Policy Review Up-date: Results from the Housing First based Danish Homelessness Strategy

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Introduction

The Danish Homelessness Strategy is the only European example of a large-scale Housing First programme, involving more than a thousand participants. The Strategy is characterized by a close partnership between the local municipalities and the national level policy makers. Seventeen municipalities (out of a total of 98) representing about two thirds of the homeless population have been involved in implementing the Strategy. The Strategy combines the provision of resources for targeted initiatives with the testing of different intervention methodologies (an evidence-based approach). This means that a number of specific housing support interventions are tested in the Homelessness Strategy, and that the use of the different interventions is continuously monitored. It involves both monitoring at an individual level in terms of documenting the effectiveness of the different intervention methodologies, and monitoring at national and municipal levels.

The evaluation of the Strategy shows that homeless people in Denmark constitute a very socially marginalized group, and are characterized by a number of other pernicious social problems, in addition to homelessness, such as substance misuse, mental ill-health, physical ill-health, low incomes, poor social and family networks, etc. (Rambøll and SFI, 2013). Homeless people therefore have complex support needs, but despite this, the Housing First approach has proven to be very successful as it enables homeless people to obtain housing and the supports required to sustain their tenancy – and with the right support, nine out of ten homeless people have been able to maintain their new home. Furthermore the evaluation points out that most homeless people are able to move into ordinary housing/apartments, and are not in need of congregate housing.

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Despite the positive outcomes and experiences with Housing First, there has been an increase in homelessness in Denmark since 2009, although this increase is not as evident in the municipalities that were part of the Strategy than in those municipalities that did not participate. There has been a particularly marked increase in youth homelessness in Denmark, as a multifaceted interaction between individual and structural exclusion mechanisms results in an increasing number of young people with complex support needs becoming homeless in the early years of adulthood. In the evaluation of the Danish Homelessness Strategy, municipalities point out that the challenge of providing enough affordable housing for socially vulnerable people, especially to young homeless people in larger cities, is one of the main reasons for the recent increase in homelessness in Denmark.

This policy review[1] draws upon an evaluation of the Danish Homelessness Strategy (Rambøll and SFI 2013).[2] Section two describes the start-up of the Strategy programme. Section three examines the overall development of homelessness in Denmark and in the municipalities involved in the Strategy. Section four describes outcomes in relation to four key targets in the Strategy. Section five describes key interventions in the programme and section six presents the outcomes of these interventions. Section seven presents the development in youth homelessness and the profile of young homeless individuals. Section eight presents results and experiences from the Strategy programme on interventions for young homeless people while section nine discusses the outcomes of the programme.

The Programme

In 2008 the Danish Parliament adopted the first national Homelessness Strategy. The Strategy followed earlier programmes aimed at strengthening social services for socially marginalized groups. The programme followed upon the first national mapping (count) of homelessness, which was carried out in February 2007. The mapping showed that in the count week there were 5 290 people who were homeless. About 500 had been sleeping rough during the count week. About 2 000 were in homeless shelters and more than 1 000 persons were staying temporarily with family or friends (Benjaminsen and Christensen, 2007). Others were in short-term transitional housing or awaiting institutional release from prison, hospital or other treatment facilities, without housing. The count also showed that the majority of the homeless people were registered in larger cities and towns.

1 A paper with a similar content has been presented as a host country paper at an EU OMC peer review of the Danish Homelessness Strategy in November 2013.

2 The author of this paper was one of the authors of the evaluation.

Funding of 500m DKK (€65m) was allocated to the Strategy programme over a period of four years from 2009 to 2012. Eight municipalities, which had 54 percent of the total homeless population in Denmark and including the largest cities in Denmark – Copenhagen, Aarhus and Odense – were invited to participate in the programme. The bulk of the funding was allocated to these municipalities. In a later round, other municipalities could apply for the remainder of the funding. Nine further municipalities, mainly medium-sized towns, were selected to participate in the programme and 30m DKK of the total funding was allocated to these nine municipalities. Four overall goals were set in the programme:

1. To reduce rough sleeping
2. To provide other solutions than shelters to homeless youth
3. To reduce time spent in a shelter
4. To reduce homelessness due to institutional release from prison and hospitals without a housing solution

A key aim of the programme was to develop and test internationally evidence-based interventions in a Danish setting. A decision was taken to make Housing First the overall principle of the Strategy. It was also decided that floating support interventions should follow one of three methods: Assertive Community Treatment (ACT), Individual Case Management (ICM), or Critical Time Intervention (CTI). An implication of the implementation of the Housing First principle was a shift away from the Treatment First/Housing Ready approach, and a criterion for projects to receive funding from the programme was that they were based on Housing First principles.

Other parts of the programme included strengthening street outreach work and implementing a methodology for needs assessment in homeless shelters. Resources were also given to a range of other local services and initiatives. Furthermore, part of the funding was allocated to provide more housing for homeless people including the construction of new housing units. The municipalities applied for specific projects and after a process of negotiating between central and local government, it was decided which specific local projects should be carried out. It was possible for the municipalities to focus on all, or just some, of the four overall goals depending on the local situation. The process of starting up, developing interventions, and implementing them at the local level took a longer time than initially expected, but most interventions had started by the beginning of 2010. As a consequence the programme period was later extended until September 2013.

