

Good practice report: New directions

Volume 2: supporting street homeless
people with complex needs



Shelter

Foreword

Photo: Eddie MacDonald



Street homelessness may be less visible to the public than it once was, but that does not mean it should be seen as any less of a problem. With the Government's active support, many homeless service providers are doing a good job in helping a number of homeless people come off the street. Clearly, however, it's not enough, because figures from rough sleeper counts haven't declined in four years and, if anything, numbers are rising.

Reaching out, Shelter's report based on consultation with more than 250 street homeless people, showed that we need more housing for street homeless people, particularly 'move on' accommodation. We don't just need more though; we also need different housing. Current services, as good as they are, are not meeting all street homeless people's needs, and the people most likely to miss out are those with multiple or complex needs. This report, from our Good Practice Unit, examines projects that, in different ways, work to address this gap.

Lack of resources is the main reason why the projects featured in this report are the exception rather than the rule. But there's a cost to ignoring homelessness that may ultimately outstrip any cost in addressing the problem, and much more can be achieved by making better use of the resources we already have. Most of the projects in this report have taken successfully to multi-agency working. By making best use of funds across different disciplines, they have helped to reduce spending on more costly services such as prisons and hospitals.

At Shelter we believe that keeping people off the streets is reason enough to justify the work of the projects featured in this report.



Adam Sampson
Chief Executive, Shelter

Good practice report: New directions

Volume 2: supporting street homeless people
with complex needs

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Summary: one size does not fit all

New directions Volume 2, like Volume one, features a range of projects that work with people from the street, through to resettlement. Together the two volumes demonstrate that needs can best be met through a diverse range of projects. Though the projects featured are diverse, they do however have one thing in common, which is to always ask themselves whether they could do anything differently in order to do them better.

This second volume examines examples of good practice in meeting the needs of street homeless people. At the heart of our analysis is the belief that homeless services do meet the needs of the majority of people effectively. But there is a significant minority whose needs are not being met by the current range of services. On the whole, this gap is biggest among people with more complex needs.

Quite rightly, most services focus on helping people to escape street homelessness, usually within a limited period of time. But for some, this approach is not working. Too many people are either unable to engage with services, or fail to comply with rules and targets that are conditional to the services provided. This volume describes projects that are working in different ways to address this problem.

Chapter summaries

Health and street homelessness Given the limited range of short- to medium-term services, a certain amount of street homelessness is, sadly, inevitable. The top priority, therefore, is to enable people to stay alive. This chapter focuses on projects that address the health needs of people who are street homeless.

Supporting street homeless people with complex needs who have no recourse to public funds A degree of short- to medium-term street homelessness is also inevitable among people with no recourse to public funds. This chapter looks at current services for this group and what more is needed from a good practice point of view.

Housing First Normally the first step off the street is into a hostel, but is this always the right move? Improving hostels, as the Government is doing, will help; but for some people hostels may be part of the problem, not the solution. This chapter looks at the American concept of Housing First and how this might apply in the UK.

Wet housing for heavy drinkers This chapter looks at another non-hostel approach, for heavy street drinkers, run by the Wallich in Cardiff.

Community Links Personality Disorder Accommodation Service People with personality disorders are not well served by most existing homeless services' provision. This chapter features the work of an exceptional service in Leeds – the Personality Disorder Accommodation Service run by Community Links, and part of a multi-disciplinary network.

Getting connected: housing homeless people who have a dual diagnosis There is another conspicuous gap in services aimed at homeless people with mental health and drug or alcohol problems, sometimes referred to as dual diagnosis. This chapter features a project in Scotland that works with dual-diagnosis clients and shows what can be achieved using a multi-agency approach.

Unhousable? Housing homeless people facing chronic exclusion Trawling through a directory of services, what's usually offered is 'low to medium support'. The Single Homeless Project (SHP) takes a different approach, actively seeking clients with complex needs. This chapter examines the policies and practices that enable SHP to offer a higher level of support.

Shifting the balance of power For all street homeless people, once accommodation is provided, they are more likely to remain in it if they can influence the way it is run. This chapter shows how Look Ahead Housing and Care's customer involvement programme targets people who normally miss out on service-user involvement initiatives.

Health and street homelessness

‘As multiple morbidity is common among homeless people, accessible and available primary health care is a prerequisite for effective health interventions. This requires addressing barriers to provision and multi-agency working.’¹

British Journal of General Practice

There is a complex relationship between homelessness and health. Health needs may be a trigger for homelessness, while homelessness can create health problems. Either way, the experience of homelessness – with reduced safety and access to services, limited opportunity for proper hygiene, nutrition and self-care, and the stress and anxiety this can cause – can exacerbate any health problem. This is particularly the case for rough sleepers and other hard-to-reach street homeless groups. Street homelessness can hinder preventative interventions or early identification of difficulties, and homeless people often present to health services with multiple problems that have already reached an acute stage.

This chapter will look at the health-related problems faced by street homeless people and some of the ways services have developed to meet these needs.

The health needs of street homeless people

Street homeless people are at higher risk of premature death and are more likely to experience health problems that include:

- physical injuries
- viral, bacterial and fungal infections
- infestations
- foot problems
- dental problems
- respiratory disorders.

The most common health needs, however, relate to drug and/or alcohol dependence and mental health problems, with a high prevalence of coexisting substance use and mental health problems (so-called dual diagnosis).²

Barriers to service

While there appears to be general consensus on the need for improved access to mainstream primary health care, complemented by specialist services for hard-to-reach individuals³, providing such access is not straightforward.

Homeless people may be unable or even reluctant to access existing services. They may be sleeping in outlying or hidden locations for greater protection (a particular concern for some women)⁴ or to avoid enforcement actions, and this makes it hard even for outreach services to make contact with them.

Concerns have also been raised as to whether services attempting to minimise some of the harm associated with homelessness act as a disincentive for street homeless people to access housing (where available) and other support.

1 Wright, N, Tompkins, C, *How can health services effectively meet the health needs of homeless people?* British Journal of General Practice, April 2006.

2 Wright, N, Tompkins, C, Oldham, N, Kay, D, *Homelessness and health: what can be done in general practice?* Journal of the Royal Society of Medicine, issue 97, pages 170–173 (2004). FEANTSA, *The Right to Health is a Human Right: Ensuring Access to Health for People who are Homeless*, Annual European Report 2006, www.feantsa.org/code/en/theme.asp?ID=35. Shelter, *Service without substance: Addressing the gaps in service provision for street homeless people with a dual diagnosis*, www.shelter.org.uk/goodpracticebriefings

3 *How can health services effectively meet the health needs of homeless people?*, op cit.

4 *Homeless Women: Homelessness Careers, Homelessness Landscapes*, Crisis, London, 2007.

Increasing access and early intervention

Homeless people need accessible, co-ordinated services to meet their health needs. The following projects have been developed to meet the specific needs of street homeless populations in a range of localities across the country.

Great Chapel Street Medical Centre, Westminster

Great Chapel Street is a comprehensive, multi-disciplinary primary health care service for homeless and vulnerably housed people in Westminster. It operates under a Personal Medical Services (PMS)⁵ contract to increase initial access to health services for homeless people, while acting as a contact point to link individuals into mainstream medical and social services.

The centre works on a drop-in basis, with appointments for those who want or need longer consultations, specialist services and review for chronic conditions. Services include:

- general practitioner services
- psychiatric services
- clinical nurse specialist (substance use/mental health)
- nurse practitioner
- counselling services
- podiatry
- dentistry
- housing, benefits and legal advice services.

