the section ‘other outcomes’.

## The housing

At the onset of the ACT-program a decision was taken by the municipality mainly to assign citizens in the ACT-program 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 for the project, as there is a general shortage of affordable, independent public housing for allocation under the municipal priority access scheme. A decision was taken, to provide housing in three separate communal housing units in the city. A further fourth unit should 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 time of interviewing in May/June 2012 almost half of the ACT-citizens had been housed in ordinary public housing whereas the other half had been housed in the three communal housing units attached to the program.

### **Independent housing**

29 citizens have so far been assigned to independent, scattered housing in the ordinary public housing sector, of whom two have since deceased. 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, the mentally ill, 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. At the time of interview the team leader assess that average waiting time is about 4 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 social welfare 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.

### **Group home - 'Colbjørnsens Gade'**

In the case of one of the category housing units, it was decided by the municipality that support from the ACT-team should be assigned to an existing group of residents 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 right next to the Central Station. In each flat the residents share bath and kitchen. 14 of the rooms are reserved for individuals from the Greenlandic minority group. 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 interviews. According to the staff interviews one reason why there are empty rooms at the place is that many potential residents don't want to live there and many would rather prefer to live in a 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 nearby homelessness shelter should be attached to the place and provide daily social support to the residents whereas the ACT-team should provide additional support within the professions of 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.

A total of 14 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 with 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.

### **Communal housing – ‘Bellahøj’**

Another category housing unit that has 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 the place had previously been a residential unit 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-program. 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 will over-go to the ACT-program as they become vacant. So far 11 apartments have become available for the ACT-program.

Each apartment consist of one room with own kitchen and a bathroom and with separate entrance from a regular stairway. The residents have their own permanent rental contract. 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 provided 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 has taken over the full support for the residents housed through the ACT-program. As will be discussed later, conflicts have occurred in this place about access to the common facilities for the formerly homeless residents, as it has been decided by staff in the house that the ACT-citizens cannot use the common facilities in the ground floor.

### **Group home – ‘Thorsgade’**

The third category housing unit which has been attached to the ACT-project is a smaller facility where there is room for 10 residents. Two of the housing units are semi-independent 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 category housing unit described above, the interviews point to certain challenges in this facility. The existing staff of the place did not have any experience with the ACT target group. Very recently it has been decided to end the attachment of this place to the ACT-program. A decision has been taken by the municipality to move the ACT-citizens in this place to other accommodation.

### **Future expansion**

It is expected for the ACT-team to expand the number of citizens receiving support from the team in near future. The team leader expects the number will eventually reach about 85 individuals. It is the intention to increase the number of citizens receiving support in independent housing. However, at the time interviewing there was a temporary halt in the assignment to independent housing as the existing support staff could not cover more citizens at the moment.

Moreover, a fourth place of ‘category housing’ is being added to the project with the first moving in scheduled for May 2012. The new housing unit consists of 18 small rowhouses – 1 or 1½ room each with own kitchen and bath. The place used to be a group home for mentally handicapped individuals. All interior of the houses has been rebuild. Based on the experiences from the existing group homes there will be no on-site staff, and no common rooms at this site and all support will be supplied from the ACT-team.

## The support provided

The monitoring system provides information of the extent of support given to the citizens. Table 4 shows how often support is given for citizens receiving support at the last period of reporting in February/March 2012. It can be noticed that 39 per cent of the citizens have received daily support. This reflects how the support given by on-site staff in the group homes has also been reported in the monitoring system. A further 38 per cent are reported to receive support once or twice a week. 16 percent have received support about every second week. Only 8 per cent (4 persons) have received support only about once a month or less. The latter probably reflects the 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. It can be noticed that this group with whom there is little contact is small.

Table 4: How often has support been provided (on average within last three months)

	Count	Per cent
Daily	20	39
About two times a week	10	20
About once a week	9	18
Every second week	8	16
About once a month or less	4	8
Total	51	100

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.