The Development of Overall Homelessness over the Strategy Period

As most of the interventions of the Strategy started up in Winter 2009/2010, the national homelessness count in 2009 has been used as a baseline in the measurement of the extent of homelessness during the Strategy period. Table 1 shows the trends in homelessness from 2009 to 2013 for both the Strategy participating municipalities and non-participating municipalities. There was a total increase in recorded homelessness of 16 percent, or a rise from 4 998 in 2009 to 5 820 homeless people in 2013. However, the trend varied by municipality. In the 8 municipalities with a full Strategy programme, homelessness increased by 4 percent on average. In the 9 municipalities with a floating support programme homelessness increased by 11 percent on average, whereas in the remaining 81 municipalities, which had not participated in the programme, homelessness increased by a staggering 43 percent on average. There were also considerable differences within the group of Strategy participating municipalities. In the capital Copenhagen, which already had the highest number of homeless people, there was a modest increase of 6 percent from 1 494 to 1 581 homeless people.

In the three suburban municipalities of Copenhagen, which were part of the Strategy, homelessness has generally increased (with the exception of Frederiksberg which is an inner-city borough with its own municipality). In the suburban municipality of Hvidovre there has been an especially large increase in homelessness. Furthermore, a substantial part of the large increase in homelessness in municipalities not part of the Strategy has taken place in other suburban municipalities in the Copenhagen area (Benjaminsen and Lauritzen, 2013). A large increase in homelessness also occurred in Aarhus, Denmark's second largest city, with an increase of 32 percent from 2009 to 2013 or from 466 to 617 homeless people, though the rate of increase levelled off between 2011 and 2013.

In contrast to developments in Copenhagen and Aarhus, homelessness in Denmark's third largest city Odense has almost been halved over the Strategy period; the number of homeless people has decreased from 208 in 2009 to 110 in 2013. The evaluation explains this development by pointing to a combination of a strong political commitment to the Housing First principle, a relatively sufficient supply of affordable housing, and an intensive floating support programme.

In Denmark's fourth largest city (and third largest municipality) Aalborg that only had a floating support programme, the homeless population has increased from 218 to 259 people. In the medium-sized towns that were part of the programme, with a few exceptions, there have been for the most part only small changes in the number of homeless people.

Table 1: Overall development in homelessness 2009-2013, Strategy and non-Strategy municipalities

Municipality	Homeless Week 6, 2009	Homeless Week 6, 2011	Homeless Week 6, 2013	Change 2009-13, Percent
Albertslund*	46	46	52	13
Esbjerg	128	130	144	13
Frederiksberg*	233	203	178	-24
Høje-Taastrup*	45	63	63	40
København (Copenhagen)*	1494	1507	1581	6
Odense	208	178	110	-47
Randers	100	64	92	-8
Aarhus	466	588	617	32
8 strategy municipalities with full programme	**2720**	**2779**	**2837**	**4**
Guldborgssund	120	100	99	-18
Herning	149	167	149	0
Horsens	87	57	77	-11
Hvidovre*	67	130	145	116
Næstved	59	66	86	46
Svendborg	63	45	32	-49
Varde	27	28	28	4
Viborg	62	60	68	10
Aalborg	218	231	259	19
9 strategy municipalities with floating support programme	**852**	**884**	**943**	**11**
17 strategy municipalities total	**3572**	**3663**	**3780**	**6**
81 non-strategy municipalities total	**1426**	**1627**	**2040**	**43**
Denmark, total	**4998**	**5290**	**5820**	**16**

*In Metropolitan Copenhagen

Source: SFI – The Danish National Centre for Social Research

In particular, there has been a strong increase in youth homelessness over the same period. Table 2 shows the development in homelessness amongst individuals between 18 and 24 years divided between the Strategy municipalities and non-Strategy municipalities in total. In total there has been an increase in youth homelessness in Denmark of 80 percent or from 633 persons in 2009 to 1 138 persons in 2013. The increase has been highest in the non-Strategy municipalities where youth homelessness has doubled, but there has also been a substantial increase of 69 percent in youth homelessness in the Strategy municipalities.

Table 2: The development in the numbers of youth homelessness (18-24 year olds).

	2009	2011	2013	Percent increase 2009-2013
Strategy municipalities	395	622	667	69
Non-Strategy municipalities	238	380	471	98
Total	633	1 002	1 138	80

Source: SFI – The Danish National Centre for Social Research

The evaluation indicates an increase in the extent of homelessness in Denmark but, with the exception of the increase in youth homelessness, this increase is mainly concentrated in Denmark's largest urban areas, and in particular in the suburban area of Copenhagen. According to the evaluation of the Strategy, the municipalities report an increasingly tight housing market in both Copenhagen and Aarhus, with a lack of affordable housing for socially vulnerable people. Such a lack of affordable housing particularly affects the housing chances of young vulnerable people as their social benefits are generally lower, which further reduces the range of affordable housing available to them.

The results from the national count also show how homelessness in Denmark is concentrated amongst individuals with complex support needs. Table 3 shows the percentage of homeless people with mental illness, substance abuse problems (alcohol and drugs combined), both mental illness and substance abuse problems) and neither of these problems. The data are predominantly based on staff assessments of users.