Each service can refer to others within the team and can make fast-track referrals into other specialist services, enabling easy access and allowing services to meet multiple, interrelated needs. This also facilitates preventative work and early intervention, helping to avoid crisis, even for low-level mental health problems, and maintaining psychological well-being.

Mobile/outreach services

For some particularly hard-to-reach groups, or in more rural localities without large urban centres, mobile services have been developed.

The Night Bus, Cardiff

This service was established in the winter of 2001/02 as part of a response to a sudden increase in numbers of rough sleepers in the capital. Cardiff is a regional centre that attracts vulnerable people from a wide surrounding area.

A working group of organisations affected by rough sleeping, including the local council, police, voluntary organisations and businesses such as NCP and the Cardiff Bus Company, was set up. With funding from Barclays Bank, a double decker bus was transformed into a mobile outreach service for rough sleepers.

The service has three elements, providing:

- emergency food and other essentials
- advice and signposting, including referral into emergency hostels
- a platform for existing specialist services, particularly the district nurse and social workers for the homeless, to improve contact with hard-to-engage clients.

Since 2006 the project has been managed by the Salvation Army in Cardiff and is part of a wider, co-ordinated approach by the city to address the multiple needs of rough sleepers.

Drugs and Homeless Initiative (DHI), Dial-a-needle, South Gloucestershire

High levels of homelessness are common among injecting drug users.⁶ Homeless users also report increased levels of high-risk behaviour including sharing needles and syringes, a prevalence of hepatitis B and C infection, and injecting-site infections.⁷ Needle exchange schemes are key to reducing harm and the spread of infection among injecting drug users. Yet, a national audit of schemes in 2005 indicated variable and insufficient provision across the UK.⁸

5 Personal Medical Services (PMS) contracts are locally negotiated. They have the ability to introduce local flexibilities not available under the nationally negotiated General Medical Services (GMS) contract.

6 Newcombe, R, *Multi-Drug Injecting in Manchester: A survey of 100 injecting drug users attending Lifeline Needle Exchange Scheme in 2006*, Lifeline 2007, www.lifeline.org.uk

7 *Shooting Up: Infections among injecting drug users in the UK 2006: An update*. Health Protection Agency, October 2007, www.hpa.org.uk/publications/az.asp#S

8 *Findings of a survey of needle exchanges in England*, National Treatment Agency for Substance Misuse, London, May 2006.

South Gloucestershire is a predominantly rural area with no centralised population of injecting drug users. In recognition of the fact that a number of injectors were struggling to obtain clean injecting equipment, DHI set up a mobile needle exchange in March 2007.

The service takes sterile injecting equipment to people's using environments, enabling more targeted interventions to address specific risks. Contact numbers (including a Freephone number) are given to existing service users, and also provided via pharmacy needle exchange services and on contact cards for peer distribution. As well as providing clean injecting equipment, the service delivers wider harm-reduction support, including hepatitis screening and sexual health advice and information. It also provides rapid assessment into tier three (structured drug treatment) services and peer distribution of injecting equipment.

While this proactive outreach model was originally developed to meet the needs of more rural and dispersed drug users, it is equally applicable to street homeless people and other hard-to-reach groups.

Genesis mobile outreach service for street-based sex workers, Leeds

Street-based sex work can present a range of dangers and risks to health. Sex workers can have multiple support needs, including homelessness, but working in these circumstances can make it difficult to access services, and support needs can stay hidden or unmet.⁹

The Genesis outreach vehicle operates from 8–11pm every Wednesday at three locations in Leeds (a further outreach session, via car, takes place from 6–9pm on Fridays). The service offers sandwiches and hot drinks, and an opportunity for outreach workers to develop trusting relationships with service

users in an accessible environment. The Genesis vehicle incorporates a private consulting area that can be used for vaccinations, chlamydia testing and other primary health care services.¹⁰

Workers dispense condoms, provide harm-reduction support and advice, and will refer on to a range of other health and support services. A local treatment service offers needle exchange facilities on the vehicle every other week. Genesis also run a scheme that enables sex workers to report clients who are violent to them, or give other causes for concern. This can be done anonymously if the women prefer, and information is forwarded and logged by the police, and shared with other sex workers to improve their safety.

Ongoing interventions can be followed up through the twice-weekly office-based drop-ins, or by one-to-one sessions arranged in convenient locations. Genesis also participates in multi-agency case conferences alongside other key statutory, public and voluntary sector agencies.

Conclusion

While visible rough sleeping has reduced, a significant number of people remain street homeless and at increased risk of various health-related problems. If they are to engage successfully with these hard-to-reach groups, services must be accessible. At times, this may require services to approach potential clients directly, rather than simply promoting themselves to the target population.

Services can also benefit from joint working across different agencies and specialisms. They should help tackle initial presenting problems, but should also provide signposting, referral, access and assistance to secure longer-term and/or other types of support.

9 *Off the streets: tackling homelessness among female street-based sex workers*, Shelter, London, 2004.

10 Although recent changes have meant that a nurse is not currently available on the outreach vehicle, this has previously been the case and it is hoped that this service will return in the near future.

Supporting street homeless people with complex needs who have no recourse to public funds

Homeless services across the UK are reporting increasing numbers of refugees and European migrants who face destitution because they are not entitled to any support from the Government.¹¹ People in this situation are facing ill health, exploitation, and street homelessness.

Nationals from the Eastern European Accession (EEA) states¹² represent the largest group of migrants in the UK, but are among the most excluded from accessing support.¹³ There is a major concern among front-line homelessness services that a significant number of EEA nationals are arriving in the UK homeless, penniless and with ongoing drug or alcohol problems. Others experience exploitation at the hands of unscrupulous employers, leaving them without a home and susceptible to becoming locked into a cycle of street homelessness and social exclusion.

People with no recourse to public funds cannot access most hostels because they are not entitled to state benefits.¹⁴ They are also finding it difficult to access treatment services, including those operating from day centres for homeless people. Thus a growing number of destitute EEA nationals with complex needs are finding themselves on the streets. It's a problem that is being experienced in towns and cities across the UK.

Accessing treatment and support services

'A lot of people on the streets cannot be referred anywhere. No organisation will touch them because there's no funding for them. They're just languishing on the streets. We see serious alcohol addictions. It's not good for them and it's not good for community cohesion.'

Philip Burke, Simon Community

Street homeless migrants are as vulnerable to mental and physical ill health and drug/alcohol problems as the indigenous street homeless population. Alcohol use is emerging as the most significant problem among homeless A8 and A2 migrant populations generally, with a particularly high use among Polish people.¹⁵ According to Homeless Link (2006)¹⁶ nearly half of all surveyed homelessness agencies working with A8 nationals in London reported that their clients had alcohol-related support needs.

However, because of the conditions of accession, migrants with no recourse to public funds (NRPF) cannot receive treatment that extends beyond

11 Failed asylum seekers or other migrants who are subject to immigration control have no entitlement to public housing, welfare benefits or to Home Office support for asylum seekers.

12 Poland, Lithuania, Estonia, Latvia, Slovenia, Slovakia, Hungary and the Czech Republic joined the EU in 2004. These are referred to as the A8 countries. Romania and Bulgaria acceded in 2007, and these are referred to as the A2 countries.

