Dignity and
Well Being

Practical Approaches to Working with Homeless People with Mental Health Problems

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Practical Approaches to working with Homeless People with Mental Health Problems

Authors

Elias BARRETO, Psychologist, CHPL
António BENTO, Psychiatrist, CHPL
Luigi LEONORI, Psychologist, SMES-Europa
Silvia RAIMONDI, Psychologist, SMES-Europa
Philip TIMMS, Psychiatrist, SMES-Europa
Pierre RYCKMANS, Medical doctor, IdR, SMES-Europa
Preben BRANDT, Psychiatrist, Projekt UDENFOR
Per GLAD, Social worker, Projekt UDENFOR
Gitte AALBÆK, Social worker, Projekt UDENFOR
Panagiota FITSIOU, Psychologist MSc, EKP&PSY
Niki DARMOGIANNI, Educational Trainer, EKP&PSY
Sofoulis TATARIDIS, Project Officer, EKP&PSY
Renia POURNARA, Attorney at Law, MfA, EKP&PSY
Jacopo LASCIALFARI, Project manager, Fondazione Devoto
Andrzej CZARNOCKI, Facility Director, Caritas AW
Anne BOCZKOWSKA, Psychologist, Caritas AW
Victor SOTO, Psychiatrist, PSSJD
Isabel Mª MARTÍNEZ, Mental health nurse, PSSJD
Inés CAMPO, Mental health nurse, PSSJD
Tony O'RIORDAN, CEO, Midland Simon
John MCEVOY, Project Manager, Sophia

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Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control

Article 25 Universal Declaration of Human Rights

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Introduction

Working with people in a situation of homelessness and mental illness is a demanding job for which no one is well prepared from the start. The multiple issues involved (health, social, housing, recovery, outreach, networking, staff care) make it difficult for a single professional, discipline or service to be prepared for all the challenges and needs at stake. It is very common that professionals starting to work with this population are confronted with their limits and feel the need to go beyond their usual ways and knowledge, developing new skills to become more attentive to people's special needs and more able to network with others.

A recurrent observation is that what one has learned from regular university and professional curriculum is not enough to face the challenges of the work with this population.
Learning from experience, learning from other's experiences, developing a reflective practice that searches for adaptive solutions for unique contexts, rather than copy readymade solutions, is of the utmost importance in this field.

This workbook aims at helping professionals to develop skills to better approach the person in need, proving a context where future professionals may become more aware of the challenges and dimensions as well as the sound principles of practice when one works with people in the situation of homelessness and mental illness.

"Practical approaches to working with homeless people with mental health problems" is the result of a three-year project (2017-19) financed by Erasmus +.

At the origin of this project lies a previous project of SMES-Europa called "Dignity and Well-Being" during 2015-16, which promoted workshops where professionals from different countries could meet to discuss case profiles focused on homeless mentally ill living in poor condition and seeming to refuse help, as well to visit services and share practices and methodologies. Three workshops took place, in Warsaw, Athens and Copenhagen, after which a qualitative analysis of more than 50 profiles was done and turned into a publication about typical pathways on homelessness and intervention (Fabio Bracci, 2017; SMES-Europa in collaboration with Fondazione Istituto Andrea Devoto).

The Erasmus + project "Dignity and Well-Being- exchange for changing" used the same methodology developed by SMES-Europa (discussion of case profiles and visit to services) to achieve a new aim: the development of a training curriculum and a workbook that could be useful for the training of future professionals working with homeless people with mental health issues.

The kick-off meeting of the project was held on the 9-10 December 2016, in Brussels. It was time to plan and look into how to reach the goals of the project.

The first workshop was held in Lisbon, on 14-18 March 2017. It was an opportunity for the group to start thinking together about how to give reality to this project. While keeping with the methodology of visits and case profile discussions, we added a new dimension. Each person was asked to reflect on what kind of knowledge and skills they found were in deficit when they began working

with the homeless, and what did they learn new in this field. A group discussion was promoted, and an analysis was done to the answers that came up individually and in group.

At the same time, it was an opportunity to visit many services in Lisbon and to learn how they are currently organised and coordinated under NPISA, a recently created unit for the planning and intervention with homelessness. A SMES conference was held in the last two days of the workshop, bringing together participants from 15 different countries. The lectures and workshops were focused on the Social, Health, Housing and Employment&Rehabilitation services.

The next workshop was held in Ireland on 25-29 October 2017. The first half of the week took place in Dublin and the second half in Athlone. It gave us an opportunity to visit homeless services in a major city and in a rural area, as well as the chance to listen to a wide range of experts and people with responsibility at the administrative and political level.

Besides the case profile discussions, this workshop also promoted a brainstorm about what are the dimensions considered essential and unavoidable when working with homelessness and mental health. The result was a scheme that guided us through the rest of the project, and that is substantiated in the seven chapters of this workbook: social, health, housing, recovery, outreach, networking and staff care. Once this scheme was established the group was able to start working on the first drafts.

A midterm evaluating meeting was held in Florence, 19-20 February 2018. There we had the opportunity to listen to field experts and academics who helped us to look in a more critical way to our aims and the developing work. In the workshops, the group worked towards a more definite sense of what were the critical contents to cover in each section, and this helped to structure and further elaborate a second draft

The next workshop was held in Athens on 7-12 May 2018. There we had the opportunity to visit several key services of Athens and organise an open discussion bringing together service users, stakeholders, local authorities and State representatives concerning the policies and everyday practices regarding homeless people and special groups among them, i.e. refugees and homeless people with mental health problems.

It was also the opportunity to look at the documents produced so far and to establish a common structure to be used in each chapter. Workshops were dedicated for each topic (seven in total), and within each workshop, a topic was discussed in two subgroups. The results of these discussions generated a document for each sub-group, then synthesised in one paper.
The last workshop was held in Barcelona between 22-26 October 2018. Again, we had the opportunity to visit several services to homeless on the city, to listen and exchange with local experts and also with experts by experience.

It was furthermore the time to collect feedback and discuss together the documents that had been produced so far and that were coming close to the final form.

The final evaluation meeting of the project was held in Brussels, 7-9 March 2019. It was the chance to go over all the things that happened during this project and to look at the intellectual outputs that came from it.

The time to present the outcomes of this project, the Training Curriculum and Workbook, was the 9th of May, 2019, in Warsaw.

It must be said that all workshops were moments of intensive work and an opportunity to invite local experts, local administrators and policymakers, reinforcing the local as well as the European net.

Besides, a lot of work has been done between workshops, at home. Sub-groups were formed for each topic, and a lot of exchanges, back and forward, took place within subgroups, between subgroups and editor and within the total group, making it a very collective work.

The description of how the project developed is necessary to make clear the process that generated this workbook. It represents the distillation of many visits, exchanges, group discussions, individual work and the accumulated experience of the partners. All of these have been working with the homeless for many years and come from a wide range of professional backgrounds and organisational cultures. Besides, there is the heterogeneity of a group that comes from 8 different countries.