Table 3: Mental illness and substance abuse problems amongst the homeless in Denmark, 2013

Psychosocial problems	All age groups (18+)	18-24 year olds
Mental illness	47	51
Substance abuse	65	58
Either mental illness or substance abuse	78	74
Dual diagnosis	31	32
Neither mental illness or substance abuse	22	26

Source: SFI – The Danish National Centre for Social Research

About four out of five homeless people in Denmark has either mental illness, substance abuse or both. About half have a mental illness, about two thirds have a substance abuse problem and one out of three are mentally ill substance abusers. Only about one out of five have neither of these problems. The figures are roughly similar for the young homeless people between 18 and 24 years, with only a marginally higher percentage without these problems (1 out of 4). This pattern follow a general thesis in homelessness research that homelessness in countries with a relatively low level of poverty and a relatively intensive welfare system is widely concentrated amongst individuals with complex support needs, whereas homelessness in countries with a higher level of poverty and a less intensive welfare system will affect a broader cohort of the population and include a large proportion of poor people (Stephens and Fitzpatrick, 2007).

Effective Interventions but Difficulties in Achieving the Four Main Goals

Although overall the results show that the increase in homelessness has been considerably lower in the municipalities that have been part of the Strategy, the targets that were set for the four overall goals of the Strategy (reducing rough sleeping, reducing the need for young people to stay in a shelter, reducing the general length of shelter stays and reducing homelessness due to institutional release) were generally not met. However, at the same time the Housing First based interventions and methods implemented through the Strategy proved to be very effective in terms of housing retention rates. A general conclusion of the evaluation is that these methods are equally effective when applied in a Danish welfare state context as they are elsewhere as reported in international studies, mainly from the US, and therefore in a very different welfare state context (Rambøll and SFI, 2013). In the following section we shall have a closer look at this paradox. First we will consider the progress regarding the four main targets.

Table 4 sets out the actual number of persons sleeping rough in 2009 and 2013, versus the target number for 2012 for the municipalities working with this target. A substantial reduction in rough sleeping has only been achieved in Odense where the target number was even surpassed. In Frederiksberg (an inner city borough in Copenhagen) rough sleeping has been reduced, but not enough to meet the target. In Aarhus rough sleeping remains almost unchanged. In Copenhagen a substantial increase in rough sleeping has occurred, hence the target has not been met. However, the exact number of rough sleepers in Copenhagen is rather uncertain. Homeless immigrants with no legal right to stay in Denmark are estimated separately in the count, as procedures for controlling for double counts are more difficult to implement for this group, and individuals identified as immigrants with no legal right to stay are not included in the figures in Table 4. However, there is sufficient information in respect of only 134 of the 259 rough sleepers in Copenhagen to conclude that they are both unique persons (no double counts) and that they are not immigrants without a legal right to stay. In other words, the figure of rough sleepers in Copenhagen, and the increase, may be inflated by rough sleeping immigrants with no legal right to stay and without sufficient identification at the time of the count.

Table 4: Rough sleeping in municipalities with specific targets of reducing rough sleeping

Municipality	Count 2009	Target 2012	Count 2013
Albertslund	5	**2**	4
Frederiksberg	28	**10**	18
København	174	**70**	259
Odense	34	**17**	9
Aarhus	66	**10**	61
Total	307	**109**	351

Source: Rambøll and SFI (2013).

Table 5 shows the number of young homeless people (between 18 and 24) who stayed in a homeless shelter for each year from 2007-2012. For this target the baseline year was set to 2007. As Table 5 shows the targets originally set were not met in any of the municipalities. In some municipalities, reductions were achieved whereas in other municipalities the number of young people in shelters increased. However, there is a tendency for an overall reduction in the number of young people in homeless shelters setting in from 2010 when the Strategy started operating with the number of young people in shelters falling from 440 in 2010 to 349 in 2012. The last right column for 2012 excludes shielded shelter places for young homeless people, as many of these places were established as part of the Strategy to avoid young homeless people having to stay in a regular shelter. As can be seen, more than a third of the shelter stays for young people in 2012 were in such shielded youth shelters. We shall consider the challenge of youth homelessness in greater detail in section 8.

Table 5: Young people (18-24 years old) in homeless shelters: Stays and persons

	Number of stays (18-24 year olds)						Number of persons (18-24 year olds)				
Year Municipality	2007	2010	2011	2012	2012 *)	**Target 2012**	2007	2010	2011	2012	2012 *)
Esbjerg	36	51	129	73	73	**0**	20	36	59	50	50
Frederiksberg	29	43	43	35	18	**4**	21	29	35	29	17
København	210	240	196	177	82	**82**	193	220	166	136	66
Odense	115	90	76	68	68	**25**	41	56	39	39	40
Randers	31	43	67	85	10	**3**	10	27	49	46	7
Aarhus	237	233	144	93	89	**10**	60	65	53	43	43
Total	**658**	**700**	**655**	**531**	**340**	**124**	**345**	**433**	**401**	**343**	**223**

*) excluding stays in youth shelters

Source: Rambøll and SFI (2013).

Table 6 shows the development in the number of long shelter stays – more than 120 days – compared to the target set for 2012. The baseline year was also set to 2007 for this target. The target was not met as the number of long shelter stays remained more or less unchanged over the period and all municipalities are far from achieving their targets.

Table 6: Long shelter stays (more than 120 days)

Municipality	2007	2010	2011	2012	Target 2012
Albertslund	9	14	11	8	**0**
Esbjerg	84	67	76	71	**20**
Frederiksberg	51	75	85	76	**21**
Høje-Taastrup	22	24	24	21	**5**
København	526	525	532	569	**400**
Odense	68	74	48	70	**20**
Randers	25	40	40	36	**21**
Aarhus	118	130	109	137	**20**
Total	**903**	**949**	**925**	**988**	**507**

Source: Rambøll and SFI (2013).

