Deliverable 6

Education and Training in Housing Related Support

The Extent of Continuing Vocational Education and Training in Integrated Housing and Support in the EU

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Executive Summary

- This report mapped the extent of continuing vocational education and training (CVET) in the field of integrated housing and support (IHS). The report was designed to support a project entitled *European Core Learning Outcomes for the Integration of Support and Housing* (ELOSH).
- Internet searching and a survey of IHS providers operating throughout the European Union (EU) were employed. The research team constructed a database of the existing CVET for IHS services.
- The research was particularly interested in assessing the impact of CVET on service user choice and control, i.e. service delivery methods drawing on ideas of *personalisation* and *co-production*. In addition, the research was also interested in learning about any CVET focused on enabling social integration for IHS service users. Social integration refers to the encouragement of processes that enable people using IHS become an active part of the communities in which they live.
- The main finding was that there was relatively little CVET for IHS services currently available in Europe. The UK offers some specific training on IHS and training is also available in Ireland. There is some provision of training by universities, some by the private sector and some by NGOs. CVET for IHS is not widespread.
- The reasons for the relatively small amount of CVET found were threefold. First, IHS tends to be concentrated in those EU member states with relatively extensive welfare systems, meaning there is less provision (and hence less requirement for training) in the South and East of the EU. Second, some Northern EU member states deliver IHS using staff with professional social work qualifications. This means some IHS services expect staff to have generic social work qualifications, rather than specific training focused on IHS. Third, IHS services can exist in multiple forms, in terms of how they provide support, the intensity of support offered and what forms of housing they offer. There are some difficulties in developing specific IHS CVET because the IHS sector can be highly diverse, although wider provision of broad, generic training may be feasible.

Preamble

The European Core Learning Outcomes for Integration of Support and Housing (ELOSH) project will transfer innovative learning results and training materials on integrated support and housing. It will use materials developed by Sitra, resulting from our expertise in training in the field of housing with health, care and support. These materials will promote the co-production of services, including citizen's needs, as its core. Partners will blend and adapt these outcomes and tools to create a flexible European pack to be tested in seven countries by housing and support providers. Finally, results and training packs will be developed, disseminated and be available as an online resource.

A critical starting point for this project was to research the extent to which Vocational Education and Training for the delivery of Integrated Housing Support already existed across the EU. Once identified, then to review how existing resources tied into the coproduction vision for this project. We are grateful to the University of York for carrying out this detailed research, and bringing together information from both ELOSH partners and a wider review of training across the EU.

This research report not only provides an assessment of existing CVET, but also paints a picture of the ongoing development of integrated housing support across the project countries . It is clear from the research that whilst not all countries offer the same models of delivery, the ambition to support independent living through enhancing service user choice and control is a central component for those delivering integrated housing support. Pockets of excellent practice exist across the EU, and the approach taken by ELOSH is to build on a core understanding of Integrated Housing Support and to provide opportunities for that country specific practice to be shared and disseminated. The research makes it clear that the work carried out by the ELOSH partnership will represent a valuable contribution to strengthening understanding of coproduction and integrated housing support across Europe. The final learning from the full ELOSH project will be made available in 2015 and more details about the project can be found at http://www.housingeurope.eu/section-47/eloshwww.elosh.eu.

Introduction

1.1 This report describes the results of a scoping exercise which was conducted to map existing vocational education and training (CVET) on integrated housing and support services (IHS). The scoping exercise was designed to support the *European Core Learning Outcomes for the Integration of Support and Housing* (ELOSH) project, which is focused on developing new CVET to enhance delivery of IHS for disabled people, people with mental health needs and those homeless people who have support needs.

1.2 The purpose of the scoping exercise was to determine the range and nature of existing training focused on the management and delivery of IHS services. There was a particular interest in how any existing CVET related to two key roles that IHS can undertake. These roles centre on enabling *social integration* to improve, quality of life, health and well-being and enabling independent living through promoting *personalisation of services.*

1.3 Social integration is designed to take people with care and support needs out of long-stay hospital wards, dedicated residential care and other institution-based services and enable them to live in housing and housing-like settings in the community. Deinstitutionalisation is one element in a process of social integration that can involve multiple levels, all of which are centred on using IHS to enable people with support needs to live as an integral part of society. Perhaps the single most important development in mid to late 20th Century welfare systems was the rise of the 'community care' movement during the 1960s-1980s which heavily influenced health and welfare systems across much of the economically developed world[1].

1.4 The other, closely related, role of IHS is to promote independent living through enhancing service user choice and control. Alongside having the opportunity to integrate within wider society, people with support needs also have to be able to exercise choices in their lives in the same ways that any other citizen can. Social integration, in a meaningful

[1] Bulmer, M. (1987) *The Social Basis of Community Care* London: Allen and Unwin.

sense, also requires that someone is able to exercise as much personal independence as is possible.

1.5 Control over one's life implies control over service use and it is within the context of promoting independent living that the *personalisation* agenda, again an integral part of the community care movement, has become important in IHS service development. Personalisation centres on maximising the capacity of individuals with support needs to design and manage their own packages of care and support. The ultimate expression of the personalisation approach, first piloted as part of the early experiments in community care, is the use of personalised budgets. Personalised budgets enable people with support needs to commission and manage their own support and care services[2].

1.6 The scoping exercise which is described in this report employed two main methods. The exercise was very brief, conducted over the course of less than three months, with four weeks of staff time being supported by the Lifelong Learning Programme alongside a financial contribution from the University of York. No resource was available for translation of documents, research or websites[3], which restricted the searches to material available in English or in English translation. First, a search was conducted of web-based resources, centred on Google Scholar and specialist databases covering peer-reviewed research on integrated housing and support, including the Web of Science (social science citation index, including sociological, anthropological and social policy research on IHS) and Medline (medical research including work on IHS).

1.7 The research team also employed a survey, distributed to organisations representing providers of housing and support across the EU. This survey asked a short number of questions about the nature of current IHS models in the areas where these organisations were active and also for an overview of the specific training available to staff working in IHS services. Many of the agencies participating in the ELOSH project

[2] Hough, J. and Rice, B. (2010) *Providing personalised support to rough sleepers: An evaluation of the City of London pilot* York: Joseph Rowntree Foundation.

[3] Basic translation was possible using on-line applications but the standard of translation provided by this software is currently of markedly lower quality than can be provided by translators.

kindly supported the distribution of the questionnaire by sharing contact details of organisations that might support the ELOSH scoping exercise. Unfortunately, despite two chase-ups being sent, most of these organisations opted not to respond within the timeframe available for the scoping exercise.

1.8 In both the searches and the questionnaire, the emphasis was on IHS services for those groups who were the central concern of the ELOSH project, i.e. disabled people, people with mental health needs and homeless people who have support needs. Some reference was made to general literature on IHS, where logistical issues, policy trends or contextual factors that have had an influence on the IHS sector as a whole. Training that included personalisation of services and which promoted social integration was specifically searched for.

1.9 The report is divided into three main sections. The following section explores the development and nature of IHS service provision for disabled people, people with mental health needs and homeless people who have support needs. This section is designed to contextualise the second main section of the report, which discusses the results of the scoping exercise on the nature and extent of IHS training available in the EU and elsewhere. The report concludes by discussing the implications of the findings of the scoping exercise for the ELOSH project.

The Development of IHS and Related CVET

Background

1.10 Integrated Housing and Support (IHS) services have developed for two main reasons. First, use of IHS in the last 30 years has occurred because moral and humanitarian questions about the quality of life and well-being of people placed in institutional settings for prolonged periods began to be raised. Second, IHS has been seen as a way of reducing the financial costs of running institution-based care and of health and social care systems more generally.

1.11 Negative evidence about the effects of institutional living has been growing since the 1960s. Institutions were expensive and they were

widely held to sometimes have damaging effects on the people they were designed to help for several reasons[4]:

- There was a lack of meaningful, rewarding and stimulating activity for people living in institutional settings. This included the chance to become involved in the paid work, education and training available to other citizens. This marginalised people in institutions in both a social and economic sense, i.e. they were deprived of the socialisation, friendship, sense of purpose and meaning that many other citizens derived from paid work. People in institutions also lacked access to a level of income that allows someone to make basic choices that can enhance quality of life.
- Removal from mainstream society undermined access to social supports. Living in an institutional setting could limit access to esteem support (the sense of being valued as a person), informational support (access to advice from friends, relatives), social companionship and instrumental support (practical help from friends and relatives). Institutional settings potentially severed connections with these social supports, which were increasingly being demonstrated as being important in maintaining health and well-being[5]. In addition, the broader social supports and benefits that might arise from living within a neighbourhood with a well-developed community were also not accessible to people who had been placed in an institutional setting, i.e. not living within society alongside fellow citizens potentially undermined access to 'social capital' for people in institutions[6].
- People in institutional settings could be stigmatised. Stigmatisation is a result of popular and longstanding cultural factors, mass media

[4] Ridgway, P. and A. M. Zipple (1990) 'The paradigm shift in residential services: From the linear continuum to supported housing approaches' *Psychosocial Rehabilitation Journal* 13, pp. 11-31; Lieberman, M. A. (1969) 'Institutionalization of the aged: Effects on behaviour' *Journal of Gerontology*, 24(3), 330-340; Paul, G. L. (1969) 'Chronic mental patient: Current status future directions' *Psychological Bulletin*, 71(2), 81.

