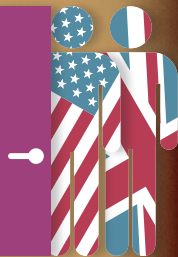


Transatlantic Practice Exchange 2016

Reports from 10 frontline professionals on an international exchange of knowledge and practice

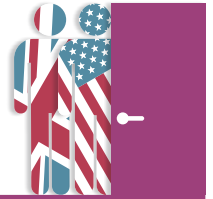


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2016

Transatlantic Practice Exchange



About the Exchange

The Transatlantic Practice Exchange is funded by the Oak Foundation and delivered by Homeless Link in England and the National Alliance to End Homelessness in the US.

Exchanges took place between April and June 2016, with participants spending up to two weeks on placement with their hosts and other local organisations.

Homeless Link and the National Alliance to End Homelessness would like to thank all the hosts and participants for their commitment and enthusiasm throughout the project.

Recruitment for the 2017 Exchange will take place in autumn of 2016. Please check www.homeless.org.uk and www.endhomelessness.org for news, or look out for tweets from Tasmin and Anna.

Participant blogs

Many participants blogged and took to social media to share their experiences of the Exchange using the hashtag [#homelesslearning](https://twitter.com/homelesslearning). See the individual reports for blog links.

Further information

UK

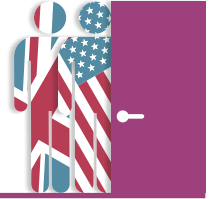
For further information on UK participants and hosts please contact Tasmin Maitland, Homeless Link's Head of Innovation and Good Practice.

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US

For further information on US participants and hosts, please contact Anna Blasco, Technical Assistance Specialist at the National Alliance to End Homelessness.

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From the UK

It is with great pleasure that we present the reports from our second Transatlantic Practice Exchange.

At a time when everything seems to be changing, with resources getting tighter and needs higher, it would be easy to lose sight of the opportunities to work differently. Yet now more than ever we need to look outside traditional boundaries, thought processes, and what we take as given. We need to find new ways of dealing with the blight of homelessness in our society and remain focused on our vision to end it.

Funded by the Oak Foundation, the Exchange is designed to provide frontline staff with the opportunity to spend two weeks in another context. In short, five participants go to services in the US, whilst five participants from the US come here. They go with a specific set of topics and questions to answer but, most of all, they go with an open mind.

The topics on both sides were varied, and the learning opportunities immense. All participants have taken home ideas that will help them to re-think their services and practice, in order to do things differently.

This is not a normal practice visit – by immersing themselves in the work of an organisation for two weeks, the participants also get to understand the context and organisational cultures in which their counterpart service is delivered. The idea is therefore not to bring home lessons to replicate, but rather to take a fresh view about how to overcome barriers, think differently and focus on solutions.

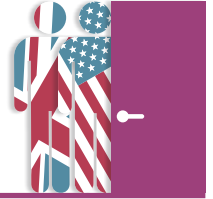
The reports are both insightful and inspiring, with each participant coming away with a new perspective on how to improve things and a new appreciation of where we get things right. As one of our participants puts it:

"Yes, I returned with lots of ideas that I want to implement within the services that I oversee – but in addition it took me out of comfort zone, challenged many of my own preconceived ideas and forced me to ask questions of my own practice. It was without doubt the greatest experience of my working life..."

It is this sort of inspiration that we need if we are to win our fight against homelessness. I hope that our 2016 participants have returned to work with renewed vigour and are already making change happen. I also hope that, by reading these reports, you are able to share in some of what has inspired them.

Mark McPherson
Director of Strategy, Partnership and Innovation
Homeless Link





From the US

The way we help end homelessness for people in the US is changing, and the result of that change is positive: homelessness has been on the decline since 2010.

Despite this progress, we have a long way to go before we end homelessness. And headwinds are stiff. The cost of renting affordable housing continues to rise at a much faster rate than do the incomes of most households. Treatment and services are often hard to access or unavailable. Nearly a third of people who are homeless are unsheltered. To continue reducing homelessness, among other things we are going to have to work smarter. This is why the Transatlantic Partnership Exchange with the UK is so important.

This class of US participants in the Exchange found much to absorb from practices in the UK. They learned how important it is to invest in and develop peer support as a critical component of any service. They got information on utilizing technology to provide robust homelessness outreach, and how to develop multi-systems collaborations to prevent and end youth homelessness.

For our part, I think the US was able to share its significant progress on implementing an across-the-board Housing First philosophy, its focus on permanent supportive housing as a way to integrate housing and health care for the highest need people, and the development of multidisciplinary teams. The US organizations that hosted UK visitors also reported learning a great deal from them.

The impact of the Exchange on its participants and their communities is invaluable. It is our hope that it informs the broader policies and practices of homelessness assistance in the US and UK. We extend our deep gratitude to the Oak Foundation for its leadership and support, and to our wonderful partners at Homeless Link for facilitating the Exchange and ensuring its excellence. Most of all, we thank and congratulate the hard-working participants, whose open mindedness and thoughtfulness you will see reflected throughout this report.

Nan Roman

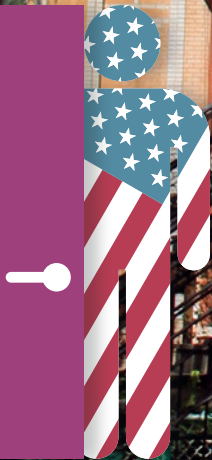
President and CEO

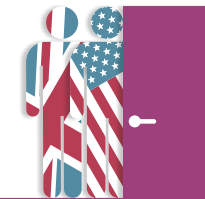
National Alliance to End Homelessness

Arthur Pearce

Shared service philosophies: Trauma-Informed Care

Heartland Alliance
Chicago





Arthur Pearce, Heartland Alliance, Chicago

Delivering shared service philosophies: Trauma-Informed Care

I have worked in the homeless sector for the past six years and currently work for SPEAR, an organisation based in Richmond-upon-Thames. I began working for SPEAR's Health Link Service as the mental health lead over a year ago. The purpose of the service is to facilitate improved health for clients through advocacy, practical support, information and advice. I was also fortunate enough to be tasked with implementing Trauma-Informed Care (TIC) across the organisation.

Our clients have a range of needs which are typically co-occurring and include illicit drug use, ill-mental and physical health, high rates of unemployment, inter-personal difficulties, and of course homelessness. Whilst I and most of my colleagues appreciate that the needs of our clients are often a consequence of the trauma they have experienced in the past, we have been lacking a consistent approach to responding to trauma positively. This is problematic because it is frontline workers in the homeless sector who get to know their clients intimately and will likely be the trusted recipients of disclosures relating to child abuse, domestic violence, torture and other traumatic events including being homeless in its own right.

It is overwhelmingly positive when a client builds enough trust in the person supporting them that they will talk about what has happened in the past and how it has affected them, but this is of limited benefit if that worker does not know how to respond effectively. Further to this, frontline workers may inadvertently work in ways which actually re-traumatise, and there are many ways in which this could occur. Not letting a client use an office phone without a justifiable reason, denying access to accommodation because someone is late on rental payments, and coercive practices to move clients off the streets are all examples of misuses of power which can mirror the abusive

relationships people have had in the past, and re-traumatise as a result. Without a framework for how we should respond to trauma, workers in the sector will continue to respond to trauma in ways which are either inadequate or harmful.

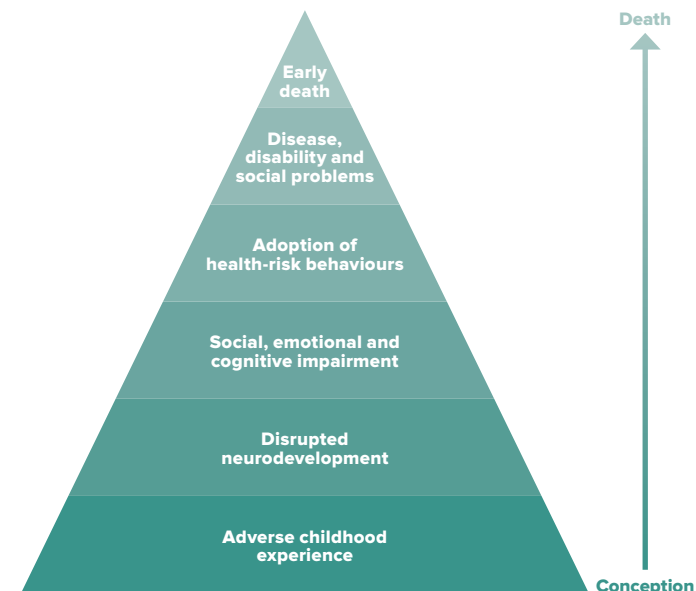
So what is TIC and why does it offer a solution to the problem? TIC is defined as an organisational structure which emphasises understanding, recognising, and responding to trauma effectively – exactly what I thought was missing in the sector. The guiding principles of this approach are:

- Safety
- Awareness
- Empowerment
- Choice
- Collaboration
- Trustworthiness.

Knowing what the core tenets of TIC are only goes some way to aiding the execution of this approach if one is not aware of what it can or should actually look like in practice. Which brings me to why I decided to participate in this year's Transatlantic Practice Exchange. Almost every reference I found to this approach was based in the US where there is generally a more constructive response to addressing the effects of trauma with the population we support than we might typically see in England. It seemed a great opportunity to learn about this approach first-hand and then to bring the lessons I learned back to England, building on the work of Jo Prestidge, one of the 2014 Exchange participants who focused on TIC.

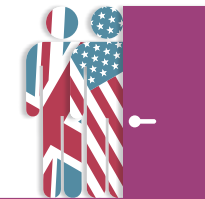
An objective way of understanding the significance of TIC is by referring to the original Adverse Childhood Experiences Study.

This US-based research demonstrated that trauma is more common than previously realised, but more importantly that it is a determinant of ill-health and low socioeconomic status – chronic issues for the homeless population. The model below provides a lifespan perspective for those experiencing adversity in childhood and unfortunately, based on my experience, this model is generally a perfect fit for much of the homeless population. Even for those individuals who have grown up in nurturing environments, trauma in adulthood is a risk factor for causing and maintaining homelessness. For example, veterans of war are over represented in the wider homeless population.



Mechanism by which adverse childhood experiences influence health and well-being throughout the lifespan

Image based on: www.cdc.gov/violenceprevention/acestudy



Arthur Pearce, Heartland Alliance, Chicago

Shared service philosophies: Trauma-Informed Care

I had five specific areas to focus on during my placement:

1. **Resources** – what resources are required to implement a TIC approach? I wanted to know if specific funds need to be allocated toward implementing this. If this can be achieved using the time and energy that staff and clients can offer, then it is important to know how this is balanced with other responsibilities.
2. **Resistance** – to know how resistance to a TIC approach from other staff within an organisation can be managed effectively. Change can be difficult for people so facilitating this in a positive way is likely to be key to implementation.
3. **Approaches** – to know what specific approaches can be employed to make a service trauma-informed. This might be changes to the physical environment, in the interactions clients have with staff, or organisational processes.
4. **Implementation** – there are a number of guides for implementing TIC although nothing specific for the homeless population. It would be useful to know which guide is used, if any, by organisations serving homeless people.
5. **Awareness** – how do US services educate frontline and non-frontline staff, as well as clients and even their partners so that TIC becomes embedded within the culture of the workplace?

US vs England context

I visited Chicago, Illinois where there are approximately 120,000 homeless people supported each year by the voluntary sector. In England, the homeless population supported by charities

is typically single homeless adults, as we have safeguards for families and, in theory, for individuals who are vulnerable owing to a disability, old age, or because they are fleeing violence. In such cases a local authority's housing options service would have a duty to provide accommodation for these individuals, but this is not the case in the US.

On my first morning in Chicago I walked around the city to get my bearings and saw a person or family who were homeless on practically every street corner. Most of these people would receive little more than \$100 worth of food stamps for the month, and I heard there were plans to reduce this to around \$30 per month. In short, given the lamentable state of homelessness in the US, it is arguably even more important than in England that the voluntary sector is there to support this group of individuals.

Heartland Alliance

The organisation hosting me in Chicago was Heartland Alliance. Established in 1888, they provide a comprehensive range of services to help tackle homelessness, including the provision of healthcare, housing, and employment. They serve a diverse range of people who experience homelessness such as families, victims of trafficking, survivors of torture, refugees, veterans, and other single homeless adults. It was their Philosophy of Care that most interested me initially, as this provided the framework which enabled all their services to acknowledge and respond in an effective way to the trauma their clients have experienced. Heartland were also kind enough to arrange for me to visit other organisations supporting homeless people across the city.

Trauma Informed Care in Chicago

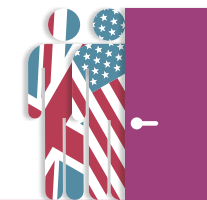
Supportive Housing Programmes

On my first day with Heartland, I met with the managers and staff team for the independent supportive housing programmes as part of Heartland Human Care Services, one of the five arms of Heartland Alliance. They provide accommodation and support to single homeless adults who would not be deemed 'vulnerable' enough for more intensive support. I was told about the trauma-informed nature of their work, and here's what stood out:

- Participants are actively encouraged to use the grievance procedure from the point at which they access services in order to feel empowered and to develop a sense of trust in providers.
- Rather than focusing on what's wrong with participants and labelling them as, for example, 'non-compliant with medication', Heartland looks to work therapeutically and understand the underlying thoughts resulting in maladaptive behaviours i.e. 'the medication is a reminder I'm HIV positive'. This increases choice, trust, and empowers participants.
- 'Transition-departure' forms ensure as little disruption as possible when being allocated a new caseworker. This is completed in partnership with the current caseworker and outlines the express wishes of the participant in relation to their future care and support. It also provides historical information so participants do not have to repeat their disclosures and risk being re-traumatised.
- Heartland embraces differences and reviews gender identity and other protected characteristics each time a

Arthur Pearce, Heartland Alliance, Chicago

Shared service philosophies: Trauma-Informed Care



support plan is reviewed. This specifically addresses the trauma resultant from discriminatory attitudes that the LGBT community experience.

Given that the core tenets of TIC are awareness, safety, empowerment, choice, collaboration and trustworthiness, it was evident that this service was trauma-informed. Furthermore, I could see that a TIC approach had been truly embedded within this service as each staff member was able to articulate their thoughts on what aspect of the way they work was trauma-informed.

Anti-trafficking

There are more than 10,000 human trafficking victims brought into the US each year. Often, victims come from difficult backgrounds and are promised decent jobs and a good wage when they arrive in the US, only to become indentured servants. Heartland supports victims who have fled their traffickers by ensuring that survivors can rebuild their lives. This is a complicated process requiring expertise and a coordinated multi-agency approach, but it can be achieved through a range of practical measures such as acquiring the necessary documents for non-US citizens. However, as with the supported housing programmes, it was evident that this service uses trauma-informed practice, which facilitates more positive outcomes than would be achieved otherwise.

A theme that I observed within the anti-trafficking services was their specific focus on preventing re-traumatisation – an important element of TIC. The team presents all possible options of support to survivors and essentially has a zero-tolerance policy on the use of coercion, which would not only undermine

their relationships with the people they support, but would also mirror the abusive power differential survivors experience with traffickers. This creates a sense of safety and control for survivors who may not have experienced this for a long time, if ever.

It is essential for all staff in the service to understand the impact of trauma and to appreciate the importance of a TIC approach in their work, no matter what their position. For example, the receptionist would not assume someone feels comfortable being left in a waiting area alone, so will try to avoid anyone being left in what is an unfamiliar or uncomfortable environment for longer than necessary. They will also make a concerted effort to be welcoming and put someone at ease by striking up a conversation. This could just be seen as professional behaviour, but the real motivation for this is part of a shared service philosophy where the way the receptionist of a service interacts with clients is just as important a consideration as the interactions of frontline workers. As also demonstrated in one of Heartland's films, this gives a greater sense of purpose and gratification to roles which are not typically seen as being important in directly meeting the needs of clients.

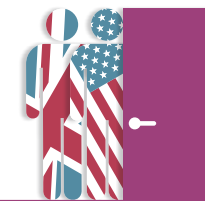
Heartland - Homeless Health

Heartland Health is another arm of the organisation filling a gap in provision for the health of homeless people. In England, we have universal health care through the National Health Service (NHS) so, as with anyone, a person who is homeless can get their mental or physical needs met without incurring any financial costs. However, this isn't a perfect system and as a whole the NHS does not always respond to the needs of homeless people effectively, so this is an issue on both sides of the pond.

I was incredibly impressed with the wide array of services available, which essentially look like primary and secondary care in England. However, as well as access to primary care for physical health, mental health and substance use, they also offer a day programme which provides practical support in terms of access to showers, washing machines and hot food. They have psychosocial treatments available throughout most of the day, including rational thinking, stinking thinking (addressing negative thinking), coping skills, and trauma counselling, which are available irrespective of whether someone is using illicit substances or not. It is clearly trauma informed to offer support that directly addresses the effects of historical trauma one way or another, but the really great thing was that none of this support was conditional. Someone might want to simply come and wash their clothes one day, and if that was all they got out of the service for the time being then so be it, but they would be welcome to join when they were ready.

The Night Ministry - Mobile Health Outreach

I also had the opportunity to visit a service managed by one of my US counterparts on the Exchange, Tedd Peso. They have accommodation services, parenting programmes, youth engagement, LGBT services, and a mobile health outreach service which runs alongside some of the other help they provide to hundreds of people in need each year. I had a brief meeting before we went out on the mobile health unit and everyone introduced themselves using their preferred gender pronoun. For example, 'My name is David and I use she and her', meaning that they would like to be referred to as 'she' or 'her' in conversation.



Arthur Pearce, Heartland Alliance, Chicago

Shared service philosophies: Trauma-Informed Care

I was taken aback by this approach as it was so removed from anything I had seen in England, and I thought it was a great way of establishing parity for individuals who identify as LGBT. When I expressed my surprise, I was told that there was initially a level of concern expressed by the Chief Executive who, understandably, thought this approach could force people to 'out' themselves. But the commitment of staff to TIC won them over, which I think demonstrates how influential frontline staff can be in steering the direction of an organisation as a whole.

Once we had finished introductions we headed out on the very impressive, tailor-made bus which provides health services including:

- Treatment for injuries or minor illnesses
- Mental health screening on mobile phones provided to young people (reflecting the trauma-informed principle of empowerment because it uses a mode of communication young people are comfortable with and which is readily available)
- Screening and monitoring of chronic health problems e.g. asthma, diabetes, HIV.

One reason this service is so important is because people may not seek healthcare from ordinary providers because they have felt vilified for using services 'inappropriately' in the past. For example, this might be the case if they have sought medical care for health issues that arise from drug use, which can be seen by providers as self-inflicted, irresponsible, and less worthy of medical attention. A trauma-informed approach acknowledges and respects the perspectives of individuals who do not feel able or willing

to access mainstream services because of this, and in line with the TIC principles of providing greater choice and empowering individuals, the mobile health outreach service was created to provide healthcare in a way that enables people who are homeless to address their health needs in an environment free of value-laden judgements on why they have any particular health issue.