Table 7 shows the development in institutional release from prisons and hospitals without a housing solution. For this target, a considerable reduction was achieved although the target set for 2012 was only met in two municipalities.

Table 7: Individuals awaiting release from prisons or discharge from hospitals within one month and without a housing solution

Municipality	2009	Target 2012	2013
Albertslund	9	**3**	2
Esbjerg	4	**1**	5
København	51	**27**	33
Odense	10	**4**	1
Randers	10	**0**	4
Aarhus	22	**4**	20
Total	106	**39**	65

Source: Rambøll and SFI (2013).

The Interventions of the Strategy Programme

A key aim of the Danish Strategy has been to implement the Housing First principle. A main part of the Strategy was to strengthen floating support services in line with evidence based methods for homeless individuals being re-housed. The three methods ACT (Assertive Community Treatment), ICM (Intensive Case Management) and CTI (Critical Time Intervention) were implemented in different combinations in the Strategy municipalities.

Figure 1: Floating support methods in the Danish Homelessness Strategy

ACT is a multidisciplinary form of floating support where a team of social support workers, a psychiatrist, an addiction counsellor, a nurse, a social office worker and a job center worker, deliver support services directly in a persons own home. This method is for individuals with complex support needs such as severe addiction problems and often a dual diagnosis of addiction and mental ill health. Individuals need the multidisciplinary support as they have great difficulties in utilizing existing services. An ACT-team has only been established in Copenhagen. At the end of the evaluation period 92 individuals had been assigned to the ACT-team. An ACT-like intervention in Aarhus can best be described as an extended version of ICM.

ICM is the provision of a case manager who gives both social and practical support and coordinates the individual's use of other support and treatment services. ICM is given for a longer time period, in principle as long as the individual has the need for this support. In contrast to the ACT-method, the target group for the ICM-method is individuals who to a considerable extent are capable of using other support services, but who need support in this process. The ICM programme has been the largest of the floating support programmes in the Strategy with a total of 1 010 individuals assigned to ICM-support in the 17 municipalities in total.

CTI is the provision of a case manager who offers support for a limited time period of nine months in the critical transition period from shelter to own housing. The target group for this method only needs more intensive support in the transition phase in which contact is established with other support services; the other support services take over after the nine months if there are still support needs. A total of 406 individuals have been assigned to the CTI-programme.

Table 8 gives an overview of the number of individuals who have been assigned to the three types of floating support and to other parts of the programme. The figures represent the number of courses for each method, therefore the total number does not represent unique individuals. An individual may for instance have started out having contact with a street outreach team, then had a needs assessment followed by an ICM-intervention. The table only includes interventions that have been financed from the Strategy programme. Local services and interventions not funded by the Strategy are not included in the figures.

Besides the floating support interventions, 757 homeless people have had a course with a street outreach team, and a risk and needs assessment has been carried out in respect of 1 481 individuals. In addition, 145 persons have been assigned to a programme aimed at securing a housing solution upon release from prison ('Schedule for a good release'). Compared to the extent of overall homelessness in the municipalities (Table 1), it is notable that the extent of the floating support programme in the city of Copenhagen has been quite modest compared to the overall number of homeless people in the city, and has been based on only two of the three support methods, namely ACT and CTI but not ICM.

Table 8: Number of courses for each intervention

Municipality	ACT	CTI	ICM	Street out-reach	Needs assessment	Good release	Total
Albertslund			30		23	0	53
Esbjerg		51	241		215	28	535
Frederiksberg		3	81	125	24		233
Høje-Taastrup			28				28
København (Copenhagen)	88	82		441	585	8	1 204
Odense		91	11		326	46	474
Randers			81		188	2	271
Aarhus	17	17	326	191	106	61	718
Total 8 municipalities	**105**	**244**	**798**	**757**	**1 467**	**145**	**3 516**
9 municipalities		162	212		14		388
Total 17 municipalities	**105**	**406**	**1 010**	**757**	**1 481**	**145**	**3 904**

Source: Rambøll and SFI (2013).

A part of the programme has been to provide new housing units and additional places in institutional accommodation. By June 2013 a total of 453 new units or places had been established. Some 125 of the housing units are in independent scattered public housing, while 26 are independent flats in congregate housing, 4 are in independent private housing, 55 are in alternative housing (skæve huse) and just 3 are in dormitory accommodation. A total of 199 places are in institutional accommodation; of these 16 are in medium-term (S.107) accommodation, 91 are in long-term (S.108) accommodation and 92 are in homeless shelters (S.110 accommodation). Most of the latter places are shielded places for young people or women. Transitional flats have also been established both in public housing (14) and in private housing (6). An additional 21 units have been established in other unspecified forms of housing.

A large part of the new housing units and places take the form of institutional accommodation and only about one third are in independent scattered housing. However, in addition to these units and places independent scattered housing has also been provided through the municipal priority access system to public housing.[3]

[3] The public housing sector comprises 20 percent of the total housing stock and is open to all regardless of income level. Municipalities have a right to refer individuals with social needs to one fifth of flats that become vacant, and in Copenhagen one third of flats that become vacant. Rent must be paid out of social benefits and an additional supplementary benefit for housing. This means that flats which have a rent which is too high to be paid out of transfer benefits cannot be used by municipalities for referral to cash benefit recipients in need for housing. Many groups other than the homeless 'compete' for housing through this mechanism – e.g. single mothers with children, disabled people and vulnerable elderly people. Particularly in larger cities, demand outnumbers the supply of vacant flats for municipal referral and in most municipalities there is a waiting time to get assigned to a flat through this priority access mechanism.