[5] Cohen, S. and Wills, T. (1985) 'Stress, Social Support and the Buffering Hypothesis' *Psychological Bulletin*, 98, pp. 310-357; Callaghan, P. and Morrissey, J. (1993) 'Social Support and Health: A Review' *Journal of Advanced Nursing* 18, pp.203-213.

[6] Lesser, E.L. (2000) *Knowledge and Social Capital: Foundations and Applications* Butterworth Heineman: Massachusetts.

and crude ideological constructs that do not reflect evidence about people with mental health problems, homeless people with support needs or disabled adults[7]. However, institutions could potentially *reinforce* stigmatisation by creating a clearly differentiated identity for people with support needs. Living in physically separated, architecturally distinct, buildings that highlighted their difference from other citizens could result in people with support needs being persecuted, marginalised and alienated from wider society. Clearly, when this occurred, it was not conducive to the health and well-being of people living in institutional settings[8].

- Institutional based care had also been criticised because it was a blunt instrument, i.e. an institution-based care system had two settings, i.e. it was effectively 'on' or it was 'off'. If someone was able to live independently without support, institutional-based care did not engage, i.e. remained 'off', but as soon as they were not able to manage living independently, the institution-based care system switched 'on', taking them out of their home and placing them in residential care or long-stay hospital. This system meant that people, who had the potential to live independently with a little support, were being placed in institutional care that was actually engineered to care for people who had near-total dependency on health and personal care services[9].
- Alongside growing evidence that institutional care presented some potential risks to health and well-being, there was also the important issue of financial cost. Building, staffing and managing institutions was expensive. Important questions about the humanity and morality of institution-based care existed alongside questions about the cost effectiveness of such institutions. Enabling people to live more independently, within the community, could not only potentially provide better outcomes but was also

[7] Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000) 'Stigmatisation of people with mental illnesses' *The British Journal of Psychiatry*, 177,1, pp. 4-7.; Phillips, D. L. (1963) 'Rejection: A possible consequence of seeking help for mental disorders' *American Sociological Review*, pp. 963-972.
[8] Perry, N. (1974) 'The two cultures and the total institution' *The British Journal of Sociology* 25, 3, pp. 345-355.
[9] Sinclair, I; Parker, R; Leat, D. and Williams, J. (1989) *The kaleidoscope of care: a review of research on welfare provision for elderly people* London: HMSO

potentially attractive to governments which sought to reduce expenditure on health and welfare services[10].

1.12 Initially, efforts and experiments in reducing the use of institutional services centred on redeploying health and social work services in new ways. These approaches were encapsulated in the ideas of community care, which combined the use of ordinary, or specially adapted, housing, situated within ordinary communities, and the use of floating (peripatetic, mobile) health and social work teams[11].

1.13 Community care sought to maximise independence, a process that ultimately involved the personalisation of care and support, giving service users more and more control over what support they had, how it worked and in how they lived their lives[12]. This was a process of personalisation that began with the use of case or care managers, who would coordinate a package of care and support in consultation with a service user, and culminated in experiments with individual budgets, effectively enabling people with support needs to directly assemble and manage their own package of support[13].

The emergence of integrated housing and support

1.14 IHS services arose because of the potential that started to be seen in combining lower intensity support with housing. It became apparent that community care had operational limits, i.e. when support needs became very high, both the risks and financial costs of looking after someone in the community - rather than an institutional or hospital setting - started to potentially outweigh the potential benefits[14]. Community care was also not necessarily generally a low cost option, deploying social workers, nurses, nurse-practitioners occupational therapists and doctors across a community, even if the costs were less

[10] Murphy, J. G., and Datel, W. E. (1976) 'A cost-benefit analysis of community versus institutional living' *Hospital and community psychiatry* 27, 3, pp. 165-170.

[11] Weissert, W. G., Cready, C. M., and Pawelak, J. E. (1988) 'The past and future of home-and community-based long-term care' *The Milbank Quarterly*, 309-388.

[12] Knapp, M. R., Cambridge, P., Thomason, C., Beecham, J. K., Allen, C., and Darton, R. A. (1992) *Care in the community: Challenge and demonstration* PSSRU: University of Kent

[13] Newman, J., Glendinning, C., and Hughes, M. (2008) 'Beyond modernisation? Social care and the transformation of welfare governance' *Journal of Social Policy*, 37, 4, pp. 531-557.

[14] Weissert, W. G. *et al* (1998) op. cit.

than using institution-based approaches, was still not a low cost option. However, it had also become clear that many people with support needs could manage with quite *low level* support.

1.15 Low level support that focused on housing-related issues and could be delivered by support workers rather than by using expensive social workers or medical professionals. A little help, ranging from helping someone manage their household expenses and providing practical advice through to some emotional support could be sufficient to ensure that someone's health, well-being and the sustainability of their housing were all maintained. Lower level support could also reduce or delay the need for institutional care and for packages of support delivered via 'community care' systems[15].

1.16 It became apparent that frail older people, and also the disabled people, people with mental health needs and homeless people with support needs who are the focus of the ELOSH project, could manage with lower levels of support and live more independent lives in the community. IHS services had the potential to significantly lower financial costs while continuing to deliver the benefits associated within living within the community for people with support needs[16].

Broad types of integrated housing and support

1.17 Initially, integrated housing and support (IHS) services had, alongside wider processes of deinstitutionalisation and the rise of community care, been developing in two main ways. IHS delivered support in *communal* or *congregate* housing-like settings and was also being used to facilitate *transfers* between institutional living and community living for people with support needs.

1.18 IHS can be used as a more housing-like and community-based version of institutional care, using models of service provision that decentralise the delivery of similar services to those provided in institution-based care. IHS using such approaches includes group homes, which resettle small groups of service users in the community within a converted or

[15] Quilgars, D. (2000) *Low intensity support services: a systematic literature review* Bristol: Policy Press.
[16] Ashton, T. and Hempenstall, C. (2009) *Research into the financial benefits of the Supporting People programme, 2009* London: DCLG.

purpose-built house. Group homes are communal and served as a base to which support, personal care and health services are delivered. In effect, while such approaches have some benefits, they could also recreate some of the limitations of institution-based services on a smaller scale, rather than actually facilitating social integration or independence or allowing for full personalisation of support services[17].

1.19 As such models are effectively still health and social work/personal care services, the financial costs of such approaches are still relatively high. The boundaries between some models of permanent or long-stay communal IHS service and some forms of institution-based care can be unclear, particularly when such IHS services are targeted at high need groups and also provide medical and personal care services.

1.20 Long stay or permanent IHS services also exists in other forms. This can include congregate accommodation-based services, effectively an apartment block or cluster of other self-contained homes with on-site (or visiting) support services that are only accessible to service users. Sometimes these forms of IHS are effectively permanent supported housing that broadly mirrors the operation of sheltered housing for older people, with an on-site 'warden' or 'caretaker' who monitors service users' well-being and provides low level support.

1.21 In Greece, 'supported living houses' are provided for disabled people and people with learning disabilities which are small, communal housing units with on-site support, designed to deliver long term or permanent support. A mix of congregate and communal supported housing is provided for people with mental health problems, again using small scale units with on-site staffing with support being provided on a permanent or long-term basis[18].

1.22 In Italy, a similar response exists, using communal and congregate social housing which follows what is termed a therapeutic community or a participative, group-based approach, in which people with support needs and support staff work collaboratively. These small

[17] Keane, R. J. S. S. (2000) 'Outcomes and costs of community living: A matched comparison of group homes and semi-independent living' *Journal of Intellectual and Developmental Disability*, 25,4 pp. 281-305.

[18] Source: questionnaire response from supported housing provider Greece.

scsale IHS services can have a particular focus on community development within a supported housing scheme and in developing relationships between that scheme and the wider community. These models are used for disabled people, people with a learning disability and people with mental health problems[19]. Some experiments are also underway in using this approach to provide IHS for homeless people with support needs, such as the Rolling Stones project in Bergamo[20].