13 *Support for people with no recourse to public funds*, Conference Report for the British Red Cross and NRPF Network, 2007.

14 A8 nationals have limited access to public services and state benefits. They must register under the Worker Registration Scheme within one month of starting work and are only eligible for public funds and services after completing 12 months of continuous employment. Further restrictions were placed on A2 nationals who have limited working rights.

15 Morris, E, *Report On East European Homeless People In London*, East European Advice Service, 2004.

16 *A8 Nationals In London Homelessness Services*. Homeless Link, 2006.

primary care, are not eligible for any state benefits and cannot receive rehabilitative treatment. Thus, local authorities are severely limited in the ways in which they can address the needs of this group.

With no current system for reclaiming money from Central Government, many local authorities are reluctant to develop specialist services or to fund measures that would increase access to existing provision.¹⁷ And many GP surgeries are refusing to register A8 nationals, even though alcohol detox could, in theory, be accessed through primary health care.

Where migrants are able to access treatment, there is no support or housing available to them afterwards. This leaves them in the same position they were in originally, making abstinence or the management of their alcohol use far harder to achieve.¹⁸ This situation is further compounded by the varied interpretations made by local authorities¹⁹ of national policy and guidance relating to treatment provision.

The Barka Foundation – a reconnections-based approach

The London Borough of Hammersmith and Fulham has experienced a sharp increase in the numbers of Polish migrants seeking housing and employment in the area. There is a corresponding increase in the number of destitute street homeless Polish people, prompting concerns regarding the number of street drinkers and the welfare of this group.

The Barka Foundation developed a six-month pilot project, funded by CLG, to provide culturally specific support for homeless Polish street drinkers in the borough.²⁰ Based in Poznan, Poland, Barka is a well-established charity that operates social inclusion programmes for homeless people with addictions and other support needs. These programmes emphasise service-user involvement and community engagement. All services are abstinence based²¹ and the programme requires an initial commitment to alcohol detoxification and rehabilitation.

A service level agreement was established between Hammersmith and Fulham council, Broadway, and Barka, with an initial target of 40 contacts and three reconnections (assisting people to return home) each month. Working from the Broadway Centre, and in conjunction with Broadway's outreach team, Barka UK contacts street homeless Polish migrants, offering a return to Poland and support through its rehabilitation and social integration programmes in their home country. Over a six-month period, Barka helped 46 people return to Poland, many of whom are engaged with Barka Communities, social enterprise schemes and training. All of Barka's leaders in the UK have received training from people working and living in the Polish community, and many have been through the system themselves.

'Barka's success is not only demonstrated by the number of people they have helped; I have been told by partners that this project has literally saved certain individual's lives, as otherwise they would have died if left on the streets.'

**James Morris, Alcohol Strategy Development Officer,
London Borough of Hammersmith and Fulham**

Reconnecting people with their native countries can be hugely beneficial when carried out appropriately, but it is not suitable for everyone. The same is true for abstinence-based housing and support. A significant number of homeless Polish people prefer to stay in the UK despite the severity of their situation here. For those who wish to remain, Barka is unable to do much more than refer the people it makes contact with to the limited services within the borough. It has direct links with employment services and Polish Alcoholics Anonymous groups. Accommodation is not Barka's main directive and it has no means of housing people. It does, however, work alongside the agency UR4Jobs, which provides IT training, employment and legal advice, and assistance in obtaining official documents. Both Broadway and

17 Fellas, O, Smith, A and Smith, F, *Destitute people from abroad with no recourse to public funds: A survey of local authorities*, Islington Council, 2006, www.islington.gov.uk/DownloadableDocuments/HealthandSocialCare/Pdf/nrpf_survey_local_authorities.pdf

18 Zapletal, A, *Cold Turkey, The Pavement*, issue 23, pages 22–23 (2007).

19 Alcohol Policy UK, 6 August 2007. The Barka pilot project in Hammersmith and Fulham, *A model for working with Polish street drinkers*. www.alcoholpolicy.net/2007/08/the-barka-pilot.html. Mills, K, Knight, T and Green, R, *Beyond Boundaries: Offering substance misuse services to new migrants in London*, Centre for Community Research, University of Hertfordshire (commissioned by the National Treatment Agency), 2007.

20 Barka works primarily with Polish street drinkers, but it will also support drug users and, in some cases, work with non-Polish nationals.

21 Services operate a 12-step rehabilitation model in both housing and work settings.

Barka offer ESOL training to those who wish to improve their English language skills.

The Barka pilot has received a great deal of interest from other London boroughs and local authorities across the UK and Ireland, and it looks likely that it will continue as a longer-term project.

A need for other options

Although the pilot project with Barka bridges some of the existing gaps in service provision for this particular group, it is, however, only one solution. A number of problems linked to housing, health, employment, entitlement and social cohesion are beginning to emerge. While reconnections-based practices, accompanied by a structured support programme, may work for some people, a balance must be achieved between developing specialist pilot projects and increasing access to mainstream services. It is vital that appropriate and culturally specific support structures are established in the UK to help those who do not wish to return home.

The public services involved in responding to these problems need to co-ordinate their response with front-line agencies that work with homeless people. Any co-ordinated response must include the faith-based organisations that are providing the bulk of support, free food and access to rolling night shelters for this very vulnerable group. The needs of street homeless people with no recourse to public funds

should be mapped at a regional level to inform policy and service developments, and statutory guidance should be developed to enable consistency and a clearer legal understanding across local authorities. The capacity of local services to respond effectively to the needs of vulnerable migrants must be increased, with financial support from both national and European funds. Language, advice and information needs must also be addressed, improving communication and making services more accessible.

Contacts and further information

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www.barkauk.org

NRPF (No Recourse to Public Funds) Network aims to support and represent local authorities by sharing information and good practice, by highlighting practical difficulties and policy issues, by developing a strategic response to NRPF and by obtaining reimbursements of support costs for people with NRPF. For more information, visit www.islington.gov.uk/nrpfnetwork

Housing First

This chapter considers the concept of Housing First and its application in the United Kingdom.

What is Housing First?

The Housing First concept was developed in New York in the 1990s.²² Its main principle is that housing is a basic human right, which should be available to anyone no matter what else is 'going on in his or her life'. Housing First approaches, therefore, place people who are not considered 'housing ready' directly from sleeping rough into permanent housing units. This contrasts with the traditional approach in which homeless people have to earn permanent housing through doing well in shelters and transitional (supported) housing. Supporters of Housing First contend this traditional system does not work well for the most 'hard to house' people because service providers consider such people 'resistant to treatment' and too 'difficult' to help.²³ This 'hard to house' group comprises 10 per cent of the total US homeless population, but one influential study found they take up 50 per cent of homeless resources.²⁴

Housing First residents must agree to pay the rent and abide by the terms of the tenancy, but access to housing is not dependent on achieving sobriety or treatment goals. This approach has been controversial because it challenges the ethical basis

upon which much drug policy is based. Nevertheless, it has had some success and been developed in other US cities. In 2007 the Department of Housing and Urban Development (HUD) completed its first major review of Housing First and its use for people with serious mental illness.²⁵ Although exploratory, this research shows how Housing First has helped reduce homelessness and encourage stabilisation.