The numbers above mainly include additional independent housing that has been provided through the programme by special agreements between municipalities and public housing organizations.

The Effectiveness of Interventions

The individuals who have received support from the Strategy have been followed by a monitoring system which measures both the extent of support received and outcomes on a range of variables such as housing situation, mental health, addiction and daily functions. The information was based on staff assessment. Table 9 shows housing outcomes for individuals attached to one of the three floating support interventions, CTI, ICM and ACT. In the table only individuals with a minimum of two recordings are included; also cases with insufficient information regarding the housing situation at either the first or last measurement have been excluded. In total the table includes 1 095 people out of the 1 521 that have been attached to the three floating support interventions. Clearly therefore there is a relatively large number of people for whom housing outcomes could not be determined. There are various reasons for this discrepancy. People who died during the period were excluded. Also people who were moved into carehomes during the period due to escalating care needs have been excluded as such housing transitions do not measure the effectiveness of the Housing First programme. Especially the ICM programme has been applied rather broadly and shorter courses of contact between an ICM support worker and rough sleepers or shelter users trying to establish a relation may have been entered into the registration system though such contact may have ended abruptly reflecting the unstable situation for people in an acute homelessness situation. Including only individuals with two recordings or more in the measurement of housing outcomes (in table 9) meets a concern to include only those people into the measurement, who have been given a reasonably substantial intervention and not conflating the measurement by including contacts which in reality more have a character of outreach work and which generally reflect the challenges of intake into the programme. In this sense the outcomes in table 9 gives the most adequate picture of the actual effectiveness of Housing First based interventions. Finally it should be mentioned that the monitoring system is based on municipal social support workers entering registrations for their users into the system. In this sense the nature of the monitoring system reflects the large scale of the programme and does not have the more rigorous nature of a (smaller scale) research project such as most randomized controlled trials.

Table 9: Housing outcomes for CTI, ICM and ACT-interventions

Housing outcome	CTI (%)	ICM (%)	ACT (%)
Have been housed and maintained housing	95	76	94
Lost housing	3	8	7
Lost housing but re-housed in other housing	(1)	(4)	(-)[4]
Lost housing and not re-housed	(2)	(4)	(7)
Not been housed throughout period	2	16	0
Total	100 (n=316)	100 (n=717)	100 (n=62)

Source: Rambøll and SFI (2013). Due to rounding the percentages do not always sum to 100 percent.

Of those who have been housed the majority remain housed throughout the monitoring period. Less than 10 percent lost their housing and were not re-housed. However, amongst the persons receiving ICM-support quite a large group (16 percent) were never housed during the period. The qualitative interviews conducted point to a combination of several factors that explain why some individuals did not get housed despite being attached to an ICM-programme. One of the main reasons reported in the evaluation is the lack of affordable housing. In some municipalities there are also reports of difficulties in turning around a well-established practice of housing referral based on the 'housing ready' model in the municipal priority access system to public housing instead of basing housing allocation on the Housing First-principle. Finally, there are also in some cases a mismatch between support needs and the ICM-support. Some of the ICM clients have more complex support needs and difficulties in utilizing the existing support system, and are likely therefore to come within the group targeted by ACT-support. However, ACT-support is not available in any of the municipalities providing ICM-support.

The results in Table 9 do not contain any information on type of housing. However, a qualitative finding from the programme has been that independent, scattered housing works better for most individuals, and that with intensive floating support, those individuals with complex support needs are capable of living on their own in independent, scattered housing. Additionally, the findings indicate that congregate housing may have unintended negative consequences such as conflicts amongst the residents, and that residents often get ensnared in an environment dominated by substance abuse.

[4] It has not been possible to record movements from one place of housing to another for the ACT-programme in the general monitoring system. A separate reporting from the ACT-team shows that 26 percent of those in receipt of ACT had moved from one place of housing to another during the period. These movements have mainly taken place for individuals who were initially placed in congregate housing whereas only few movements have happened for those who were initially placed in scattered housing.

Table 10 illustrates a range of other outcomes reported by staff. The table includes the combined outcomes for all three floating support interventions and for all age groups combined.

Table 10: Outcomes – changes from first to last reporting (%)

Item	More positive	Unchanged	More negative
Alcohol	17	65	18
Hard drugs	14	72	14
Hashish	16	65	19
Physical problems	19	58	23
Mental problems	25	52	24
Daily functions	26	50	24
Financial situation	33	44	23
Social network	29	45	26

The Table is based on outcomes for 1 111 individuals and is for the CTI, ICM and ACT-programmes combined.
Source: Rambøll and SFI (2013).