1.23 In Ireland, there is widespread use of group homes, which like the IHS services in Italy and Greece, are small scale, communal schemes, sometimes with onsite support and sometimes with visiting support. These are mainly used for people with a learning disability and people with mental health problems and can provide long term or permanent support homes[21]. In Finland, the situation is similar, with widespread use of supported congregate housing, again for people with learning disabilities and mental health problems[22].

1.24 Another example, used for long term and recurrently homeless people with high support needs[23] in Denmark, is the Skaeve Huse model[24]. Another example, again provided for formerly homeless people with support needs, but sometimes offering apartments in blocks that are also available to other citizens, is the Common Ground model, mainly used in the US[25] and Australia[26]. There are also congregate or communal versions of the Housing First service model[27].

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[19] Questionnaire response from Italian service provider.

[20] http://www.operabonomelli.it/programma-di-vita/casa/residenza-semi-protetta/rolling-stones

[21] Questionnaire response from Irish service provider.

[22] Questionnaire response from Finnish service provider.

[23] This group can be defined as people with recurrent or sustained experience of homelessness who also present with high rates of severe mental illness combined with problematic use of drugs/alcohol and often poor physical health. They may also be characterised by high rates of (low level) criminality and long-term worklessness. In the USA and some other countries they are referred to as chronically homeless people.

[24] Meert, H. (2005) *Preventing and Tackling Homelessness–Synthesis Report. Denmark 2005: Peer Review in the Field of Social Inclusion Policies* Brussels: European Commission, DG Employment, Social Affairs and Equal Opportunities http://www.euro.centre.org/data/1148041219_67216.p

[25] http://www.commonground.org/

[26] Parsell, C., Fitzpatrick, S. and Busch-Geertsema, V (2013) 'Common Ground in Australia: An object lesson in evidence hierarchies and policy transfer' *Housing Studies*

[27] Pleace, N. (2012) op. cit.

1.25 The use of IHS services as a means to facilitate the transition between institutions began with the idea that a sudden move from institution to housing might be problematic. Groups like people with a severe mental illness might be ill-equipped, it was thought, for independent living, because they lacked experience and had support or health care needs that needed proper treatment and management in order to be able to live independently. IHS services that were designed as *staircases* to independence emerged, particularly in the field of mental health and later in homelessness IHS services.

1.26 Staircase services work by providing steps each of which is designed to aid a transition towards independent living. The initial step is institution-like, i.e. a regulated, heavily staffed ward-like environment, which is followed by a series of subsequent steps into ever more housing-like and independent living, culminating in moving into ordinary housing and living an (where possible) entirely independent life[28]. Sometimes these IHS services are self-contained and sometimes they involve steps between physically separated stages.

1.27 In Greece, hostels are provided for homeless people that, alongside providing physical shelter and food, also offer mental health services, health care and service centred on social and economic integration[29]. These services usually operate on the basis that homeless people will stay for up to six months, during which time progress is intended to have been made in making the homeless people using them 'housing ready' (i.e. ready to live independently). This 'staircase' service model is widely used in France, the UK, Sweden, Denmark, the Netherlands and many other countries at the time of writing.

1.28 The staircase approaches used to resettle people with support needs are built around two assumptions. The first assumption is that someone from an institution is, by definition, institutionalised, and has to be taught to live independently[30]. The second assumption is that, if unmet support needs, untreated illness and/or aspects of their behaviour required someone to be placed in an institutional setting.

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[28] Ridgway, P. and A. M. Zipple (1990) op. cit.

[29] Questionnaire response from Greek service provider.

[30] Jones, A., Quilgars, D. and Wallace, A. (2001) *Life Skills Training for Homeless People: a review of the evidence* Edinburgh: Scottish Homes.

This leads to an assumption that there is little point in re-housing them unless their support needs were met, their illness treated and any 'problematic' elements of their behaviour 'corrected'. Staircase approaches therefore attempt to meet need, provide training in independent living and modify what is seen, or assumed to be, problematic behaviour.

1.29 Various hybrid models of the staircase approach exist. For example, in France, a rental intermediation model is used for providing homeless people with accommodation in the private rented sector, but for a fixed term of up to 18 months, during which time they are supposed to secure alternative housing while learning to live independently[31]. The UK too has various shared and self-contained 'transitional' or 'move-on' projects that provide ordinary housing with support, from which homeless people and other potentially vulnerable groups, such as people with mental health problems are supposed to 'move-on' after 12, 18 or 24 months on the basis that they will have learned to live independently and been able to secure their own, permanent home.

1.30 In practice, while the staircase approach have achieved some success, the failure rate in such services had often been found to be high. The reasons for this were various, including sometimes inadequate funding or issues with the poor design and management of staircase IHS projects[32]. However, the main reasons for a high failure rate centre on people with support needs *pooling* in staircase services and *abandoning* staircase services[33].

1.31 Pooling occurs because individuals on the staircase become 'stuck', unable to meet the criteria to move on to the next step and satisfy the service criteria for being given access to independent living in the community[34]. Abandonment of staircase services occurs because the sometimes strict requirements and sanctions used to modify

[31] French service provider questionnaire response.

[32] Rosenheck, R. (2010) Service Models and Mental Health Problems: Cost Effectiveness and Policy Relevance, in I.G. Ellen, and B. O'Flaherty, *How to House the Homeless* New York: Russell Sage Foundation, pp. 17-36.

[33] Sahlin, I. (2005) The staircase of transition: survival through failure. *Innovation: The European Journal of Social Science Research*, 18, 2, pp. 115-136.

[34] Busch-Geertsema, V., and Sahlin, I. (2007). The role of hostels and temporary accommodation. *European Journal of Homelessness*, 1, pp. 67-93.

behaviour, including requiring total abstinence from drugs and alcohol and compliance with treatment regimes, can lead to some people to disengaging from staircase services[35]. A relative lack of effectiveness, combined with often quite high financial costs, has begun to start to undermine the use of staircase approaches in the EU, particularly in the field of homelessness service provision, though staircase services remain widespread[36].

1.32 There is considerable evidence that IHS services that use a mixture of highly *personalised* 'floating' (mobile/peripatetic) support and *ordinary* housing scattered across *ordinary* communities tends to be more effective than staircases or permanent communal/congregate supported housing. The evidence is particularly strong for higher need groups with mental health problems, including chronically homeless people[37]. Such IHS services can be described as 'housing-led'[38], i.e. services that provide ordinary housing in ordinary communities and deliver personalised support using floating support teams. While housing-led services initially developed as a form of resettlement from long stay institution-based care, they are now used as a service response in their own right. For example, people with severe mental illness whose housing is at risk, or who have been homeless, can be moved into housing-led services *without* having any stay in communal or congregate IHS or institution-based services.

1.33 In France, which had a longstanding history of institutionalised responses to the needs of groups including people with mental health problems and learning disabilities, a major change in policy occurred 20 years ago. Health and public policy has become focused on maximising individual independence and community integration for people with support needs, by providing social and practical support

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[35] Ibid.

[36] Busch-Geertsema, V. (2013) *Housing First Europe: Final Report* http://www.socialstyrelsen.dk/housingfirsteurope/copy4_of_FinalReportHousingFirstEurope.pdf

[37] Busch-Geertsema, V. (2013) op. cit.; Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review* Edinburgh: Scottish Government; Pleace, N. with Wallace, A. (2011) *Demonstrating the Effectiveness of Housing Support Services for People with Mental Health Problems: A Review* http://www.york.ac.uk/media/chp/documents/2011/NHF%20final.pdf

[38] O'Sullivan, E. (2012) *Ending Homelessness – A Housing-Led Approach* Dublin: Department of Environment, Community and Local Government.

to people in their own homes[39], reflecting the move towards community care in several countries.

1.34 In recent years in France, a trend towards personalisation of services has intensified. Developments have included the creation of mutual support groups (GEM) which focus on giving disabled people, people with learning disabilities and mental health problems an active role in designing their own support services. This has included the development of shared activities such as arts-based activities, leisure activities and the development of their own shared housing[40].

1.35 However, there is also some use of a wide range of other services, including communal, congregate and sometimes institutional settings for people with high support needs[41]. Ireland[42] and the UK also have a similar mix of communal and congregate supported housing combined with individual units of housing allowing someone to live in an ordinary community with visiting support.