This heterogeneity contributed to a richness of points of view that helped to shape the dynamics and the process of the group working together. Although you can find in this workbook a multiplicity of perspectives and points of view, there is an underlying coherence and unity that is the result of a three-year journey as a group, whose members came to understand and appreciate their differences but also the common ground of values and experiences that unites them.

This workbook provides seven sections that we could describe as dedicated to four pillars and three beams that hold together the building of a coherent intervention in homelessness:

1. Social
2. Health
3. Housing
4. Recovery
5. Outreach
6. Networking
7. Staff care

These four pillars are the social, health, housing and recovery aspects involved when working with homelessness towards their dignity and well-being, and the three beams are outreach, networking and staff care that permeate and connect all those aspects.

In each section, you will find an introduction to the theme, the main ideas and concepts, expected difficulties, good practices and a study case or case profile that highlights the issues described. You will also find a glossary and bibliography.

The first section deals with the social aspects since homelessness inserts itself in the social fabric of communities and networks of social relations. Since social factors are as much part of the problem as the solution, this chapter will provide a context for a reflection about the role of social factors, social protection and social work related to homelessness.

Health and mental health needs demand to be addressed when one works with homeless people. So, the second section is dedicated to the challenges that severe health and mental health difficulties pose to intervention. This chapter will help to learn about the role of health interventions in the street, emergency services, hospital admission and discharge, compulsory admissions and good practices of health care to the homeless.

The third section deals with the subject of housing, a crucial aspect in homelessness. This chapter will enable to learn about the importance of housing and the establishment of a home, working from a perspective of housing as a right, the role of emergency and long-term housing and the sound principles of working in housing.

The fourth section is dedicated to the process of recovery. It will help to clarify the specificity of recovery as distinct from treatment, its difficulties and how to manage them, the role of professionals and the good principles of practice that foster recovery.

Intervention in homelessness has generated multiple forms of outreach work that stand as a hallmark of work with this population. The fifth section will focus on outreach practices and will provide a context to learn about outreach as an attentive and respectful attitude, service and model of work, about the phases and professional roles in street outreach, as well as the sound principles of outreach practice.

Working with the homeless requires networking, and the sixth section is dedicated to this subject. It will help to raise awareness of the importance of networking as a multi-layered approach with structural and operative levels. It will also help to learn about how to build and sustain a network, how to prevent difficulties and to identify good principles of practice in networking.

Finally, it must be said that working with homeless puts professionals in contact with intense forms of human suffering, stigma and inequalities that may affect staff's well- being and ways of working. Thus, the seventh section is dedicated to staff care and training, how to prevent burnout, and how to foster healthier forms of team culture and functioning.

The contents here presented do reflect a journey which has been a great learning experience for those who participated in it, and we only wish that it can be replicated and touch other people in the same way that it did the authors.

Social

Introduction

The fundament for any analysis and discussion of the general social right of homeless people must be aware of the 'Universal Declaration of Human Rights' and particularly the articles 2, 22 and 25.

"Social protection is commonly understood as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups" (Devereux & Sabates-Wheeler, 2004: i).

"This definition is in line with usage in international development and may be different from social policy definitions in high-income countries. Social protection is usually provided by the state; it is theoretically conceived as part of the 'state-citizen' contract, in which states and citizens have rights and responsibilities to each other" (Harvey et al., 2007).

Social assistance is a type of social protection, and it is a direct action with clear and immediate results. It is usually provided by the state and financed by national taxes. Support from donors is also important in lower income contexts. Transfers are non-contributory, i.e. the full amount is paid by the provider. Some are targeted based on categories of vulnerability, and some are targeted broadly as part of low-income groups. It seems more correct to speak about social protection than social assistance. Organising public services based on social protection creates automatically the conditions to deliver social assistance, labour market interventions and on the other hand facilitates the development of a social, informal protection net powered by donors, charity and community-based interventions.

Homelessness is a vulnerable condition related to many social factors, and social protection is at the same time part of the problem when lack of resources, safety net, legal status of permanence in the country become barriers and part of the solution for what concerns the positive actions that can help a person

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Universal Declaration of Human Rights:

Article 2. Everyone is entitle to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 22. Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

to find opportunities to break free form their condition and.

Social Rights have to be guaranteed by the Social Protection System. Thanks to the operating of the Social Protection System the conditions are created to prevent the social differences and the exclusion processes.

Social Rights	»	Social Protection	»	Social Prevention	»	Social Assistance

Prevention is the main aim of (must be part of) social protection. All the social protection systems in every country, are built to protect the most vulnerable against livelihood risks and enhance the social status and rights of the marginalised. In this specific field, social protection systems have the duty, as part of the prevention, to promote the end of the social drift by living as homeless in the streets and preventing returning to street homelessness after getting a place to live through the social assistance process.

Taking care of the last ones means taking care of one's community. Homeless people living in severe and chronic social, physical, psychical precariousness are a symptom of the malaise of a permanent injury to democracy and social cohesion. A community able to listen to the voice of its most vulnerable people is a community ready to take care of itself. The exclusion of homeless people with mental illness is a way to create two different typologies of the human being — the included ones, with rights, duty and relationships and the excluded ones without all these things. A rights based society should not accept to include someone if this means to exclude others. The community has to be the context in which everyone can be included and has the duty to take care, collectively, of those who are not productive and autonomous. This is not only for the well-being of the individuals but overall for the health of the whole community.
Because of a new reality in Europe, where also homeless people have the opportunity to move around between the member states social rights and social protection have come under a new challenge. , b These migrants are not indisputably covered by the national social legislation of the country in which they are resident as homeless.

Main Ideas

Social Professionals as mediators to the services

In delivering social services the main actor is the social professional in all his aspects and forms, changing from country to country. But generally *"The social work practice to socially marginalised people can be divided into casework and into direct service delivery, which we might term social caretaking. Some employees will manage both"* (Louise Christensen 2018). The professional meeting the homeless who is in the street assumes the role of first contact, mediator and link between the homeless people and the services. Very often in homeless people, we can see a total absence of connection with the world and very often the threshold to access to the specific services and facilities is too high for them. For these reasons the action of social professionals is fundamental, starting from the ones involved in the outreach work (see 'Outreach' chapter) ending to the institutional social workers. From this point of view, social professionals become a sort of translator for the homeless people, able to describe the way to work with the system and able to facilitate the access to the opportunities that can be useful to break free from the condition of homelessness. Communication between the different type of social professionals and mutual recognition between formal and informal protection system seems to be necessary to build meaningful pathways.

- Professionalism
- First-hand meeting
- Casework
- Mediator
- Translator
- Networker
- Co-work between services

Rights and the individual will

Building meaningful pathways with, and not for or on, homeless people with mental illness is often a big challenge that can appear as impossible to win. In every moment the social professional has to take in mind that the main actor is the homeless people and that there is no external director or someone who knows better than him the solution of his problems. Dignity and respect of the choices of the users sometimes can bring social professionals into significant contradictions. Speaking about rights should include talking about the individual will, speaking about law should consist of speaking about justice. Many times good pathways are interrupted by legal barriers (i.e. documents), other times it is not possible to give a complete answer to the needs because of lack of resources.