On the majority of items the situation of the individual remains unchanged over the period, and for most items the number of persons with a more positive assessment more or less equals the number of persons with a more negative assessment. There are slightly more individuals with a more positive assessment than a more negative assessment on the items daily functions, financial situation and social network, whereas there are more people with a more negative than positive assessment on physical problems. In the qualitative interviews, it was noted that when formerly homeless people obtained housing, their physical problems which were unmet when rough sleeping, re-emerged, and unmet health support needs came to the surface. The question is whether the rather large number of individuals with unchanged or more negative outcomes on these items should be seen as a failure of the Housing First model? The qualitative interviews with homeless persons shed some light on these results. Most of the interviewees expressed great relief at finally obtaining housing, but they also explained how they faced severe challenges in life such as continued addiction and weak social relations. Many also explicitly stated that if they did not receive floating support they would lose their housing again. This shows, that despite still having on-going difficulties, the overwhelming majority remained stably housed, once they are provided with floating social support. However, many challenges still remain and individuals often need other interventions, such as access to meaningful social activities that can facilitate contact to other people and help counteract loneliness.

The experience from this large-scale Housing First programme in Denmark demonstrates that Housing First, driven by evidence-based floating support interventions is an effective approach to enable individuals with complex support needs to exit

homelessness and retain their housing, with housing retention rates in excess of 90 percent. An important point is also that it is not possible to predict who is likely to end up losing their home again. Therefore, the experiences point to Housing First as the 'default intervention' meaning that own housing with intensive floating support should be tried as the first-line intervention for the rehousing of homeless people and that other housing forms (congregate housing) should only be used for those individuals who (repeatedly) do not succeed living on their own even with intensive floating support. For these individuals it is important to have other options such as high-intensive supported accommodation, congregate housing or alternative housing such as the 'skæve huse'. It is also important to underline that while Housing First offers a combination of housing and support that gives a high chance of becoming re-housed and sustaining the tenancy, many challenges still remain and that further interventions and support are most often needed.[5]

The Rise in Youth Homelessness

Youth homelessness has increased over the last few years. In the national count in 2009, 633 young people between the age of 18 and 24 were recorded as homeless in the count week. This figure increased to 1 002 in 2011 and 1 138 in 2013, an increase of 80 percent in four years. This increase has occurred in both Strategy and non-Strategy municipalities and is therefore a general trend rather than the result of an increased focus on young homeless people in the Strategy municipalities. In contrast to the sharp rise in homelessness amongst 18 to 24 year olds, homelessness amongst 13-17 year olds remains low. Only 26 young teenagers aged between 13 and 17 years were recorded homeless in the count. Twenty-one of these are reported as staying together with at least one parent, most in short-term transitional housing, at women's crisis centres or with family or friends, while 5 were recorded as not being with any parent, but were instead staying with other relatives or friends. The low number of homeless teenagers is largely a result of very intensive welfare services for children with support needs. In the following analysis we shall only look at homelessness in 18-24 year olds.

The count in 2013 showed that 74 percent of homeless 18-24 year olds are males. First generation immigrants account for 6 percent of the homeless 18-24 year olds while a further 16 percent are children of immigrants. However, the percentage of homeless youths with an immigrant background is higher in the large cities; in Copenhagen 37 percent, and in Aarhus 40 percent of homeless youths are either immigrants or children of immigrants. The largest category amongst the homeless

5 These conclusions are in line with the results from the Housing First Europe social experimentation project (see Busch-Geertsema, 2013).

youth accounting for half of the total, were youths staying temporarily with family or friends during the count week. Youths sleeping on the streets in the count week accounted for 6 percent, while 23 percent had stayed in homeless shelters, including emergency night shelters. Minor groups were awaiting institutional release from prisons or hospitals without a housing solution, while others were reported with an unspecified homelessness situation.

Slightly more than half of the homeless youth were recorded as having some form of mental ill-health. This number has increased from 35 percent in 2009 and 43 percent in 2011. Substance abuse is a problem for 58 percent of homeless youths. The most common substance abused by the young homeless is hashish which is reported for 50 percent. Almost one in five use hard drugs and 13 percent report a problem regarding the abuse of alcohol. One in three of the young homeless are reported to be mentally ill substance users while one in four of the homeless youth are reported to have neither a mental illness nor a substance abuse. For 33 percent of the homeless youth, mental illness is reported as an important cause of their homelessness and for 32 percent drug addiction (including hashish) is reported as an important cause. For 18 percent eviction is reported as an important cause, showing that despite their young age, these young people have already experienced an eviction. For 38 percent financial difficulties are reported, and for 25 percent a lack of appropriate housing is mentioned. Some 31 percent reported that they were no longer able to stay with friends or family. Only 34 percent of the 18-24 year old homeless people are reported to have a social support person and equally only 34 percent are reported to be on some waiting list for housing – 30 percent for individual housing and 4 percent for supported housing.

The evaluation of the Strategy points to the combination of a group of young people with severe social problems, a shortage of affordable housing and relatively low incomes as the main reasons why it has been a challenge for the municipalities to fully implement the Housing First approach for young homeless people, although the results from the Homelessness Strategy show that Housing First is the most appropriate approach for young homeless people. At the same time the complex support needs of the young homeless people show a need for developing holistic interventions with an emphasis on both the housing and the social support dimensions.

Experiences from the Strategy Programme on Interventions for Young Homeless People

A substantial number of those who received housing and support from the Strategy are young people aged between 18 and 24. This age group comprises about one quarter of all persons who have received support from the CTI, ICM or ACT programmes. In Table 11 housing outcomes for individuals 18-24 years and 25 years and above are compared with the outcomes for those over 25 years of age. More than one in four of the young homeless never got housed despite being attached to a support programme. The corresponding figure is only 8 percent amongst persons 25 years or older. Of those who become housed most stay housed, but 9 percent of the total group of 18-24 year olds lost their housing; 5 percent were not re-housed, compared to 3 percent of those aged 25 years and older.