1.36 Housing-led services have three key features:

- Ordinary housing in an ordinary neighbourhood is provided immediately, without a stay in a communal or congregate supported housing setting being required. Some evidence suggests that if the housing used is scattered, i.e. IHS service users are living next door to ordinary citizens, not to other service users, social integration may be further enhanced[43].
- Personalised support goes to the service user, following them if they move. Real choices are available including the choice to *not* use support, care and medical services when they are offered and a *harm reduction* philosophy, i.e. there no requirement for sobriety, via personalisation of support service delivery. Access

[39] Questionnaire response from French service provider.
[40] Ibid.
[41] Source: Questionnaire response from service provider.
[42] Source: Questionnaire response from service provider.
[43] Pleace, N. (2012) *Housing First* DIHAL; Pleace, N. and Bretherton, J. (2013) ' The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness' *European Journal of Homelessness* 7, 2, pp. 21-41.

to housing is also not conditional on compliance with treatment or sobriety, i.e. there is a separation of housing and support[44].

- The same housing rights available to an ordinary citizen are available to the person or household using a housing-led IHS service are made available, either immediately or at the point when someone is judged to be living independently.

1.37 Housing First services are a form of housing-led approach. However, it should be noted that Housing First refers to *specific* types of relatively *intensive* IHS service and that lower intensity housing-led services are *not* forms of Housing First[45].

1.38 At the time of writing IHS exists in three broad forms:

- Permanent or long-term communal/congregate supported housing. Support can be delivered through visiting services and/or situated on the same site either during defined working hours or, in more intensive services, may be available on a 24-hour, seven day a week basis.
- Staircase-model IHS which use communal and congregate accommodation that is designed to prepare people with support needs for independent living, through training them to live in their own home. Staircase services are designed to ensure that any support needs or behaviours that might undermine someone's capacity to live independently are being successfully managed before they move into settled housing.
- Housing-led services that provide IHS through using a combination of ordinary housing and floating support services, including a distinct sub-category of Housing First services.

1.39 Many variations exist within this broad framework, such as:

- Core and cluster or hub and wheel models, in which a central core, which can be institutional care or a highly supported housing-like communal/congregate unit, provides care and support both to people living within that unit and to people living nearby in ordinary housing or housing-like settings.

[44] Pleace, N. and Bretherton, J. (2013) op. cit.

[45] Pleace, N. (2012) op. cit.; Busch-Geertsema, V. (2013) op. cit.

- Apartments or houses that are ordinary housing to which a support service is attached. Unlike floating support (mobile/peripatetic services), the support remains attached to the housing, rather than following an individual or household as they move. Such services are quite often time-limited.

1.40 Basic emergency accommodation, which is often communal and provides only basic shelter, food and sometimes support services, also exists. Many examples of these services are emergency/night shelters for homeless people. These services are not really an example of IHS in the modern sense and thus fall outside the scope of the ELOSH programme. These sometimes large, basic, services that are little more than short-term dormitories were common across the EU 30 years ago, particularly as responses to single homelessness and people living rough. Such services have sometimes become less common, particularly in parts of the Northern EU, but many examples remain[46].

1.41 Housing related services for disabled adults also extend into other areas that are not the direct concern of the ELOSH programme. In particular, the modification of ordinary housing, using occupational therapists to equip and adapt housing by making bathrooms accessible, providing stair-lifts and through a wide range of other modifications, can be used for disabled adults of working age to enable them to live independently. The building of purpose designed housing for specific sets of needs, such as housing designed for wheelchair users, is another way to enable disabled people to live in the community. Alongside physical modification to the surrounding environment, accessible, adaptable housing can facilitate and enable independence by counteracting, or removing, the effects of specific disabilities. Equipment, adaptations and specially designed housing can be used within an IHS service, but do not constitute IHS when a disabled person is living entirely independently without support.

[46] FEANTSA (2012) *On the Way Home? FEANTSA Monitoring Report on Homelessness and Homelessness Policies in Europe* Brussels: FEANTSA.
http://www.feantsa.org/files/freshstart/Policy%20documents/On_the_Way_Home.p

Considerations in developing training for integrated housing and support services

1.42 All forms of IHS can be provided by health and social work professionals. For example, a qualified social worker can be used in a housing-led service because their training enables them to perform the required roles on two levels. First, in Northern Europe, social workers are likely to be trained to case manage and support an individual to live independently in the community. Second, social workers are trained to meet specific support needs and facilitate and coordinate access to required services, for example in meeting the needs of a particular service user. Social workers will generally have been trained to enable the independence and respect and protect the rights of the people they support, i.e. to enable personalisation of support services[47]. Medical professionals will also increasingly have been taught values-based practice, centring on respecting the wishes and rights of the people they care for[48].

1.43 The role of CVET in relation to IHS is not fixed, because the nature of IHS provision is not fixed. The evidence base suggests that services that deliver flexible, tolerant support, which service users can either partially or wholly personalise to their needs, tend to be more effective, as does IHS that employs ordinary housing, perhaps particularly when that housing is scattered (i.e. service users live among other citizens, not in a physically separate apartment block). Evidence about Housing First models, which combined intensive, personalised, case management and ordinary housing is particularly strong across a range of different countries. While Housing First can be delivered using personalisation of support in congregate, single site, settings, the evidence base suggests that the use of ordinary housing with floating support is probably the more effective model[49].

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[47] Parker, J. and Bradley, G. (2010) *Social Work Practice: Assessment, planning, intervention and review* London: Sage.

[48] Fulford, K. W. M. (2011) 'Bringing together values-based and evidence-based medicine: UK Department of Health Initiatives in the 'Personalization'of Care' *Journal of Evaluation in Clinical Practice*, 17, 2, pp. 341-343.

[49] Pleace, N. and Bretherton, J. (2013) op. cit.; Pleace, N. and Quilgars, D. (2013) *Improving Health and Social Integration through Housing First: A Review* DIHAL.

1.44 However, there are scholars, service providers and policy makers who do not accept the premise that IHS using independent ordinary housing and personalisation of support services to promote social integration is necessarily the most effective model. Some argue that IHS using a staircase approach, which while it does not have the same level of success in housing sustainment as housing-led approaches, is ultimately more effective in enabling people with support needs to live independent lives[50].

1.45 For others, IHS that provides long-term or permanent supported housing in a communal or congregate setting is viewed as being the best solution for some groups. This is because long term or permanent communal/congregate supported housing is viewed as minimising risks by enhancing the extent staff can monitor service users. In addition, because some service users might become isolated, bored and find themselves without social supports, if they were living alone in ordinary housing in the community, long term supported housing is sometimes seen as the preferable solution[51].

1.46 These arguments mean that the development and provision of CVET for IHS takes place in a politicised atmosphere in which arguments about the forms that IHS should take are ongoing. While the pursuit of personalisation of support services and the use of ordinary scattered housing is supported by considerable evidence, that evidence is not always accepted. One key decision in the development of CVET for IHS services therefore centres on the nature of IHS for which the CVET is to be designed.

1.47 To add somewhat to these existing complications, the development of CVET also has to take into account some variations in the quality of the existing evidence base. Crucially, while there are associations between the use of ordinary housing, scattered across ordinary communities and better rates of housing sustainment and successful individual

[50] Kertsez, S.G.; Crouch, K.; Milby. J.B.; Cusimano, R.E. and Schumacher, J.E. (2009) 'Housing First for Homeless Persons with Active Addiction: Are we overreaching?' *The Milbank Quarterly* 87, 2, pp. 495-534

[51] Pleace, N. and Bretherton, J. (2013) *Finding the way home: Housing led responses and the homelessness strategy in Ireland* Dublin: Simon Community

living, the evidence is *not* entirely complete, nor is it entirely consistent. Three points can be made here:

- There are groups of people for whom housing-led IHS is not successful. While this is usually a minority (sometimes a very small group[52]), there is a clear evidence that while housing-led IHF is apparently the most effective model, it may not be the best solution for all service users. The detail of why some people fare less well in housing-led IHS services, including Housing First services, is not fully understood at present[53].
- Evidence on the extent to which these housing-led forms of IHS deliver social integration is mixed. People housed in the community in ordinary housing have *potentially* greater opportunities to secure access to social support and social capital, but proximity may not guarantee access to these rewards from social integration. The mechanisms by which IHS using ordinary housing, dispersed across ordinary communities may deliver – or fail to deliver – social integration are not fully understood at present[54].
- IHS that use personalisation of services and ordinary housing often differ in their operational *details*. For example, there are many types of housing-led service, including variants of the Housing First approach[55]. The variation within the IHS sector has sometimes led to criticisms that IHS services are too varied and inconsistent to allow clear comparisons or to determine what exactly underpins the delivery of good quality service outcomes[56].

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[52] Benjaminsen, L. (2013) *Housing First Europe: Local Evaluation Report Copenhagen* http://www.socialstyrelsen.dk/housingfirsteurope/copy_of_Copenhagen_HFE_Local_Evaluation.pdf

[53] Busch-Geertsema, V. (2013) op. cit.