The mass scale of homelessness, and the lengthy periods many homeless people spend in basic shelters in the US could lead one to think that US homelessness policy and practice is not comparable with the UK. The idea though, that there is a sub-group of homeless people, particularly those with co-occurring mental health and substance misuse problems, whose needs aren't served well by current services, does strike a chord. It could be the case that, in this country, hostels (even good quality ones) won't lead to an end to homelessness for some people. After all, the official UK rough sleeper count has not declined significantly since 2003²⁶ and a survey by Shelter of 257 street homeless people in England found that a high proportion had complex needs and a pattern of recurring homelessness.²⁷

To test the applicability of Housing First in the UK, Shelter funded a study of the Bridge Project in Exeter run by Bournemouth Churches Housing Association.²⁸ After some time searching, this was the closest approximation to a Housing First project

22 Padgett, DK, Gulcur, L, Tsemberis, S, *Housing First Services for People Who Are Homeless With Co-occurring Mental Illness and Substance Abuse*, 2006, www.pathwaystohousing.org/TopMenu/PTHousing/Images/Padgett_RSHP_Jan_06.pdf

23 Aron, YL, Burt, RB, Hedderson, J, Johnson, MS, Ortiz, JM, Zweig, MJ, *Strategies for Reducing Chronic Street Homelessness*, US Department of Housing and Urban Development, 2004, www.urban.org/publications/1000775.html

24 Culhane, DP, Poulin, SR, Hoyt, LM, and Metraux, SM, *A Study of the Impacts of Welfare Reform in Philadelphia: Public Shelter Utilization, Demand for Public Housing Programs, and Public Housing Program Recipient Outcomes*. US Department of Housing and Urban Development, Office of Policy Development and Research, Washington, 2002.

25 Pearson, CL, Locke, G, Montgomery, AE, Buron, L, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness Final Report*, US Department of Housing and Urban Development, 2007, www.huduser.org/Publications/pdf/hsgfirst.pdf

26 *Homelessness Statistics September 2007 and Rough Sleeping Ten Years on from the Target*, CLG, 2007, www.communities.gov.uk/documents/housing/pdf/hspolicybrief20

27 *Reaching out*, Shelter, 2007, www.shelter.org.uk/publications.

28 Filby Moore Associates, *Living Without a Label*, The Bridge Project, Exeter, May 2007 (unpublished).

that we could find in England. The Bridge Project is unusual in that it houses people straight from rough sleeping into standard social housing units across a number of locations in Exeter. This stands in contrast to the mainstream approach in which rough sleepers move on to self-contained housing only after a successful stay in a hostel.

The Bridge: 'not quite Housing First'

Although there are many parallels between the Bridge Project and Housing First, such as an emphasis on harm minimisation, there are also some differences. The most significant is that the Bridge study found that the project worked best for people who were 'committed to change', yet in the US Housing First tends to be used for people who are considered the most difficult to serve and assessed as not committed to change; to use the American term, not 'housing ready'.

Who might benefit from Housing First?

People who have been street homeless for a considerable period and who have not been served well by conventional approaches, are the main target group for Housing First. But the approach can work for a wider group of homeless people too. In the US some Housing First programmes are aimed at families with children. Housing First may be of value to older homeless people who sometimes have difficulty with the more youthful culture prevalent in certain hostels, and it could also be considered for areas away from major cities, where hostel provision is limited or even non-existent. The Bridge was also being used for rough-sleeping couples because hostels in Exeter, like those elsewhere, generally cater only for single people.

Variety, however, is the key, and while some people will benefit from Housing First, others will benefit from communal accommodation. Indeed, while offering a Housing First approach is good practice, it must also be acknowledged that not everyone wants to 'move on' and there is a good case for offering permanent communal arrangements too.

A qualified success

The HUD review studied 80 people for a year after they had been provided with Housing First accommodation. For some, Housing First didn't work. Perhaps this is inevitable when working with the most hard-to-serve client group. The review also concluded that even where success was achieved, Housing First is not without its challenges. Even so, 83 per cent of people studied in the review were still in their accommodation after one year, although some of these had spent time away from their accommodation during the year.²⁹

What makes Housing First work?

Clearly, providing self-contained housing for people with complex problems, who may have been homeless for some time or have a past history of not sustaining tenancies, is a risky business. To achieve success, there are two main imperatives:

1 Good assessment and referral procedures

Referrals to the Bridge have to come from the Street Homeless Outreach Team (SHOT) who have expertise in assessing the needs of rough sleepers.

2 A wide array of supportive services

Something emphasised in both the Bridge study and the work in the US is the crucial role played by support services. The Bridge study found that, for some, moving into settled accommodation straight from the street could be a huge 'culture shock'. Responsive, comprehensive, quality support is needed to help residents deal with this. Such support wasn't always available, and accounted for some people leaving the project.

In the US, successful Housing First programmes go one step further. This may explain why people who aren't considered 'housing ready' can be taken on; something the Bridge struggled with. Successful Housing First programmes offer an array of supportive services, and in some projects staff are available 24 hours a day. Access to integrated substance abuse and mental-illness treatment services is also emphasised³⁰, as is the need for a long-term commitment to support.

²⁹ Pearson, CL, Locke, G, Montgomery, AE, Buron, L, *The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness Final Report*, US Department of Housing and Urban Development, 2007 (page 97), www.huduser.org/Publications/pdf/hsgfirst.pdf

³⁰ Ibid (page 99).

Conclusion

The Bridge Project is a valuable resource for homeless people in Exeter, but it does not fully offer the more radical approach developed by some of the US Housing First projects. There is a compelling case for the Bridge and other projects in the UK to develop along the lines of Housing First. The UK may not suffer mass homelessness on the same scale as the US, but we don't have all the answers and indeed our response can be quite formulaic or linear: street to hostel to move-on to tenancy. It is clear this approach doesn't work for everyone and a range of approaches is needed, including Housing First.

Contacts and further information

A copy of the evaluation of the Bridge Project can be obtained from Shelter's Good Practice Unit. Email goodpractice@shelter.org.uk

Further information about Housing First in the United States can be found on the National Alliance to End Homelessness website at www.naeh.org/section/tools/housingfirst

Wet housing for heavy drinkers

Problematic alcohol use continues to be a major cause and consequence of street homelessness.³¹ In many localities wet provision is in place at hostels and day centres for street homeless drinkers unable to abstain. This chapter looks at wet provision in Cardiff, where self-contained and semi-self-contained wet housing has been developed by the Wallich as an alternative to wet hostels and day centres.

The need for wet services

The need for wet services for street homeless heavy drinkers who aren't willing or able to stop drinking has been recognised for some time.³² In some localities provision has been put in place to meet needs. This tends to take two main forms: wet hostels (or wet units within hostels) and wet day centres. Although the benefits of such accommodation in reducing homelessness are well established³³, the development of these services has been limited, because their emphasis is on harm reduction involving palliative care. Most funding goes to services that focus on rehabilitation.

Guidance for good practice in wet provision is also limited. For wet hostels a notable exception is *Finding the Key* by Providence Row³⁴, a guide examining effective key working in wet hostels. Wet day centres have received more attention, perhaps because they are seen as an alternative to street drinking, which has been a target for enforcement activity.³⁵ The report for the King's Fund by Sheffield Institute for Studies on Ageing examines good practice in wet day centres in some detail.³⁶

The wet day centre/hostels' approach works well for many heavy drinkers. Lives are saved, health and

behaviour is improved. But the Shoreline Project took a different approach. Developed in partnership between Cardiff County Council and the Wallich, it became operational in 1996.