Table 11: Housing outcomes for 18-24 year olds (%)

Housing outcome	18-24 year old	25 years or older
Have been housed and maintained housing	63	88
Lost housing	9	5
Lost housing but re-housed in other housing	(4)	(2)
Lost housing and not re-housed	(5)	(3)
Not been housed throughout period	28	8
Total	100 (n=335)	100 (n=803)

Source: Rambøll and SFI, 2013.

The housing outcomes are not broken down by housing type, but the qualitative experiences from the programme show that as with older homeless persons scattered housing works for the young homeless whereas conflicts and a negative environment marked by substance abuse arise more in congregate facilities. The somewhat higher (but still small) number that lose their housing may be a consequence of unmet support needs, but the difficulties of paying rent out of a relatively low income are also highlighted in the qualitative interviews with municipal civil servants and support workers.

It is a general experience in the municipalities that many of the young homeless people are already known to the social system and many have received social interventions already from childhood. This indicates a general challenge in service provision in the transition into adulthood for children who have been receiving support from the social system. Although initiatives have been taken to strengthen after-care in the transition from childhood into adulthood, for most there will be a change from the often highly intensive interventions for vulnerable children into often less intensive services for young adults. Often these children have weak family ties and social networks, and at the same time many are ‘system-tired’

meaning that they have a long history of social interventions, and show resistance to receiving further support and may have withdrawn from the support system. Therefore it can be a challenge to establish contact, build a relationship, and maintain contact and motivation for further interventions, and it is important to develop new ways for working with this group. When contact is established, the Strategy experiences suggest that being able to assign a case manager with a relatively low caseload to each person is of key importance to ensure that the young individual gets access to other necessary interventions such as cash benefits, social activation measures, and treatment if necessary.

Even when contact is established and a support relationship is formed, the municipalities' experiences show how structural barriers such as the lack of affordable housing remain a challenge in many cases. Through the Strategy programme, more shielded places for youth in emergency/temporary accommodation have been established to accommodate young people in an acute homelessness situation. However, the evaluation shows, that there is often a considerable waiting time until a permanent housing solution can be established and therefore homeless young persons often have to stay in such temporary places for quite a long time.

In the qualitative interviews, mixed experiences regarding the stays in temporary accommodations were recounted. Some of the young individuals staying in temporary accommodation with other homeless youth, found the longer stays manageable, especially as the alternatives are emergency shelters or random couch surfing with friends who often also have social problems. Other interviewees complained about conflicts, drug use, and drug dealing etc. in such places. According to the staff interviews, some individuals may benefit from a longer stay but the main reason for long stays is the long waiting time for ordinary housing; staff interviews point in the main to the most favourable option being rapid access to ordinary housing with sufficient floating support. On the other hand, there are good experiences with designating apartments in scattered housing for individual young homeless people and through intensive case management supporting them in learning how to live on their own and thereby also sustaining a tenancy.

The interviews strongly suggest that the intensive floating support methods of Critical Time Intervention (CTI) and Intensive Case Management (ICM) are equally well-suited for giving support to young homeless individuals as for homeless people in general. Thus, CTI is a method of providing support for young people in need of intensive support for a relatively short period and around becoming housed and linking up with existing community services, with ICM the main support intervention for young people with relatively more complex and longer-lasting support

needs.[6] However, the methods used must generally be adjusted to the particular needs of building a relationship, maintaining contact, and supporting continuous motivation that characterizes the situation of the young homeless people, and thus there may be a need for further methodological development and refinement.

Hence, an important finding from the programme is that the Housing First principle apply equally to young homeless people as well as to older or more entrenched homeless people. Also, for the large majority of young homeless individuals, housing in independent scattered housing with floating social support remains the most favourable option, whereas congregate housing for young people seems to involve the same risk for social conflicts, stress and an environment marked by addiction problems and other social problems, as this form of housing does for homeless individuals in general. Finally, the tendency of a rising number of homeless young people with complex problems point to a general need for more focus on early prevention and early intervention including a need to strengthen support in the transition period from adolescence to early adulthood for a group of young people with severe psychosocial challenges and who have often been known to the social system since their childhood.

Conclusion

As the Housing First paradigm spread from the US to Europe, Housing First has been incorporated, at least in part, as a leading principle in homelessness strategies in several countries including Norway, Ireland, Finland and France. However most examples of Housing First programmes in Europe are small-scale, often being local projects in only a few cities and with a small number of participants. The Danish Homelessness Strategy is one of the few examples of a large-scale programme (with more than a thousand participants) and also an example of how this has been possible due to a strong political commitment to the programme both at central and local government level. The results from testing the support methods CTI, ICM and ACT in a Danish context are overwhelmingly positive, with housing retention rates in excess of 90 percent, demonstrating that these interventions have the same high success rates in bringing homeless individuals into housing as in other countries where these methods have been used and tested. The results show that with intensive floating support designed around evidence-based support methods, most homeless people can become housed, and even in ordinary

6 The ACT-method has almost exclusively been used for individuals aged 25 years and above with very severe support needs.

housing. This is an important result that generally underlines the need for continuing the shift away from Treatment First/Staircase models towards Housing First that is taking place in many countries.