[54] Pleace, N. and Quilgars, D. (2013) op. cit.; Johnson, G.; Parkinson, S. and Parsell, C. (2012) *Policy shift or program drift? Implementing Housing First in Australia* AHURI Final Report No. 184 AHURI: Melbourne

[55] Pleace, N. with Wallace, A. (2011) op. cit.; Pleace, N. (2012) op. cit.;

[56] Tabol, C.; Drebing, C. and Rosenheck, R. (2009) 'Studies of "supported" and "supportive" housing: A comprehensive review of model descriptions and measurement' *Evaluation and Program Planning* 33 pp. 446-456.

1.48 Complexity exists in providing CVET for IHS for disabled people, people with mental health problems and homeless people with support needs because various models of IHS exist, which do not all work by following the same assumptions, or by using the same methods. The detail of operation within broadly similar types of service may also vary significantly. Finally, CVET which follows a specific line of evidence and argument, i.e. that personalisation of service delivery and social integration through the use of ordinary housing are the most effective approaches for IHS to follow, may *not* be accepted as a valid approach by IHS service providers whose perspectives on service effectiveness differ.

1.49 Alongside this, there is the question of what IHS services are trying to achieve for their service users. Initially, IHS tended to focus on either the delivery of a settled, supportive environment in a housing-like setting, or on enabling people with support needs to live in mainstream housing, using either a staircase or housing-led approach. Housing sustainment is, however, increasingly seen as an *inadequate* response to the needs of groups including disabled people, people with mental health problems and homeless people with support needs. Sustaining someone in housing may not, in itself, deliver or facilitate access to better social supports, social capital, meaningful activity (including paid work where practical) or reduce the risks of isolation, boredom, stigmatisation and alienation[57].

1.50 Developing CVET for IHS may therefore need to incorporate multifaceted IHS service designs. IHS services can, through joint working and via case management and/or through direct provision of personalised support, attempt to address a wide range of needs among disabled adults, people with mental health problems and homeless people with support needs. This can include:

- Promotion of *economic integration*, through access to education, training, work-related activity and facilitating access to paid work.
- Avoidance and minimisation of *stigmatisation*, e.g. through avoiding environments characterised by high rates of anti-social

[57] Pleace, N. and Quilgars, D. (2013) op. cit.; Johnson, G. *et al* (2012) op. cit.

or nuisance behaviour (or 'toxic' neighbourhoods) where someone might be victimised or persecuted.

- Ensuring *health and well-being* are maximised, through access to required medical treatment, assistance with managing stress, mental health problems drugs and alcohol (where these are an issue).
- *Sustaining housing*, through ensuring reasonable security of tenure, adequate space standards and standards of repair and avoidance of overcrowded living situations. Affordability of housing is also central to housing sustainment.
- Promoting access to *positive social support*, including esteem support, informational support, social companionship and instrumental support and enabling access to social capital within communities and neighbourhoods.

1.51 It does also need to be noted that some of these areas are not precisely understood and are sometimes disputed. For example, the concept of social capital, the idea that communities and neighbourhoods are environments that offer beneficial opportunities to derive social support from neighbours, is contentious. Some argue that the 'community' is talked about in terms of offering benefits to poorer people and socioeconomically deprived neighbourhoods, is either variable or sometimes non-existent. For example, affluent people, who are clearly solidly integrated into society, often do not live within 'communities' which are like those that can supposedly 'benefit' poorer people. Instead, affluent people can have dispersed social networks, little contact with neighbours, and separate themselves off from wider society[58].

1.52 Offering CVET designed to help IHS service providers promote access to 'social capital' therefore presents some challenges. CVET based on the idea that there are 'communities' offering 'social capital' may be viewed as logical in some contexts, such as in the South and East of the EU. In other contexts, such as parts of the Northern EU, where

[58] Atkinson, R., and Kintrea, K. (2001) 'Disentangling area effects: evidence from deprived and non-deprived neighbourhoods' *Urban studies*, 38, 12, pp. 2277-2298; Savage, M., Bagnall, G. and Longhurst, B. (2005) *Globalization and Belonging* London: Sage.

'community' existing in a form that provides 'social capital' may be more difficult to identify[59], CVET focused on such assumptions may receive a mixed reception.

1.53 This amounts to a situation in which development of CVET for IHS for disabled people, people with mental health problems and homeless people with support needs should bear two points in mind:

- IHS services are not standardised in two senses. First, there are broad models of IHS that follow differing core assumptions (e.g. staircase approaches compared to housing-led services) and second, the operational detail of IHS services of the same broad type may differ considerably.
- Some assumptions and operating principles of housing-led IHS services are inconsistently evidenced or are not fully understood. This means it may not always be possible to ground the design of CVET within a clear, consistent evidence base.

1.54 This suggests that the development of CVET may need to be confined to areas which are relatively well evidenced, and in which the balance of evidence is clear, allowing trainers to present a clear case as to why a particular approach is being advocated. CVET focusing on community-based IHS services, including those which use ordinary housing and person-centred services, will however be contentious from the points of view of some IHS service providers and some politicians and policy-makers in the EU.

The extent of existing CVET provision for IHS services

Research evidence

1.55 The existing evidence base, in terms of both peer-reviewed research and policy research focused on IHS, does not provide a map of the provision of IHS services in Europe. Studies and evaluations of IHS services tend to be relatively small in scale, looking at individual services, or sometimes a pilot of a new IHS service model across

[59] Li, Y., Savage, M., and Pickles, A. (2003) 'Social capital and social exclusion in England and Wales (1972–1999)' *The British journal of sociology*, 54, 4, pp. 497-526.

several sites, rather than exploring the IHS sector as a whole. There are some exceptions, for example national level evaluations of entire IHS sectors focused on a specific group of people with support needs[60], or looking at IHS provision as a whole[61], have been undertaken. However, much of the literature on IHS for disabled people, people with a mental health problem and homeless people is confined to relatively small scale studies.

1.56 The strength of the evidence base on IHS services has sometimes been criticised when reviews of the existing research have been conducted. These criticisms have sometimes included the limited scope of research, i.e. the tendency towards a lot of quite small scale studies, and also criticised the detail of information that is included in reports. Often the specific way in which IHS services operate is not detailed in the existing evidence base and this can include a lack of information about the education, training and experience of the people providing IHS services. Control or comparison groups are also not often included in evaluations and research, making clear identification of the specific outcomes of IHS services harder to assess. A recent Cochrane review of IHS for people with mental health problems concluded that the evidence base for these services was weak for these reasons[62], reviews of IHS services for homeless people with support services have reported similar conclusions[63].

1.57 There is, however, some evidence from the existing evidence base that can help give a broad picture of the IHS sector. The findings of this research can be summarised as follows:

- IHS services tend to be more concentrated in those European societies with more extensive welfare and health care systems.

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[60] Quilgars, D. and Pleace, N. (2010) *Meeting the Needs of Households at Risk of Domestic Violence in England: The Role of Accommodation and Housing-Related Support Services* , London: Communities and Local Government.

[61] Pleace, N. (2013a) *Measuring the impact of Supporting People* Merthyr Tydfil: Welsh Government Social Research

[62] Chilvers, R.; MacDonald, G. and Hayes, A. (2009) *Supported housing for people with severe mental disorders* The Cochrane Collaboration; Priebe, S., Frottier, P., Gaddini, A., Kilian, R., Lauber, C., Martínez-Leal, R., and Wright, D. (2008) 'Mental health care institutions in nine European countries, 2002 to 2006' *Psychiatric Services*, 59, 5, pp. 570-573.

[63] Tabol, C. *et al* (2009) op. cit.

These countries tend to be those in Northern and North Western Europe, including Scandinavia, Germany, France, Belgium, the Netherlands, the UK and Ireland.

- There are differences between how IHS services are staffed and resourced. While there are exceptions, the UK and Ireland are both more likely to be delivering IHS services using support staff who are *not* qualified social work or medical professionals[64]. By contrast, IHS in other Northern and North Western EU countries tend to use staff who are, for example, qualified social workers and/or include medical professionals in IHS services[65]. This pattern is a very broad one and there are exceptions, it must also again be noted that details on the level and nature of staff training are often omitted from research on IHS services.
- While IHS services are present in Southern and Eastern Europe, the pattern of service provision is more likely to involve institution based care, and also the use of large, basic accommodation services, such as emergency shelters for homeless people, that do not offer many support services[66].
- The evidence base on IHS services for disabled adults is not well developed. Evidence on IHS for older people, including older people with physical disabilities and limiting illness is extensive, but these IHS services do not operate in the same way, or support the same group of people as IHS services for disabled working age adults.