Findings

1. Resources

For the most part it was the investment from staff which was the largest resource required for this to be successful. The finance specifically allocated to the implementation of Trauma Informed Care was small, if any at all, in most cases. The only direct cost for Heartland seemed to come in the form of mandatory training on TIC which provided a baseline understanding for all staff. However, if the provision of trauma counselling were seen as directly part of a TIC approach then there would be associated costs, although I believe they simply saw this as part of healthcare provision, even though it complemented TIC.

2. Resistance

This was not a common issue because the organisation was explicit about its commitment to TIC. Individuals interested in working with Heartland would have to be invested in this approach otherwise they were likely in the wrong job. There were also a far greater number of staff clinically trained to deliver trauma counselling than you would find in England, so they had a background conducive to appreciating this approach.

3. Implementation

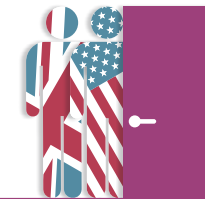
No specific guide was used by Heartland and it was encouraging to see that they had achieved the implementation of TIC without one. They drew upon the experience of staff and clients in order to make this work. There are certainly a number of specific guidance documents available online, but I believe the Creating Cultures of Trauma-Informed Care toolkit is applicable to homelessness services and provides a step-by-step guide to implementation from kick-off event to evaluation.

4. Awareness

Heartland scrutinises its policy and procedure framework to ensure the language is accessible to clients. This empowers them to understand what service provision ought to look like and then challenge this if they feel services are falling short. All staff have training on TIC which provides a foundational knowledge. Some of the health programmes also discuss the impact of trauma with clients so they gain insight into their own problems and can start to appreciate why they experience the difficulties they do.

Applying learning in England

I have already had meetings with specific services based in London to discuss TIC and how I have implemented this approach, and will continue to do share this learning. I have even more to share now that I have completed the Exchange so I am able to begin facilitating the implementation of TIC at a local level, including within my own organisation. At SPEAR, I have discussed my learning with my colleagues and have already incorporated this into the TIC training I was delivering prior to my trip.



Arthur Pearce, Heartland Alliance, Chicago

Shared service philosophies: Trauma-Informed Care

I will be discussing TIC at multi-agency meetings, such as our own homelessness forum, with the hope that support services outside of the homelessness sector also have a desire to adopt this approach so that we can create a trauma-informed community beyond individual services. I have read of these communities in the US and they include a TIC response from education, police, health, and offending services.

I would like to see more psychotherapeutic interventions available for our clients with substance use issues in England, as they were with the Homeless Health service, and will certainly be advocating for this at various forums. There didn't seem to be such a high degree of concern around the guidance supporting psychotherapy for our client group in the US as there is in the UK. We hear time and time again that our clients will have to engage in group sessions at their local drug and alcohol service before receiving mental health interventions. This is often appropriate, however there are some people who are desperate for psychological support and would be able to engage with this despite their substance use issues, but who are currently excluded. We have some specialist psychotherapy services for homeless people in central London and the response from my clients accessing these services has always been positive.

Conclusion

There has been a vital gap in service provision as almost all of the issues our clients face are the result of repeat trauma in childhood, traumatic incidents in adulthood, or both. It is therefore imperative that services do what they can to respond to trauma effectively including not operating in ways which re-traumatise.

Trauma Informed Care is an approach which enables homelessness services to achieve their objectives, whether that is simply sustaining the transition from homelessness for their clients or improving wellbeing in all domains. This approach and its implementation needn't require large financial investments and can become largely self-sustaining once embedded as a workplace culture.

It is time for us to get to the root of the problem and give the people we serve the opportunity to tell their stories in a safe, non-judgmental environment, while knowing they will be listened to and supported in ways which create lasting change.

If you are interested in finding out more about my Exchange, please read my blog:

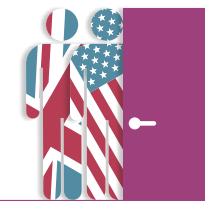
transatlanticexchange2016.wordpress.com

Heather Yeadon

Permanent Supportive Housing for people with enduring needs

Central City
Concern
Portland





Heather Yeadon, Central City Concern, Portland

Permanent Supportive Housing for people with enduring needs

I am Senior Project Worker at Wintercomfort for the Homeless, in Cambridge, which is a day centre for homeless people. My Exchange placement explored Permanent Supportive Housing for those with enduring needs.

The term 'enduring needs' refers to those whose needs are longer term than the transitional/hostel housing model caters for, but who will require ongoing support in order to maintain accommodation and wellbeing. This came out of some work in Cambridge involving Wintercomfort, which looked at the need for longer term support for some people who were in the hostel system and faced difficulties moving on due to their need for ongoing support. These people often ended up in a 'revolving door' scenario, repeatedly accessing homeless services. Several organisations in Cambridge have been working together to look at the type of support or housing models that could be implemented to better serve this population.

The learning objectives for my time in the US were:

1. What is it that makes Permanent Supportive Housing (PSH) successful for complex needs residents?
2. How do the services work together to provide wrap-around support, particularly during transitions from one service to another?
3. How is the service personalised and what additional support is available to the most complex needs clients?
4. In PSH how are peer mentors recruited, trained and supported to perform their role?
5. How do PSH projects build community within the projects and within the wider society?

Part of the Cambridge context is the lack of money available from the council to fund new housing models, so I tried to look at different perspectives on the topic to come up with ideas that might be realistic within budgetary constraints.

From a personal perspective, I was excited to have the opportunity to learn about US services, and went with an open mind, not only to learn about this topic, but also to discover new ideas. I was interested to see how learning from the US might apply to the day centre in which I work.

Central City Concern

I was hosted by Central City Concern (CCC) in Portland, Oregon. Formed in 1979, they are a multi-faceted service with 1,589 apartments in 22 buildings. CCC's mission is to provide comprehensive solutions to ending homelessness and creating self-sufficiency.

There are 11 health centres, employment services, and sobering services. Housing options include transitional housing, permanent supportive housing, and family housing. They use Housing First and harm reduction approaches as well as alcohol and drug-free projects. 62% of their housing is drug and alcohol free.¹

CCC are a growing organisation, open to new ideas and approaches to best serve the community. They are currently in the process of building new accommodation to provide more affordable places to live. They serve about 13,000 people each year.

CCC's core programmatic approaches include:

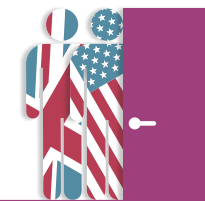
- Direct access to housing which supports lifestyle change.
- Integrated healthcare services that are highly effective in engaging people who are often alienated from mainstream systems.
- Development of peer relationships that nurture and support personal transformation and recovery.
- Attainment of legitimate income through employment or accessing benefits.

Learning and findings

Complex needs, wrap-around support and personalisation

One of the CCC teams that works on permanent supportive housing (PSH) is the Community Engagement Project (CEP) Team. They provide wrap-around support to enable people to succeed in housing. The people that can access it have been chronically homeless and typically have a substance abuse problem often combined with a mental or physical health problem. They are often in scattered site housing, approximately 60% with private landlords, and some are housed within CCC's accommodation. I learned first-hand what contributes to the success of the team, how they work together, and how the service is personalised.

The CEP team is multi-disciplinary, with a housing specialist, psychiatrist and peer support worker as well as case workers, typically trained to Master's level in a social work field, as well as having a dual diagnosis qualification. Therefore they have a lot of readily accessible expertise to serve their clients.



Heather Yeadon, Central City Concern, Portland

Permanent Supportive Housing for people with enduring needs

Case workers integrate therapeutic approaches into their client work. During one visit the case worker encouraged the client to use mindfulness in his everyday tasks. This client would perhaps not have gone to a specific mindfulness session, but instead the technique was introduced during a conversation that took place at his home.

The support is flexible. On one occasion a caseworker received a call from a client who was really struggling, and was able to see him at short notice at his home. This helped the individual to get support when he needed it, to deal with how he felt and make some steps towards the agreed support plan. They have a 'clinician of the day' who is on hand to help with issues that arise that have not been planned for that day.

The team uses a harm reduction approach. They explore with the clients what could lessen their suffering. The aim is not necessarily to curtail their use of substances, if this is not what the person wants, but to focus on how to make their life better. The team are advocates for their clients; helping them to communicate what they want for their lives. In terms of their addictions, the client may be at pre-contemplation stage, so the workers use motivational interviewing techniques alongside harm reduction to try to help them to begin the process of recovery gradually, keeping the person at the centre.

Clients can be on this programme for as long as is necessary, often between three and seven years. It can be longer or shorter, depending on the person and their progress towards stability. Measures of stability include maintaining their accommodation for more than two years, having a support network in place, and managing their support needs effectively.

The team helps people to build stable support networks by working with their social networks. This could be, for example, by offering support to landlords and to other people they regularly engage with, such as neighbours, family and friends. They also hold and encourage clients to attend group sessions to learn about different things that might help them, as well as to meet others in similar situations.

It helps that CCC are able to provide most of the support services that a client might require in-house, as they have a shared philosophy and shared ways of working that help to ensure smooth transitions for clients between services. They use the term 'warm hand-over' to explain the process of ensuring a smooth transition. This might involve initially accompanying a client to appointments with someone new and accepting that a transition may take a significant amount of time to become stable. Some programmes check in with their graduates for a period of time after they have graduated (i.e. moved on from the service), and some have alumni groups to enable their graduates to return. These things help to prevent people going backwards in their recovery during transition periods.

Consistency and stability were considered to be important aspects of supporting this client group to engage. The whole team can access client support plans to ensure consistency. The team meet once a week to discuss clients and share knowledge and expertise.

Part of the success of this programme is that they have been able to prove that providing this wrap-around support is cost effective as it reduces client engagement with high cost

emergency services. For those with complex needs providing wrap-around intensive support can have a positive influence on the individual and wider society.

Recruitment, training and support for peer mentors

Using peer support volunteers had been suggested as a cost effective way to offer support to clients in the 'enduring needs' groups. I therefore wanted to learn more about how this might work in practice.

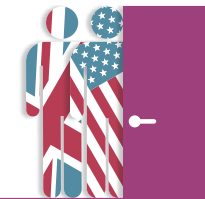
At CCC, people are eligible to apply to work in a Peer Support Worker role after being clean and sober for two years. Prior to this they may have worked in the On-Call team, a CCC social enterprise that provides work for CCC clients as temporary staff to cover the front desks of their projects. People do not need to have a specific period clean and sober to work for the On-Call team.

The Peer Support Worker role involves a 40-hour training course and trainees learn about a range of topics including: employee conduct, mental health, addiction, evidence-based practices, diversity, communication, clinical notes, nicotine cessation, the services CCC provides, terms and definitions, and trauma-informed care. It's a paid role, valued in line with staff who are social work qualified.

Direct experience is seen as just as valuable as other forms of study, and the workers are often integrated into a multi-disciplinary team. CCC also has one project that is entirely run by Recovery Mentors, people with experience of recovery from drug addiction.

Heather Yeadon, Central City Concern, Portland

Permanent Supportive Housing for people with enduring needs



Peer Support Workers advocate for their clients and support them to attend appointments and engage with services. I met one of the co-ordinators of Peer Support Services at Clackamas County and she said that every day she re-visited the National Ethical Guidelines for Peer Practice to keep these at the core of how she performed her role. The guidelines include things such as being empathetic, person-driven, and respectful. She explained the importance of advocacy and how within her role it was important to always be on the side of the client and fighting for their wishes, even if these varied to what other people within the team might think.

At CCC 46% of staff have lived experience and 25% have experienced CCC's programmes directly. People with lived experience fulfil roles at all levels and within all departments of CCC. Their expertise is used to inform practice with individual clients, as well as with programmes and CCC as a whole. The culture of the organisation, and the pride they take in their workforce, helps to ensure people feel supported within their role. The Peer Support Workers receive regular management supervision.

The Recovery Mentor programme is a housing project for people who want to stop using drugs, and is based on the 12-step Narcotics Anonymous programme. The workers are previous addicts, in recovery, who have been through the programme. They continue to attend NA meetings with their clients and this helps to reinforce the messages of the programme and focus on looking after their own recovery, as well as giving them strength to help others. NA has some useful facets for making a resilient team. When I asked the team about how they dealt with people relapsing, they

explained that you cannot own other people's successes or failures. Doing the 12-step programme is a strong basis for understanding how to support and be supported by others. It also promotes the belief in a higher power, of people's choosing, and this seemed to give people strength to perform their roles.

Building community within projects and wider society

In our research, in Cambridge, support networks were highlighted as one of the issues that people in the 'enduring needs' group face, so I was interested to learn how building community could be beneficial in creating support networks for people and therefore curtailing the use of more expensive forms of support and getting people reintegrated into the wider society.

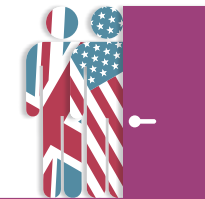
There were many different ways that I could see projects at CCC helped people to build support networks and feel a part of their community. One of my initial realisations was that other people going through the same programme are one of the most effective resources. This was particularly noticeable within the alcohol and drug-free housing where it makes the clearest sense to build a support network with others who have the same aim. A clean and sober support network was seen as crucial to maintaining sobriety. On-site projects deliver a lot of activities that encouraged interaction between clients. In some programmes there is a lot of contact initially, such as people having to go to a daily check-in to get more help and prevent isolation. There are compulsory activities, like meetings, movie nights, games nights and meals, so people get to know each other and form supportive bonds with others.

The Narcotics Anonymous programme also offered people community support by giving them a sponsor and asking them to do 'service'. They were therefore receiving a service from someone who was being successful in their recovery and were providing a service to others.

Resident meetings gave people an opportunity to talk about how they were feeling within the community and deal with any conflict that arose. At the meeting I attended, people discussed how the showers had been left running. The recovery mentors explored this with the group and encouraged positive ways to deal with the situation, which bred understanding and tolerance of others.

As I mentioned earlier some of the other programmes helped build community support for an individual by working with the people in their lives. So, for example, a neighbour might be given the contact number for the case manager. For people living in scattered site housing it is harder to build community, and often people tend to isolate. They try to overcome this risk by having groups at CCC, providing bus fares, and by accompanying people to activities in their local area.

Giving each person a role or responsibility can help to build community. Social enterprise, Clean and Safe, helps to people to fulfil a crucial role within the wider community by working in a paid role as part of an employment training programme. Their role involves keeping the streets clean in the Downtown area of Portland. This is a great link between the wider community and the people in CCC projects. The Employment Access Centre at CCC provides various routes into employment including a Supported Employment programme.



Heather Yeadon, Central City Concern, Portland

Permanent Supportive Housing for people with enduring needs

Entering employment is seen as a crucial part of people's recovery and integration into wider society.

CCC also have culturally specific services which enable people from the same background and culture to be a part of a community specific to their own culture.

Applying my learning in England

I will be feeding back to the work group in Cambridge about my findings from my time with CCC, and will be presenting at Wintercomfort and in other local meetings.

I would like to see all new housing projects consider the option of using multi-disciplinary teams. It would be beneficial to have peer support workers as part of the teams to help promote recovery, and offer hope and understanding. This role could provide the link for people to be able to engage better with existing services and influence services to be better engaged with client's desires. I will be able to share my understanding of the sort of training that might be required and some of the philosophies around this role locally and nationally. However having professional support such as a psychiatrist, that can work in a flexible and integrated way, is of equal importance and I would be interested to look at how we can build more understanding and co-operative relationships with specialist services.

I am interested to learn more about Narcotics Anonymous concepts and how some of the ideas can be applied outside of the traditional 12-step programme to help build community and support networks. Some of the aspects of community that

I saw were embedded within the cultures of the projects and I think it would be interesting to speak to NA here to better understand some of the concepts and how they could be used to benefit clients as well as staff teams.

Engaging with the Housing First England movement would be the best way to further my understanding of PSH in the UK and be able to feed my experiences at CCC into the work that they are doing.

Use of Permanent Supportive Housing means more accessible housing is needed on an ongoing basis. We need to fight for more affordable housing so that people have more choice and are able to access the private rented sector more easily if they wish to, as well as accessing flexible and person-centred support services more easily within the community.

Conclusion

My two weeks with CCC taught me a lot more about the nature of recovery and how multi-faceted this is. In order to recover from an addiction and re-integrate into society a person may have to change the way they think, the way they spend their time, and the people they spend their time with and have a deep determination to succeed. I have a deeper understanding of how going through medium needs transitional housing models does not necessarily offer the kind of transition that people need in order to recover fully, and as a result there is a higher chance of re-entering services. Therefore it seems really important that people receive appropriate professional support and the support of a community of positive influences around them.

I'm not sure the 'revolving door' will go away. The process of change is hard and bumpy, and many things can go wrong along the way, but there are always new options to try, and the ending of any placement can be used as a learning experience for both the client and the people supporting them, rather than seen as a failure. If we continue to look at the common causes of repeat homelessness in a holistic way, including internal and external factors for the person and whether there were any measures that could have prevented the housing breakdown, this will help guide and focus us on solutions that avoid repeat homelessness.

Permanent Supportive Housing is really effective. In our smaller setting, making the case for this level of investment and associated cost savings will be challenging. Working alongside national projects such as Housing First England, as well as local services such as the Cambridge MEAM project, will enable me to explore the feasibility of implementation. By understanding what makes PSH a success, we can reflect on how to integrate some of this learning into existing services, as well as considering PSH as a concept in its entirety.

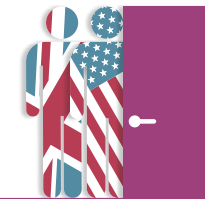
I can see Wintercomfort's service delivery more clearly in light of my Exchange, including how important the long term, problem solving and flexible nature of the service is, as well as how it fits in with other services. It has made me re-evaluate what we are doing and think about how we can best communicate our value to ensure we get funding to continue this work. My time in the US has also informed my day-to-day practice and I have been able to share these new ideas with my team.

1. Harm reduction focuses on safer/reduced use of drugs and alcohol, as opposed to abstinence

James McCombe

Rapid Rehousing





My name is James McCombe and I work as a team leader for No Limits, a young people's information and advice service in Southampton. Two of the main problems young people access us for support with are housing and homelessness.

I have worked at No Limits for about 12 years. Over that time, despite various policies and initiatives from both national and local government, young people now seem to have fewer housing options, fewer chances with housing providers, less access to long term housing and less housing security.

When I applied for the Transatlantic Practice Exchange I was looking for a solution to one of the biggest challenges we face as an organisation when attempting to house young people, which is getting private landlords involved. In the UK due to reductions in local services and reducing numbers of social housing units, the solution for homelessness is increasingly seen to be shared housing within the private sector. However in certain cities in the UK including Southampton, young people on low wages or reliant on benefits can find it almost impossible to find a landlord who will house them. This is both due to the amount of money needed to pay a deposit and first month's rent plus any letting agency fees, and the fact that landlords consider young people to be a very risky client group with the potential to lose them a lot of money.