Despite the impressive results of the interventions that have been developed, implemented and tested through the Strategy, overall the developments in homelessness in Denmark show the paradox of effective interventions for those who have received these interventions, but at the same time that the overall goal of reducing homelessness has not been achieved. Homelessness has actually increased during the Strategy period, albeit much less in the Strategy municipalities than in the non-participating municipalities. A range of barriers at both micro and macro level explain this development.

A key barrier is an increasing lack of affordable housing available for allocation to people with a relatively low income. This is especially the case in Denmark's two largest cities, Copenhagen and Aarhus, which have both experienced a general population growth exceeding 1 percent annually in recent years. In contrast, in Denmark's third largest city, Odense, there is a reasonable supply of affordable housing, and well developed methods for allocating dwellings to marginalized groups, and in this city it has been possible to halve the level of homelessness over the Strategy period. More specific developments in housing policies reinforce the lack of affordable housing for marginalized groups. Paradoxically, one of the measures adopted to deal with the economic crisis has been to intensify the process of renovating public housing estates. This generally improves the quality of housing, but such renovations are widely financed by loans and increased rent levels. As social benefits and housing support have not risen accordingly, an unintended consequence is a decrease in the proportion of the public housing stock that is affordable for people on social benefits. A further mechanism which reduces the number of housing units available for marginalized groups is the use of social mix policies and especially 'flexible letting', which enables certain groups to be given precedence in new lettings in public housing estates in order to strengthen the social mix. Municipalities and housing associations locally set the criteria and special priority has been given to people in employment. However, this mechanism also reduces the number of flats available for socially vulnerable groups.

The lower cash benefits for young people between 18 and 24 years old is an important barrier for finding affordable housing for this group. The lower benefits have been set at the same level as student benefits, in order to motivate young people to avail of education rather than rely on cash benefits. However, students have the possibility to supplement their income from jobs which the cash benefit receivers cannot do, and for socially vulnerable young people, with a low chance of starting education, the lower cash benefits therefore significantly reduces the

possibility of finding affordable housing. Young people between 18 and 24 years with certain psychiatric diagnoses (mainly schizophrenia, other psychotic diagnoses, schizotypal disorder and borderline) are exempt from the lower benefits, but a range of other conditions such as ADHD are not covered by this exemption.

Besides the individual and structural barriers described above, organizational and cultural challenges of implementing Housing First are highlighted in the evaluation. It should be borne in mind that the programme has been a pilot programme introducing the Housing First approach and aimed at developing and testing Housing First based interventions in Denmark. The process of developing and implementing the methods has resulted in a large increase in knowledge of these interventions in the municipalities and has also shown that the mind shift away from Treatment First/Housing Ready is a long intensive process, which necessitates a continued focus on organization and implementation. Challenges also appear in other parts of the support system. The Treatment First approach is still widespread in the addiction treatment system, and in the housing allocation system. In some municipalities it has been possible to achieve a shift in attitude, whereas in others it remains a challenge. This also depends on local organizational aspects, for instance whether or not the housing allocation office is organizationally integrated with the social/homeless services. Also in the shelter system, it has been a challenge to implement the Housing First approach and to facilitate the mind shift away from long shelter stays to earlier placement in own housing with support. Here it should be borne in mind that from the viewpoint of the shelters the reality often facing their users is long waiting times for housing and often also a scarcity of available floating support.

As mentioned, the overall scale of the Danish programme is relatively large with more than thousand individuals served by the floating support services established through the programme. Still, these services do not cover the whole target population of homeless persons in need of support. Figures from the last national count in 2013, show that only 28 percent of homeless people have a social support worker attached and only 32 percent are on a waiting list for housing (27 percent for own housing and 5 percent for institutional accommodation). Here it should be borne in mind that individuals who have been housed through the Homelessness Strategy and maintained their housing no longer count in the homelessness statistics.

Setting ambitious goals was an important part of securing a strong political commitment to the Strategy – and this commitment has been very important throughout the Strategy period for implementing the Strategy and its interventions. At the same time it should be borne in mind that the programme has mainly been a large-scale social experimentation project aimed at developing evidence-based

and effective methods for providing support to homeless people with complex support needs when becoming re-housed. In this sense the programme has been very successful and the results are very valuable.

The results show that with right combination of housing and targeted support most homeless people can exit homelessness, and that with intensive floating support the majority are able to sustain a tenancy in mainstream housing, with only a minority in need of more specialized housing and support services such as integrated housing in congregate facilities. The results indicate that these conclusions are also valid for young homeless people. With intensive support young homeless people can be housed in regular housing and a process of reintegration into society can begin. Amongst the three intervention methods tested in the Danish Strategy, the ACT-method is especially aimed at mentally ill substance abusers who fail to use or benefit from the existing treatment system. The experiences from the ACT-programme has shown that this method is a very successful way of providing support for homeless individuals with complex support needs, and that the method enables the provision of holistic support for this group. The team in Copenhagen serves about 80 individuals at any given time. Considering that the latest national count from February, 2013, showed that there is more than 1 500 homeless mentally ill substance abusers, there is a considerable potential to upscale the ACT-programme, both in the capital, where the pilot scheme has been tested, and in other larger municipalities. Also considering, that most homeless individuals in Denmark either have mental illness or engage in substance abuse, there is also potential to upscale the provision of the two other floating support methods which have been tested in the Strategy, ICM and CTI. The extent to which such a scaling up of the programmes is needed, and their dimensions in different municipalities and in different subgroups of the homeless, could be further examined.

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