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[64] Pleace, N. (2013a) op. cit.; BMRB (2005) *The Supporting People Baseline User Survey Report* London: ODPM; Pleace, N. and Bretherton, J. (2012) op. cit.

[65] Busch-Geertsema, V. (2005) 'Does re-housing lead to reintegration? Follow-up studies of re-housed homeless people' *Innovation: The European Journal of Social Science Research* 18, 2, pp. 202-226.; Benjaminsen, L., Dyb, E., and O'Sullivan, E. (2009) The Governance of Homelessness in Liberal and Social Democratic Welfare Regimes: National Strategies and Models of Intervention *European Journal of Homelessness*, 3.

[66] FEANTSA (2013) op. cit.; OECD Social Policy Division (2012) *Integrated Services and Housing Consultation: Consultation Summary* OECD: Paris http://www.oecd.org/els/soc/publicationsdocuments/ISH%20consultation%20summary%20FINAL.pdf

CVET on integrated housing and support across the European Union and Beyond

1.58 Web searches were conducted to identify training models and any training currently available in the field of IHS for managers, practitioners and front-line staff working in IHS and/or for those interested in pursuing or developing a career in IHS. The terms covering IHS and housing related support are broad and different terms are used in different countries and contexts. However, the key focus in the searches were IHS services within which housing, support (often including health and care services) are provided as an integrated package for disabled adults[67], people with mental health problems and homeless people with support needs.

1.59 The search was predominately web-based and adopted a dual tier strategy employing two key search engines, Metacrawler and Google. Metacrawler was initially used as it combines several search engines and then Google was used in order to check for any additional training provision or providers. The researchers discussed and drew up a list of relevant search terms; these were broadly based because, as noted above, different terms are often employed. The search terms used were:

- Supported housing
- Housing related support
- Housing support
- Integrated housing and support
- Integrated care and housing
- Housing and care
- Housing and assertive community treatment (ACT)[68]
- Housing and intensive case management (ICM[69])

[67] As adults with a learning difficulty can be people who also have a physical disability, IHS services for people with a learning difficulty were also included.

[68] ACT provides a comprehensive team of medical, psychiatric, personal care and housing related support services for people with severe mental illness living in IHS.

- Housing and critical time intervention (CTI[70])

1.60 A list of five sub-search terms was also established:

- Training
- Education
- Qualification
- Accreditation
- Courses

1.61 These five sub-search terms were combined with the nine search terms above, for example, searchers were run on 'supported housing and training', 'supported housing and education', 'supported housing and qualification' and so forth. A small number of exclusions were also set. One exception was that training details must be given in English, due to time and resource limitations noted above. In addition, training specifically relating to housing support for *older* people was not included. IHS for older people has developed into a separate sector, using models such as sheltered housing, extra care housing and wide-area scattered alarm systems with mobile warden services that are not employed for other groups of IHS service users.

1.62 Individual searches were run on each of the search term combinations; however, data saturation was apparent when the same training courses and providers reoccurred within different search combinations. Searches using the terms 'supported housing', 'housing related support' and 'housing support' identified the vast majority of training providers and courses, particularly the former search term. The other terms rarely identified any new training, apart from the last one, 'housing and critical time intervention'; this identified some USA based training.

1.63 As far as possible, information was collected from relevant websites on who provided the training, the target audience, duration, where the

[69] Intensive case management is an IHS model that provides a high degree of contact between a case manager and a service user, i.e. full time support staff may have a caseload of five or ten individuals only.

[70] Critical Time Intervention is an IHS model that provides intensive case management for a limited time period.

training was conducted (work place or classroom) and the level of training and its scope. This information was then read and summarised by one of the researchers.

Overview

1.64 Questionnaire responses from supported housing and IHS service providers in France, Finland, Greece, Ireland, Italy and Slovenia indicated that specific training on IHS was not widespread, or not thought to be available, in those countries. Instead, IHS and other services used staff who were qualified in other areas, such as social work qualifications.

1.65 Thirty-two training providers were initially identified and information from their websites was retrieved. When information was not available on websites, email requests for information were sent. On reading all the information collected, six providers were excluded as their training was found not to be relevant. This was due to training being generalist rather than relating to IHS or exclusively targeted on IHS services for older people. Twenty six training providers were finally included in the search results.

1.66 Beyond the UK, searching identified a small amount of North American training and within Europe, some Greek provision. However, little other European training on IHS was found. Whilst it is recognised that this may have been due to language barriers, English is often used as a common language within some European countries, especially, Scandinavian countries.

1.67 The following sections provide details of search results with training information reported in four sections: training leading to a recognised qualification or accreditation, training provided by organisations with charitable status, consultancy based training and international training.

Training Available

Accredited Training Courses

1.68 Eleven providers were identified with training courses leading to a recognised professional housing qualification from the Chartered

Institute of Housing (CIH[71]). Six of the 11 providers were either academic institutions (Cardiff Metropolitan University, Glyndwr University, Dublin City University and DTK College of Technology and Management) or had close affiliations with academic institutions (Centre for Housing and Support and The Skills People). The remaining providers were a mix of private organisations (Dutton Fisher and Associates Ltd, BHT Training and Aurelia Training), fee paying networks (The Sheltered Housing Network) or voluntary organisations (Birmingham YMCA).

1.69 Cardiff Metropolitan University runs two interrelated courses focusing specifically on supported housing which build on one other: the Supported Housing Higher National Certificate (HNC) and the Supported Housing Diploma/BSc (Hons)[72]. Both courses are part time. The HNC course runs for 16 months and students are not necessarily practitioners.

1.70 The Cardiff Metropolitan University courses appear to offer a broad introduction to supported housing with components in, for example, housing practice, housing law and housing and welfare policy. The course is assessed through a mix of exams, essays and projects and learning is primarily classroom based. There is, however, a practice module and for students not currently working in the field, work experience is organised. Successful completion of the HNC course facilitates automatic progression to the Diploma/BSc course. This is a flexible course targeted at practitioners working in the field of housing. Participants can choose to study for the diploma or continue studying for the honours degree. The diploma incorporates level two of the CIH qualification and the degree, level three of CIH's qualification. The

[71] Training draws on three levels of professional development validated by the UK Chartered Institute of Housing (CIH). Level two providing a basic understanding of the housing sector and important stakeholders, this is viewed as introductory. Level three developing further knowledge of housing and housing related issues, identifying different areas of housing related practice and teams working together and finally, level four, which considers team supervision and management. These levels are cumulative and build upon one another. http://www.cih.org/Qualifications

[72] The UK has a range of educationally accredited courses. Honours degrees – usually three years full time study or five years part time study. Higher National Certificate and Higher National Diploma – more technical than degree courses. These can be standalone qualifications or used as a pre-cursor to degree course. Foundation degrees – two year courses usually work based, on successful completion students can progress to the final year of a degree course if a degree is wanted.

course combines both practice and theory with the latter including housing and social care options, such as housing management, partnership working, community care, homelessness and addictions.

1.71 Two providers ran foundation degrees in supported housing, The Centre for Housing and Support and Glyndwr University (Wrexham). The Centre for Housing and Support's Foundation Degree is accredited by the University of Plymouth. The course is three years with flexible learning opportunities for staff working in the field of housing with support. Experience is valued and taken into account if applicants lack formal qualifications. Learning is through a mix of face-to-face tutor led sessions which are classroom based with other students, alongside independent study. Independent learning combines individual tutor support and virtual support through an on-line resource site. Work-based learning is an integral part of the course through work based assignments and personalised self-reflection. The course curriculum combines both generic housing options and topics, such as housing policy, housing law and managing people with specific options around supported housing (especially in the final year), for example, international perspectives on supported housing, supported housing services and a supported housing research project. Successful completion of the Foundation degree incorporates level four of the CIH's certificate.

1.72 Glyndwr University's foundation degree similarly prioritises work based learning and is targeted to practitioners in the field. Study is part-time over two years and aims to provide students with an understanding of generic housing issues and topics in order to place supported housing and its delivery in context. There are modules on, for example, the social, economic and legal context, housing and developing sustainable communities, leadership and management alongside more specific modules such as, supported housing and service delivery. Learning is through a mix of traditional seminars and work-based tasks and reflections. E-learning is not presented as an option. The course is accredited by the CIH but specific information of CIH qualifications is not provided.