Table 5: Duration of a support visit

	Count	Per cent
1-5 minutes	0	0
6-15 minutes	1	2
16-30 minutes	13	26
31-45 minutes	3	6
46-60 minutes	12	24
61-90 minutes	8	16
More than 90 minutes	13	26
Total	100	100

The monitoring system also provides information on which of the professions represented in the team has been in contact with the citizens (table 6). All citizens have been in contact with the social support workers. 71 per cent have been in contact with the nurse. One out of three has been in contact with the psychiatrist, and equally one out of three with the addiction councilor.

57 per cent have been in contact with the social office worker, who is a case worker from the social office who has authority over assignment to other kinds of social support from the municipality. A third have been in contact with other staff which may be the case worker from the jobcenter 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 is different from 'brokered' case management, where the case manager facilitates support to mainstream support services.

Table 6: Which type of staff has had contact with the citizen during the last 3 months

	Count	Per cent
Social support worker	51	100
Social office worker	29	57
Social assistant	10	20
Nurse	36	71
Psychiatrist	18	35
Addiction councilor	17	33
Other	17	33
Total	51	100

There are three main dimensions in the support provided from the ACT-team. There is the social and practical support delivered mainly by the social support workers. Then there is a considerable element of health related support – physical and mental – provided by the nurse, the psychiatrist and the addiction councilor. And then there is an element of administrative support where the integration of the social office case worker and job center case worker 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 problems, 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 program], 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 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 [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 also 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 assess 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.



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 are partial user's fees up to a certain level of expenditure for pharmaceuticals. For some of the citizens it can be difficult to cover 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 citizens begin to have a need for more intensive nursing care, and especially how such needs may evolve 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 developing care needs should be integrated into the team, or whether such support should be attended by the specialized care units 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 abuse, 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-program 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 councilor offers the possibility of counseling in the citizens own home, 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**

Staff with administrative authority from the social office and the job center are part of the ACT-team. Job centers have authority over cash benefit payments and the assignment to social activation programs 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 programs. 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 these administrative authorities 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 felt was 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 lack of rent payments. She facilitates access to activity projects for those citizens who are capable to participate in such activities, which gives the citizen a possibility for meaningful activities and social contact in their everyday life. About 10 of the ACT citizens currently 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.

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 gives him 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.

## **Housing outcome**

A fundamental element in the housing first approach is that a permanent housing solution should be provided early in the course of an intervention together with floating support to enable the formerly homeless individuals to live on their own. Both ACT and ICM have proven to be effective methods of social support.

A first question is how we should measure the housing chances of participating in the ACT-program? 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 project 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 program 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 program 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 every third month 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.

As mentioned earlier a total of 64 citizens have been housed through the program so far, while 12 are waiting to be housed. Most of those waiting to be housed have been assigned to the team very recently, and some are waiting to move in to the 18 new row houses which have been attached to the program after a renovation.

Of the 64, who have been housed through the program by mid-June 2012, 29 have been housed in individual flats and 34 in the 3 category housing units. One citizen is housed in alternative housing ('Skaeve huse').

Of the 64 who have been housed, 54 were still receiving support from the ACT-team.

Of the remaining ten, two have died. One has moved to a flat in another city on his own initiative. Another is waiting to be moved to another form of housing with more intensive support and now receives support from another municipal support unit. These four will not be included in the calculation of the chance of staying housed.

Three have finished receiving support from the ACT-team but are still living in the flat they received through the program - one did not need support any longer and the two others now receive support from another unit as they no longer need the intensive support from the ACT-team. In this way these three citizens counts amongst those still housed.

Three citizens have lost their housing and also do not receive support from the team any longer, due to specific reasons.

The following table shows the chances of still being housed, or no longer being housed, for citizens who were initially housed through the program, excluding the four specific cases mentioned above.

Table 7: Housing situation, June 2012 amongst participants initially housed

	Count	Per cent
Still housed	57	95
No longer housed	3	5
Total	60	100

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 stability chances above cannot directly be compared with housing outcomes in effect studies such as the Tsemberis study. We also cannot compare the housing chances for the ACT-program to a control group. However, a housing stability rate of 95 per cent so far, is obviously very high. In this way the results show that the ACT-program is highly effective in bringing homeless individuals out of homelessness and keeping them housed.