In a rental market where there is a high demand for shared housing and where students, single adults (25 to 35s) and young people (under 25s) are all competing for the same housing, young people are often considered far too risky to house. In Southampton we find it particularly difficult as we have two universities with a seemingly endless supply of students wishing to live in the shared housing available,

with parents who will act as guarantors. They are far more desirable tenants than young people on benefits with no one to act as a guarantor.

I knew that for many years the US has had a large private rented sector and low percentage of social housing. The US has seemingly maintained a buoyant private rented sector with long-term security of tenure. However many cities in the US have high rents and young people are young people all over the world so I felt it would be interesting to learn about schemes to encourage landlords to house young people.

It was suggested by the National Alliance to End Homelessness for me to visit Northwest Youth Services (NWYS), a youth homelessness service in Bellingham, Washington State.

In May 2016 I visited NWYS to learn about Rapid Rehousing for young people. Rapid Rehousing for young people is described by the US Department of Housing and Urban Development as an approach that incorporates the following: rapidly moving youth into permanent housing, offering short to medium term financial assistance, and providing developmentally appropriate case management and services.

I had four specific questions I wished to answer during my visit:

1. How do they encourage landlords to house young people in the private rented sector?
2. How is it financially viable / how are they funded?
3. How do they work with young people to encourage them to take responsibility for their tenancies and behaviour?
4. How do they help young people maintain their tenancies in the long term?

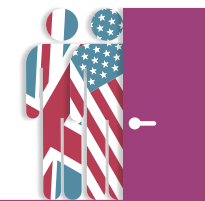
Homelessness in Bellingham

Bellingham is a small city in Whatcom County in the north west of Washington State with a population of 85,146. Bellingham has a growing and very visible homeless community. The Whatcom County annual homeless census for 2016 counted 719 individuals who were considered homeless. This included those living in emergency shelters (25%), out of doors (30%), transitional housing (26%), abandoned buildings (1%), vehicles (13%) or a structure lacking basic amenities (6%).

This means that 216 people were street homeless in and around Bellingham on any given night. Southampton has a population of 249,500 so over twice the size of Bellingham. If Southampton had a quarter of that number I can't help but think it would be considered a crisis.

Some figures relating to young people are particularly alarming. 163 of the 719 were under 18 years old, or 23% of all homeless persons. 16% of all homeless persons were less than 10 years old. 56 persons counted were 16 to 21 years old. 96 persons were 16 to 24 years old and 7 homeless minors (age 13-17) were unaccompanied.

Like Southampton, Bellingham is a university town and even though, as in Southampton, student accommodation has been and is being built, the student population still takes a high percentage of the rental market. Bellingham has a rental vacancy rate of just 0.2%, so finding accommodation in the private rented sector is a real challenge. If you add landlords' prejudices against young people or possible mental health or substance misuse issues, finding accommodation for the clientele of NWYS must be very challenging indeed.



In the UK, a Crisis mystery shopping exercise found that for single people under 35 years old on the shared accommodation rate of housing benefit, in a number of areas only 13% of the shared accommodation advertised was affordable. Once landlord willingness to let to benefit claimants was taken into account, this figure fell to under 2%. Once again, if you add prejudice against young people, this figure would probably drop dramatically.

Northwest Youth Services

NWYS offers a range of programmes aimed at ending youth homelessness in Whatcom County. These include street outreach, a shelter for 13–17 year old runaways, a transitional housing programme, and a permanent housing programme. They also have a vocational programme, a teen court, and an LGBTQ (Lesbian, Gay, Bisexual, Transgender and Questioning) group called the Queers Youth Project.

Initially it may seem strange for a youth homelessness service to facilitate a juvenile detention diversion programme such as a teen court. However when you consider that in the US having a criminal record can be a real barrier to housing, and that landlords are able to check someone's criminal record, it makes sense that NWYS offer a diversion programme to decrease future barriers to housing. It may also seem surprising that NWYS has a young person's LGBTQ group, but when you consider that in the recent Whatcom County annual homeless census 23% of homeless youth identified as lesbian, gay, bisexual, transgender, or queer it makes more sense. It was reported to me that being ostracised from one of the more religious rural communities or one of the Native American tribes due to sexuality or transgender issues often led to homelessness for LGBTQ young people. The Queers Youth Project is a support group and also

provides training and advice to services and organisations on how to best support LGBTQ young people.

NWYS offers a vocational programme which includes one to one support with creating CVs, looking for work, and applying for jobs and college. They also have an art space where young people can learn about screen printing and sewing amongst other arts and craft skills, with a shop to sell products made by the young people.

A gardening project called We Grow employs five young people for five hours a week during the growing season. They grow vegetables in a garden next to NWYS which are sold to local restaurants and at the local farmers market, and donated to the local food bank. The project is run with the support of a local university which provides a staff member who teaches the young people about various growing techniques and know-how. Agriculture is one of the biggest employers in the region (and I guess the newly legal cannabis trade need growers too) so being able to put this work experience on a CV is fantastic. NWYS employ youth in other roles such as the janitor at the offices, giving young people vital work experience.

NWYS has a street outreach team called Detour. The team are out seven days a week, providing seven hours of outreach each day. Not only do they engage the homeless young people of Bellingham, they also visit the more rural communities of Whatcom County as well as the county jail.

Housing support

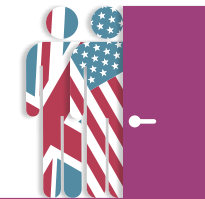
NWYS has two main housing programmes: the transitional housing programme and the permanent housing programme.

Transitional housing is a studio flat within Francis Place, Bellingham's first permanent supported housing which is run by Catholic Community Services (CCS). NWYS has ten units within the complex. The young person can stay for up to 18 months. They have a case manager assigned to them that they have to meet regularly. Having a case manager is a prerequisite of receiving the housing subsidy that pays their housing costs. That would be a little like having to have a floating support worker to receive housing benefit in the UK.

One of the things that seems to work well is that NWYS provides the case manager and CCS take care of the landlord duties. This means that the case manager is not caught up in playing bad cop one day and then trying to play good cop the next. In my opinion, this is one of the things that does not work so well in young people's supported housing in the UK, frequently leading to fractured relationships with the young people. Young people often say they feel their support worker is always harassing them (e.g. about rent payments) and they don't feel they can approach them for support.

At the end of the 18 months in transitional housing, if the young person moves on into the community they can access a further year of support from their case manager. This means the support stays fairly consistent and, more importantly, the relationship is maintained.

Permanent housing is similar but is 'scattered location', which means that the young people live in the private rented sector. Once again the housing subsidy comes attached to the case manager so if the young person stops having support they also lose the subsidy. In this programme the support lasts for up to two years, however if the young person has a crisis after that time they will still be able to access the case managers for support.



The young people are not assessed to decide which programme they access rather it is up to them and they are trusted to know what's best for them. This seemed to sit within the whole Positive Youth Development approach that is adopted by NWYS. Also if a young person felt that it was not working they could swap programmes, particularly from transitional. If the housing fails they can either swap programmes or go back on the waiting list for housing, depending on the nature of how it failed, but they won't get excluded.

Case managers will typically have a mixture of clients who are in the transitional housing and permanent housing programmes. They have a case load of 14 young people, which seemed low to me, but I was told it was to guard against burn-out and give good quality support.

In both programmes the young people are encouraged to save as well as to pay a portion of the rent. This is on a sliding scale and as time goes on they will be expected to pay more until the end of the subsidy where they should really be paying the full rent. There is some flexibility in how much the housing subsidy can pay so market rents can be matched. Some young people may be able to access a permanent housing voucher but these are rare.

The support that the case managers offer is holistic in nature. Support with mental health and accessing the limited services available, substance use, relationships and domestic violence and tenancy issues were some of the issues I either heard about or witnessed support for.

One of the things that stood out for me was the upfront, honest, three-way relationship between case manager, young person and landlord. Right from the beginning they

are honest with the landlord that there will be some problems but that they will work through them. This is probably helped by the fact that NWYS will cover damages. However it struck me that the upfront, honest approach created a much more equal relationship. I was told how, when a case manager tells the landlord about a young person smoking weed on the premises, it meant there were no secrets and seemed to increase trust all round.

I have to say there was a waiting list for the housing programmes of around a hundred young people, most of whom were street homeless. This means that the 'rapid' aspect of the approach is not actually possible. I found it difficult to reconcile this with the low caseloads but, as Executive Director Riannon Bardsley said: "we want to do what we do well". I believe that the fact homelessness and youth homelessness is more culturally acceptable in the US than in the UK takes the pressure off and allows this way of working. NWYS is working hard in partnership with city and other partners to remedy this. More permanent supported housing is due to be built, with 20 units going to NWYS. There is also a chance they may get some units in a big student housing development being built at present.

Conclusions

How do they encourage landlords to house young people in the private rented sector?

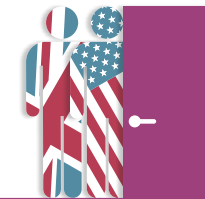
It seems that NWYS faces a lot of the same issues as we do in the UK. With very few vacant properties on the market it can be a challenge to persuade a landlord to take on a young

person, especially a young person with no rental history or other barriers such as a criminal record. However, the fact that they can match market rates and that the support of a case manager is guaranteed helps to convince landlords. NWYS, like No Limits, use the fact there is a point of contact – either the case manager or floating support worker – for the landlord to speak to as a big selling point to landlords. Also like No Limits, the other way they encourage landlords is by appealing to their social conscience. This is probably helped by the fact that Bellingham has a very visible and large homeless community.

How is it financially viable and how are they funded?

NWYS receives the bulk of its funding from government streams: federal (Department of Housing and Urban Development), county (health department), and city (housing levy). They have the same struggles as smaller charities in the UK do when it comes to trying to attract philanthropy or corporate funding. The fact they are not a nationally known organisation means there is little glamour in donating to them. As Board President Jeannine Lyon said to me, donors are not interested in stuff they cannot see such as staff wages, they want a shiny big building with their name on it.

The fact that the housing subsidy is flexible and allows them to cover the market rent and also damages means it is financially viable for the landlord. If damages occur and the lease is in the tenants name then it won't necessarily impact the NWYS subsidy amount or length. It may jeopardise their lease, which is up to the landlord. When the lease is in NWYS' name the damage amount gets added to the youth's account and NWYS ask that they pay them monthly to reduce the



account balance. If the damage is significant and/or there is a pattern of behavior around damages then that could impact their housing.

How do they work with young people to encourage them to take responsibility for their tenancies and behaviour?

The case managers at NWYS work in a very similar way to No Limits. Their central approach is 'positive youth development', which seems a very client centred approach. The fact that they had smaller caseloads must help. However I can't help but think that the fact there is no safety net – and street homelessness is very much a reality if you mess up – must encourage the young people to take more responsibility. In the US there seems to be a strong culture of individualism and personal accountability, I think more so than the UK.

How do they help young people maintain their tenancies in the long term?

At NWYS I was constantly told it's all about the relationship with the young person to the point of giving support even when a case has been closed. Riannon put it to me like this: "if you left home from supportive parents you'd still call now and then for advice or when you find yourself in crisis." This I think gives the young person confidence to make mistakes. Also the vocational programme which gets young people into work helps them to work towards financial security for their long term future.

The outreach team seems to be essential in keeping the young people engaged with the service. If the case holder is struggling to catch up with a young person they can let the

outreach team know. The team will keep an eye out for the young person and try to re-engage them. It was great to see how this type of assertive outreach can support the young people in their journey. You can see that if a young person disengages with the vocational programme or fails in their housing it will be the outreach team who will catch up with the young person, giving them the chance to let the young person know they haven't given up on them and support is still available. The team also visits the county jail so if the young people go inside for a spell there is still contact.

Application of learning

In some ways the particular differences between the US and the UK's welfare systems and housing laws make it difficult to apply learning to our own practice. For example, the differences between UK housing benefits and the housing voucher/subsidy system in the US. The UK's Housing Benefit, which will soon be part of Universal Credit, has been for a while now pushing more responsibility onto the tenants. So as much as possible the benefit is paid to the tenant and they are responsible for paying it to the landlord. In the US housing subsidies are paid to the supporting agency and then administered by them and, indeed, only paid if the tenant is engaging with the support provided.

One of our biggest barriers in Southampton is that the shared accommodation rate of housing benefit is significantly lower than market rates. The simple fact that the housing subsidy that NWYS offer has flexibility and can cover market rents makes a significant difference. The completely different welfare systems make it difficult to make changes in this area.

We will continue to advocate on behalf of young people in whichever way we can to highlight the complete disparity between local housing allowance rates and market rents.

In a lot of ways the practice of NWYS reflected our own approach at No Limits. They offered a holistic, person-centred approach and much like ourselves put the relationship with the young person right at the centre of the support. They believe, like us, that this is the biggest single reason for their successes. One aspect in their approach that we could learn from was their very frank and open communication with the landlord from the beginning. It was effective to let the landlord know that there are likely to be problems, but that between the young person, case manager and landlord they should be able to work them out. I believe we are more inclined to try and sell the young person to the landlord in the best light we can, for fear of them not being accepted. However I believe adopting the level of honesty I saw at NWYS would create more trust and hopefully better working relationships.

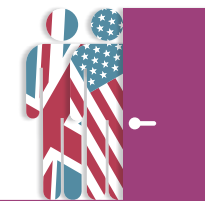
With the current government's policy of austerity, the chance of a growing community of street homeless young people seems likely. A multi-disciplinary street outreach team of housing, substance and advice youth workers is definitely an idea we are interested in exploring to engage young people in the community.

During my visit I blogged about the individual projects run by NWYS. Please visit my blog here: visittonwys.wordpress.com

Jonny Goldsmith

Housing First





The dominant approach in the UK to housing homeless people can be described as linear in nature, and involves someone progressing through a series of residential services until they are deemed ready to live independently. Three months in one service, followed by six months in another and – hey presto – their support needs have been addressed and they're ready to move on, 'rewarded' with somewhere to call home. Then, if required, they're provided with time limited support within their own home.

Whilst that model may work for some, it hasn't worked for all. As a result, in Lincolnshire, where I oversee P3's street outreach service, we now have a group of people who, because of past 'failures', have been left with next to no housing options.

Frustrated with the transitional nature of services in the UK – and in particular frustrated by the fact that there is little or no alternative for those where that model doesn't work – the Exchange offered me the opportunity to travel to the US to find out more about Housing First. It also came at a time when we as an organisation had decided to initiate our own Housing First project in Lincolnshire and I was hoping that what I learnt might help to shape our own service delivery.

The reason I decided to look specifically at services for those people with serious mental illness was quite simply because a lot of the people who I am referring to – the people we are working with who have little or no housing options – suffer with serious mental illness.

Whilst in the US there were several key areas of learning that I wanted to explore:

- **Prioritisation** – how do US services prioritise those suitable for their projects?

- **Intensive Case Management (ICM) vs. Assertive Community Treatment (ACT)** – which model of support is preferable and why?
- **Overcoming scepticism** – how have US services overcome scepticism they've encountered along the way?
- **Sustainability** – how have US services ensured continuity of service?

Pathways to Housing DC

The majority of my time in the US was spent with my host organisation, Pathways to Housing DC. Founded in 2004, they offer support to some of the most vulnerable people across Washington DC, and specifically to those with serious mental illness, via their street outreach and Housing First services. As the pioneers of the Housing First concept – and as a result having a great deal of experience and several mature programmes – I believed they would offer the best opportunity to answer my questions.

In addition to spending time with Pathways to Housing DC, I also had the opportunity to spend time with Friendship Place and Miriam's Kitchen, as well as staff at both the National Alliance to End Homelessness and the US Department of Housing and Urban Development.

US context

The sheer scale of the problem they are trying to tackle in the US struck me most. Not just in terms of the number of people they have sleeping on the streets, but in terms of the level

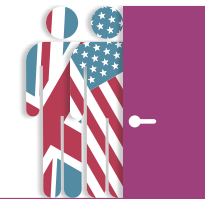
of disability amongst those people. With serious mental and physical disability on what felt like every street corner, as well as a lack of resources (and perhaps willing amongst some communities) to tackle the problem, for many of the people I came into contact with it felt as if they had little hope.

The biggest difference I noticed between the systems in the UK and the US, which would perhaps help to explain why they have so many obviously disabled people sleeping on the streets, is the lack of legislation protecting their most vulnerable. Yes, our own system may be far from perfect – and we may argue that legislation doesn't go far enough – but at least our communities have the protection offered to them within legislation such as the Housing Act, the Care Act, or the Mental Capacity Act. Add to that what appeared to be an inefficient housing voucher system rather than a welfare system for all, access to primary healthcare which is historically based on your ability to pay, and the social movement known as deinstitutionalisation – and you start to understand why the US has the problem it does.

Findings

Fidelity

There are so many service variations, so which one is right? Indeed, critics of Housing First will tell you that, because there are so many variations in service design, reports of successes might not actually be referring to Housing First services. Prior to travel I had a very clear view of what a Housing First service should look like. For example, it should always be scattered site and support should always be provided by the ACT approach. Nothing else would do.



However, my time in the US taught me this actually doesn't always have to be the case. There isn't a 'one size fits all' approach, Housing First itself is a conceptual model and services should adapt to fit the context they are in and the needs of those that they serve.

And, whilst it was clear from my time in the US that Housing First, like every other solution to end homelessness, can take many forms, it was also clear that whatever form it does take there are a unique set of principles that guide them:

- Housing is offered without any preconditions.
- The support on offer is permanent although the acceptance of support¹ is not a prerequisite to ongoing housing.
- An emphasis is placed on client choice and control without coercion.
- They take a harm reduction approach to treatment rather than advocating abstinence.
- There is a focus on increased community integration.

The VI-SPDAT

The US, like the UK, is in the middle of an affordable housing crisis. So, with demand outstripping supply, how do they prioritise people for the limited amount of resources that they have? With so many people sleeping on the streets, how do they decide who to offer a home to first?

The answer in Washington DC is the vulnerability index service prioritisation assistance tool, or the VI-SPDAT for short. It's the tool used across Washington DC (and several states) to identify who is eligible for what housing and support intervention and who is most in need. It's their way of moving the conversation

away from who is eligible for support, to who is eligible for support and in the greatest need.

Assessments are scored and all information is entered on a database which is used by all agencies across the District. Every fortnight representatives from various agencies meet to case conference the individuals, and to allocate available housing vouchers. The general rule of thumb is that the person with the highest score gets the next voucher, although the meeting is used as a way of promoting discussion – a way of remembering that behind the score is a human being.

Critics of the VI-SPDAT will tell you that it isn't scientifically based and allows for too much subjectivity. They will also tell you that it is a tool that relies on too much self-reporting – therefore it is designed to help those who say they're in need, although in recent times it has been adapted and now allows for an element of professional judgement.

Advocates will tell you it's efficient, and that much like any 'single point of access' it helps to avoid duplication between agencies and alleviate frustrations from people who have potentially been assessed time and again, to the point of exhaustion. Even advocates accept it is far from perfect, with one telling me "while it may be a crappy tool – at least it's a consistently crappy tool."

Whether perfect or not, to me, it seems to be a way of providing consistency and removes the 'who you know and what you know'. It removes the prioritisation of those who shout the loudest or those who providers receive the most emails about. It helps to ensure Washington DC houses their most vulnerable.