Why not a wet hostel or wet day centre?

Research into street drinking in Cardiff found that while drinkers could access hostel accommodation that allowed drinking on site, they had difficulty remaining in it because they couldn't adapt to the rules that are typical of such hostels. Shoreline, on the other hand, began with the assumption that street drinkers have their own rules and group dynamics to which the management of Shoreline had to adapt.³⁷

The Cardiff research also noted that street drinking tended to occur in gangs. The gangs were important as social support networks; they had their own code of conduct, and members would act to protect each other. In Cardiff, therefore, it was felt that the most sustainable way forward was to develop housing that took account of this group dynamic, and to house the gangs together.

Some street drinkers do have accommodation but feel isolated if they drink alone. However, inviting round fellow drinkers can lead to behaviour that breaches tenancy conditions and causes them to lose their accommodation. So such people tend to drink communally, in public locations. Shoreline felt that housing people in groups where they could drink together would help reduce street drinking as well as street homelessness.

31 Shelter, *Reaching out report 2007*, www.shelter.org.uk/publications. Broadway, *Street to Home Quarterly report for London*, April–June 2007, www.broadwaylondon.org/broadwayvoice/S2H%20Quarterly%20Report%20full.pdf

32 Holder, T, Woodhead, J, *Ultimate Choice: Evaluating the need for a wet hostel in Leeds*, Leeds City Council, 2002.

33 Ames, C, *Wet and Dry Services: A Briefing*, Homeless Link, 2007 www.homeless.org.uk/developyourservice/servicetype/drugalcohol/wetanddry

34 Providence Row Charity, *Finding the Key*, 2003, www.lhf.org.uk/Publications/FindingtheKeyFinalReport.pdf

35 Fitzpatrick, S, Johnsen, S, *The impact of enforcement on street users in England*, Joseph Rowntree Foundation, York, 2007.

36 Crane, M, Warnes, AM, *Wet Day Centres in the United Kingdom: A Research Report and Manual*, Sheffield Institute for Studies on Ageing, 2003.

37 Diggins, B. *The Shoreline Project*, the Wallich (unpublished paper).

Housing First

The Shoreline Project has elements of the Housing First approach (discussed in pages 13–15) in which street homeless people move directly into settled accommodation. Shoreline is a mixture of shared houses and self-contained cluster flats aimed at matching clients' preferences and meeting the Housing First principle that people will only remain in accommodation if it is what they actually want. Move-on accommodation at Shoreline is therefore limited, although a number of clients have now begun to live independently and, in some cases, have returned to work.

Accommodation sites and problems with neighbours

Shoreline's properties are sited in locations that will cause minimal neighbour disturbance. For instance, using corner houses avoids having neighbours on two sides. Initially there was some community resistance to the project. But the Wallich made strenuous efforts to allay fears, including providing a 24-hour phone line that neighbours could use to report problems and by developing good liaison with the police. Neighbour problems are now minimal and local residents' forums see Shoreline as a solution to street drinking rather than a cause of neighbourhood problems. Crucially, clients like their housing, so they limit activities that might jeopardise their tenancies.

How does the Shoreline Project operate?

Referrals comply with the Wallich's anti-discrimination and diversity policies and procedures. Because of the importance of group dynamics in the houses, referrals must be acceptable to clients already accommodated at any project where a vacancy occurs.

Shoreline residents are not faced with lots of rules. Existing rules concentrate on not upsetting other residents, staff or neighbours. The aim is to make the properties as much like an ordinary home as possible so, for instance, overnight guests are allowed.

Support is intensive; each house has a designated worker, there is a round-the-clock staff rota, and all Shoreline staff have experience of work with street drinkers. Having said this, the method of support is low key, and focuses on developing solutions. This model, used throughout the Wallich, is based on the principles of solution-focused brief therapy, the cycle of change, and motivational interviewing. All staff are

trained in the basic techniques of these approaches during their probationary period with the organisation.

The Wallich recognises that alcohol users may also take illegal drugs, and it has an inclusive drug policy that works within the law to avoid exclusion and to promote harm reduction.³⁸

Reductions in drinking – improvements in health

Once off the streets, although drinking does not usually stop, it tends to become much more controlled. Residents may drink lower-strength alcohol, start drinking later in the day, and pace themselves more effectively. All clients have periods of abstinence; for some this may be days, for others, months. In a few cases clients do continue to drink very dangerous levels of alcohol. Clients are aware of the risk and staff continue to provide support. Clients respect the fact that in the Shoreline Project they are allowed to live and die with some degree of dignity, not alone on the streets.

Detoxification is now a planned process and happens at the client's request rather than respite care away from street living. Clients' general health also improves following better access to health services. All Shoreline clients are registered with a GP; previously, they would have accessed health services only via emergency departments. Clients also feel they can talk openly about their health with Shoreline staff. This leads to early intervention, as opposed to the deterioration until crisis point that tends to occur with street homeless drinkers.

Other projects

Although not a widespread approach, there are other examples of non-hostel wet provision including Docherty House Heavy Drinkers' Project run by Manchester Methodist Housing Group, and Albion Supported Housing run by Framework Housing Association in Nottingham.

If an area lacks wet provision, its response to street homelessness is likely to be incomplete. The work being done in wet hostels and day centres is vital, but when considering wet services, commissioning agencies and other dispersed wet providers should also consider the Shoreline approach.

Contacts and further information

For information about the Shoreline Project contact Bruce Diggins. Email bruce.diggins@thewallich.net

38 For more details visit www.drugsandhousing.co.uk/Wallich%20Clifford_files/frame.htm

Community Links Personality Disorder Accommodation Service

Introduction

Personality disorder is a difficult concept and one, it could be argued, which covers most social ills. According to Pidd (2005)³⁹ personality disorders are common in all their forms. Between 10 and 13 per cent of the adult population as a whole meets the criteria for personality disorder, and prevalence rates rise significantly among psychiatric hospital and prison populations. People with personality disorders are more likely to experience other mental health problems and to have multiple and complex needs relating to housing, employment, relationships and drug or alcohol use. It is unsurprising, then, that homelessness agencies report high levels of personality disorder among their service users.

Homeless people with personality disorders experience particular difficulties accessing services, resulting in a high level of unmet need. Specialist accommodation services are particularly important for such people, because housing and homelessness agencies are very often the only services actively engaged with this group. It is therefore essential that homelessness and housing practitioners have specialist skills and knowledge in this area.

Falling between two stools

Being diagnosed with personality disorder can change everything for service users. Many practitioners believe that personality disorder is untreatable and that there is little that mental health services can do to help. 'It becomes, in effect, a dustbin diagnosis', and a way of rationing limited mental health resources.⁴⁰

'Lucy has been diagnosed with personality disorder. I believe it's because she can be difficult to deal with and very demanding of attention. Most services don't feel equipped to deal with her behaviour, which they perceive to be too challenging. Mental health services refuse to accept that Lucy suffers from mental health problems and that she should be receiving appropriate mental health care and support.'

Manager of a homelessness day centre, Manchester

National mental health policy has traditionally developed around the concept of severe and enduring mental illness (which excludes personality disorder) and mainstream mental health services have developed accordingly.⁴¹ Thus, while some specialist personality disorder units do exist, the needs of people with personality disorder are largely unmet by the majority of health and social care services. Exclusion from the Care Programme Approach⁴² also prevents people from accessing many mental-health-supported housing schemes, and homeless people with personality disorder can fall between Supporting People services and mental health treatment services.