On the other hand, nobody can force another person to enjoy his rights if this is not his will. Rights, individual will, law and justice are concepts that influence in every moment the work of social professionals. The only aim is to give back dignity to homeless people and to let them become the actors of their own life. Assistance has to be tailored to the specific needs of individuals.

Also, homeless people want to have the power to choose and have the right to have an influence on their own lives both on an individual level and on an associative level by going together in user-associations.

This has led to a growing acceptance that homeless people should be listened to concerning what their opinions are about their own life, which kind of interventions they would accept and what they want for the future, in their contact with social workers and social institutions.

• Dignity and respect
• Right to choose

Reconnection to the individual's safety net

By its nature, the facilities delivered by the social protection system are an artificial context. They are useful to create opportunities to break free from the condition of homelessness, but they are artificial, system made. Another thing is the individual real life. Very often persons follow pathways in which shelters, day centres, soup kitchen are a sort of parallel world, that risks becoming the only world they access and that risks to bring them in a chronic condition of dependence from the protection system. More, relationships built in a context of help are influenced by the roles, professional vs users, that can be an obstacle to live a real experience of friendship. The risk is that homeless people rebuild their life in something created expressly for them, increasing disempowerment and dependency, i.e. neverending vocational and rehabilitation programmes. Many homeless people with mental illness, at the same time, are not able to be included in society because of their lack of productivity, autonomy, health. Very important seems to be the opportunity to re-connect these persons to their safety net, as relatives, friends, job, etc. Giving them the chance to live a real life in a deinstitutionalised vision of the world in which the community supports the weak and the vulnerable.

• Risk of chronicity
• Relations
• Rebuilding relations
• Safety net

Difficulties

Poverty

It is the impression that poverty in European countries, in terms of housing prices for both rented and owner-occupied housing, plays an often overlooked role in understanding the homelessness and thus are often overlooked in the effort of both the prevention social intervention. Or maybe they are pushed in the background because poverty and housing prices are social conditions that are wrapped up in an irreversible set of political and traditional rules. There is some research concerning this.

- Relative poverty
- Research

Pressure to intervene due to social alarm and lack of resources

"Data demonstrate that, while that a range of health and support needs and behavioural issues, particularly in the teenage years, do significantly contribute to the risks of homelessness in young adulthood, their explanatory power is less than that of poverty."

And further: "However, again, it should be noted that the relationship between these 'social support' factors and homelessness is generally weaker than that with material poverty and economic status." (Glen Bramley & Suzanne Fitzpatrick, 2018)

A person lying in the street, in bad sanitary conditions, using the neighbourhood for his physiological needs and in some cases also with antisocial behaviour, creates social alarm. The conflict is between individual needs and society's needs. Where is the border between them? How long can a person live in front of the door of the house or the shop of another person?

Also if he is ill, even if he is in a condition of need? Very often social professionals have to face the social alarm created by homeless people with mental illness and very often they are crushed between their professional attitude and the will of the stakeholders, the decision makers and the politics (funding the project they work in). The intervention has to keep in mind the two different forces that are playing the game, and it is not always possible. At first glance, it could be easy to side with the homeless people, more if we are speaking about social professionals, but this is not always the best way. The social alarm can push politics towards decisions against homeless people promoting intervention based on an 'urban makeup' vision instead of a person-centred intervention.

Another conflict in which social professionals are often involved is related to time. It is clear that to engage a homeless with mental illness it is a process that takes time, but on the other hand, the society asks the social professionals to do it as fast as possible and to 'remove' from the street, the person as soon as possible. In the same way, it is clear that to realise a meaningful pathway it is necessary a long term plan, but often resources, shelters' rules, and other kinds of pressures force the social professional to work faster. How can a person living in the street for many years, change his life in a few months?

- Individual needs and society needs
- The process takes time

Difficulties in diagnosis

In the common way to think, the majority of people living in the street do it because of their own choice. Detecting if it is a real choice is another significant difficulty to face, and in the same way, it is difficult to identify if a homeless is ill or if his antisocial behaviour is the result of a bad character. Diagnosis is always difficult. Homelessness is probably the result of a multifactorial process composed by a combination of subjective and objective forces, and rarely it is possible to understand which are the real reasons that brought the person in the homelessness condition. Maybe diagnosis is not so necessary?

- Own choice
- Diagnosis
- Multifactorial

Lack of cooperation between health and social services

In an effort to obtain resources, homeless people are often confronted with a complex set of providers from a variety of systems that do not communicate with one another (Dennis, Cocozza, & Steadman, 1998), (John R. Belcher & Bruce R. DeForge 2012). The lack of cooperation between health and social services in delivering answers to needs composed of social and health aspects is one of the biggest difficulties. It is not a bad will of the professionals involved but the result of different training pathways, different languages, different objectives. Very often there exist no multidisciplinary team able to face the complexity brought by the homeless people with mental illness and the interventions are fragmented and 'unplugged'. The difficulties in mutual recognition between social and health professionals are the main reasons for this lack of cooperation. One way to bridge the gap between the two systems could be to include, in addition to the professional psychiatry, a social psychiatric thinking based on general humanistic principles such as care and understanding, performed by all types of psychiatric staff (Brandt, P., Proposal for a social psychiatry theory based on experiences from a programme for homeless mentally ill; 1996).

On the other hand, there are no specific training courses aimed to improve specific tools to face in a holistic way the social and health issues of people homeless with mental illness.

- a complex set of providers
- multidisciplinary team
- social psychiatry

Gender

It is estimated that around 80% of people who are roofless or houseless are men. Women are a minority and are often 'hidden homeless': they keep a roof over their heads (sofa surfing) through remaining in a relationship with a man; they may be physically and sexually abused but are unable to walk away due to lack of alternative housing options. Those women who are roofless most likely experience severe mental illnesses, have very complex needs and will, therefore, require very

specific support. Homeless women consider themselves losers, bad mothers and the like.

• Minority
• Neglect of gender issues
• Special needs

Undocumented people

It has become more common to meet people who are homeless and sleep on the streets, but who are not citizens in the country where they are currently living. Undocumented people have no access to most of the social services and facilities because of the national legislation. This is a severe barrier for homeless people with mental illness migrating from one country to another. In these cases no action aimed to integrate or include the person is possible, and the interventions are designed only to answer to the fundamental needs (food, clothes and, often only during the winter time, emergency housing).

Homeless Women in a Men's World: "Good mothers wouldn't have to go to a shelter.' There's a moral judgement about homelessness, and when you are caring for a child that judgment gets harsher."