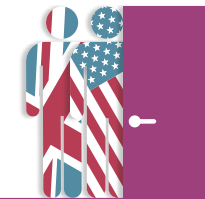
Provision of support

Intensive case management (ICM) uses a case management model alongside practical housing support to assemble a support package involving several service providers. The case manager acts as a broker who tries to facilitate access to support for the services that the individual both needs and wants. Assertive Community Treatment (ACT) is a health and social care system, in miniature and in one place, and is the highest level of support on offer prior to hospitalisation. ICM offers a level of support which is slightly below that.

Pathways to Housing DC uses both, and what was so impressive about the Pathways ACT teams was the amount of resources that they had at their disposal. They have specialists who provide psychiatric, drug and alcohol, and medical support under one roof – as well as peer support and specialists who work to provide economic inclusion and to enhance personal relationships.

The ease of communication, the ease of access to information, the result of the increased educational opportunities to the staff within those teams, and the streamlined treatment pathways – common sense it may be, but seeing it in action I will admit to being green with envy!

As impressive as the amount of resources on offer within the ACT teams was, the thing that I found equally impressive was that whether support was provided via ICM or an ACT team it could be provided in any setting. Once a person was committed to the programme, they were committed to the programme. It didn't matter whether they were evicted from the accommodation they were in, whether they were



hospitalised (either voluntarily or involuntarily), or whether they were sent to prison – the teams continued to provide support which helped to establish continuity and to prevent some incredibly complex people being passed from team to team or potentially falling through the gaps.

Morality versus Great American Dollar

It was clear from my time in the US that there is support at a federal level for Housing First. It's referenced throughout the Federal Plan to end homelessness, and the US Department of Housing and Urban Development now favour bids from Continuums of Care that work to Housing First principles.

Critics in the UK will tell you it is expensive as you're linking people in with services they haven't previously accessed. They're right. Critics will also tell you that the argument that it can create cost offsets is nonsense as any cost offsets can never be realised.

However, what is clear in the US is that they've seen past today and looked at the tomorrow. They've realised that it is far more cost effective to house someone than to wait for them to reach crisis point; far more cost effective to house someone prior to their mental health deteriorating to the point where they need to be detained involuntarily in hospital; far more cost effective to house someone than wait for them to have a stroke on the street which means that they have to live out their days in a nursing home.

Indeed in recent times, the Center for Medicaid and Medicare Services, which is part of the Department of Health and Human Services, has clarified that Medicaid monies – monies

usually reserved for clinical services and medications – can be used to pay for housing related services. They've realised that housing is healthcare.

If there is support at a federal level – why do they still have so many people sleeping on the streets? Like us, the US have a shortage of affordable housing, and whilst without doubt it is this which is having a significant impact, another explanation offered to me by the majority of the people I put that question to is that it's the communities themselves.

“We expect people to pull themselves up by their bootstraps” was a phrase I heard on an almost daily basis whilst in the US – a phrase that sums up the rather callous approach within some communities when it comes to helping people who fall on hard times. Perhaps the best example of this is that, as of now, only 32 States have extended the protection offered by Medicaid to those on low incomes under the provision of the Affordable Care Act.

One way in which Pathways to Housing DC try to overcome this and to engage their community is by using the community themselves. Once a month they invite members of the community into their building to hear more about what they do. Staff talk about the mission of the organisation, put forward the fiscal and moral arguments for offering housing without preconditions, as well as explaining what services they offer; then both clients and ex-clients alike share their very personal experiences of services.

During my time with Pathways to Housing DC I had the privilege of attending one of their 'Opening Doors' tours and got to hear one man's story of how he'd gone from living on the streets

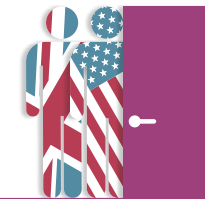
– where, when his mental ill health was at its worst, he blew half his hand off with a stick of dynamite – to the point where a number of years later, after he had been through one of their programmes, he was living in his own home, working full time, and running ultra-marathons! Following these talks they would then invite the members of the community present to become community ambassadors and to take what they had learnt back into their community. This approach is simple but effective.

Graduation

'Permanent' doesn't necessarily mean permanent. If, as the concept suggests, housing someone and providing them with stability allows them to address the other things going on in their life – to be proactive rather than reactive; to focus on recovery rather than survival – then at the point they no longer need the programme's intensive services there is an expectation that they will graduate. This frees a place (and allows for the reallocation of their permanent supportive housing voucher) to someone else who is need.

However, the problem US services are having is that when a person is allocated a housing voucher, unless they no longer want it or their income increases to the point where they are no longer eligible for it, it is theirs for life. It is a problem everyone I spoke to acknowledged, and one way that the US are currently trying to tackle the problem in some areas is by incentivising people to graduate.

In the VI-SPDAT US services have a clear and consistent way of identifying who is eligible for PSH, but what they don't have is a clear and consistent way of identifying when someone no longer needs it.



Ignoring the potential cost savings in other areas that PSH may bring, in comparing it to what we have now in the UK in terms of housing interventions, it is relatively expensive. Therefore, if we are going to adopt it, then as well as having a clear and consistent way of identifying who is eligible, it would seem logical to ensure that we have an equivalent process identifying when it is no longer needed – that way ensuring available resources are used as efficiently as possible.

Applying my learning

My own organisation, which was incredibly supportive throughout the application process, has been equally supportive since my return. I've spent time with our Chief Executive telling him about what I found and have had the opportunity to share my experiences both within the teams that I oversee as well as colleagues at our recent annual managers' conference. I've also had several questions asked of me of our local commissioner of housing related support services.

If I could take one particular thing from my time in the US and transfer it to the UK it would be the way in which they offer support to their most vulnerable. Yes, our two systems are very different, but what they have accepted is that there are a number of people who, in all likelihood, will require support indefinitely. They've not continued with the utopian ideology that everyone's support needs can be addressed in a specific amount of time.

What I would like to do now is to find a way to set up our own ACT team – a team that can offer support to some of the most challenging, complex and vulnerable people across Lincolnshire for however long they need it and in whatever setting.

Housing First, and in particular the ACT team approach, obviously requires a significant level of initial investment. In times of austerity, when investment in homeless services has fallen and when there can be challenges guaranteeing funding for any period of time, Housing First might force us to look outside of the traditional routes of funding homeless services as per our US counterparts. Yes, it may be difficult to break down and navigate the complexities of cross-ministerial and departmental government collaboration, but that's exactly what they have managed to do in the US and therefore, more than ever, it highlights the need to build bridges and relationships across a variety of different systems.

Building relationships with adult social care commissioners and exploring the opportunities that the Care Act brings to fund future services is one example of how we may be able to look outside the traditional route of funding services. The use of personal budgets to fund such services – and therefore moving away from block contracts towards a more individualised form of commissioning – would also seem to fit with the policy of personalisation that has been pursued by successive governments.

Conclusions

The Exchange, whilst offering me the opportunity to find out more about homelessness in the US and in particular their Housing First services, offered me so much more. Yes, I returned with lots of ideas that I want to implement within the services that I oversee – but in addition it took me out of my comfort zone, challenged many of my own preconceived ideas and forced me to ask questions of my own practice. It was

without doubt the greatest experience of my working life and one that I cannot recommend enough.

To everyone who made time for me – before, during and after my time in the US – thank you. I will be forever grateful.

Read Jonny's Exchange blog here:
<https://jonnygoldsmith.wordpress.com>

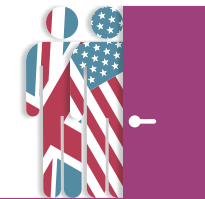
1. Support in the UK sense of services, as opposed to financial support

Steph Ratcliffe

Housing is healthcare: from the West Coast to East London

Housing for Health
Los Angeles





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Homelessness and poor health are intimately related. Evidence shows poor health can contribute to homelessness just as homelessness can lead to a rapid deterioration in health.¹ Rough sleepers and those who are vulnerably housed may experience practical problems such as safely storing medication or keeping wounds clean, as well as institutional barriers like difficulty registering with a doctor. The stress of not having safe housing can exacerbate mental health conditions and increase the risk of people choosing to self-medicate with drugs or alcohol.

In addition, poor health can make it difficult to leave homelessness. Someone suffering post-traumatic stress disorder (PTSD) or anxiety may feel unable to leave the familiarity of the streets and manage the 'claustrophobia' of housing. Likewise, someone using substances may choose to sleep outside in order to pursue their addiction. In both cases access to mental health and substance use treatment is needed alongside housing support if the most vulnerable and entrenched rough sleepers are to make the giant leap into housing.

I'm a Senior Worker at Providence Row, a day centre in East London. Providence Row works with more than a thousand homeless and vulnerably housed people, offering an integrated service of crisis support, advice, recovery, and learning and training programmes.

I'm interested in how we can end homelessness and improve the health of this community by tackling homelessness and health simultaneously. I visited Housing for Health, part of the Los Angeles County Department for Health, to study an innovative and integrated approach bringing healthcare and housing support together into one centralised and client centred package. I had two learning objectives:

1. How is a 'whatever it takes approach' used to engage entrenched rough sleepers with their housing and healthcare needs?
2. How are people linked to community healthcare services to avoid costly hospital admissions and improve the likelihood of them successfully maintaining their tenancy?

Housing for Health

In LA county 1 in every 250 people is homeless and many of these 57,735 individuals have severe and long lasting health conditions.² The most common health conditions include diabetes and related limb loss, hypertension, heart disease, asthma, PTSD, undiagnosed mental health conditions, and drug use from spice to crystal meth.

Historically, it has been administratively and financially more difficult to access healthcare in the US and, although the Affordable Care Act introduced in 2010 has improved access to healthcare for the most vulnerable, institutional barriers and misinformation are still an obstacle.³ The homeless community are more likely to access emergency healthcare, costing the LA Department of Health \$70 million a year.⁴

In 2013 Mitch Katz, newly in post as Director of the Los Angeles County Department of Health, set out to address this. He launched Housing for Health – a division within the Department for Health charged with the following objectives:

1. Quickly create 10,000 units of permanent supportive housing
2. End homelessness in LA County

3. Reduce inappropriate use of expensive health care resources
4. Improve health outcomes for vulnerable populations.⁵

Housing for Health sources accommodation and operates the Flexible Housing Subsidy Pool to ensure properties are affordable. They also commission supportive services including outreach services and intensive case management (floating support services) to ensure housing is sustained in the long term.

In effect, housing is viewed as a healthcare need and is 'prescribed' to patients alongside other treatments. Since launching Housing for Health has housed 2,100 people through their rental subsidy programme and by 2017 they plan to bring that total to 4,500.⁶

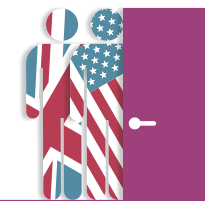
Findings

Outreach

For many, the first contact they have with Housing for Health is through the C3 outreach service. The team covers Skid Row a 54 block area that constitutes the largest encampment of homeless individuals in the US.⁷ The outreach service has 20 workers split into four teams, each covering a quarter of Skid Row. Each team has a mental health worker, substance misuse worker, and nurse who are contracted out from other parts of the health service. They are joined by a Housing Officer from LA Homelessness Response Team and a volunteer who is an expert by experience.

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Each worker is encouraged to 'stay in their lane' to maximise use of their expertise but there is a clear expectation that all are responsible for case work related to housing, such as completing referral forms.

Feedback from staff suggests multi-disciplinary teams result in clients receiving more consistent and holistic support so they are less likely to fall between the gaps as they are passed from one agency to the next. In addition, having a nurse on the outreach team breaks down barriers to receiving medical care including fear, cost of travel and accessibility.

Routes off the street

Once a client has been seen by outreach and identified as having a healthcare need, they are referred to the Housing for Health programme. They could also be referred by participating hospitals, emergency rooms and clinics. Clients can choose if they want to be housed as a family unit and give their preferences about where in LA County they would like to be housed or where they are not prepared to live.

The referrals are processed by Housing for Health, who access information on the clients' conditions and number of emergency admissions. Clients are then given a priority rating on the basis of their healthcare needs.

Housing for Health have learned the importance of getting clients off the streets quickly – whilst worker and client are in regular contact and when the client's motivation is strong. However, as the availability of permanent housing cannot meet demand, the team rely on interim accommodation. The

physical layout of interim accommodation ranges from single occupancy units to large open plan shelters but, in all cases, clients receive high levels of wrap-around support, intensive case management and a target driven move on.

Clients are linked to an intensive case manager as soon as they enter interim accommodation. Case managers work with no more than 15 clients at one time and are responsible for supporting the client to manage their health care and access housing. Case managers may be based on site, but are always an additional resource to the key workers who are responsible for the day to day running of the accommodation.

Supporting the client to manage their healthcare

Case managers are not healthcare professionals but receive training on the specific healthcare needs of the client group. This includes practical tips around self-care, tools for helping clients count out medication at the start of the week, setting reminders for repeat prescriptions, and harm prevention information.

Case managers liaise with healthcare providers and, where possible, arrange for practitioners to visit the client on-site at their interim accommodation. Key to success is case managers' strong working relationships with doctors based at homeless healthcare surgeries who they regularly call for advice and guidance or for support following up appointments with specialists.

Supporting the client into housing

With huge pressure on interim accommodation, the role of the case manager is to support the client to move into permanent accommodation as soon as possible. Each

team of case managers has a weekly conference call with Housing for Health to run through the list of clients in interim accommodation and update on progress towards move on into permanent accommodation. A doctor also joins this case conference to provide support around medical need and advice on the most appropriate move on option.

Once a client is in permanent accommodation the case manager will continue to work with them at the level necessary to help them retain their accommodation. This includes a weekly meeting for the first six weeks.

Interim accommodation

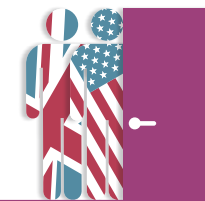
There are two types of interim accommodation clients can access depending on their level of need. Clients whose healthcare requires a higher level of day to day care (e.g. insulin dependency, wounds that need dressing or those with mobility needs) tend to stay in recuperative care. Other clients are referred to stabilisation accommodation.

I visited the Illumination Foundation recuperative centre in Orange County which consisted of a shared male bedroom, shared female bedroom, activity room, kitchen and large yard. The relationship between staff and clients was impressive. Many clients had behavioural health needs as well complex physical health conditions and the team were clear that the only way to manage this in an environment where clients had very little privacy was through trust and holistic support.

Staff took the time to explore and build on clients' strengths such as their resilience or the ability to care for a pet. This approach resonated though all aspects of the centre from

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activities, informal support planning, offering clients additional responsibilities, as well as the day to day communication between staff and clients. It felt like an environment everyone enjoyed being in.

Staff proudly showed me through to the backyard and explained that many clients came to the centre with pets from dogs to rabbits and even hens! These animals were often all the clients had, and staff felt strongly that they should be accommodated as best as possible: “If we have to vaccinate dogs to get to humans then we will vaccinate dogs,” a keyworker told me. To meet this need the ‘Peanut’ cage was established in the back yard – named in memory of Peanut the dog.

Staff saw their role as supporting clients to manage their own healthcare and, although trained healthcare practitioners were on site, they purposely took a hands-off approach. For example, they sat with clients and provided moral support as they learnt to inject their own insulin, provided guidance as they dressed their own wounds and offered a watchful eye as they counted out their own medication. The approach clearly helped instil self-worth, self-confidence and the independence clients would require to manage in permanent housing.

Permanent supportive housing

The process by which clients moved from interim accommodation into permanent supportive housing is thoroughly client centred. The Housing for Health ethos acknowledges that many clients have experienced high levels of trauma, have often been homeless for their entire adult lives and may even be second generation homeless. As a result,

if clients are to retain housing successfully, they need to be involved in each and every step of the process.

I was lucky enough to attend an induction session for 15 women who had been accepted onto the Housing for Health scheme and were about to be introduced to their case manager. As the women introduced themselves it became clear that the average length of homelessness was 15 years and their worries ranged from how they would afford pots and pans to transport. It was reassuring for them to hear that they could work together with their case manager on all decisions from location to the colour of their furniture.

Case managers would support them to link into community healthcare as well as to try out new initiatives. For example, healthcare providers have found there to be a huge stigma associated with accessing mental health support. To overcome this, as well as barriers around transport, clients are offered talking therapy over Skype using an iPad.

Whilst many of the women I met during the induction would be able to manage scattered site housing, those with higher support needs might move to somewhere like the Star Apartments run by Skid Row Housing Trust. The light and airy building contains small self-contained apartments with a doctor’s surgery and case management on site.

Again, it is communication and positive relationships that are key to success. Linda Stack, Senior Nurse Practitioner who runs the surgery tells her patients: “We’re going to have a long-term relationship.” Clients can attend a range of health and wellbeing sessions including depression support groups

and diabetes classes, planting vegetables in a patio garden or a music jam session. They are also able to access gym equipment and are invited to regular BBQs on the roof where they give feedback and suggest activities. Key work sessions are regular but tend to be informal with minimal paperwork. Instead, case managers and clients focus on one or two goals based around the client’s priorities.

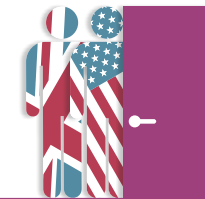
For clients who have been homeless for long periods, moving into permanent accommodation is only the first step towards recovery. One of the biggest challenges facing permanent supportive housing is how to manage challenging behaviour that often results from trauma and affects responses to a perceived stressful situation. Clients may more easily feel a heightened sense of danger, lack impulse control or the social markers for managing more complex interactions.

Supportive housing workers must tread a fine line between creating a safe and positive environment for all whilst enabling vulnerable people to retain their housing by teaching them to behave in an appropriate way. One supportive housing unit credited its success in avoiding evictions to employing restorative justice as a client-centred behaviour management strategy.

In restorative justice the victim and offender are involved in the justice process and both of their needs are taken into account. After an incident has occurred, a dialogue is facilitated to establish the harm that has been caused. The offender is supported to repair the harm done by apologising or making an appropriate gesture, as well as exploring what measures can be put in place to prevent another incident from occurring.

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Learning

The aim of my research was to learn how we can end homelessness and improve the health of this community by tackling homelessness and health simultaneously. I've grouped my learning into 3 recommendations. The common themes are flexible service provision and holistic support that addresses the person themselves rather than a specific need.

Multi-disciplinary teams

Homelessness and health are intimately related and we'll get the best outcomes for our clients if our support reflects this. By working in teams that are based on specialism we risk offering a disjointed service and losing clients between the gaps as they are referred from one specialist service to another. However, if we recognise that a person's needs are related and structure our teams to reflect this, we'll offer clients more consistent support, cut out the need for time consuming referrals and avoid an 'us and them' attitude to other services. Multi-agency working at its best is more than running through a list of names at a meeting once a week, it's working together day in, day out.

At Providence Row, effective joint working is enabled by different teams sharing an office as well as a database. Staff from different teams meet clients together and work on joint action plans. As part of our personalised approach, workers also share information on how clients would like to be supported and communicated with.