Health, care and housing services often view this group of people as difficult because their behaviour may, at times, be bizarre, challenging or aggressive and their problems multiple and complex. Rejection from accommodation and support services often leaves hostel and outreach workers to support people in the best way that they can, without specialised training or input from mental health services.

39 Pidd, F, *Personality Disorder – Everybody's Business*, Mental Health Review, September 2005.

40 George, C, *Dustbin Diagnosis*, Mental Health Today, September 2006.

41 The Mental Health Act 2007 changed the definition of mental disorder and criteria for detention with the removal of the treatability test. Both amendments have implications for people diagnosed with personality disorder.

42 This is the statutory framework for planning and reviewing post-discharge care for patients with severe and enduring mental health problems.

The National Personality Disorder Programme

The exclusion of people with a diagnosis of personality disorder from mainstream mental health services was illustrated clearly in policy guidance published by the Department of Health in 2003.⁴³ The guidance was critical of NHS provision and placed an expectation upon mental health services to take the lead in developing integrated services inclusive of personality disorder. The National Personality Disorder Programme⁴⁴ was developed and in 2004 the Department of Health commissioned 11 national pilot projects, each offering different approaches to addressing the needs of people with personality disorders.⁴⁵

Leeds Personality Disorder Network is part of the National Personality Disorder Programme. It is a multi-disciplinary project that links partners from health, housing, social services, probation and voluntary sector agencies. Nearly all clients supported by the Network have substantial housing needs and require specialist housing support.

Community Links Personality Disorder Accommodation Service

Leeds Personality Disorder Accommodation Service (LPDAS) is managed by Community Links, a large mental health charity that operates a range of housing and support services across Yorkshire and Humber, and is part of Leeds Personality Disorder Network. Leeds Primary Care Trust commissions the service, and referrals are accepted through the network, which is open to all agencies.

LPDAS provides:

- direct one-to-one support with service users
- advocacy and brokerage
- specialist housing assessments
- consultation, advice and support for practitioners
- personality disorder training packages.

Being part of the network enables LPDAS to deliver a co-ordinated and consistent approach to meeting clients' housing needs. The service has

developed excellent relationships with external practitioners, in particular care co-ordinators and health support workers, and this has enabled excellent communication between services. Close collaborative working also allows for the risk, very often accompanying this group, to be shared among practitioners.

Support, advocacy and brokerage

Core features of personality disorder relate to difficulties in forming and maintaining relationships, managing emotions and maintaining tenancies or coping with changes in accommodation. Thus, therapeutic housing support is essential in addressing the housing needs of homeless people with personality disorders. LPDAS develops trusting relationships with service users, providing them with ongoing emotional and practical support. The service is not tied to location and LPDAS works across tenure, helping people to find and keep accommodation or move to more suitable housing. Support is attached to the individual and follows them wherever they are, eg hospital, prison, hostel, etc. LPDAS will advocate on its clients' behalf and act as broker for other services.

LPDAS clients often have multiple and complex needs, and deeply rooted patterns of behaviour. Where other services may have excluded service users on the grounds that their behaviour is too challenging, LPDAS promotes the view that service users can achieve positive changes in their lives, and recovery is central to the service ethos.

'They [LPDAS] have provided me with help and support from the beginning in finding emergency accommodation... and then in accepting a priority extra flat... now I can live very independently which I thought I'd never do. [If the service hadn't been available] I would probably be at risk of harming myself or others, in prison or living rough on the streets.'

LPDAS service user

43 National Institute for Mental Health in England, *Personality Disorder: No Longer A Diagnosis Of Exclusion*, Policy Implementation Guidance for the Development of Services for People with Personality Disorder, Department of Health, London, 2003.

44 A collaborative initiative between the Department of Health and the Home Office that includes the development of policy, services, treatment approaches, training, education and research.

45 Visit www.personalitydisorder.org.uk for details of the national pilot projects.

Housing assessment

LPDAS has designed its own housing assessment tool that focuses specifically on the needs of people with personality disorders. It is a collaborative, holistic and client-centred needs assessment that formulates housing recommendations. The *Framework for Understanding Personality Disorder* assessment tool is used directly with service users and with front-line workers to aid understanding of their clients' needs.

Consultancy and supervision

LPDAS recognises the difficulties that front-line workers can face in trying to provide housing/hostel services for people with personality disorder, and the stress and strain that this can cause.

Supporting front-line workers is as important as the direct support of service users. Without support and expert advice, front-line workers can be reluctant to work with service users. LPDAS adopts a problem-solving focus in its support of service users and practitioners, and in its response to practitioners' concerns. Consultation and advice is available to all practitioners working in the Leeds Metropolitan District.

'There is an openness and genuineness to their advice and consultation work which is very enabling. They are willing to be flexible but are also clear and considered. They have a keen eye on the difficulties that this type of work can present to workers.'

Probation officer, Leeds Personality Disorder Network

Training

It is essential that all agencies working with people with personality disorder have the necessary competencies to deliver effective support to this group. LPDAS has developed a rolling programme of extensive training sessions for housing support workers to increase their knowledge and skills, and to inform their approach towards service users with personality disorder.

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The framework, assessment and other tools developed by Ray Middleton are called 'BLUEPRINT'. Please contact Ray for a copy or for further information.

Getting connected: housing homeless people who have a dual diagnosis

Introduction

Supporting people who have both mental health and drug or alcohol problems continues to pose a major challenge to front-line housing and health services. Despite some improvements in specialist services, provision remains patchy across the UK.⁴⁶

Many mental-health-supported housing providers operate drug-free referral policies, or they require formal mental health diagnoses and involvement with secondary mental health services. These criteria can exclude a large number of homeless people who suffer from common mental health problems. Many people are, at best, placed in inappropriate accommodation, often in 'hard to let' properties in undesirable areas with little access to the local infrastructure. They are left without support, leading to tenancy breakdown and eviction. Where referrals to specialist accommodation projects are accepted, health and support agencies previously involved with the service user frequently withdraw contact. Project workers can then be left trying to salvage tenancies and re-engage people with services.

One service seeking to bridge the gaps and work in the more holistic way needed is the Midway Project in Glasgow.

The project

Funded primarily by Supporting People, with smaller grants from Glasgow Council Social Work Department and Greater Glasgow Health Board,

Midway Services supports homeless people who have both mental health and addiction problems to maintain independent tenancies. Midway places service users in fully furnished temporary flats provided by GHA (Glasgow Housing Association) through the Hamish Alan Assessment and Diversion Team. Service users can remain in these flats for up to 42 weeks while Midway works with external and internal care and support agencies to establish a support package that will remain in place once the person moves into a permanent tenancy.

Midway receives referrals from a wide range of services including:

- internal drug and alcohol crisis services
- hospitals
- hostels and homelessness agencies
- social services
- prison and probation services
- the voluntary sector
- self-referrals.

People using the service have dual needs and may not have a formal mental health diagnosis, but all will be assessed as being vulnerable.

Getting connected

Midway provides the emotional and practical support that enables people with both mental health and drug or alcohol problems to achieve some

⁴⁶ *Service Without Substance: Addressing the gaps in service provision for street homeless people with a dual diagnosis*, Shelter good practice briefing, July 2007. *Helping practitioners to plan, organise and deliver services for people with co-existing mental health and substance use needs*, Turning Point Dual Diagnosis Good Practice Handbook, 2007.

stability, manage their addictions and maintain an independent tenancy. For resettlement to be successful in the longer term, people need to be linked into a range of services, both statutory and voluntary, and these services must provide an appropriate level of care and support. Midway is particularly successful in making the right connections and keeping these connections in place.