They can be EU-citizens or can be from outside the EU. Everyone recognises that those homeless people are difficult to help because the national social laws do not give these people all the rights. The final case in this chapter shows the need to be able to collaborate between social workers across national borders. on services for homeless people Homelessness and mental illness without a regular status of permanence

The European Commission against Racism and Intolerance:

"Recommends that the governments of the member States: […] Respect the fundamental human rights of irregularly present migrants, inter alia in the fields of education, health care, housing, social security and assistance, labour protection and justice…".

• Fundamental needs
• Transeuropean network
• Transeuropean cowork

Stigmatisation

People who become homeless are often referred to by their label, "homeless," taking on a less-than-human quality that also has other connotations that they are perceived as threatening/dangerous, nonproductive, and personally culpable. Breaking this stigma is not easy, but at the same time, it is fundamental to build integration pathways. Recognising homeless people like human being with equal opportunities, skills, wills of the others is at the same time one of the most significant barriers and one of the biggest challenge.

• Homeless people are human beings.

Aggressive behaviour

To be close, in proximity, to the people, also means to be close to their emotions, their joys and their pains. Sometimes social professionals are subject to aggressive behaviours by homeless people. When it is possible the training of the professionals should allow them to prevent aggressions but sometimes the "acting outs" are sudden and unpredictable. Handling the aggressive and violent behaviours, it is one of the most difficulties for social professionals. Often they feel not adequate

to give the right answers, and this is one of the first cause of the burnout and the turn over of the professionals.

- Preventing aggressions
- Handling aggression and violence

Good Practices

Improving services for socially excluded people requires strategies to reduce and eliminate these barriers of poverty, isolation, service fragmentation and hostility. As social and health care professionals we must root out prejudice; to ensure that our services are non-discriminatory and facilitate access to care. We must ensure that we assist people in helping themselves and in our efforts to help we do not end up increasing disempowerment and dependency.

Curiosity

- Curiosity is the basic attitude to face the complexity of homelessness and mental illness.
- Every human being is the result of a long process made by choices, experiences, success and failures and every individual has his richness worth of respect despite the social and health condition. Very often the social professional is moved or pushed to intervene to respond to the emergency but sometimes it is better to take time to listen, to know and to appreciate with a curiosity attitude.
- Nobody has the right answer except the person herself, so, sometimes, instead of an attitude of interventism seems to be better to listen with curiosity what the other one has to say.

Choosing a method, measuring quality and documentation of results

- It is essential to be aware that there is a need for consistency between the method selected for an organisation's social work and the group of socially disadvantaged and homeless people for whom the activities are aimed.
-    A pragmatically built-up method in the organisation can be used, but there must still be an awareness of what it is has been doing and why. It can also be chosen to use the prefered method, for example, 'Housing First' as the basis for the work. In any case, it is important to agree on the choice of method.
- We are doing social work with human beings, and we owe them that the work is continually based on quality goals.
- Finally, documentation of the results of the actions performed, based on goals set for the job, must be submitted continuously.

Proactive attitude and anticipation

- A proactive stance is a result-oriented behaviour, instead of one that waits for things to happen and then tries to adjust (react) to them. Proactive behaviour aims at identification and exploration of opportunities and in taking preemptive action against potential problems and threats, whereas reactive behaviour focuses on fighting a fire or solving a problem after it occurs. Proactive people are continually moving forward, looking to the future, and making things happen. They're actively engaged, not passively observing. Being proactive is a way of thinking and acting.
- The proactive individual has a vision and has an image of what could be done, and sets goals in line with this vision. With a proactive attitude, it is possible to anticipate the events and to settle all the resources that could be useful before then they are. For instance, it could be

helpful to arrange the hosting in a shelter and the following discharge to another service even if the homeless person is not ready yet to accept it. Waiting in our own office for things to happen has like the unique result the necessity to work in emergency and to patch an old jacket with a roll of tape.

Communication and visibility

- Social work is often invisible and collects results that could be not appreciable. To fight against the pressure of social alarm, it seems a good practice to give visibility to our job. Good communication with the political level establishment share goals and strategies to fight the social exclusion of people homeless with mental illness. At the same time organising events, opened conferences and seminaries could be useful to share with the communities the values and the meanings of our job. On the other hand, having the opportunity to listen to the voice and the needs of the community, the politics, the stakeholders, through good mutual communication, enables the building of new strategies. Very often the expected results are the same, f.i. do not have people rough sleepers inside the train station, but the motivations are different (giving a respectable look to the station for the passengers is the motivation of the politics, finding a better, more dignified and healthy place for homeless people is the motivation of the social professional). If there is a common and shared will on the expected result, it could be possible to enlarge the resources available for the common goal, instead of using different resources one against the other. Advocacy, lobbying, community empowerment, sensitisation and awareness on the homelessness issues through a good communication should be a fundamental frame of social work.

Choose, enlarge choices

- In the day to day routine, there is the risk to use prepacked solutions to answer to homeless people needs offering them pathways already built. During the exchanges we had, it seemed clear how important it is giving to the persons the opportunity to choose what it is better for them. Of course, the first goal has to be to "preserve" human life, but after that, all the other choices have to be in the hands of the homeless people. Having a house, paying the bill and so on is not for everyone the best way. We should be able to leave the choice to the person we meet. Making available to them all the resources and the solutions we can but leave them the dignity to choose without forcing them towards something instead of something other.
- On the other hand, it is true that sometimes persons are not able to see all the opportunities they have. For this reason, it is equally essential trying to enlarge the possibilities of choice of the person, showing him/her other and new solutions. Like the majority of the actions of the social professional also, in this case, the challenge is to find the right equilibrium between the two different attitudes.

Tailored services

- Before tailing the service, it is important to meet with respect and using the time for really knowing the other.
- Services and facilities have to be tailored to the person's needs and have to be flexible to answer in the most tailored way are possible. Rules, lack of resources, lack of time make the services' system strict and rigid. Because of that very often people have to be tailored to the

services instead of the opposite. Trying to modify the services and the facilities measuring them on the effective needs brought by the individual allows building pathways believable and achievable.

- People in homeless conditions with mental illness rarely can follow the demands of the services and often this is one of the reasons for the revolving doors phenomenon.
- If the homeless person is from abroad, it must be included in the considerations for social efforts about and when in the process one should help the homeless return to the country where he is a citizen.

Relationship

- Social professionals have the big opportunity to spend time with people they are engaged with. In the opposite of health professional, they can enjoy continuity in the relationship with homeless people with mental illness. They have time to build a relationship based on mutual trust but time also to know in a deepened way the people, to listen and to collect better their needs, to give them dignity in their approach to life. This is maybe one of the most important tools a social professional can have: day by day relationship shared moments and mutual recognition in the ever closer ties.