On a national scale the UK could take inspiration from the LA approach. Meaningful and productive joint working between different organisations certainly exists in the UK, but

relationships can be fragile and inconsistently implemented across the country. Often it relies on the commitment of individuals and is at risk from high staff turnover or shifting organisational priorities. We could benefit from developing a culture where there is an expectation of joint working and where services are commissioned in a way to make this straightforward.

From a frontline perspective this could involve better information sharing between primary care health, mental health, public health commissioned services and housing workers. A practical example could involve, for example, a day centre or outreach team alerting hospital staff if someone known to be rough sleeping attends Accident & Emergency so they receive a more appropriate service.

Alternatively it might involve workers from public health, mental health or substance misuse teams joining outreach teams or day centres so they have better access to the homeless population. For this to be implemented consistently across the country all stakeholders will need to work together to develop protocols, systems and commissioning plans that facilitate it.

Flexible and person-centred approach to healthcare

As discussed above, better joint working between agencies could lead to easier access to healthcare. Housing for Health recognised that mainstream services were not accessible to many homeless people. Workers needed to be flexible enough to meet them wherever they are, for example, counselling with a mental health professional on a bench or in a car on the way to an appointment was a crucial first step.

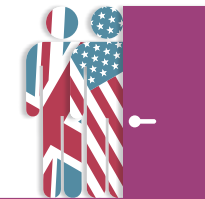
On a national level, whilst recognising that role of outreach and in-reach healthcare workers, we also should seek to improve access to mainstream health services for homeless people across the country. This could involve training on homelessness for National Health Service (NHS) staff, longer appointments times and improved awareness about the right to register with a doctor.

In LA, staff worked hard to put clients at the centre of their own journey and to involve them in every decision along the way, including how they access and manage their healthcare. In the UK, we should seek to implement a similar approach starting with the basics. For example, treating people for the reason they are there before moving on to other issues.

At Providence Row we are working to expand our Health and Wellbeing programme to provide increased healthcare and wellbeing services for clients in the day centre setting as well as building strong relationships with local NHS services. Part of this process has been collecting feedback from clients and developing our service in response. For example, we recently launched a self-harm support group in response to client demand.

Recuperative care and step-down beds

Finally the UK could take inspiration from the recuperative care model and expand the provision of 'step-down' and 'step-up' beds across the UK. Recuperative care provides clinical support for homeless patients whose health needs mean they are unable to access hostel or supportive accommodation but who don't require a hospital bed.



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In LA, recuperative centres did important work in relieving pressure on hospital beds whilst providing a safe space for patients to recover and learn to manage their healthcare in a supportive environment. Key to success was a clear plan regarding which agency was responsible for the move on into permanent accommodation as well as who was accountable if the client needed a higher level of support.

Pathway charity has already conducted research into step down beds and found that 'Across the three Trusts an estimated total of 4410 bed days could have been saved in a year if medical respite (recuperative) options were available.'⁸

Conclusion

Although our systems, legislation and cultures are very different to those in the US, the difficulties faced by people experiencing homelessness are similar. The challenges faced by workers and organisations supporting our most vulnerable people are also remarkably similar. In both countries we can develop our responses by integrating the support available to clients to offer a holistic, flexible service that puts clients at the centre of their journeys.

Read Steph's Exchange blog here:

stephratcliffe.wordpress.com

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Anna Litt

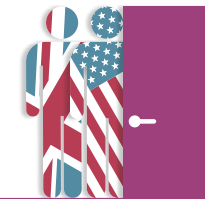
Effective methods for tenancy sustainment

Thames Reach
London



Anna Litt

Effective methods for tenancy sustainment



Anna Litt is a Licensed Clinical Social Worker practicing at Health Care for the Homeless in Baltimore, MD.

One solution to homelessness seems clear, housing. However, after working in a Housing First program for the past four years, I have seen that housing is not as easy a solution as it appears. People who have experienced homelessness face many struggles on their path to remain in permanent homes: paying and managing their bills, communicating effectively with landlords and neighbors, independent living skills, isolation, engagement with providers, continued substance use and mental health issues. Any one of these dilemmas can precipitate a housing crisis, and in combination they could potentially place an individual at risk of eviction.

It is the task of supportive housing programs, to prepare newly housed individuals with the skills and tools needed to maintain housing, but what are the effective methods of going about this? There is a plethora of research to speak to the cost effectiveness and longitudinal benefits of permanent supportive housing, but not many guides on how to do it well. Practitioners are left to improvise solutions and manage situations as they arise. However, in the UK, there are several organizations that work to prepare individuals for housing and beyond. I spent two weeks in London learning about the programs and practices of these organizations in hopes of developing a better understanding of practices to increase tenancy sustainment. While the models of housing may be different than Housing First, I learned much from each program about skill development, peer mentoring, engaging with clients, and housing preparedness.

There are several programs that I chose to explore:

- The peer landlord program and the employment and resettlement programs of Thames Reach
- The Home for Good program of the Passage
- The Private Renting program of Crisis UK.

My aim was to examine how skill building, mentoring, and engagement engender individuals with knowledge and also confidence to help increase housing success. There are several questions that I explored:

1. **Engagement with the community** – How does participation in programs aimed at tenancy sustainment effect relationships with landlords, neighbors, and community members?
2. **Skill building** – What types of skills are being taught? How do they affect a person's independence, tenancy, and relationships? How is information accessible and utilized by individuals of varied cognition and ability?
3. **Engagement with treatment** – How do skill building and mentoring programs affect engagement with care providers? Are they access points towards additional mental health and wellness?
4. **(Cost) effectiveness** – Will supplying individuals with skill building and social support opportunities decrease costs of relocation, eviction or increase the length of stay for individuals in their home? Does engagement effect tenancy sustainment?

In the exploration of these ideas and programs I hoped to develop a better concept of what works in supportive housing. While the field of permanent supportive housing is not entirely new, it is also not yet developed to its potential. Much work needs to be done to make this model accessible to individuals

experiencing homelessness on a larger scale. Developing an idea of best practices in supportive housing, practices that bolster tenancy sustainment, will help further dissemination of this model.

Learning

Thames Reach Employment and Resettlement Program

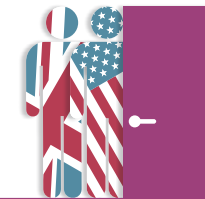
The first organization that I had the opportunity to learn from was Thames Reach. Located in London, Thames Reach's mission is "to ensure that every Thames Reach service user has a decent home, supportive relationships and a fulfilling life." With a staff of about 300, 22 percent of whom are individuals with lived experience of homelessness, Thames Reach is committed to creating a pathway of recovery. I focused on learning from the Employment and Resettlement Program.

The Employment and Resettlement Program offers opportunities to individuals of varied experience and ability with a focus on engagement and empowerment. They accomplish this through skills training, group support, drop-in advice clinics, and volunteer/internship opportunities. I found it fascinating how Thames Reach put such intention into gathering service users' feedback. I was also impressed that the program is not looked at as a "treatment," but as a learning and development program operated through Human Resources. These steps taken intentionally in order to preserve equality in relationships rather than establishing a hierarchy.

One service within the Employment and Resettlement Program is the TRaVEL (Thames Reach Volunteering and Employment

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for Life) group. It is an eight-week program during which participants learn and gain skills regarding volunteering and job readiness. At the end of the eight weeks, participants will volunteer two days a week, at Thames Reach or elsewhere, for two months. Once their eight-week stint is complete, they are supported into more long term volunteering or work. I was struck by the warmth, openness, and humor of the TRaVEL group, and by the participation and enthusiasm of the members. One member described the importance of volunteering by saying, “it’s supporting others by supporting yourself, and your own development.”

Other training opportunities offered include Moving in Moving On (MIMO), a training program that teaches basic construction and home improvement skills, and has literacy groups, computer skills groups, farming programs, and peer advising. As one facilitator and former Thames Reach service user reported, these opportunities do much more than skill building, “some people are dealing with depression, or other issues. The program gets them away from it, gets them out, gets them moving forward.”

Research has shown the benefits of peer mentoring programs in engaging individuals in care, developing support systems, and reducing symptoms (Journal of the World Psychiatric Association, 2012) and Thames Reach utilizes this model with its base of peer advisors. I was able to see this in action when observing the Employment Academy’s drop in advice center. The center is a place where individuals can walk in off the street and utilize resource guides, undertake job searches, or speak one-on-one with a peer advisor. Peer advisors are individuals who have gone through the TRaVEL program

and chosen to volunteer at Thames Reach, and are currently or formerly homeless. I witnessed Peer Advisors assist with resume crafting, formal letter writing, job searches, and even benefits assistance. I had the pleasure of shadowing a freshly minted peer advisor (his first day on the job) and witnessed him adeptly assessing two new referrals. He engaged the individuals with compassion and empathy and referenced his own life experience to give them an offer of hope. We got to discuss his journey and how volunteering at Thames Reach has bolstered his confidence, provided resume building experience, and reacquainted him with the professional field from which he had been removed. As he said, “it’s been good volunteering. I used to work in the corporate field. This has been a good step to get familiar with the working world again.”

The Passage’s Home for Good Program

The Home for Good program offered by an organization called the Passage. Their mission also directly addresses recovery as a pathway: “Our mission is to provide resources which encourage, inspire, and challenge homeless people to transform their lives.” The Passage, which houses the largest resource center in the UK, also offers a range of services for individuals experiencing homelessness including prevention projects, outreach teams, housing advice, health care, education, training, and employment opportunities, pastoral services, and multiple accommodation projects. They have a staff of 100, and a contingent of 400 volunteers.

The Home for Good program came out of findings that the first six months of being housed are the most difficult and critical for people who have exited homelessness. Housing can be isolating, scary, and overwhelming. Home for Good has found

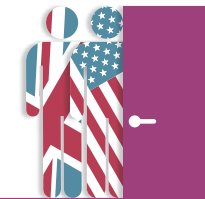
an innovative solution for tenancy sustainment: community engagement. The program matches a newly housed person with a volunteer who is a sort of ‘neighborhood buddy’ from the community. The pair meet, set up a series of relationship understandings (frequency of contact/communication patterns, desired activities to engage in, shared interests, as well triggers and contingency plans), and meet for at least 6 months. This relationship helps build a network of support for the newly housed person. It is a unique relationship, different from one with a staff member or provider. As a staff member reported “it’s a softer relationship that allows for different topics to come up.” This partnership has many benefits: a first welcoming face in a new place, peer mentorship, and socialization. It can also serve as early detection strategy. Often an individual shares stressors or even housing issues with a volunteer in casual conversation before a housing support worker has been made aware. Volunteers are recruited from borough volunteer centers, religious institutions, and corporate partners.

I found the Home for Good program very intriguing. I’ve had several conversations with clients at my own job who, due to past behaviors while using substances or in crisis, developed guilt and shame that made them reluctant to return to church. But having a ‘buddy’ from their church to welcome them back, or even just to talk with, could be just the kind of encouragement needed.

Volunteers are provided monthly group supervision and training. However, for the most part, staff intentionally attempt to have a low key role to allow the relationship to blossom on its own. The program, which reports a 97 percent tenancy

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sustainment rate, has basis in research: numerous studies have shown that social relationships bolster mental health wellness and stability (NIH 2006, 2011, AARP 2008).

Crisis UK Private Renting Program

Crisis UK is a national charity with sites across the UK which engages single homeless individuals in a wide range of programing and interventions as well as in large scale advocacy work. Like Thames Reach and the Passage, Crisis UK offers a wide range of education, and skills and employment training in their state of the art Skylight Centers. Their programs are awe-inspiring with classes like English as a Second Language and opera singing; however, I spent my time learning about the Private Renting Program.

The Private Renting Program provides supports for tenants and landlords, including pre-tenancy classes, landlord forums, mediation, vacancy assistance, and ongoing relationship building. Individuals, who are in search of housing or about to be housed, are assisted in tenancy location and invited to participate in Renting Ready groups. These groups focus on developing skills and plans in preparation for housing, such as: housing options, preparing the home, budgeting and bill paying, food preparation and shopping, and communicating with room mates or landlords.

Landlords are also provided with support. Crisis UK provides landlords with data on why housing works and makes a positive impact on the community. This serves as a myth-buster and destigmatizes individuals who have experienced homelessness. Landlords are also invited to “landlord forums.” These forums are a means to engage landlords for one evening and provide

resources that may be helpful to them, for instance information on housing processes and policies or even information on legal rights. They also provide an opportunity for landlords to be introduced to staff. These forums may incentivize landlords to establish a relationship with Crisis UK by showing that Crisis UK can serve landlords’ needs and provide valuable support. As Bridget from Crisis UK explained, it is useful to see landlords as clients too, with their own set of needs and goals. “It’s all about helping, not seeing someone or something as a problem, but in what other ways can we help.” Bridget emphasized finding the right fit for both the client and the landlord as “you want to set them up for success, each failure can do some damage.” The conversation was very helpful in seeing things from a different perspective, and as a reminder to continually strive to build relationships that are parallel.

Findings

Many patterns began to form as I learned, observed, and reflected. First, is it coincidence that organizations that are so passionate about creating avenues of opportunity are committed and sustained by volunteer work? Each organization that I spent time with was sustained and bolstered by volunteers, both client volunteers and those from the community. It is policy that mimics practices. It is community in action: individuals learning from one another. And it is strengths-based: seeing the gifts that we all have to offer and not adhering to some hierarchical method of learning.

Second, different themes of support were highlighted in each program. At Thames Reach, education, training, and employment were promoted. While at the Passage, the

importance of building social supports was emphasized. And at Crisis UK, tenants’ rights and the relationship with landlords was underscored. When thinking about developing best practices of tenancy sustainment it is important to pull from a broad scope of resources.

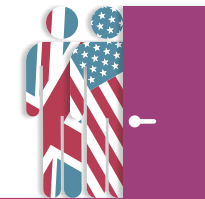
The third pattern came from a discussion with a homeless services provider who commented that the US seemed ahead in its housing policy, specifically with Housing First. And while this may be true, I kept thinking about how all of the programs I visited in the UK never once used the word ‘treatment’, how each one is based on approaching the client where they are and offering what the client wants to work on, each with the aim and intention that homelessness does not define who they are but is just a stage in their life. They seemed aimed at creating a path of recovery. Even the vocabulary the programs used evidences a person-centered approach. ‘Key workers’ for what the US might call social workers – a key, meant to help unlock a situation. ‘Advice’ instead of what we might call case management – ‘case’ a real live human person, not just a case. ‘Guidance’ instead of benefits assistance. The overall emphasis on peers that each program utilizes and the terms used evidence a person-centered approach. While many programs in the US are similarly person-centered, including Housing First, there is still a struggle to create a pathway of recovery. The US may be ahead with the Housing First approach, but the UK taught me a lot about the perspective of treatment and recovery.

Practice and policy implications

As I reflect on my experience in the UK, and on the differences and similarities between their homeless system and that in the

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US, I can't help but think that maybe both have a long way to go. For both countries, it appears that the systems of 'support' can often be entangling. While the programs I learned about in the UK provided individuals with skills and confidence and took a pathway perspective, I also learned that the housing benefits on which many rely are temporary or contingent on looking for work. Once individuals are employed many can no longer afford housing. This is similar in the US: individuals receiving economic or housing support often lose benefits once employed, or face increases in rent that place them at risk of eviction.

The systems are designed against success or independence. And yet, our attempts at solutions are to ask people to engage in treatment, or skills training, or prescribe them with a diagnosis, when really, having an emotional or psychological reaction to a broken system seems appropriate. Viktor Frankl wrote, "More and more, a psychiatrist is approached today by patients who confront him with human problems, rather than neurotic symptoms." (Man's Search for Meaning). Are we stigmatizing people instead of the system? Many of the clients that we see have experienced abuse, the trauma of homelessness and other traumas, chaos, crisis, poverty, brain injury, and hunger or more. By sending that individual to seek help in one therapist, or one case manager, or one treatment program, are we sending them the message that something is wrong with them and not the system? If we continue to emphasize treatment, are we losing sight of the bigger picture?

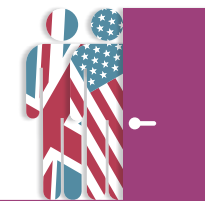
I had the opportunity to shadow some remarkable organizations and plan to implement much of what I learned. I especially hope to incorporate into my practice

the building of community relationships, taking a wider perspective on recovery, and advocating for greater peer support development. I have the great fortune of working at an equivalently noteworthy place which is initiating some of these very ideas: skills training, peer led recovery, and harm reduction. However, there must also be policy change. My practice will be forever changed by the opportunity to experience a new perspective, but the need for policy change is even more forefront. Policies are needed that allow for affordable housing, and a living wage, that grant second chances and opportunities, which engender individuals toward recovery. We need to stop seeing people as problems, but rather systems.

Erika Schmale

Street outreach





Erika Schmale is Regional Coalition Manager at Homeward, Richmond, VA.

Many communities across the US struggle to provide needed outreach to people experiencing homelessness. Due to limited funding for outreach, communities may not be able to increase their staff, but outreach efforts can coordinate with existing community resources or add contact points to improve their current staff's effectiveness. Communities must be creative and use existing resources to identify, engage, and connect individuals sleeping outdoors to shelter and housing.

I went to Nottingham, UK to learn:

1. The nuts and bolts of an effective outreach team including process, reporting, and use of data.
2. How outreach efforts partner with law enforcement, health, and housing resources to increase resources for individuals experiencing homelessness.
3. How outreach efforts engage community members to increase the capacity to reach individuals experiencing homelessness throughout their area.

During my two weeks in Nottingham, I shadowed the organization Framework, a charity and specialist housing association. The organization was founded to help rough sleepers, but now provides recovery services, employment advice, mental health services, and prevention, because all of these services impact homelessness. I specifically shadowed Framework's Street Outreach Team, observing early morning outreach, talking with members of the street outreach team, and meeting with many of their partner agencies.

Street outreach in Nottingham

The city of Nottingham, UK is 29 square miles with a population of 314,300, 22.5 percent of whom live in households affected by income deprivation. In 2015, Nottingham estimated that 14 individuals were living outdoors on any given night and this number continues to rise in 2016.

The Street Outreach Team was formed to achieve the following objectives in the City of Nottingham:

- To reduce rough sleeping
- To quantify the extent of rough sleeping and monitor trends

The Street Outreach Team is Nottingham's primary response to homelessness. There are no shelters or other access points within the city. Nottingham City Council's Housing Aid office the referral source for hostels (similar to transitional housing in the US) and affordable housing in the city. Housing Aid prioritizes housing based on need, which includes health concerns and homelessness.

The Street Outreach Team has a service manager, service outreach team leader, eight outreach workers, a resettlement worker, and an intern. Three of the outreach workers are part of No Second Night Out, which offers a rapid response to individuals found sleeping outdoors for the first time. This includes hotel stays, referral to Housing Aid, assistance finding market-rate housing, or reconnection to friends and family elsewhere. The two outreach programs work together as one team.