### **Independent housing versus category housing**

A key question in the international research literature is whether housing should be in independent, scattered housing in ordinary housing, or in collective housing such as group homes/integrated housing? And should the term housing first be reserved to independent housing such as described by Tsemberis (2010) or can other types of housing such as communal housing be used? 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 alternative for these groups is rather a return to rough sleeping or homelessness shelters?

In the ACT-program in Copenhagen both independent, scattered housing, and different forms of ‘communal housing’ are applied. The category housing varies from the apartments with full individual facilities in ‘Bellahøj’ to the shared apartments in the group home in ‘Colbjørnsensgade’. Influenced by the experience that many citizens preferred independent housing, and the challenges that occurred in the different category housing units, independent housing was increasingly used as a housing solution during the project.

As mentioned above, a very high overall housing stability rate has been achieved in the project. Amongst those who have been housed in independent housing all have stayed housed – a housing stability rate of 100 pct. Amongst those who have been housed in category housing 31 out of 34 have stayed housed, corresponding to a housing stability rate of 91 pct. In this way a high housing stability rate has been achieved both for the individuals who live in independent housing and for the individuals living in the category housing units.

Besides the cases of individuals who have lost their housing there have been a few cases where individuals have moved between the different housing types involved in the project. A few have moved from one category housing to another, and a few have moved from a category housing flat, to an independent flat. In one of these cases the individual was evicted from his category housing flat due to a severe violation of house rules. However, he was since rehoused in an ordinary flat in public housing.

In the interviews there are many reflections on the different housing types. There are indications that the independent housing has worked out better. The interviewed citizens living in independent flats are generally very satisfied with living in their own flat. Amongst the residents in the communal housing units there are mixed opinions. Some are happy about living in the category housing units, whereas some dislikes living there and would prefer their own flat. Some residents in the large 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 ‘Bellahøj’ (...) 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>5</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 neighbours’ door and ask if they should have a beer and watch a movie in TV. I will not say that such housing is bad, it depends a lot on where and how they are located and what is expected.”

In one of the group homes the residents already lived there 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 one-site support workers describes 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 (in charge of welfare benefits) 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

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<sup>5</sup> The support workers from the ACT-team has recently taken over the provision of floating support for the citizens living in ‘Bellahøj’.

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.

It has only been possible to carry out one interview with a resident of this group home. She 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.

Amongst the residents in the category housing facility (Bellahøj) with a mix of ACT-citizens and mentally ill residents, there are mixed opinions about living in the communal housing unit. The residents all express satisfaction with their apartments and generally also express that they appreciate the contact with other residents in the house.

One interviewee in the category 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 category housing unit. She says:

"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 shared 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 shared 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 'Bellahøj' reflects on the restrictions in the access to the common facilities: "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 'Bellahøj' 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: “Kapernaumskirken” [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 Dorthe [name of support worker changed] and the others?”

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

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 Nørrebro, 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 ‘Bellahøj’ 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 Bellahøj...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."

In this way there are mixed experiences with housing 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 at the same place have also occurred in the communal housing units attached to the ACT-program. As there is probably an element of selection to the different housing forms used in the program, it is not possible to assess how the situation of these individuals would have been like, if they had been assigned to independent housing.

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 interviewees who lives in independent housing at the time of interviewing, at first lived in the category 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 'Bellahøj' [the location of the category housing unit] 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 category housing units. He says "I know many who might need that kind of apartment in 'Bellahøj', 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 'Bellahøj' (the large communal housing unit), 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 shared 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. In this way, it is an important result from the program, that with the multidisciplinary support from the ACT-team it is possible to for individuals with complex support needs to live on their own in independent housing in ordinary public housing.

## 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 February/March 2012. As there is no information in the system on whether citizens have moved internally between the different housing types the tables are only calculated for the citizens in all and not separate for each housing type.

Table 8: Does the citizen in your opinion have an alcohol abuse? Per cent.

	First report	Last report
Not at all	14	20
To a minor extent	8	16
To a certain extent	27	24
Very much	49	41
Don’t know	2	0

N = 51

At the first recording 76 pct. of the ACT-citizens had an alcohol abuse to ‘a certain extent’ or ‘very much. This figure dropped to 65 pct. at the last recording registered.