Case

Told by the social worker involved in the case:

I found Claire a late evening during my outreach work in the streets of Copenhagen. She was sitting on a bench in a square in Vesterbro, called Vesterbro Torv. She was wearing ragged clothes, and she looked very exposed and vulnerable. She didn't wear any shoes, and she was so dirty, that it was plain to see, that she hadn't showered for a long time.
She was cursing and yelling out loud at people passing by, and it seemed that she saw something, the rest of us didn't see. She spoke with a deep, rusty and monotone voice, chanting the same three or four lines over and over again. Her behaviour was so conspicuous, that she drew a lot of attention, leaving her even more vulnerable and exposed in the streets of Copenhagen.

I approached her on the bench, offered her a cigarette and contact were established. Claire wasn't dismissive by my contact attempt, and I was a little surprised with her reaction. She spoke French, so we had some troubles communicating, but we managed to understand each other with gestures and with a little help from Google translate. She seemed very happy with my presence, and she was eager to talk.

In the following days, I visited Claire on the bench and helped her out with the most basic things. For instance, I gave her a pair of shoes and a good sleeping bag. I also got our Mobile Cafe to come by with some food in the evenings.

After a little while, we managed to get her into a night cafe for women. You usually need Danish social rights to stay there, but the night cafe agreed to let Claire stay if we tried to find a more permanent and sustainable solution. During her stay we had a meeting with an interpreter, so Claire had the opportunity to explain to us why she was here in Copenhagen, what her plans were and how we could help her the most. During this conversation, we realised that Claire was very tormented by her thoughts and how she perceived the world. She told us she was stalked by French-Arabic men in the streets and that they wouldn't leave her alone.

Furthermore, she told us that her family was living in Norway and she was on her way up there, but she got stuck in Copenhagen. She also told us that she previously had been admitted to a hospital in Oslo. Claire desired to go to Norway and live with her family and going back to her home country, France, was not an option.

As a result of this meeting I decided, in cooperation with the employee from the night cafe, to involve a psychiatric street team. The team had the opportunity to contact the psychiatric hospital in Norway and ask them if they had been in contact with Claire before. They told us that she had previously been admitted and that she had an entry ban in Norway. They also said that she had no family in Oslo, but the illusion of having relatives in Norway was a part of her psychosis and mental illness.

After the nurses from the psychiatric team met Claire a couple of times, we resolved to set up a meeting with Claire, the two nurses and a psychiatrist also from the psychiatric street team, an

employee from the night cafe, an interpreter and me. The outcome of this meeting was that Claire voluntarily agreed to be admitted to a psychiatric hospital in Copenhagen. So, after the meeting was finished, Claire and I went to the psychiatric ward. We had an interview with a doctor, and hereafter Claire was admitted.

When Claire had been admitted for about a week, I was contacted by a social worker from the hospital. We arranged a meeting with Claire, the psychiatric street team, a psychiatrist from the hospital, a nurse and a social worker also from the hospital and me. The hospital said that they were ready to discharge her but wanted to know what plans were made for Claire. The psychiatric street team and I advocated that Claire should have a long admission and when she started to benefit from the medical treatment, we would then talk to her about going back to France, as this was her only real option.

Claire stayed at the hospital for about two and a half months, and I came and visited at least once a week. She got better and better for every time I visited her, and after two months, she agreed to go back to France. While Claire was hospitalised the psychiatric street team and the hospital, found out that she had family and a place to live in the eastern part of France with help from the French consulate in Copenhagen.

After that, we arranged that I should fly to Geneva with Claire, where we would be met by two representatives from the psychiatric hospital in France. Claire already knew the two staff members from the past, so it was apparent, that she felt that she was in safe hands. They took her back to the hospital in the Alps and admitted her there, and when she had finished her treatment, they would help her back to her apartment.

Questions:
-    What strengths and risk factors do you identify in the intervention described?
-    What could be the critical moments in the process?
-    Starting from your experience can you imagine a different intervention? If yes can you describe it?

Health

Introduction

Mental and physical health problems are strongly connected to homelessness. It is best to see homeless people not as constituting a separate category, but as being a group of people who find themselves at the extreme end of the spectrum of social exclusion. Some of the most powerful determinants of health are embedded in conditions of social inequality (Pickett and Wilson, 2009) and these are not usually directly affected by health interventions.

As with other socially-excluded groups, homeless people die earlier and have a higher prevalence of mental and physical illnesses than the general population (Fazel, 2014, Aldridge 2017). Migration, a major source of homelessness, is linked to a range of health problems, including mental health problems (EPRS, 2016). Like other groups at the bottom end of the social-economic scale, they likely to be subject to the "inverse care law" and so less likely to receive the health care that they need (Tudor Hart, 1971).

Psychosis, multiple trauma and addiction are often causes of homelessness, whereas emotional distress, anxiety and depression can be responses to homelessness (Leng, 2007).

Physical health problems can arise directly from the specific dangers of being homeless, from a lack of the normally-assumed social framework for health, or be worsened because of the lack of access to treatment. For example, if you suffer from diabetes, tuberculosis or other illnesses, it is hard to take care of your health in the streets while homeless because:

- You will be more vulnerable to extremes of temperature, more likely to become wet, and more likely to be assaulted.
- You will generally lack control over life to establish and maintain the basic routines to maintain health. These include a healthy diet, clean clothes, adequate rest, security of possessions and privacy. This is also likely to affect your ability to take medication regularly.
- You will often not be able to conform to the arrangements for clinics – many health and social services have limited contact with this population and do not design their services to address such needs adequately.

There have been statements from European bodies concerning healthcare and those who are homeless or socially excluded. In 2016 the European Parliament issued a statement regarding the right to health services for refugees or asylum seekers, with or without papers.

In the same year, Mental Health Europe (MHE, 2016) issued a paper strongly arguing for refugees and asylum seekers to have full access to appropriate health services, particularly where issues of trauma arise.

In spite of these assertions, the PROMO study (Canavan et al., 2012) has demonstrated major issues with access to health care for homeless people in Europe. Their summary comments: "Input from professionally qualified mental health staff was reported as low, as were levels of active outreach and case finding. Out-of-hours service provision appears inadequate and high levels of service exclusion criteria were evident. Prejudice in the services towards homeless people, a lack

of co-ordination amongst services, and the difficulties homeless people face in obtaining health insurance were identified as major barriers to service provision."

In addition, there is evidence that, within health services, there can be considerable stigmatisation of certain groups of patients, including homeless people (Jeffrey, 1979).

Main Ideas

Accessibility

Direct access to care and resources is crucial, especially for undocumented people. Homeless people tend to experience multiple problems simultaneously, so they can easily be perceived as difficult to treat and thereby become "unwanted" by mainstream services. At the same time, homeless people tend to find it hard to deal with bureaucratic barriers, waiting lists and complicated treatment plans. The more rigid and complex a service is, the more likely it is that homeless people will be excluded from that service, or to lose contact with it. Health services should be aware that:

While general populations have difficulties adhering to treatment plans, homeless people have added difficulties in doing this.