The outreach team staffs a 24-hour hotline to receive referrals from community members, including local partners, and calls from clients. They also receive referrals via text and StreetLink, England's national rough sleeper referral service. Early each

morning, at least two team members visit the referral locations provided via call, text, or StreetLink and other known locations. After outreach each morning, the team reviews the individuals found during outreach and assign a worker to complete contact assessment with new individuals. Every day the SOT also sends a list verifying those outdoors to Housing Aid to receive priority access to hostel beds. Staff continue to follow up and go out to clients sleeping outdoors to help connect them to needed housing and support services.

Utilizing outreach to end chronic homeless in the US

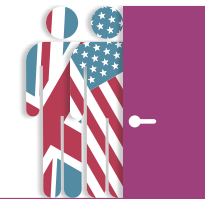
In June 2016, US Interagency Council on Homelessness (USICH) released the criteria and benchmarks for ending chronic homelessness. One of the five benchmarks is focused on outreach. USICH states that persistent, coordinated, and creative outreach is essential to ending chronic homelessness. This means:

- Full geographic coverage
- Clear connection to shelter and housing
- Partnerships with law enforcement, hospitals and emergency departments, prisons and jails, libraries, and job centers
- Data to determine who is in need and to track results
- Person-centered and an emphasis on building rapport and trust.

The Street Outreach Team offers strategies for communities seeking to improve their outreach efforts to meet these federal criteria.

Full geographic coverage

By going out on a daily basis and offering 24 hour access to outreach workers via phone, text, and StreetLink, individuals



throughout the area can easily ask for help and outreach workers can cover the area on a regular basis to reach those who may not ask for help.

Clear connection to shelter and housing

Through daily reporting and monthly case conferencing with Housing Aid, Street Outreach Team formed a partnership with Housing Aid. The reporting, meetings, and relationship, strengthens SOT ability to advocate for individuals who are unsheltered, but are not receiving the needed connection to hostels or housing.

Outreach alone will not reduce homelessness. Individuals need housing. In Nottingham, individuals deemed intentionally homeless or those not from the area have barriers to accessing hostels and housing. Once a person gets into a hostel, there are many steps to permanent housing, making the process slow and leaving opportunities for a client to mess up and end up back on the streets. These barriers reaffirmed the importance of housing first practices used in the US, so that individuals sleeping outdoors are able to move indoors without jumping through a lot of hoops.

For example, Beth was found sleeping outdoors in early May. She had a history with domestic violence, sex work, and health issues. She was referred to a hostel bed three times, went to the hostel, and was then denied by the provider because of the behavior of her partner, staff turnover, and having high needs. After much effort, she received a bed in a hostel in early June; the first step of many to permanent housing. During the month of May, she continued to sleep outdoors and was hospitalized.

Partnerships with law enforcement, hospitals, etc

Personal relationships, agency partnerships, and community working groups all contribute to the Street Outreach Team's ability to provide clients with needed resources. Having a champion of homelessness within local government allows the Street Outreach Team to better advocate for individuals who may be more difficult to serve. However, only focusing on personal relationships means building a new relationship when the champion leaves their position. By having formal partnerships with agencies, the Street Outreach Team and the other agencies are able to share consistent information with clients, make better referrals, and constructively raise issues with each other. Working groups create space for multiple agencies to come together, network, build resources, and work on larger change that would not be possible to accomplish alone.

The Street Outreach Team has relationships with local government, police, the local hospital, community health programs, a case coordination agency, day centers, and local businesses. The Street Outreach Team participates in at least three monthly multi-agency case conferencing meetings. All of their partnerships rely on information sharing protocols to appropriately share client information. The Street Outreach Team discusses individuals rough sleeping with multiple agencies; this leads to better access to housing and healthcare.

During a multi-agency case conferencing meeting, an outreach worker updated the group that one client relapsed after having successful two weeks in treatment. The whole room was saddened by the news, but not disappointed in the client. They all seemed to know him and want to see him succeed. One person expressed his

success in getting through two weeks. The group offered support to the worker and the individual returning to their community.

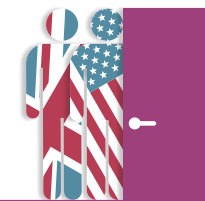
The Street Outreach Team works together with police and local government through a case conferencing meeting focused on individuals who habitually drink in the streets or beg. The Street Outreach Team communicates with the hospital about frequent users of the emergency department and one community health care worker comes out on early morning outreach once a week. These partnerships benefit all agencies involved. Local government and police want to remove the sight of street drinking and begging, the hospital and community health agency want people to receive needed health care without unnecessary emergency department visits, and the Street Outreach Team is able to connect individuals to needed resources.

Data to determine who is in need and tracking results

The Street Outreach Team tracks all individual contacts and outcomes through a database recording every physical visit, hotline call (from individuals or another agency), and failed appointment. The database allows the team to keep up with a transient population and monitor program performance. Since the team goes out 365 days a year and has a database to track all interactions, they have an accurate count and understanding of the needs of those sleeping outdoors. This allows the team to be a trusted knowledge base for rough sleeping.

Person-centered and emphasize building rapport and trust

Daily outreach and a 24 hotline allows the team to build rapport and trust over time by interacting with those sleeping outdoors almost every day.



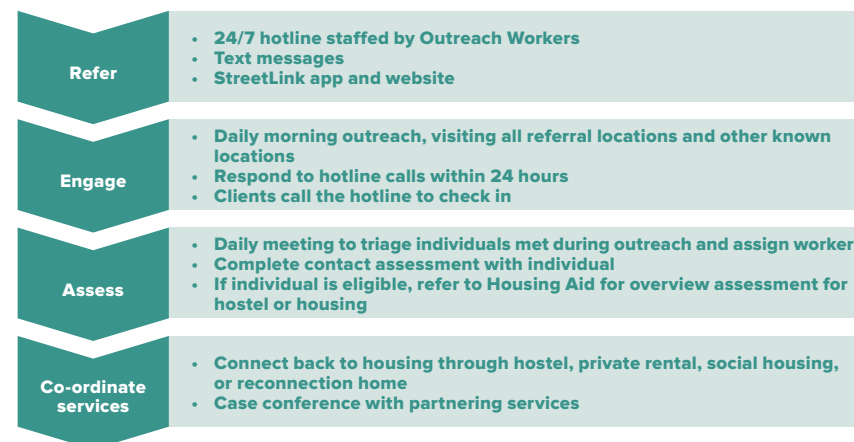
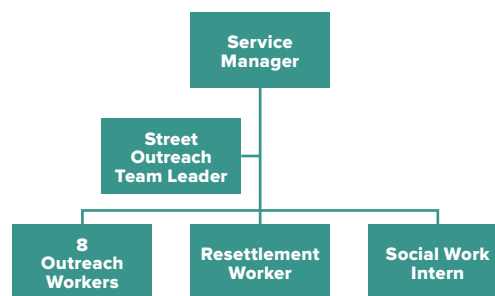
Actions to bring back to the US

Building partnerships and making community-level changes take time, persistence, and a willingness to come back to the table. A leader within Framework stated it best, “Homelessness has been a problem for the last 45 years. We won’t solve it tomorrow.” Framework’s Street Outreach Team is a model assertive outreach program, but it can’t solve the big issues like immigration policies and lack of housing resources on their own. Therefore they can never reduce homelessness on their own. Success happens when those with different knowledge, skills, and experience – but similar goals – come together.

Through individual champions, agencies partnership, and community working groups, communities in the U.S. can continue to improve services provided to people experience homelessness. I was inspired by many of the practices in Nottingham, and below are a few ways to bring these practices into US communities.

- Encourage housing authorities to prioritize people experiencing homelessness for affordable housing like public housing and housing choice vouchers.
- Develop outreach as a main component of your community coordinated entry system.
- Ask for participation in from people with lived experience in planning. Framework has service users representation on their board, a forum to advise on policies and procedures, and representation on hiring panels.
- Utilize non-outreach workers, like mental health counselors, hospital social workers, health outreach workers, police, and even volunteers, in your outreach efforts to build

Framework's Street Outreach Team



outreach capacity. Workers from the hospital, community health, and hostel participate in outreach.

- Spend time brainstorming housing options and other resources with colleagues. SOT has daily check-ins and weekly meetings with outreach workers and multiple monthly case conferencing meetings with other agencies.
- Empower clients to advocate for themselves. Framework contracts with an outside advocacy group to support clients in asking questions, making a complaint, or saying thanks to the agency.
- Determine an easy way that community members, both in the community and at partnering agencies, can report the location of someone possibly sleeping outdoors. In Nottingham, phone, text, and StreetLink allow community members to be helpful by reporting locations for outreach to visit.

- Track outreach efforts to have documentation of homelessness, evaluate effectiveness, and celebrate success. Framework has a database, but they also report individuals and locations visited daily on an electronic form and they share case studies with partner agencies to celebrate successes and point out needed system improvement.

Thank you to the National Alliance to End Homelessness, Homeless Link, and Oak Foundation for the opportunity. Thank you to Framework for allowing me to come learn from their team. Thank you to Jason Marriott and the Street Outreach Team for being amazing hosts. Thank you to all of the people and agencies that took time to talk with me during my time in Nottingham.

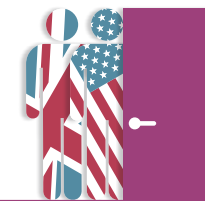
Kendra Lutes

Creating a more integrated and flexible system of services



Fulfilling Lives
Newcastle &
Gateshead





Kendra Lutes

Creating a more integrated and flexible system of services

Kendra Lutes is Clinical Supervisor, Homeless Services at Terry Reilly.

The US and the UK are both grappling with the question of how to better address the needs of their most vulnerable individuals. In some ways, the picture in both countries looks very similar – the most vulnerable are individuals struggling with problems related to lack of stable housing, mental health and addiction, and frequent interaction with the criminal justice system. Commonly, the most vulnerable also have the most difficulty accessing or staying engaged with healthcare and support services. In addition to the human factor driving policy in both countries to address the needs of this group, there is also increased awareness and concern about the cost to the larger healthcare and criminal justice systems with vulnerable people often disproportionately using higher cost services – jail, the emergency room, and emergency shelter.

In the US the term 'chronically homeless' is often used to describe people in the most vulnerable group. Using the US Department of Housing and Urban Development (HUD) definition, someone who is chronically homeless has experienced homelessness repeatedly and for a long duration – at least four times in the past three years – and has a disabling physical, mental health or substance misuse condition. The January 2015 point-in-time count resulted in 83,170 people nationwide identified as chronically homeless which is 15 percent of the total number of people identified as homeless in the nation. Permanent Supportive Housing (PSH) – housing with wrap-around support such as case management, healthcare, transportation, and assistance with skills of daily living – is currently widely used across the US to address the needs of people experiencing chronic

homelessness, and has demonstrated efficacy in terms of client outcomes and cost savings. However, as there is no national consensus about what constitutes PSH, program models vary greatly in terms of the type and extent of support provided. In addition, support is often dictated by funding which can be hard to find.¹

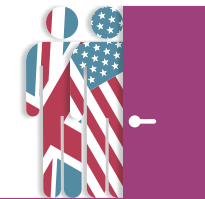
In the United Kingdom, people experiencing homelessness, mental health problems, substance misuse, and/or criminal offending, are often referred to as Multiple Complex Needs or simply Multiple Needs (MN). The launching of the Making Every Adult Matter (MEAM) coalition in 2008 strengthened a national focus on people with MN. MEAM is comprised of three national charities representing homeless services, mental health, and the criminal justice systems. The MEAM approach advocates for a higher level of care coordination and increased flexibility in terms of service design and provision. MEAM is largely considered to have laid the foundation for Fulfilling Lives, another national program focused on people with MN which rolled out in 2014.²

Fulfilling Lives consists of 12 programs in 12 different sites across the UK; it is funded by The Big Lottery which distributes 40 percent of lottery funds nationwide.³ The purpose of Fulfilling Lives is to create a more integrated and flexible system of services for people experiencing MN, which for the purposes of the program is defined as people experiencing two or more needs. The definition of homelessness for Fulfilling Lives is broad, encompassing people who are in shelters, on the street, and staying with friends or family. Each of the 12 sites has the flexibility to design their services to meet the needs of the local community but all sites share common principles and ways of working including using a

strengths-based approach, providing wrap-around care, and prioritizing service-user involvement. System change is integral to Fulfilling Lives, as is learning from service users about what works best for them; to this end, each program site will work with a target number of participants experiencing MN for between five to eight years, and in the process learn from their experiences about the kinds of barriers and blockages they face as they interact with the local system of services. All sites function independently but also meet together regularly for trainings and to plan initiatives at the national level. Additionally, there is a national evaluation team that compiles and reports on the work being done by all of the sites; all sites also have their own local research and evaluation team. The expectation after the funding period is that voluntary and statutory services will have achieved systemic change to the benefit of the most vulnerable people in society sufficient so that there will be no need for the program to continue.⁴

Fulfilling Lives, Newcastle & Gateshead

In May I spent two weeks with the Fulfilling Lives program that covers Newcastle and Gateshead, two communities on either side of the Tyne River in Northern England. Newcastle and Gateshead have a combined population of approximately 500,000, according to the 2011 census. Fulfilling Lives Newcastle/Gateshead (FLNG) was funded for eight years with a participant target number of 600 over the lifetime of the project. FLNG serves people with three or more needs. The following information from the FLNG Evaluation report from the first year of the program provides a snapshot of FLNG participants:



Kendra Lutes

Creating a more integrated and flexible system of services

- 130 people participated in the program
- 83 percent of the participants that identified as homeless when they were referred to the program had all four MN
- A high number of participants had a history of criminal offending – 90 percent for males and 77 percent for females and 100 percent of people with a history of offending also had problems with either substance misuse or mental health.⁵

Fulfilling Lives was not intended to provide a new service to the community – it does not provide housing or mental health counseling – but to better connect people to existing services with the help of Service Navigators and Brokers. Navigators are typically the first point of contact with participants. The primary job of the Navigator is engagement – engaging with the participant to learn about them and their needs, and then facilitating the participant’s engagement with community resources and services. The Brokers primary job is to try and create more flexibility in the system and reduce the barriers that the Navigators and participants encounter as they engage with services and service providers. Generally, people are referred to FLNG when they have exhausted other resources and/or there is a perception that they need a higher level of care coordination than the referring agency can provide.

Learning

I was interested in learning from FLNG about best practices in multi-agency and multi-system care coordination and Peer Support. My research questions included:

1. **What factors support engagement and retention** in supportive services and housing?

2. **Does a multi-agency approach** increase access and coordination of services?
3. **How can we better integrate people with lived experience** into every aspect of service delivery, including program development, delivery, and evaluation?
4. **How does peer involvement** affect participant engagement and retention?

The Year One FLNG evaluation reported that of the 130 participants, only 11 percent disengaged from services, with disengagement defined as no contact for at least 3 months.⁶ I spent some time with a FLNG Navigator who gave me a sense of what he does and how he helps people stay engaged. He told me about his efforts to connect with someone for over three months before he was finally able to meet with him face to face – but he did not give up on him and the person was not dropped from the program. The Navigator draws on his past experience in substance misuse treatment – sometimes by disclosing it to inspire trust or hope, and sometimes simply as a way of helping him understand participant’s behaviors. He said, “That’s what people with lived experience are good at – the engagement piece.” This statement stood out for me as a reminder of the value of peers, whether they function specifically in that role or simply bring that experience to their job; their insider knowledge of the system allows for a fundamentally different kind of relationship than that of a professional. Hiring people with lived experience as front line workers is an engagement strategy that works well with people with MN.

The organization and governing structure of FLNG facilitates communication and collaboration which supports successful care coordination across multiple agencies and systems.

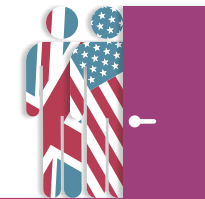
FLNG is a partnership among several community agencies. The lead agency, Changing Lives, is a charity that provides an array of services to people experiencing homelessness as well as other vulnerable groups. Seven other agencies also partner with FLNG in that they employ the Navigators, so that Navigators work for FLNG out of partner agency sites throughout the community. FLNG also maintains close ties with local governmental groups that are often directly involved in providing services and/or funding for services.

Additionally, FLNG has a Strategic Reference group comprised of local service representatives that provide guidance and expertise on the four MN areas. On the national level, FLNG staff attends quarterly trainings and meetings with their counterparts from other Fulfilling Lives sites across the country. For example, during the two weeks I was in Newcastle, I attended a workshop for Navigators about system change, and on a separate occasion I went to a meeting of site leaders who were beginning to consolidate ideas regarding system barriers that they wanted to address on a national level. Experts (people with lived experience of homelessness) meet at least quarterly with experts or their equivalent from other Fulfilling Lives sites as the National Expert Citizens Group.

Without a doubt, working across multiple agencies and systems is complicated. What I learned from attending community meetings with Brokers was that taking a systems’ approach to problems is central to relationship management. In one instance, I attended a meeting with a local community provider with which there had been some tension reported by Navigators around perceived referral rejection. I observed how the Broker took a wide-angle look at the problem in a way that

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was very non-blaming of the partner agency or any individual staff member. The system focus was epitomized in statements like, “We just need to trust one another – everyone is doing their best job,” and “The system is failing this person.” By the end of the meeting, the Broker had a better understanding of recent changes and pressures the community agency was facing and agency staff had a better understanding of the purpose of the FLNG program.

Taking a systems approach to problems shares something with taking a strengths-based or trauma-informed approach with people – it requires consideration of at least some of the formative events, influences, and even relationships that shape both problems and people. This is particularly true of people with MN, because problems usually have a long history and are very entrenched. It can be difficult to maintain a strengths-based or non-deficit saturated approach. Staff benefit from formal support or supervision to prevent burn-out and compassion fatigue.

Reflective Practice – time built into the work week for people to get together to reflect in a structured format about the work – was one way I observed FLNG supporting staff. Every six weeks, FLNG staff participated in a Learning Community (LC) facilitated by a professor at Newcastle University Business School.⁷ The LC was a very structured time set aside for reflection on previously agreed upon topics - either clinical or logistical. For example, at the LC I observed, one of the topics was the use of personalized budgets – money that is available for each participant to pay for needed services; for the following meeting, one of the topics suggested was service user manipulation. The goal of reflecting on practice

is not to solve problems – although the group might come up with a collective action plan around a topic -- but to be heard, share knowledge, learn from one another, and create some consistency across the practice. Without exception, the FLNG staff said the LC was one of the most valuable aspects of their job. Front line staff said it was more valuable than clinical supervision. One staff member expressed feeling increased comfort and trust over the course of the meetings, suggesting that reflective practice has the potential to strengthen cohesion and build a better working group – one that promotes professional growth and quality performance.

One of the key features of FLNG is the Expert group. Experts are people with lived experience that have transitioned from being service users only to participating in some way in the system change work that is integral to Fulfilling Lives. The Expert group provides guidance and direction at various levels of the program and the intent is for them to have a high degree of participation and influence. The FLNG Expert group met weekly to assign tasks and report back on projects; they also facilitated groups, had a weekly potluck and participated in their own reflective practice group. Funding was available for Experts to acquire specialized training; one of the Experts I met had just completed training to facilitate groups for women who had experience domestic violence and another was attending mindfulness training. One Expert was the group’s representative at the national Fulfilling Lives forums; he expressed an interest in using the skills and knowledge he was acquiring as an Expert with FLNG in a field other than health care.