Everyone referred to Midway Services has a care manager, usually a Social Worker, Community Mental Health Nurse or an Addictions Worker.

‘Midway has given me my first experience of being housed and supported in fifteen years. I have always just gone from the hostel to the street to a different area, and the process starts all over again. They took me out of that cycle.’

Service user rehoused by Midway

Most service users require wrap-around services and care managers are formally obliged to sign an agreement with Midway, agreeing to continue providing support throughout their involvement with the service.

‘Practitioners have to tick the box from the outset.’

Tracy Lundie, Manager, Midway Services

A support plan is drawn up with each individual, focusing on his/her particular needs. The plan is reviewed regularly and aims to help that person take greater control of their lives and manage their mental health and addiction problems. This person-centred, recovery-oriented approach is central to the ethos of Turning Point Scotland.

‘Support is provided on a sliding scale; it can be increased or decreased according to need and moulded to suit the individual.’

Midway Services Co-ordinator

Midway works in a participatory way with other agencies and with other Turning Point Scotland

projects, to offer a holistic range of services. Turning Point Scotland has developed the Glasgow Pathways Group; an inter-agency system that provides a clear and accessible route for referrals to, and advice from, other Turning Point Scotland services.

Staying connected

‘Disengagement from external services is very rare as all service expectations are clear from the outset.’

Tracy Lundie, Manager, Midway Services

Midway works in partnership with external agencies and has systems to ensure that all are clear about their support roles and the level of input required from them. This is managed by bringing service users, and the practitioners involved in their support, together at review meetings every eight weeks. All agreed action points are recorded and sent to the relevant agencies. If agencies don't provide the agreed level of support, Midway will seek help from their named Senior Officer at the Mental Health Commissioning Team (Homelessness) who will assist in re-engaging the agency with the service user.

Midway Services has developed in such a way that it can delay housing applications and extend its support and housing service until the individual is ready to move on. For example, if a client is finding it difficult to manage their addiction, and if deteriorating mental health is affecting their ability to maintain a tenancy, Midway will delay their council housing application and extend support until the client has achieved stability.

Continuity of care

Once a service user has moved into a permanent tenancy, agencies may withdraw support. Loneliness, boredom and isolation can lead to deterioration in mental health, increased use of substances and heightened vulnerability. Midway attempts to counter this by providing follow-up support for eight to 12 weeks after the move. During this time Midway will continue to liaise with care managers and housing officers to ensure an appropriate level

of support. Midway contacts all service users three months and six months after they have moved, to monitor their progress and assess their situation. There is some flexibility within the funding to pick individuals up again if they are experiencing problems; helping to manage their crisis while advocating for a different package of care from their care manager. This enables continuity of support and prevents a revolving-door scenario.

Midway encourages all those it works with to participate in the development of the service, facilitating a service-user forum that provides a safe space for people to get together, socialise, learn new skills, and discuss what's good about the service and what they feel needs to change. Those interested in staying involved can continue to attend the forum after moving on.

'I come back to the forum for uncomplicated support. It's lonely otherwise; you can slide back into bad habits, become reclusive and paranoid. You can learn stuff as well and they're always at the other end of the line.'

Service user rehoused by Midway

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Unhousable? Housing people facing chronic exclusion

Housing people facing chronic exclusion is challenging, but it is a challenge that needs to be faced more often if rough sleeper levels are to fall. The Single Homeless Project (SHP) in Camden takes up this challenge with some success. This chapter discusses the principles and operational policies that enables it to do so.

SHP runs projects across London. The two in Camden: Dennis Handfield House and the 165 Project, are for people with the most complex needs. Referrals come from local agencies, and accommodation comprises a mixture of shared and self-contained facilities, providing a total of 55 bed spaces. SHP projects can be seen as something of a last resort for people failing in the mainstream homeless system.

An inclusive approach

SHP sees everyone as having an equal right to housing, no matter what his/her background. While many agencies claim to espouse this value, SHP puts it into practice. So, whereas in other projects the emphasis is often on who is excluded, SHP focuses on inclusivity. Its publicity states that they 'work with clients who may well have chaotic lifestyles or display challenging behaviour, and who may well have been excluded or excluded themselves from other services'.

Having taken on this challenge, SHP staff admit that, as potential residents, some clients will 'look appalling on paper'. They are people accused of 'not engaging', being chaotic or having challenging behaviour, people evicted for acts of aggression or violence, for rent arrears, and for being health and safety risks. Most will also be taking more than one drug, and have associated and often undiagnosed mental health problems or personality disorders.

The assessment process at the SHP projects, does not involve judgement on this basis. Rather a full

risk assessment is made of an individual's likely behaviour and the ability of the project to manage that behaviour. Once accepted into a project, a picture of actual behaviour is built up over the whole length of the stay, and an understanding of the underlying reasons for such behaviour is sought in order to try and address it. Clients are seen as people who are gifted, compassionate, and intelligent, with great potential. Their backgrounds and the skills they have developed in order to survive are seen as valid. Staff recognise that they have as much to learn and vice versa. This approach underpins SHP's practice.

Drugs policy and practice

A truly inclusive service must include providing housing for people with ongoing drug use. SHP accepts that drug use will happen, and that it needn't be a barrier to providing services.

To do this, staff must work within the law by having a clear drugs policy, using the relevant resources available, such as www.drugsandhousing.co.uk, and must consult and liaise regularly with the police. The drug policy allows clients to be honest with staff about their drug use, making for a safer environment. It also creates a platform from which reducing drug use can be addressed.

Recruitment, retention, ratios

SHP staff are expected to have a commitment to SHP principles and a good understanding of the client group. Working with people who have the most complex needs requires creativity, flexibility, and ability to handle setbacks. Therefore, investment in recruiting, training and retaining resourceful, well-motivated staff is essential. To enable successful key working, the staff to client ratio at SHP is low, with one member of staff for every two or three clients, and 24-hour waking cover.

Staff–client ratio is a sensitive subject, because the nature of competitive tendering and a squeeze on available funds means staff quality and ratios could be compromised. Commissioners need to consider this carefully; working with people with high support needs is not something that can be done successfully on the cheap, and the cost of trying to do so could be high.

The plan and the process

Under Supporting People funding to access supported accommodation, homeless people must agree to a support plan that will include targets to help them move towards independent living. All too often, however, well-intentioned but over-ambitious targets can do more harm than good. Inability to make sufficient progress can lead to a sense of failure, any benefits gained from controlling substance use and behaviour can be lost, and homelessness can recur.

SHP staff aim to create realistic support plans based on what the client wants to achieve, not what the worker wants the client to achieve or what goals the client thinks would satisfy the worker. The plan also recognises that clients do not necessarily lack motivation or aspiration and have often already achieved a great deal.

Day-to-day work with clients needs a careful, drip-drip approach. SHP’s housing in Camden emphasises that it is a place of change, but for multiply excluded people, change can be slow. Staff need to accept that sometimes even their careful approach won’t be enough to stop a client continuing with harmful behaviour. To quote one member of staff, ‘watching a client slowly deteriorate in front of you, never seeming to hit rock bottom in order to bounce back up again, can be incredibly frustrating and soul destroying, but it’s frustrating for the client as well as those around them. It doesn’t matter how good the service is if the person in front of you doesn’t want it’.