- Services should not make it difficult to access their services – access needs to be as easy and quick as possible (and not just for homeless people).
- Because of myths within services regarding entitlement to those services, homeless people need access to and knowledge of their rights regarding access to healthcare.
- Aftercare and follow up after discharge from hospital presents specific problems. Without a physical home to go to, or a supportive social network, one needs to consider that a homeless person may well be being discharged to a hostile an unsupportive environment. It is particularly important that, for a homeless person, a clear and robust aftercare plan is made. Without this, any gains from the hospital admission can easily be lost. However, this is often not done for homeless people before their discharge from the hospital.

Attention to Relationships

It may be that, in some contexts and with some clients, adequate care and treatment can be delivered without needing to pay attention to the relationship between the client/patient and the service provider. This is absolutely not true with homeless people – it is a central, essential part of the work. Effective interventions with homeless people depend on the establishment of a good relationship with an individual – but can also, sometimes, be cultivated in a group setting.

A good relationship and a working alliance with the homeless person is the only way to continuing contact with services and, where necessary, to optimise engagement with treatment or other health interventions.

Paying attention to interpersonal and relational aspects is as important as other, more obviously "technical" concerns. Although these are often referred to as "soft" skills, they are capable of being learnt, communicated and measured, so should be seen as "hard" skills as much as any more obviously physical and technical skills.

The ability to create and maintain a helping relationship should be seen as a technical concern

in its own right. Group interventions can also be effective as they foster a sense of belonging and enable shared non-hierarchical learning.

Outreach

The notion of going to meet with potential patients or clients, sometimes without any invitation, rather than waiting for them to come and see you.

Given the almost-universal medical tradition of responding to a health need clearly expressed by an individual, how can this be justified in ethical terms? Are we not in danger of offering unwanted treatment in a paternalistic fashion? The traditional model of offering medical assistance is based on two assumptions. One is that the doctor/nurse is available; the other is that the potential patient is not impaired by any sort of intoxication or brain disorder. Both practical experience and research into homeless populations show that neither of these assumptions holds true for much of the time for many homeless people. They are either unable to access appropriate services for practical or cultural reasons or are so impaired by physical or mental illness or intoxication, that they are unable to access the services to which they have a right.

So, outreach can be both a strategy for:

• Case detection.
• Follow up and continuing care (further material concerning this will be found in the separate "Outreach" chapter).

In health, it is an approach that can be applied to the assessment and treatment of both mental and physical health problems.

There is a range of outreach styles, from proactive/assertive approaches to more gradual, participative and receptive styles. These styles are influenced by national cultural attitudes, economic circumstances, specific ideologies of mental illness and homelessness – and the legal structures that control some aspects of psychiatric treatment.

As a result, there can be no universally-applicable "prescription" for the practicalities of outreach. However, there are probably universal principles that can be applied to most situations   - see the section dedicated to outreach

Structurally, health outreach can involve a range of professionals and non-professionals, including:

• Mobile clinics.
• Dedicated clinics in existing health establishments.
• Visiting clinics in existing homeless settings such as hostels, shelters or day facilities.
• Consultation settings with non-medical homeless organisations.
• Visits by individual health workers.
• Peer support, peer educators, working 1:1 or in groups.

The intensity and frequency of such interventions will depend both on the resources available and the attitude of the staff – see the section on hospital admission. An assertive outreach approach

(Coldwell & Bender, 2007) has been shown to be an effective model of care for homeless people with mental health problems.

Networking

This is essential because, usually, a homeless person will face multiple health and social problems at a single point in time. If only a health problem is addressed, it is often the case that other active issues will undermine any gains from an otherwise effective health intervention. And, in this population, multi-morbidity should be assumed to be the norm rather than the exception. This can include both a range of physical disorders, mental disorders and drug or alcohol problems, all of which need to be considered for each homeless person.

So - no single professional, or non-professional group can, on its own, provide adequate care and support when they first encounter a homeless person. Even most multi-disciplinary teams do not have the full range of resources within their team to address the full range of possible issues. Clearly, not every issue needs to be addressed at the same time – one must be guided by the patient's priorities and by what is practical – or bearable – for the individual patient. But the critical set of skills and resources may not be available when they are needed by the patient.

Active networking can go some way towards resolving this problem by connecting up dispersed resources in such a way that they can be activated/engaged when needed. By establishing an active network, a person or facility working with homeless people with mental health problems should be able to offer the most comprehensive service possible.

Facilities such as hostels, shelters, soup kitchens, day centres and shower facilities, should have the capacity to be involved in active person-centred networks, using both formal agreements between organisations and informal communications between practitioners.

In terms of continuing, planned work, networking and collaboration with other professionals and services are needed to construct a comprehensive (or at least multi-faceted) service plan involving the provision of basic needs and a plausible plan for the future.

All professionals and other people working with homeless persons would benefit from training in how to create and maintain networks and active collaborations (see section on Networking).

Communication

Phone or email communications are clearly vital – but personal meetings can engender a sense of personal trust between services that can make things work much more smoothly.

Accompanying/bridge-building

Many homeless people have had poor experiences with health systems – in common with many other marginalised groups – or may be disabled by mental illness, illiteracy or dependence problems. Advocacy and emotional support through interactions with various health and social systems, therefore, have an important part to play in services for homeless people. It can also play a part in establishing and reinforcing a therapeutic relationship, with an individual worker or with

a team.

Emergency services

Emergency services (such as Accident and Emergency departments/Emergency rooms)- are crucial points of entry into the health system for homeless people. However, if a homeless person does try to use a hospital emergency department, he or she can be looked upon with suspicion, as if they are only looking for a meal or bed (Jeffery, 1979). This prejudice can lead hospital staff to overlook the very real health needs of that homeless person.

On the other hand, a homeless person can arrive at the emergency room after a long period of involvement with community services and outreach teams, who have worked hard to make this attendance happen. Staff working in emergency services need to know that these services exist, and should prioritise communications with them.
They also need to be aware of the services network t
hat can be activated and enlisted to help these clients — having the involvement of a social worker or social nurse right from the start can facilitate the recruitment of these community services.

Information

Good recording of social and clinical information is clearly necessary for sustained and coherent clinical activity, and professional accountability. However, it is also vital in terms of being able to describe and evaluate the service that is being provided.

The usual professional standards apply to work with homeless people, so all activities and socio-demographic data should be carefully recorded. If interactions and interventions are restricted by the environment, then this should be documented. It is clear that the situations in which one can meet many homeless people are not ideal, and that one can often not do as much as would be possible in a clinical environment.

Attention should be given to how information is shared between different parts of the system – e.g. between hospital wards, outpatient services and community services. Again, the same confidentiality standards apply to homeless people as do to anyone else.
It may be helpful to have a "tagging" or "alerting" system of some sort to ensure that everybody who needs to know is alerted when a homeless person comes into the hospital.

Hospital admission:

Most work with homeless people is best accomplished by working collaboratively in the community. However, hospitalisation can be needed when an individual:
• Has health needs that cannot be met with outpatient/outreach treatment.
• Has lost the capacity to make informed decisions about their health care and is neglecting their self-care or attention to safety.
• (rarely) poses an immediate risk to themselves or others.