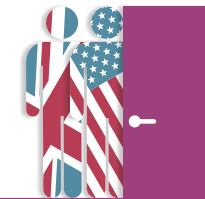
FLNG Experts were involved in a wide array of activities; for example, they provided feedback on program proposals and

presented at community events. To advance the influence of the Expert group, FLNG hired an Expert Lead to help organize and integrate the Expert’s work with that of Navigators and service users. A small group of Experts had recently completed training in research techniques and were about to start a research project funded by a local government entity that involved interviewing service users to gain a better understanding of the relationship between homelessness and health inequalities. The FLNG Research and Evaluation lead had co-developed the training curriculum and provided the training. This development was part of a sustainability strategy in that an Expert evaluation team was ideally suited to conduct paid research with service users. Another idea in the exploration stage was a crisis center staffed by Experts. One of the system problems that had been identified by FLNG was with crisis services; for people in crisis there are not many options besides the highest level of care, hospitalization, and even that was difficult to access. A crisis center with Experts as the first point of engagement would provide service users and providers with more options for support, as well as potentially divert hospitalizations.

Application

On a recent webinar a speaker remarked that people who are homeless need more than a Health Home – a single site where all of their health care needs are addressed – they need a Health Community.⁸ A program like FLNG helps thread together a community of support.

The multi-agency care coordination work of FLNG is transferable to the US and in some communities has already begun. One example is the US Department of Housing and



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Urban Development (HUD), coordinated entry requirement. HUD requires communities receiving federal money for homeless programs to develop a streamlined and prioritized process for people to access housing resources. While coordinated entry is still in the planning stages in my community, I have already noticed a higher degree of communication and collaboration among agencies and a greater sense of homelessness as a shared problem versus everyone doing their own thing in isolation. This degree of multi-agency collaboration can serve as a model for other parts of the social services system, such as healthcare. Using a system change framework like the one so integral to FLNG is helpful because it does not allow for “that’s just the way it is” thinking and can force communities to adjust programs and service to fit people rather than the other way around. Without a commitment to creating a more connected and flexible system, there will always be a need for Navigators, Case or Care Managers and Social Workers to help people access and move between systems.

The holistic model of service user involvement depicted by the FLNG Expert group is hard to imagine in the US without being part of a national, or at the very least, state-wide agenda. Peer involvement requires significant agency commitment and can be hard to sustain financially without grant funding, which is usually time limited. Currently, throughout the US, Peer Support Specialists are employed in diverse ways. In my community, peers are part of Assertive Community Outreach (ACT) Teams, do outreach and provide mentoring and support in mental health and substance misuse agencies. Peers are beneficial to service engagement and could be used even more with people experiencing homelessness. In addition, while it is not uncommon for homeless service programs to

have consumer or peer advisory boards, it may be helpful to think about ways to train or skill-up this group to increase their participation or influence in community settings.

Conclusion

The experience with FLNG was extremely positive and continues to influence my thinking. Learning about the Expert group expanded my idea of what is possible for peer support in my own work setting and community. As a small example, upon my return to the US, I suggested a modification to the supportive services model of a local Housing First project with which my clinic is involved to include more time allocated to peer support. I also hope to start a Peer Advisory Board that will be influential over the lifetime of the project, helping services fit the needs of participants. I have also noticed and taken up more opportunities to try and create flexibility within the local healthcare system; some of these opportunities have included collaborative efforts with other community agencies. Additionally, a system change framework has encouraged me to gain a better understanding of how the work I do on a daily basis fits into broader State and national agendas.

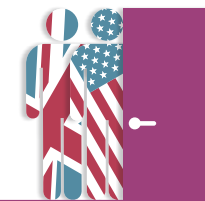
Finally, I would like to thank everyone at Fulfilling Lives, Newcastle and Gateshead who were very welcoming and generous with their time and knowledge. Also, thank you to the other regional Fulfilling Lives staff that made me feel welcome during various meetings and trainings. Your commitment to improving the system for people with MN is inspiring.

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Rachel Yoder

The Positive Pathway for youth and young adult homelessness





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In April 2016, I spent two weeks in London with Depaul UK to study best practices for addressing youth and young adult (YYA) homelessness. I focused especially on how community-level plans and collaborations are used and whether they could be replicated in the US. To this end, I spent my time looking at two specific models of collaboration: The Positive Pathway framework and the London Youth Gateway partnership.

Research question

- How does the Positive Pathway framework support a community in **developing and implementing a unified plan to end and prevent YYA homelessness**, and can this framework be effectively replicated in Philadelphia?

Learning objectives

- **Learn best practices** from Depaul UK and others for addressing YYA homelessness and for developing a coordinated, community-level approach using the Positive Pathway model.
- **Explore how to analyze the scale of the problem** and adopt a common definition for YYA homelessness
- **Learn how these frameworks could be implemented in Philadelphia** to support a more coordinated community approach to YYA homelessness

I spent most of my time in London, but also traveled to Whitley Bay and Newcastle to visit Depaul UK sites in the North East of England.

Depaul UK

Depaul UK is a national organization which is a part of the Depaul Group, originally begun in 1989 as a response to the growing number of people experiencing homelessness on the streets of London. Depaul UK specifically serves young people experiencing homelessness through: supported accommodation; employment and educational programming; floating support; and the Nightstop scheme. Each year, Depaul UK supports over 700 individuals through their various services and housing.

Depaul UK is incredibly value-driven and person-centered. Their stated values are core to all of the work they do and they relentlessly hold to them: “everyone has a place to call home and a stake in the community.” Depaul’s Philosophy of Care reads:

"Welcome. We are glad you are here. In this place you can take steps towards a better future. You will lead the way. We will ask, listen, and help. We will work and walk with you. Welcome."

Young adult homelessness

In both the US and the UK, homelessness is difficult to quantify because of its hidden and transient nature. This is particularly true for youth and young adults who are experiencing homelessness. Homeless young people are less likely to spend time in traditional homeless systems of care (safe havens or emergency shelters, for example) and may be less likely to disclose that they are experiencing homelessness because of social stigma.

According to a recent federal report, there were 36,907 unaccompanied homeless youth on a single night in 2015 in the United States; 87 percent were between the ages of 18 and 24.¹ The National Alliance to End Homelessness expects that this is a significant undercount and estimates that in a year, there are 550,000 unaccompanied youth and young adults who are homeless for more than one week.²

Similarly, official statistics for youth and young adult homelessness are likely an undercount in the UK and only include individuals who have approached a local authority for assistance. According to Homeless Link, 13,490 young people had an accommodation duty accepted in 2014 and 2015. Centrepont (a national UK charity) estimates that approximately 130,000 young people (ages 16 to 24) a year ask for local authority assistance.³

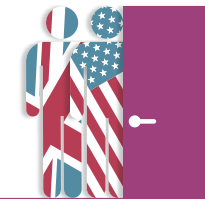
Differences and similarities

The UK and the US approaches have key similarities and differences that are essential to understanding the context of policy and practice -- most notably in government responsibility and the social welfare system.

The UK has a much stronger welfare system and social safety net (and historical government commitment). In the UK, most people are entitled to a Housing Benefit,⁴ a means-tested state housing subsidy that most UK citizens (and some European Union citizens) can claim to pay for part or all of their rent. The Housing Benefit is available towards the cost of rent whether you are unemployed or working, and has traditionally provided significant support to vulnerable youth. There are also income and disability benefits.

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However, due to changes proposed by the Conservative Government in the UK, the funding landscape has changed and is expected to change significantly more as key adjustments to the welfare system are implemented. Organizations expect to be adversely impacted by these changes and other austerity measures imposed by Parliament. The amount of Housing Benefit has already been reduced and other changes may include the removal of housing support altogether for some individuals who are out of work, and additional employment or job-seeking requirements for others. Many expect that, given the changes to Housing Benefit and other welfare programs, the number of homeless youth will continue to rise in the UK.

At the same time that resources are decreasing in the UK, it seems the US may be increasing resources. More federal attention is being devoted to the issue of YYA homelessness, some additional resources have been brought forward, and there is hope that this will continue.

The UK and the US also share many similarities and challenges. The causes of youth and young adult homelessness are similar and both countries face a growing number of young people experiencing homelessness. Both countries are also seeing similar increases in legal highs and the use of drugs such as PCP and K2.

The availability of data on YYA is limited in each place. In the United States, the US Department of Housing and Urban Development only recently began requiring Continuums of Care to collect specific YYA information in their Point-in-Time counts. The UK has no national data collection requirement, though local authorities collect data on statutory homelessness and rough sleeping numbers are recorded.

In both countries, there is extremely limited data on “hidden homelessness” (couch surfing or staying with friends and family,) and those who do not meet the federal or statutory definition of homelessness.

Positive pathways

The Positive Pathway is a flexible framework for local authorities and their partners to use locally to provide a planned approach to homelessness prevention and housing for young people. It aims to help public service commissioners and providers of services to work together in planning and delivering services for young people recognizing that safe, decent, and affordable housing underpins achievement of other positive outcomes – whether they relate to education, training, employment, health or safer communities.⁵

The Positive Pathway is similar to a Continuum of Care in the US, but is organized around a specific age group and is tied to a borough and local authority. For example, in London, there are 33 boroughs each which could have its own Pathway, while in New York City, a similar-sized city to London, there is one Continuum of Care. It is not obligatory for local authorities to have this Pathway and each local authority will adapt the model to fit their own local circumstances. The Positive Pathway framework was developed by St Basils, a youth homelessness charity in Birmingham and the West Midlands, in 2012 (and updated in 2015) in consultation with local authorities and other service providers to serve as a guide local authorities to implement and organize local services for young people. According to Homeless Link, 64 percent of local authorities across England reported there was a Positive Pathway in their area in 2015.⁶

The Positive Pathway framework is designed to serve as a blueprint for how services for young people should work together. It is intended to be highly collaborative and prevention-focused. A Positive Pathway has five service areas: information and advice for young people and families; early help; integrated response ('hub' or 'virtual hub') and gateway to commissioned accommodation and support; commissioned accommodation and support; and a range of housing options.⁷

The Pathway is typically ordered from high to medium and low support. Individuals move from high support to low support (or, if needed, the other way around). The local authority usually acts as the referrer and gate-keeper for the Pathway. In both the Camden and Greenwich Pathways, there are approximately 200 young people.

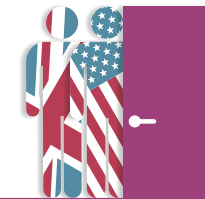
Learning

There are several core components of a Positive Pathway that are key to the effective replication of this framework. First, and most importantly, young people are the experts. Young people are included in system-level planning at every stage of setting up a Positive Pathway. In service provision, the framework is designed to see young people as the experts of their own journey and ensure that the care is centered on each person.

Notably, the Positive Pathway approaches the delivery of services from a 'whole systems' approach. This approach ensures that every provider or government agency that may be involved in an individual's care is included in the Pathway. This ensures a more proactive, seamless, and integrated set of resources for young people that avoids duplication and unnecessary barriers.

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The model also encourages communities to think proactively about developing services based on expressed need (as demonstrated by feedback from young people and data). Together, communities and agencies develop a range of prevention resources and housing and support services that can be tailored to meet an individual's need. The model has a heavy emphasis on prevention and some high performing Pathways show an 85 percent success rate for prevention efforts.

The Pathway's integrated response – or 'hub' or 'virtual hub' – is an invaluable component of this model and supports integration of services. In the 'hub' public sector and provider agencies are co-located and young people can easily access resources. In many boroughs this has been an important catalyst in improving communication and coordination of resources. More important, this space is a safe space where young people can access resources as they are comfortable.

The Positive Pathway framework pools resources, creates common tools, and promotes a shared understanding to eliminate inefficiencies and avoid duplication. To this end, a Pathway often employs a single Pathway Manager who acts as the point person for every young adult within the Pathway. This person is responsible for leading smooth collaboration. Ideally, every organization in the Pathway attends regular meetings so that every professional involved in a young person's care is on the same page and proactive planning can occur. Other important pieces of highly effective pathways include, use of data and shared outcomes, a single point of access and referral coordinator, shared referral forms and common risk assessment processes, and a prioritization process for referrals.

There are several real-world challenges that can hinder the effectiveness of a Pathway. First, because of policy and funding,

the length of time individuals may spend in a Pathway is limited. Many professionals noted that while two years should be the minimum standard, the reality is that young people are able to spend less and less time in the Pathway because of policy shifts. Additionally, in practice a Pathway can be extremely rigid on how individuals move through the system (from high to low support) and not allow individuals to titrate with respect to their needs and care. This can create systems that expect young people to have linear journeys - expectation fundamentally at odds with a person-centered approach.

While there is a benefit to the Pathway being tied to a specific local authority, this can also create challenges. Services may be inconsistently provided. A Pathway in one borough can be distinctly different than another because of the availability of funding and the priorities of local authorities. This is often particularly noticeable in access to and quality of referral, services, and accommodation for those who do not meet the statutory definition of homelessness. This is not a product of the design of the Pathway, but rather a result of how services are funded and delivered in England that can create challenges for implementing the framework. Additionally, there is not a common assessment tool used across all Pathways. In London, this creates a somewhat fragmented approach at the city level.

London Youth Gateway

The London Youth Gateway⁸ is a pan-London service partnership commissioned by London Councils. This unique partnership is composed of New Horizons Youth Centre, Depaul UK, Stonewall Housing, and Alone in London. Together they provide additional services across borough in London and provide feedback and insight into overall city-level challenges.

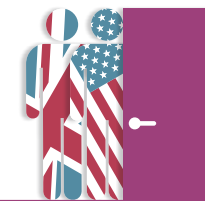
This collaboration brings together four well-respected organizations – each with its own focus and service niche – to provide a holistic set of services, including a specialized youth drop-in center, supported accommodation, and LGBTQ services. It is a collaborative, single-pathway approach and provides: coordination of advice and support; homelessness prevention; education, training, and employment; and emotional and physical well-being support and advice. The Gateway does not replicate local service provision; instead, it supplements it. The Gateway makes approximately 800 referrals each year to reconnect beneficiaries to relevant statutory or voluntary services.

The Gateway connects to individuals through satellite outreach sessions, prison outreach, workshops in schools, and other safe spaces. The New Horizons Youth Centre acts as a hub of services for the partnership and is especially unique in London because it is the only specialized day center and individuals do not need to have a local connection, whereas many local authority services are only funded to work with people from the borough in which the service is based.

Partner organizations in the London Youth Gateway have a long history of collaboration and share an ethos. Notably, partner organizations do not dictate one another's practices, but recognize their own roles and unique service niches. The Gateway is well known amongst young people and provider organizations and serves as a much-needed supplement and partner to local authorities.

Learning

The London Youth Gateway augments local authority services across London and targets a hard-to-reach group of



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young people who are homeless or at risk of homelessness. Many of the individuals who are served do not meet the statutory definition of homelessness and so local authorities have no obligation to house them, even if they are eligible for Housing Benefit.

The Gateway highlights the importance of coordinated points of access, an accountable point-person within the system, coordination between sectors, and a city-wide approach. Most notably, the Gateway demonstrates the importance of services and housing that are not just attached to the statutory definition of homelessness. The system should have flexibility to respond to individuals who do not meet the federal definition of homelessness.

Findings

The Positive Pathways framework and the London Youth Gateway are effective models for communities in the US in organizing community-level plans for youth and young adult homelessness. Communities in the US have seen tremendous progress when key stakeholders collaborate and establish a single comprehensive plan to address specific sub-populations. Most recently, communities have achieved 'functional zero' in Veteran's homelessness by creating broad collaborations that operate with a single plan and priority list (and, importantly, with targeted resources).

Communities should have a shared understanding and strategy for prevention and the provision of YYA homeless services and housing. This is critical to both the Positive Pathway and London Youth Gateway. This strategy should

set up a distinct and age-appropriate set of resources for young people instead of trying to fit them into adult homeless services.

One of my biggest takeaways is that the US must adopt a 'whole systems' approach to youth and young adult homelessness. Both Positive Pathways and the London Youth Gateway do this well. This system should be focused not only on crisis, but on prevention and early help resources. To do this, the range of public sector programs involved in a young person's care must be seated together at the table, and integrated data on who is experiencing homelessness must be available. This collaborative approach should include homeless and behavioral health service, juvenile justice, public benefit, school, and the child welfare systems. Additionally, communities should consider involving private sector groups, including business organizations, local universities, health systems, and faith communities.

The system should be designed to meet the unique needs of each young person, as expressed by the young person. Young people are the experts and should be included in every phase of designing and implementing a community-wide response. Ongoing mechanisms for securing feedback and involving young people in leadership and decision-making should be adopted.

Other key considerations

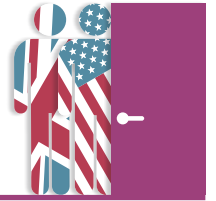
- **A hub or virtual hub of services** – The hub should serve as a safe, low-threshold space for YYA to drop-in, meet their basic needs, and engage with staff. Co-locating services among agencies is important for streamlining and improving collaboration.

- **Coordinated entry and assessment across the system** – We can see the effectiveness of these approaches on a small scale through Positive Pathways and the London Youth Gateway. As communities move toward the HUD required coordinated entry, communities in the US should create YYA specific gateways and assessment tools.
- **System mapping and clear points of entry** – The Positive Pathway framework provides a clear map of how an individual is to move through housing with clear and accessible entry points, with a major focus on prevention and slowing the crisis down. This is a key asset to communities and also an important component of coordinated entry.
- **Streamlined paperwork and admission criteria between programs** – To support moving individuals among programs quickly depending on their needs, organizations should streamline paperwork and create common assessment tools. Government agencies should ensure that contracts and funding streams allow for flexibility and movement between programs.
- **One accountable point-person** – Both Positive Pathways and London Youth Gateway incorporate a single point-of-contact who is responsible for ensuring the ongoing collaboration. Communities should consider adopting similar models to improve coordination.

Practice and policy implications for the US

National level

At a national level, the Positive Pathways model and the London Youth Gateway illustrate the importance of federal resources



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for planning and coordination. While recent federal resources have been allocated for Continuum of Care planning, more is still needed. And, of course, more resources are needed for actual services and housing. Additionally, to ensure government participation in planning efforts, federal departments should require or incentivize local agencies to participate in the planning process. A good example of this is the national buy-in from the Department of Veterans Affairs to the efforts to house Veterans who are homeless. Because of this coordinated effort, veteran homelessness has been reduced by 47 percent nationally since 2010. The national support was essential to ensuring the effectiveness of these efforts.

Local level

At a local level, these models build on the good work of many communities. As noted earlier, many CoCs have engaged or are engaging in 100 Day Planning processes, Bootcamps, or other planning efforts. All of these have a heavy emphasis on system mapping and intentional system design. The Positive Pathway framework can serve as key groundwork to continue this work for YYA systems. Communities should dedicate resources to local-level collaborative planning for youth and young adults. These planning processes should be focused on ending current homelessness, but also creating a system that will sustainably be able to respond to future needs.