Table 9: Does the citizen in your opinion have an abuse of hard drugs? Per cent.

	First report	Last report
Not at all	63	69
To a minor extent	4	2
To a certain extent	16	10
Very much	16	18
Don't know	2	2

N = 51

The majority of the ACT-citizens are not abusers of hard drugs. At first report 32 per cent had an abuse of hard drugs to a certain extent or very much. This figure has fallen to 28 per cent in the last report.

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

	First report	Last report
Not at all	20	27
To a minor extent	10	16
To a certain extent	39	25
Very much	20	29
Don't know	12	2

N = 51

Contrary to hard drugs, many of the ACT-citizens are hashish abusers. 59 per cent had an abuse of hashish at the first report. This figure dropped slightly to 54 per cent in the last report.

Table 11: 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	18	18
To a minor extent	29	33
To a certain extent	31	31
Very much	16	18
Don't know	6	0

N = 51

47 per cent at first report and 49 per cent at last report, was assessed to have physical health problems to a certain extent or very much.

Table 12: Does the citizen in your opinion have mental problems or mental illness? Per cent.

	First report	Last report
Not at all	8	18
To a minor extent	22	16
To a certain extent	37	27
Very much	27	37
Don't know	6	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 64 per cent at both reports. There was an increase in the ‘very much’ category from 27 per cent to 37 per cent, which probably reflect that for some of the citizens their mental problems have become more known to the support workers over time.

Table 13: 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	22	25
To a minor extent	25	24
To a certain extent	24	29
Very much	12	18
Don’t know	18	4

N = 51

36 per cent were reported to have difficulties in maintaining daily practical activities. This figure was 47 per cent at the last recording – probably again due a better knowledge about capabilities, as the ‘don’t know’ category dropped from 18 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 14: 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	27	39
To a minor extent	14	20
To a certain extent	25	18
Very much	20	24
Don’t know	14	0

N = 51

45 per cent at first report and 42 per cent at last report are assessed to have financial problems that make it difficult to pay the rent and utility bills.

Table 15: 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	6	6
To a minor extent	22	20
To a certain extent	27	22
Very much	41	53
Don’t know	4	0

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 68 per cent at first report and 75 per cent at last report, the increase partly due to a drop in the don’t know category.

Due to an error in the monitoring system it has not been possible to calculate the proportions with either progress or regress on each item, on individual level. This information will presumably be included at a later stage of the study.

To sum up, there is some indication that the share with alcohol abuse has dropped somewhat from first report to the last report, but for the other items the overall picture is rather that of status quo, rather than any progress. This picture is very consistent with what the citizens report in the qualitative interviews. None of the interviewees reported to have totally quit their addiction, and most also reported on difficulties in other dimensions of their life, such as health problems, and the need of support to practical matters in daily life and to getting their bills paid.

## Conclusion

Almost all individuals who have been housed as part of the ACT-program have remained housed until now. Of the 60 citizens who have been housed through the program, only 3 have later lost their housing. In this way 95 per cent of the citizens who have been housed through the project have so far managed to stay housed, with the support from the ACT-team.

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, also a nurse, a part-time psychiatrist and a part-time addiction councilor is 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. They 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 program 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. At the time of interviewing almost half of the citizens in the program lived in independent housing, and the rest in the three communal housing units attached to the project. A fourth housing unit, based on row houses was about to be taken into use.

The high rate which stays housed is found for both the citizens who live in independent housing, and for the citizens in the communal housing units. 100 per cent of those living in independent housing have stayed housed, and 91 per cent have stayed housed in the communal housing units.

However, there have been certain problems attached to the use of communal housing in the program. The presence of on-site support staff not part of the ACT-team, has only worked out well in one of the category housing units whereas it did not work out as well in the two other places, as the existing staff had little or no previous experience with homeless individuals with complex support needs. In one of the category 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 category 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.

As no randomization to the different housing forms is involved no conclusive evidence can be given on the relative effectiveness of either ordinary or communal housing from the study. However, the experience from the project points towards a trend in the research literature in favor of 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-program 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.

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