In certain circumstances, an involuntary/compulsory admission to hospital may be needed.
It may be helpful to have a standard protocol for admission, agreed between the in-patient wards,

community services and local homeless services.

To be effective, in-patient treatment must fully take into account the conditions a homeless person is likely to face if they return to the street if it is to discharge the person in a way that allows them to continue their recovery. Discharge to the streets should never happen.

To achieve this, community services and professionals in homeless services, who have been involved with the individual, must take the initiative in communicating with and sharing information with, in-patient staff. This can be termed "inreach".

In such a context, discharge from hospital can happen without joint working with the community services, resulting in inappropriate treatment, lack of treatment or inappropriate discharge from the hospital. A meeting between in-patient and community staff should always happen before a homeless patient is discharged from the hospital.

Homeless services need to "inreach" to in-patient staff while one of their clients is in hospital.

To optimise a hospital admission:

Keep an "accumulative history" for the patient, that will allow the Ward staff to quickly grasp the essentials of your clients' predicament.

- Use an "admission plan" protocol to succinctly set out the reasons for admission, what has and has not worked in the past, and what the anticipated outcome for the admission would be.
- Have regular joint meetings between the homeless team and mainstream teams.
- Maintain the intensity of your input during hospital admission.
- See your client on the Ward within 24 hours of admission. This can be reassuring for them, but can also help you to ensure that the ward staff understand the case.
- View the admission as not just as an opportunity for safeguarding and treatment, but also as an opportunity for change.
- Be very clear about your clients' capacity to make important decisions – like whether to stay in hospital or not or to consent to or refuse medication. Wrongly-assumed capacity can be used as a reason to discharge the patient inappropriately, or not to provide treatment.

Outpatient services

Easy access to such services is essential. Good examples are the "Open psychotherapeutic group" and "Open consultation" models that work regularly, every week without an appointment.

Coordination / joint work with social services

Collaboration with social services is essential. Even if the system is over-loaded, homeless people have the same rights of access to it as anyone else. Social services need, and appreciate, collaborative work to help to deal with their most difficult cases with mental health problems. On the other hand, mental health services need to collaborate with social services to create appropriate arrangements after hospital discharge.

Coordination with Health Authorities - compulsory treatment

Compulsory treatment is always (or should be) a complex and difficult process. Pro-active collaboration with health authorities can make this process more effectively, and more helpfully for the individual concerned. Once mainstream health services understand the benefits and effectiveness of treating homeless patients, they are likely to be much more positive about working with homeless services.

Research, training and case discussion

These need to be incorporated into the regular life of any team, not just as occasional events. They not only enable homeless services to demonstrate what they are doing but are also be fulfilling and motivating for team members.

Good Practices

Outreach

Outreach work is fundamental to working with people who have often avoided health and services or people who have experienced such services as inaccessible and unhelpful. It must address social, mental and physical health needs.

Access to mainstream services

At the same time, mainstream services should increase access for homeless people. Open door services without an appointment or waiting lists are good ways to achieve this.
Hospitalisation

There should be clear, well-established and agreed on protocols for compulsory admissions, which include:

- Sending assessment and reports of the person prior to admission.
- Actively and negotiating a bed to be used, not just relying on the emergency department.
- The homeless team should maintain regular contact with hospital staff during the admission.
- Pre-discharge meetings should be arranged towards the end of any hospital admission (mental or medical). These will involve the hospital team and the homeless team (with a social worker) to plan future accommodation, and organise a discharge / follow up plan.
- Staff should be trained in cultural aspects of mental health, particularly how non-European people may view mental health issues and how they might be dealt with.

Work with our professional colleagues

Advocacy, good information and marketing about homeless people and issues are vital to helping other professionals become less suspicious/pessimistic about homeless people, and thus more likely to make their services accessible to homeless people.

We need not to meet our colleagues as though we are asking for favours from them – we honestly see this (from both sides) as a way of improving everybody's life and, most importantly, the life of the patient – a win-win scenario.

Having said this, there can still be a stigma regarding both homeless people and specialist homeless services which may need to be addressed.

Professional training

Offering trainees training opportunities in homeless services, whether medical, addictions, housing or social support. Most medical, nursing or social work students find such placements extremely rewarding and are likely to become more sensitive to the needs of homeless people – and to become more skilled in helping them.

Support for staff

Not all stories end happily – so burnout is always a possibility in homeless services. Staff welfare and effectiveness cannot be taken for granted. Planned supervision and staff care are needed for good practice to be maintained. (See section on staff care.)

Prevention

Prevention is generally described in three ways (WHO). The involvement of health services in preventing homelessness can be:

Primary

"improving the overall health of the population"

Most of the primary drivers of homelessness fall outside the remit of health or social services – although it can be argued that work to improve the treatment of and follow up of, mental disorders by such services could reduce homelessness.

Secondary

"Improving detection of disorders"

In the UK, the recent Prevention of Homelessness Act (2017) has placed an obligation on both social and health services to take preventative action if a person in contact with their service is in danger of becoming homeless. For some reason, this does not apply to out-patient or community services, but it certainly encourages a more assertive approach to maintaining accommodation for vulnerable people. Prior to this, some local council housing services had formal liaison arrangements with local mental health services, which would allow extra input to people who were in danger of losing their accommodation.

Tertiary

"Improving treatment and recovery"

The provision of specialist mental health services for homeless people can be seen as a way of reducing the impact of health problems that have precipitated, or continue to perpetuate, homelessness, thereby leading to a resolution of the homeless situation

This is a more contentious area - tertiary prevention can be taken to represent a continuing service to minimise the impact of a condition – or homelessness – on a person's well-being, while not aiming at any final resolution of the problem. Are we really happy to view our services as merely helping our clients/patients to survive homelessness, rather than as being part of a way for them to escape homelessness?

Difficulties

"Hard to engage"

Homeless people can be seen by mainstream services as difficult to engage – but this will usually have much to do with access to basic rights, social security and language barriers.

Overlap of physical, mental health and drug/alcohol problems

Mainstream services often have separate and strictly demarcated services for mental illness and alcohol/substance issues. Many homeless people will often have problems in both these areas – but then this is increasingly the case in the domiciled population as well.

Street Assessments

A street assessment can clearly be sub-optimal in terms of confidentiality, comfort and quietness, and the time available. However, it is absolutely justifiable when the alternative is no access to services at all.

There are difficulties inherent in conducting a health assessment on the street:

- Lack of privacy.
- Lack of control of the environment.
- Difficulty in persuading the person to stay.
- Lack of recognition by other agencies (e.g. police) of the individual's mental health needs.
- Communication difficulties in a noisy environment.
- Sometimes, sheer physical discomfort!

So, it is particularly important that experienced health professionals, able to evaluate these complex situations, should be carrying out such street assessments.