No warnings and time out

SHP has adopted two policies that have succeeded in reducing the number of clients who have to leave its projects:

- SHP does not issue stepped warnings. If a client’s behaviour becomes difficult, a meeting is held and a contract is agreed and signed by the client and worker. This is not done in the heat of the moment, but after a period of calm and contemplation. The contract is written in the client’s own terms; it describes the behaviour that is unhelpful, emphasises positive aspects, points out what needs to change and explains the consequences if the unhelpful behaviour continues.
- In addition for behaviour that needs addressing immediately, ‘time out’ can be agreed. This is made clear when someone first enters the project and is promoted as a way of helping people to retain their accommodation, not as a way of getting rid of them. Clients are asked to voluntarily leave the project for an agreed temporary period which varies from a few hours, to a few days to allow them and the situation to cool down. For someone used to homelessness, the mental demands caused by the change in environment in moving from unhoused to housed, even via a supportive project like SHP, can be incredibly challenging. In some cases it is a challenge that can’t be overcome, and the person’s ensuing behaviour can lead to permanent exclusion. The flexibility gained by the time out policy can be crucial in overcoming this.

Conclusion

Despite every effort to keep clients engaged, the SHP Camden projects cannot succeed with every client, and evictions do sometimes occur. It is also worth noting that because of funder requirements, the projects’ inclusive approach does not usually extend to people without a local connection. Even so, within these limitations, SHP projects in Camden are about as inclusive as it is possible to be, and wider adoption of their model would make a big contribution to reducing rough sleeping and the revolving door syndrome.

Contacts and further information

Further information about the projects discussed in this chapter can be obtained from Caroline Lamont at SHP. Email clamont@shp.org.uk

Shifting the balance of power

For agencies in the voluntary sector providing support services for vulnerable homeless people, much has been achieved in the field of customer involvement in the last 10 years. Indeed, involvement is now an auditable requirement of any agency in receipt of Supporting People funding. There are plenty of examples of good practice and innovative thinking; the Supporting People user involvement guide is perhaps the most comprehensive document on this subject.⁴⁷

Yet while progress has been good, it remains the case that only a minority of most agencies' customers are engaged in involvement activities, and their involvement is often limited in scope. This chapter focuses on Look Ahead Housing and Care's work to overcome this. Its customer⁴⁸ involvement programme won the 2006 Andy Ludlow Award.⁴⁹

Achieving engagement

Many hostel residents have institutional backgrounds and will not be used to exercising control over their environment. Some people may feel – ironically – that life on the streets offers them greater autonomy. In a hostel, therefore, it is an uphill task convincing previously street homeless people that they are not being deprived of the power to make their own life choices. By contrast, people who live in their own homes and are engaged with services only through floating support can feel distant from the organisation that serves them and see little relevance in involvement activity.

Widening customer involvement

One agency that has successfully broken down barriers to involvement is Look Ahead Housing and Care. Look Ahead provides housing and support to vulnerable people across London and south-east England. Eighty-two per cent of their customers are single homeless people or rough sleepers who have additional support needs, such as drug and alcohol misuse or mental health problems.

Look Ahead has been operating most of the more common involvement practices for some time. This includes customer satisfaction surveys, consultation meetings and participation in staff recruitment. It became aware, though, that although involvement activities were open to all, only a relatively small number of people were participating. Further, the customers that did participate tended to be involved in multiple activities, leaving the majority not engaging with any involvement activity. Look Ahead also noticed that young people, and those with mental health difficulties and learning disabilities, were least likely to be involved.

The first step to overcoming this disparity was to consult with customers to find out what was needed to increase take-up of involvement activity. From this, three linked priorities were established:

- 1 Enabling customers to engage in involvement through a training programme that takes account of the needs of different client groups.
- 2 Extending the range of involvement activities.
- 3 A commitment to create a structure of accountability to customers so that they have real influence in shaping the organisation at all levels.

⁴⁷ Godfrey, M, Callaghan, G, Johnson, L, Waddington, E, *Supporting People: A guide to user involvement for organisations providing housing related support services*, ODPM, London, 2003.

⁴⁸ Agencies use different terms to refer to the people they serve. This chapter uses 'customer' because it is the term chosen by Look Ahead following consultation with their own customers.

⁴⁹ The Andy Ludlow Award is given annually to a London agency that demonstrates good practice, innovative and creative solutions for tackling homelessness. For more information visit www.londoncouncils.gov.uk/cat.asp?cat=2424

Enabling involvement through training

Training doesn't just get more people engaged with involvement. For vulnerable people, skills gained through training will benefit them beyond their time in supported housing, and will help reduce their chances of becoming homeless again.

Look Ahead obtained funding, principally from the Housing Corporation, to devise a training programme to offer to customers from across the organisation. The programme included a number of modules: listening skills, responding skills, non-verbal communication, working safely, working with difference, and personal development, as well as understanding Look Ahead's various customer involvement initiatives.

Training was tailored to allow underrepresented groups such as single homeless people, young people, people with learning disabilities and people with mental health difficulties, to participate. To maximise its effectiveness, trainers with experience of working with these groups were recruited to deliver the training.

The programme exceeded its target, reaching more than 120 customers, most of whom had not previously been engaged in involvement activity. Look Ahead is committed to continuing the programme – vital, given that the organisation's average tenancy length is less than two years.

Extending the range of involvement activity

Customers who complete the training programme have the skills and confidence to be influentially involved at all levels:

- **Customer Services Committee** Customers have the opportunity to build strong relationships with board members and senior management, and are involved in the scrutiny of performance and quality data.
- **Policy Focus Group** This can influence policies and procedures in a range of areas including drugs, antisocial behaviour, and complaints.
- **Staff recruitment** Customers devise questions, sit on interview panels and get involved in inductions.
- **Periscope** Look Ahead's customer magazine written for customers, by customers.
- **Peer quality auditing** This is a flexible process that varies according to the scheme being audited, the people doing the audit, and the customers

the auditors are speaking to. Look Ahead gives guidance on what auditors need to monitor but allows them to formulate questions based on subjects that they think are important. Customer feedback informs the overall quality audit grade for the scheme and, probably more importantly, can lead directly to improvements in service, often with immediate effect.

A commitment to accountability

Meaningful involvement can only happen if customers have faith that they can influence change. At Look Ahead, senior management are committed to responding to recommendations arising from involvement activity, including action from the peer quality audits and Customer Services Committee.

A change for all

The training programme has increased involvement though it remains the case that only a relatively small proportion of the organisation's overall number of customers are formally involved. However, the trained customers have become informal representatives for the wider customer group, and there is increased confidence and belief among customers as a whole that giving your view is something worth doing.

Staff and customers

'It's a chance to meet new people, learn new skills and it teaches people how to focus their lives. If I wasn't here, I'd probably still be sitting in my room, not having a voice, feeling unheard, not part of anything'.

Transferring power to customers can give rise to legitimate concerns among staff. As part of its implementation of the new involvement programme, Look Ahead took great care to consult with staff and deal with their concerns at all stages in the process.

Contacts and further information

Further information, and Look Ahead's customer training programme handbook, can be obtained from katelawless@lookahead.org.uk or by visiting www.lookahead.org.uk

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