1.73 Skills People is part of Lewisham College and runs the Supported Housing Pathway, a level three CIH certificated course. This course is

part time (six hours per week for 36 weeks) and targeted to those working in supported housing seeking to improve their skills and knowledge. It provides a mix of core general housing units from the CIH level three certificate and units from the college's supported housing pathway. There are nine broad based units in total: delivery of housing services in the UK, professional practise skills for housing, housing and health, housing and older people, housing and young people, identifying the needs of supported housing clients, funding, monitoring and reviewing housing with support, social factors affecting housing and supported housing and housing related services. As with the above courses, this course combines theory and practice, with students assessed using traditional methods (essays and coursework) and work based practical tasks and self-reflective learning.

1.74 A private college (DTK College of Technology and Management) in London was found running two courses, which similarly built on each other: the professional certificate in housing and supported housing management followed by the advanced diploma and, the professional certificate in social care, supported housing and disability management proceeded, as before, by the advanced diploma. Both courses were presented as routes to employment for students. The first course combines a general introduction to housing with a supported housing focus and the second course has a broader focus studying social care, disability and housing. The latter appeared more suited to participants aiming to enter the field of disability and supported housing. Information on the college's website was limited with few course details such as duration, who the courses were accredited by or if any work experience/placements were offered to students to complement classroom based learning.

1.75 Within the private sector, the Sheltered Housing Network provides training and support for those employed in sheltered, supported and allied housing services and offers three inter-related courses. A Foundation in Housing Related and Community Based Support, a level two accredited course called the National Certificate in Sheltered and Supported Housing Studies, level three accredited and finally, the level

four, National Diploma in Housing Related and Community Based Support.

1.76 All three courses offered by the Sheltered Housing Network are delivered flexibly through regional study centres or virtually through the Sheltered Housing Network's e-learning site. There is also provision for in-house learning for organisations. The seven month foundation course, as the name suggests, provides an introduction to sheltered and supported housing for those who have just started working in the field or aspire to working in the field. Key modules include principles of sheltered and supported housing, providing effective support and identifying client support needs. Assessment is theory and practice based with the latter requiring students to produce a reflective practice log. The National certificate requires a further 10 months of study and appears to contain many of the same core elements as the foundation course but in greater depth. Additional modules include working in partnership with others and promoting quality services. Self- reflective practice is, once again, emphasised. The third and final course offered, the National Diploma is, as before a further 10 months. However, the focus in this course is more research based with students learning about and then developing their own research skills. The Network also provides a mentoring service. This service includes guidance and support for staff undertaking supported housing professional qualifications, i.e. a mentor with whom to discuss their course.

1.77 Focusing on homelessness, two courses were found, an undergraduate certificate in homeless prevention and intervention and a level three certificate in supporting homeless people. The first course is offered by Dublin City University in Ireland. It is targeted primarily at practitioners working within the field of homelessness and provides a broad introduction to homelessness, its concepts, definitions and classifications. Although not specifically centred on supported housing, the role of securing and maintaining appropriate and supported accommodation and the development of independent living skills are studied. The course is taught over 18 months through a mix of face-to-face seminars and online study drawing on a range of traditional assessments (essays and assignments), group work and

personal practice self-reflective exercises. Successful completion leads to a third level undergraduate certificate.

1.78 The second course, a certificate in supporting homeless people, is a level three CIH accredited course is offered by at least five different providers in England: the Centre for Housing and Support, Birmingham YMCA, Aurelia Training, BHT Training and Dutton, Fisher and Associates. The course again provides a general introduction to homelessness, homeless services and prevention and then focuses more specifically on housing and supporting homeless people through three course modules. These modules centre on involving housing service users in decisions, the role of support workers for independent living and developing skills for professional practice. One group focused upon is young homeless people. Although run by a range of providers, all offer the course through flexible learning options delivered within a six month period drawing on a mix of face-to-face workshops run by tutors and on-line e learning with virtual tutor support. In addition to out-of-house tutorials and workshops, largely at regional offices, some providers offer companies in-house options, depending on staff numbers.

Organisations with Charitable Status

1.79 In the UK, both *Shelter* and *Sitra* give details of specific supported housing workshops for housing practitioners. The two workshops run by Shelter are delivered in-house, whereas Sitra's are held at external venues. Both organisations provide similar workshops: a general introduction to supported housing and, supported housing and the law. Both Shelter and Sitra's introductory workshops are one day events and targeted at a broad audience of staff new to supported housing, practitioners working in different areas of housing or those just wanting to know more about supported housing.

1.80 The reported aim of both organisations workshops is to provide a general overview of Government's[73] framework for IHS services and different sector partnerships, such as housing, health and social care.

[73] Strategies for IHS now differ across the UK. The former Supporting People programme, a comprehensive IHS strategy, still exists in Wales and Northern Ireland, but has been wound down in Scotland and England.

The focus of the second set of workshops around housing law differs between the organisations. Sitra's one day workshop is a general and broad introduction. Shelter's two day workshop is described as more focused, combining a general introduction with special attention to issues of security of tenure and homelessness and housing allocations. The target audience is more clearly staff working in supported housing.

1.81 Academy4Training, a relatively new social enterprise between four southern housing associations in England runs a one day introductory course for staff working in IHS entitled, the A to Z of supported housing. This one day course considers current changes to housing and social care and their impact on supported housing, developing partnerships and supporting clients with chaotic lifestyles.

1.82 One organisation, Cymorth Cymru (an umbrella body of organisations working with vulnerable people in Wales) gave details of a one day introductory supported housing workshop (externally located) for staff working in the field of housing in Wales. The workshop is presented as a response to the Welsh Government's Supporting People programme with an opportunity for current staff to share practice and workers new to the field to develop their knowledge. For more experienced and supervisory staff, Cymorth Cymru also provides a one day course on legislation relevant to supported housing in Wales, particularly, social care and homelessness. The workshop is broadly based and designed for practitioners from a range of housing and social care sectors.

1.83 Opportunities to explore policy and/or legislative changes, their impact and implications for supported housing practitioners are also offered by the Housing Support Enabling Unit, a joint initiative based on a coalition of care and support providers in Scotland and the Scottish Federation of Housing Associations. Amongst the numerous workshops and training events they run, some are specifically targeted to practitioners working in supported housing.

1.84 The workshop and training events provided by the Housing Support Enabling Unit consider recent policy changes and their implications for supported housing staff. For example, recent workshops have included events for housing support service managers around recent Scottish

registration requirements and how they relate to IHS services. Other workshops have considered welfare benefit changes and the growth of personalisation and self-directed support for service users. Workshops are usually one day out-of-house events with a mix of information giving and practice sharing amongst staff working in the field.

1.85 Focusing on young people, the National Children's Bureau has published a practical guide[74] to help staff working in supported housing to promote the health and well-being of young people living in supported housing. Accompanying this practice guide is a training module. These resources arose from a national development project and were written in association with providers of supported housing for young people, especially foyers. The training module is designed for staff and managers working with young people in supported housing projects and provides a facilitator with all required training materials (information, hand-outs and exercises). The format is designed to be flexible with the option for organisations and trainers to run a one day event, two half days or six two hour sessions.

Consultancy Based Training

1.86 The search identified a small number (four) of UK based consultancies providing training workshops around supported housing. Depth of information provided on their websites varied considerably. On two websites (Lemos and Crane and LinQs) training workshops were targeted to housing practitioners and provision of flexible and accessible learning opportunities.

1.87 Lemos and Crane's website lists a range of e-learning training course areas, one of which is supported housing. Within this, courses are aimed at staff of all levels and cover a wide range of topics; however, there appears to be a strong legal focus. Topics include eligibility to and allocation of supported housing, landlord and tenant/licensee agreements, the legal fundamentals of support and managing anti-social behaviour. Training courses are written by a range of established UK housing professionals and academics. Online learning involves

[74] http://www.ncb.org.uk/media/499644/supported_housing_-_a_practical_guide.pdf

activities, quizzes and case studies which students work through in a personal workbook.

1.88 LinQs similarly provides training in a wide range of areas, one of which is 'housing with care'. Within this, there are a number of broad training areas, for example partnerships between housing and care, health and safety, mental health awareness and leadership and management. Training is targeted at managers working as housing managers, care managers in IHS and IHS commissioning managers. Flexible delivery is highlighted with workshops, e-learning and distance-learning workbooks. Course duration is not specified but flexibility and targeting training to client needs is, once again, highlighted, for example, taking a specific workshop or combining several workshops into a training programme.

1.89 The remaining two consultancy websites provide sparse training details. However, both present themselves as providing supported housing training for practitioners. For one consultancy, (Support Solutions) training appears to be in-house for organisations and includes an annual conference. The forthcoming 2014 conference will discuss the current funding and commissioning environment and associated changes for housing support and the social care service provision of vulnerable people. The conference format includes speaker briefings and workshops. For the other consultancy (Social Care and Support Training Solutions) it was unclear if workshops were in-house or out-of-house at external venues. However, the workshops offered are presented as broad based and targeted to meeting the requirements of 'Supporting People' standards. Training areas included; protection of vulnerable adults and safeguarding children and young people, professional boundaries of managers and staff, person centred planning and motivational interviewing within supported housing.