The UK's policies and practice for addressing youth and young adult homelessness can serve as an effective model for services in the US. Building on the great work and established record in the UK, the US can adopt and replicate practices to create a stronger system of care for youth and young adults. Learning and knowledge sharing between the two countries should continue as we all work toward the common goal of ending homelessness.

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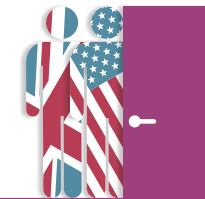
Tedd Peso

Prevention and diversion for youth at risk of homelessness



St Basils
Birmingham





Tedd Peso

Prevention and diversion for youth at risk of homelessness

Tedd Peso is Manager, Advocacy & Community Affairs at The Night Ministry

In May 2016, I traveled to the UK to spend two weeks working alongside and observing the staff at St Basils, the largest provider of housing and related supportive services to young people experiencing homelessness in Birmingham, England.

My learning goals for the trip were to:

- **Examine the UK's good practice framework for providing services to youth** – the Positive Pathways Framework.
- Specifically, to **investigate the role of prevention** in the Framework and how local organizations implement prevention in their system of care.

However, once I arrived and gained an understanding of the political environment in which services were being provided, I expanded my initial intent to include more about:

- How St Basils Pathway **prevents, diverts, and then moves young people out of homelessness.**

St Basils

St Basils is a 44 year-old charity that provided advice and support services to more than 4,100 young people and housed 1,213 young people experiencing homelessness in Birmingham during fiscal year 2015. St Basils' housing programs serve youth ages 16 through 24.

St Basils has a full range of prevention, housing, support and engagement services as well as services, which aim to ensure

young people develop the skills, and have the support needed to move on successfully.

Positive Pathway

The Positive Pathway Framework was created in 2012 and updated in 2015 to respond to changes in national policy and legislation. The new Pathway includes five steps:

- Information and advice for all young people and families
- Targeted help for those who are at-risk of becoming homeless
- Integrated response and gateway to accommodation and support (“The Hub”)
- Commissioned accommodation and support
- Range of housing and options.

The updated Framework responds to three key points:

1. An understanding that the existing system was limited to helping youth in crisis and required an approach that included prevention activity, a range of housing options, and educational and vocational support.
2. A concern that young people leaving care still had multiple or complex needs and required more support to make a positive transition.
3. A realization that in a time of budget pressures and service reductions, the system needed an idea of how change would happen. In this area, the focus seems to be on engaging young people in the economy so that they are not reliant on social welfare benefits.

While not mandated or implemented across the nation, the Positive Pathway is supported by two Government-funded national youth homelessness advisors who are placed at St Basils and work with Local Authorities across England to ‘roll out’ the Positive Pathway. Each of the 326 Local Authorities in England is eligible for two days of technical assistance from the advisors to assess their capacity to implement a Positive Pathway. The advisors can also attend meetings, facilitate trainings and offer on-going support if time permits. During the first six months of this contract year, the advisors will have worked with 80 Local Authorities with a goal to work with at least 150 each year.

In 2015, 64 percent of Local Authorities and 78 percent of providers reported that a Positive Pathway was in place in their community.

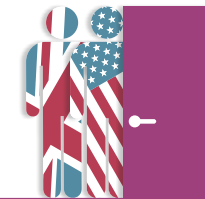
Anna Whelan, one of the national youth homelessness advisors, says two things must exist in each Local Authority to create an effective Pathway: strong support from senior officials and a point person who builds the relationships required to develop the local Pathway and coordinates the day-to-day work.

St Basils has just commissioned an independent evaluation of the Positive Pathway to provide an understanding of how effective the Framework is at supporting Local Authorities to improve or develop their services by utilizing the Pathway model to fit the local context.

In addition to the Positive Pathway Framework, St Basils and a national children's charity, Barnardo's, created The Care

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Leavers Accommodation and Support Framework -- a model that Whelan considers a “sister model” to the Pathway. This Framework aims to help organizations that support young people in the area of housing and support as they leave care in England to prevent and end homelessness among care leavers.

Youth Homelessness in the UK vs. the US

Young people in the US and the UK become homeless for very similar reasons. In the UK, 47 percent of young people became homeless because their parents told them they could no longer accommodate them. In the US, 51 percent of homeless youth reported that they became homeless when their parents told them to leave. Young people I met in Birmingham told me that family conflict often resulted from economic stressors. However, youth mentioned a history of neglect, abuse, disagreement with sexual orientation, or religious conflict as other reasons for their homelessness.

In addition they struggle with similar needs – there is not enough age appropriate housing, finding a job that pays a living wage can be difficult, and suitable affordable housing for young people is very limited. Both sets of youth experience mental health issues. In the UK, 34 percent of youth report mental health issues; while, in the US, 62 percent of youth report symptoms associated with depression and 80 percent report living with symptoms of post-traumatic stress disorder for more than one month.

However young people in both countries are incredibly resilient. In the US, 83 percent of street youth report having

healthy self-esteem. In the UK, 65 percent of homeless youth are engaged in employment, education, or job training.

St Basils Pathway

St Basils has implemented the Pathway that does not simply solve a young person’s immediate housing crisis but addresses their long-term needs and helps them achieve outcomes that lead to independence.

Prevention

St Basils has implemented a variety of prevention efforts throughout their system designed to prevent young people from entering the homeless services system or prevent a return to homelessness once they leave their programs.

The Schools Training and Mentoring Project (STaMP) is a key part of the prevention work that St Basils conducts with young people. St Basils has identified that remaining in the family home and pursuing education is a protective factor that guards against repeated instances of homelessness. STaMP is a 50-minute program offered to Birmingham students, grades 7 to 13. The program helps young people understand the ways in which youth become homeless and the impact that can have on their lives. Students identify their physical, emotional and social needs and then consider how those needs are met by a fictional teenager experiencing homelessness. The program is co-presented by a St Basils employee and a young person who has experienced homelessness.

Overall 55 percent of students showed a marked difference in the age they thought it was sensible to leave home on pre-

and post-tests, rising from 16 to 19 as being the mean age for leaving home. St Basils educates approximately 900 students a year through STaMP yearly; however, the program competes with required curriculum and, therefore, getting into schools can be a challenge.

The young people I spoke with all thought that the UK as a whole should be doing more to provide resources to young people while they are in school. The UK has not implemented a homeless liaison program and stigma around homelessness is significant. As a result, young people say warning signs go unnoticed by educators.

Coordinated entry and gateway to accommodations

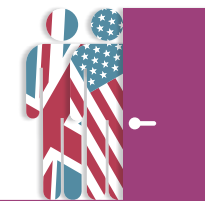
Chicago and many US cities provide multiple entry points into the homeless service system for young people, including overnight shelters, emergency shelters, transitional living program, drop-in’s, and street outreach. In Birmingham, all homeless youth must access housing through St Basils’ centralized intake site. The Hub is a partnership between:

- Birmingham City Council, the Local Authority which serves those individuals whom the city has a statutory requirement to house
- Children’s Services, which help determine placement for 16 and 17 year olds
- St Basils, which provides intake and assessment and connects young people to a variety of accommodations.

Diversion from homeless services is a key aspect of the Hub’s services. If it is safe and appropriate, once the St Basils

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worker has interviewed the young person and obtained their permission, they contact the parent or guardian to determine what, if any, services St Basils can provide to keep the young person at home. If that does not seem likely, the worker will determine if there is an alternative placement, agreed upon by the young person and the parent. If family reunification does not seem likely, the young person will receive a full assessment and meet with the Hub's housing placement team.

Once young people are assessed, the housing placement team will use the assessment to locate the appropriate accommodation. This can be difficult because accommodation providers can turn away a young person whose needs are deemed to be too high for their site. In fact, this was the number one reason why young people were turned away from services last year in the UK, accounting for 63 percent of turnaways, and suggests that changes to funding may be causing accommodation providers to create stricter eligibility criteria.

Accommodation and support

Similar to the US, youth at St Basils are provided with a range of shelter accommodations. There are a very limited number of direct entry beds where youth can stay while they are waiting to receive an assessment at the Hub; a Nightspots host homes program; and a supported accommodation program that forms the majority of St Basils' housing stock and feels similar to US transitional living programs.

The major difference between our two systems is the amount of social welfare benefits available to young people in the UK. In addition to free health care, young people in England often receive Job Seeker's Allowance if they are looking for

employment, Income Support if they are unable to work or are a 16 or 17-year old enrolled in certain types of training, and Housing Benefit. Housing Benefit is paid directly to St Basils to help pay the young person's rent.

These benefits are currently under attack by the Conservative Government with a variety of proposals that threaten a young person's ability to access benefits, or force young people on benefits to jump through hoops (for example, job search conditionality) to keep receiving them. These changes could potentially threaten St Basils' rental income, and thus their ability to provide housing for the young people. In addition to benefit changes, the Local Authority in Birmingham has decreased the maximum length of stay for many young people from 24 months to a year or less. This means that St Basils has less time to provide support to move people out of homelessness and the young person's time at St Basils must be more impactful.

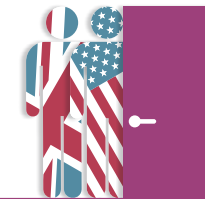
St Basils' basic life skills course is a five-part workbook that helps develop a resident's skills for independent living – budgeting, money management, cooking skills, leisure activities, and landlord and tenant duties. The program is designed to be completed in a young person's own time and can be adapted by the life skills worker to best fit the young person's learning style. The program is incentivized so each young person who completes the program is invited to attend an annual cap and gown ceremony and receives a gift card. Best of all, the program is accredited by the Open College Network which means that completion of the life skills course allows the resident to place an entry-level certification on their resumé.

Last year, St Basils worked with sports psychology students at the University of Birmingham to develop the Mental Skills Training Program (MST), which engages techniques designed by sports coaches to establish aspirations, set goals and utilize support networks that build confidence, develop teamwork skills, and problem-solve. All this is aimed at building the mental resilience needed to cope with rejection or disappointment and to train young people to refocus on their goals and try again.

The 10-week program culminates with a three-day trip to a nature area that provides young people with the opportunity to partake in new activities that helps them discover a sense of achievement.

The MST Program is currently in its second year of a three-year implementation. During year one, researchers noted that the program seems to be having a positive, short-term impact on the perceptions of the young people who take part. During one early session, participants self-identify the mental strengths needed to achieve their "future selves." By the end of the program, young people show that they have developed a more positive belief in their abilities in those self-identified mental strengths. Researchers also note significant improvement in self-worth, perseverance and engagement.

St Basils identified that moving young people off of benefits can be challenging, especially if they want them to remain at St Basils. When a young person begins working, their benefits are immediately impacted and they often move out of their housing because rent at St Basils is often more than in the community due to the supportive services.



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Therefore, to provide young people with opportunities to enter the workforce and live benefit-free, while transitioning to independence, St Basils created the Live and Work Scheme in 2015.

A partnership with the National Health Service (NHS), Live and Work Scheme provides young people with the opportunity to receive paid apprenticeships in the health care system while living benefit-free in accommodations operated by St Basils. These young people receive a lower level of support and live more independently while they learn to budget, accumulate savings, and pay rent that is more comparable to rental costs in the community.

Staff report it has been a challenge to convince young people to leave public benefits for apprenticeships which are generally low-paying. As a result the program has struggled to fill its beds during year one. However, the young people I met at the Sandwell Live and Work Scheme were excited about the skills they were acquiring at the NHS, pleased with the independence that the program affords them, and had specific career paths in mind for when their apprenticeships are completed.

Aftercare

When young people leave a St Basils project, they are offered aftercare services that are similar to those in the US. However, as we all know, young people may experience repeated incidents of homelessness. For those youth who have not found success at any program, the UK Government created a three-year funding program called the Fair Chance Fund, which is the UK's first homeless youth program funded by

social impact bonds. St Basils is one of seven organizations across the UK participating in the project and the only organization to offer housing as part of its model. St Basils' Fair Chance program provides intensive case management and mentoring to help the most vulnerable young people for whom all other services have failed to find accommodations, enter education, and connect to employment. Payment for services is provided when the organizations meet specific outcomes related to housing, employment, education, and training along a specific timeline.

Fair Chance is an example of how St Basils is adapting to the new environment on both an organizational level and a client level. With traditional funding models threatened by benefit cutbacks, St Basils has taken advantage of an emerging funding source to gain experience and learn best practices early. At the same time, they are helping to make sure no young person falls through the cracks and are creating outcomes in line with the Pathway framework.

Summary

My time at St Basils provided me with the following takeaways:

1. The Positive Pathway, while more linear than most systems of care found in the US, has provided St Basils with a framework to create a system that goes beyond a crisis response, offering prevention and a range of housing options and support services. The Pathway's adaptability to threats from emerging government policy has allowed St Basils to be proactive in its service delivery, creating programs that encourage employment, attempt to meet

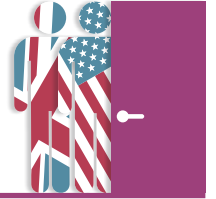
young people where they are at on life's journey, and provide the necessary support to assure no young people fall through the cracks.

I plan to review the Pathway evaluation when it is released to learn how the available technical assistance helped Local Authorities develop or improve their systems. As the US moves forward in its efforts to end youth homelessness by 2020, additional widespread, government-supported technical assistance specifically around implementing existing frameworks could be a promising model for local communities to access if there is a desire to create or improve systems of care. However, it is critical, I believe, that this assistance must be widespread and include landlords and affordable housing developers so they appreciate their role in this effort and better understand the young people we support.

It is also important to note that in the majority of communities where implementation of the Pathway has been successful, there has been an individual whose job it is to coordinate the development of and the Pathway and manage its operations.

2. Specific to my work with homeless youth in Chicago, there are two values I experienced at St Basils that I hope will guide the next stages of my career.

At the organizational level, St Basils sees challenges as opportunities to learn from and adapt emerging innovation to best fit the young people it serves, even when this means navigating complex or non-traditional partnerships. This has



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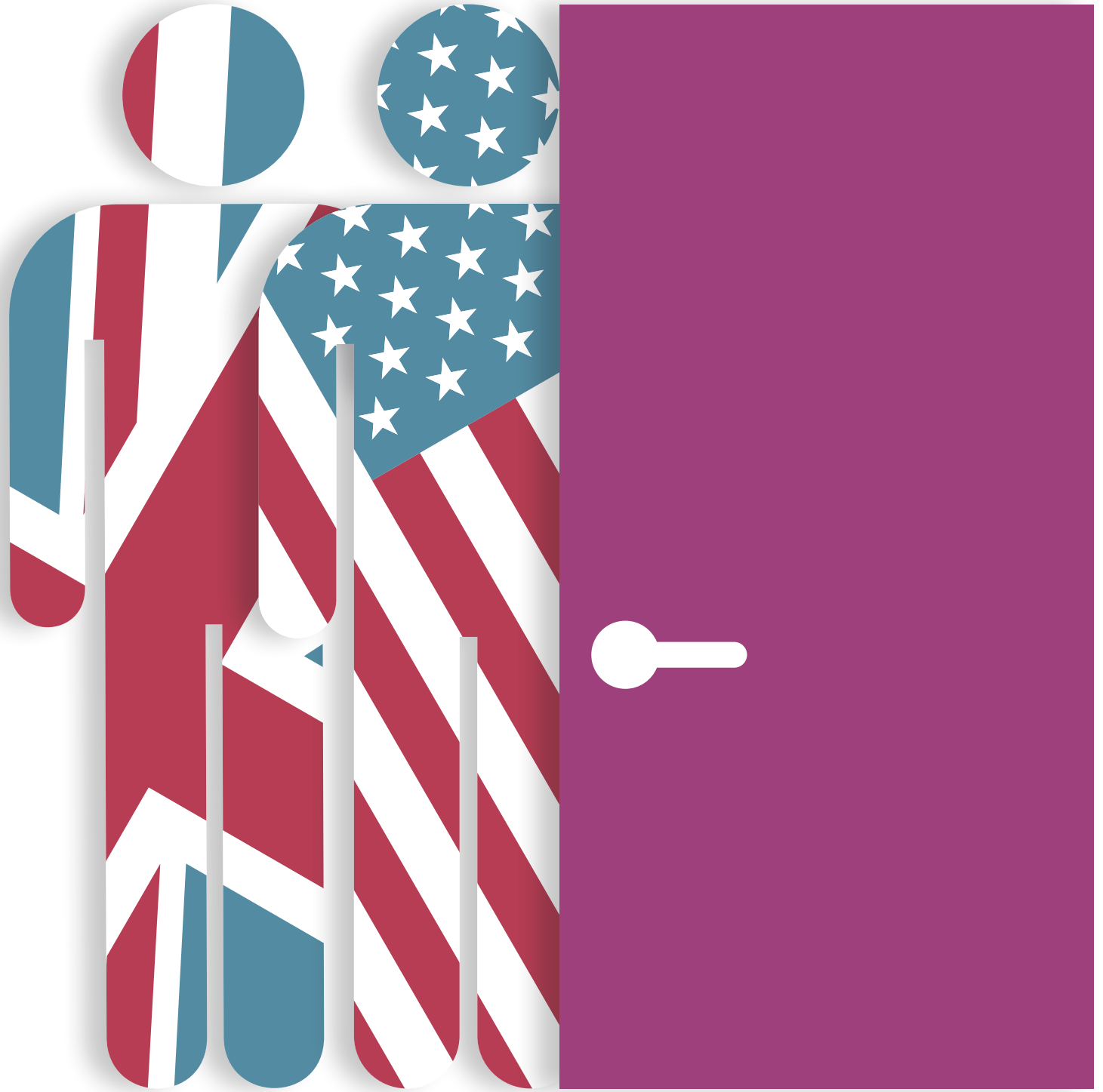
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allowed St Basils to remain a leader in the field for more than 40 years and has positioned them well to partner with the Fair Chance Fund and the NHS to fuel new program growth.

Also, St Basils places a high value on incorporating youth voice throughout their programs. Rarely have I seen this value ingrained so deeply in an organization as it is at St Basils. Through a variety of youth councils and opportunities for resident feedback and input, St Basils' youth engagement program helps build confidence and self-esteem so that young people understand that they can positively impact both their own futures and those of their peers. This summer, two former residents of St Basils' housing programs joined its Board of Directors – the culmination of an ongoing process to develop a relationship between young people and the Board.

As we come together in our communities to create, review and update plans to end youth homelessness, develop new programming and make critical funding decisions, it is essential that young people become fully embedded into each of those discussions, that their input is valued and that their concerns are addressed.

I want to thank all of my new friends and colleagues at St Basils for sharing their time with me, especially Tamzin Taylor-Rosser and the young people who are part of St Basils' National Youth Reference Group – an inspiring group of youth leaders whose feedback enhances programming at St Basils and throughout the UK.






What we do

Homeless Link is the national, membership charity for organisations working directly with homeless people in England. With over 500 members, we work to make services for homeless people better and campaign for policy change that will help end homelessness.

Let's end homelessness together

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