1.90 In addition to its aforementioned accredited courses, the Sheltered Housing Network also provided a wide range of in-housing training for supported housing practitioners. The list of training workshops was broad, not all focused on supported housing. Those that appeared more focused included; health and safety, risk assessment, supervising staff and tenant participation and consultation in sheltered/supported

housing. Workshop details were limited as the onus was on 'bespoke' training relevant to the needs of each organisation.

Other CVET for IHS

1.91 Four US training providers were found. Training varied from generalist to more focused, particularly around Critical Time Intervention (CTI) and Motivational Interviewing. The most general training appeared to be provided by the Corporation for Supportive Housing, a charitably funded organisation based in New York. Four online training modules are outlined but it is not clear who they are targeted at, their duration or level. The modules listed are: introduction to supported housing, co-ordination between housing managers and supported housing providers, 'streamlining' access to supported housing and delivering supported services to different service user populations (no indication of which populations).

1.92 In one state (Connecticut), the Department of Mental Health and Addiction Services has established a training programme for supervisors and staff working in supported housing services. The programme consists of 11 courses, six of which are compulsory for all new staff (and existing staff must also undertake them) to complete, the aim appears to be to ensure staff have a basic level of knowledge and competency, especially when working with clients with mental health conditions or addictions. All six core courses are one day training events; five are workshop based and one e-learning. The workshop courses are broad based and include housing based case management, housing law, motivational interviewing, working with tenants with substance addictions and understanding mental health. Online training focuses on supported employment for permanent supported housing clients.

1.93 Critical time intervention and motivational interviewing training is provided by the Center for Urban Community Services based in New York (however, training is provided beyond New York) which provides supported housing services. The centre provides flexible learning options with workshops or on-site training provided, which can be customised to organisations' specific needs.

1.94 The Center for Social Innovation based in Massachusetts similarly provides e-learning and on-site critical time intervention and motivational interviewing training for a broad range of health and social care based staff. Online learning methods include trainer webcasts and an opportunity to engage with other practitioners via a virtual forum.

1.95 In Greece, in-service training for mental health professionals and staff is delivered by the Society of Social Psychiatry and Mental Health. The Society operates largely in the administrative region of Phokida and provides a wide range of services for people with mental health conditions, including mobile psychiatric units, hostels and housing with integrated support. Training is provided through a range of approaches from in-house informal training to more formally accredited CVET. In the former, staff participate in regular practice based meetings which act as workshops providing opportunities for staff to learn and share ideas and experiences. The Society works with the University of Thrace to provide more theoretically based courses, however, due to limited language translation, the exact scope and nature of training provided is unclear. Despite this, it does appear that formal training focuses on supporting those with mental health conditions rather than other allied service providers.

Conclusions

1.96 There is evidence to suggest that IHS services are concentrated in Northern and North Western Europe. While IHS services are clearly present in other parts of the EU, the extent of IHS services, the range of support they offer and a higher degree of specialisation within the IHS sector tends to be associated with more affluent EU member states with relatively highly developed (and high cost) welfare, social work and public health systems[75].

1.97 Models of IHS that use personalisation of support services and which employ approaches centred on social integration through using ordinary, scattered, housing while clearly present across the EU,

[75] Meert, H. (2005) op. cit.; Busch-Geertsema, V. (2013) op. cit.

appear to be in the minority. Much of the IHS provision for homeless people with support needs and people with mental health problems appears to still use congregate and communal settings. For homeless people with support needs and people with mental health problems, a high proportion of IHS services follow a staircase model, with variations in how 'tolerant' that staircase approach is. While in some countries, there is an emphasis on using equipment and adaptations, along with purpose built specialist housing for disabled people, the use of institution-based settings, group homes and long stay congregate supported housing appears to remain quite widespread. Long stay and permanent IHS services are also used for chronically homeless people and for people with mental health problems and severe mental illness.

1.98 This scoping exercise found that training provision for practitioners is frequently generalist, i.e. an introduction to the principles and ideas of supported housing. There appears to be less training around specific groups of clients and consideration of their needs. Where training for working with specific groups was found, it was targeted more to people with mental health conditions and homelessness.

1.99 A small number of supported housing accredited courses were identified. Within these courses, supported housing modules are incorporated alongside more general housing modules. As these courses are often for practising practitioners in the field, courses appear to combine theory and practice with a strong emphasis on the importance of self-reflective practice. These courses were often provided in the UK and Ireland, both areas in which personalisation of support and the idea of social integration using ordinary housing, while not universally accepted, are within mainstream thinking about IHS services.

1.100 With training frequently targeted to practitioners in the field, flexible and accessible learning were recognised as important. E-learning options are apparent, especially, for those undertaking longer training courses, with support provided through the provision of virtual tutors. Flexibility is also offered for shorter training courses through in-house customised workshops.

1.101 Existing provision of CVET does not appear to be extensive for several reasons:

- The IHS sector is diverse, working with a wide range of people in a variety of ways. Different IHS services also do not necessarily share a common operational philosophy. These variations may make the development of standardised CVET for IHS challenging in some respects.
- When IHS has been created with a specific health, personal care or social work related focus, the origins of that IHS service tend to be reflected in how it operates and how the staff within the service are trained. Medical and social work professionals are often employed in IHS services developed in this context. The training of these professionals will already often be orientated towards personalisation of services and social integration.
- The idea of a distinct and discrete IHS service sector that requires *specific* training and education appears to be most widely accepted in the UK and in Ireland. This may help explain why existing CVET appears relatively concentrated within these two countries. Questionnaire responses, while not extensive or always very detailed, suggested that in France, Finland, Greece, Ireland, Italy and Slovenia, people working in IHS services would have other forms of qualification, such as social work qualifications.

1.102 Training and education takes on a role as a form of *advocacy* of best practice, rather than a more neutral sharing of a basic approach that is universally agreed upon in this context. Some of existing evidence base for IHS is contested by those who argue that more regulated and controlled environments and the use of staircase approaches, including behavioural modification, is better for people with mental health problems and homeless people with support needs. Designing CVET that contradicts these views means designing CVET that will only be seen to have utility by some IHS service providers and policy makers.

1.103 Other areas of education and training also contain contention and conflicting views, such as the debates as to whether drug and alcohol services should pursue harm reduction or an abstinence based

approach[76]. In this example, CVET that follows and advocates a harm reduction approach is clearly challenging some perceptions of what is best practice, when some academics, service providers and perhaps service users regard abstinence based approaches as the only effective solution.

1.104 For disabled people the debates are different, here the group home approach can be contrasted with combining floating support with ordinary housing that has been equipped and adapted or housing which has been purpose built and CVET designed accordingly. However, the most enabling and supportive solutions for disabled adults may also be viewed as too expensive for some European contexts. Costs may also be prohibitive for some of the IHS models targeted at people with mental health problems and homeless people with support needs, as service models like some of the American versions of Housing First are, in some EU countries, seen as being prohibitively expensive. If CVET is designed on the assumption that a given level of resources are available, when in some contexts those resources are not present, this will restrict the applicability of that CVET in some areas of the EU.

Ways forward

1.105 Taking things forward in developing new CVET focusing on personalisation and social integration presents some significant challenges. New training will need to consider what it is seeking to achieve, how that relates to different forms of IHS in different contexts and whether it is practical to develop generic training or better to focus on specific training for particular models of IHS.

1.106 CVET for IHS which follows the line that *personalisation* of services and *social integration* pursued through the use of ordinary housing scattered across ordinary communities is the most effective approach will be following the findings of the bulk of available evidence. Nevertheless, that evidence is not complete and not always entirely robust and there are those who do not accept it. New CVET for IHS services will need to

[76] Neale, J., Nettleton, S., and Pickering, L. (2011) 'What is the role of harm reduction when drug users say they want abstinence?' *International Journal of Drug Policy* 22, 3, pp. 189-193.

be carefully designed to ensure it does not present only partially substantiated approaches to delivering IHS services as being clearly evidenced and established good practice.

1.107 Developing CVET that introduces, describes and makes a clear, accurate case for personalisation and social integration using ordinary housing would be a means by which to disseminate good practice in IHS service provision across the EU. Such CVET would be broadly applicable to all forms of IHS service for all groups of service users as well as the disabled adults, people with mental health problems and homeless people with support needs who are the focus of the ELOSH programme.