Compulsory Assessments

Mental assessment for compulsory admission is a difficult and complex process. Professionals working within the health system, and those outside it, can often have very different and contradictory perspectives. For example, there can be a great concern in the community about the health situation of a homeless person – but, at the same time, this person can be seen in the emergency room (or on an in-patient ward) as having no significant mental health problem.

A person can be disabled by their symptoms, yet not obviously unwell. If the focus of an assessment is purely directed towards symptoms, the person's impairments may be overlooked. It is, therefore, advisable to perform a formal assessment of a person's capacity (Pathway, 2016) to make important decisions for themselves. This will often be clearly impaired, even when symptoms of mental illness are not disclosed to the interviewer.

Communication

A focus only on health or only on social needs tends to foster a lack of communication between professionals, statutory services and charity/NGO services. If doctors only talk to doctors, or social workers only to social workers, misunderstandings, lack of necessary information, duplication of effort and poor results will follow. The same applies to the medical domain to in-patient and community services.

Cultural differences

Many homeless people are immigrants or refugees, from different parts of the world. Different cultural expectations, ways of behaving, and thinking can complicate mental health assessments, behaviour, treatment and symptoms.

Multiple – or so-called "revolving door" admissions are not necessarily a problem as they can be part of the relationship-building process. The crucial element is that lessons should be learnt from each hospital admission so that the persons care and treatment can be enriched and become more effective.

Case

Case Profile: Rita

A 54th-year-old Finnish woman who left Finland in 2017, after the death of close family members, and came to Barcelona on her own. Her father, her half-sister, her son and her daughter lived in Helsinki, but she stopped contacting them a year before coming to Barcelona.

She said that she had been a nursing assistant and worked in France and Sweden, but had not worked for a long time. She said she could speak eight languages and enjoyed travelling, reading and music.

Mental health problems:

Paranoid schizophrenia /schizoaffective disorder with multiple psychiatric admissions in several EU countries over the last 15 years due to her psychotic symptoms.
 Mental and behavioural disorder due to Alcohol, dependence type

Past substance abuse:

IV heroin from ages 17-27, with periods in detoxification units and programs with methadone and buprenorphine.
•   Past abuse of IV cocaine from ages 15 to 27, occasional current use.
•   Consumption of LSD and amphetamines in youth.
•   Currently a heavy smoker

Other health problem: Cor pulmonale, asthma, diabetes, HBV and positive HCV. Epileptic seizures in the context of brain neoplasia years ago, and a diagnosis of narcolepsy.

December. 2017: She was referred to our team from a shelter with ideas of self-harm but, before our first visit, she had to be referred to the A&E department due to an opiate overdose. From intensive care, she was discharged again to the shelter (she wasn't admitted to a psychiatric ward).

From the shelter, she was admitted to a respiratory medicine ward and again referred back to the shelter where we continued to follow her up.

February 2018: From the shelter, she was referred to a medium stay psychiatric unit without our knowledge, due to plans made during her admission for her chronic obstructive pulmonary disease. She was again discharged, without any plans for her accommodation. She had lost her place at the medium stay unit and the shelter, so an emergency hostel had to be organised with the help of a social worker after an urgent referral by our team.

March 2018: In hostel (although an inadequate placement for her breathing problems).
April 2018: Admitted to a medium stay psychiatric unit where she overdosed with heroin, possibly wishing to harm herself. She was admitted to an intensive care unit and then to a psychiatric ward.

June 2018:   Discharged and placed in the same shelter as before (no other placement would accept her). Our team then started to work to return her to Finland, her country of origin.
September 2018: Another admission to a respiratory medicine ward. On discharge, we managed to place her in a convalescent unit where her pulmonary condition could stabilise for her return trip to Helsinki.

October 2018: Returns to Helsinki, a trip organised by our team.
We can see from the case a person with serious physical and mental health conditions who was willing to accept help but whose support was interrupted several times by her medical and psychiatric situation. This required urgent action, but also a long-term plan for her recovery and it wasn't always possible.

The effort by staff to provide a long term follow-up independent of her placement meant that her care and support could continue in spite of changes in her accommodation.
On the other hand difficulties and inefficiency in the coordination between different professionals was constant despite many emails, phone calls and meetings.

Questions:
- Which strengths and risk factors do you identify in this client?
- Which were the critical moments in the process?
- Which professional interventions would you like to underline as positive and which as negative and which were missing?

Case profile: Alan

A 38-year-old English man who had lived for several years in a large night-shelter for homeless men in South London. He had been allocated a bed but chose, instead, to sleep on a wide window-ledge in a large dormitory on the first floor, using rags that he gathered from the street rather than blankets offered by the shelter staff. He had a national insurance number and so was eligible for benefits. His shelter fees were paid automatically from his benefits, but he never claimed his other financial entitlements.

He never spoke and avoided contact with both staff and residents. When he was not asleep on the window ledge, he went out early in the morning, returning late at night. He was dressed in scavenged clothes which he never washed. He would never shower, and the skin of his face and hands were covered in ingrained dirt. He never ate in the shelter, and it was unclear where he found his food. As the years wore on, the staff had become increasingly concerned over his extreme social isolation, apparent self-neglect and loss of weight. They, therefore, referred him to the START team, a mental health outreach team for homeless people.

We first approached him early one morning – his response was to get up and leave the shelter, without talking to us at all. We noticed that, under the dirt, he looked extremely pale and that his bedding was infested with lice. We tried three more times, and each time he just got up and left the hostel.

Given his extreme self-neglect and weight loss, it seemed likely that he was suffering from some sort of mental disorder, probably a psychosis. We, therefore, arranged for him to be assessed under

the Mental Health Act and he was admitted to a psychiatric ward. In initial physical examination showed that he was both covered in insect bites, presumably from lice, and that his haemoglobin level was 3g/dl (compared to a normal of 13-17 g/dl). This meant that he was in danger of becoming blind through his extreme anaemia. He had a blood transfusion and was subsequently treated for psychotic illness, eventually being able to live in supported accommodation.

Points to highlight:

- This man never asked for help – and, in fact, actively avoided it.
- His severe mental illness had never been identified, over many years.
- Although he was extremely socially isolated, his predicament was well-known to the NGO/voluntary sector staff who ran the night shelter.
- While never being an immediate danger to himself or others, his self-neglect gradually created a significant danger to his physical health - and his infestation created a problem for other residents of the hostel.
- Although he was entitled to his benefits, his mental state meant that he was unable to use them.
- The outreach team made several attempts to engage with him before arranging the compulsory assessment.
- The mental health team worked closely with the people who knew Alan best – the staff of the night shelter.
- The action of outreaching to this man meant that he received a service which he had not had over the preceding decades.

Housing

Introduction

Housing constitutes an important part of the assistance that needs to be offered to a homeless person with mental health support needs. Housing has two aspects of vital importance to any human being. The first and more obvious one is the mere roof over one's head – with its amenities (appropriate temperature, running water, electricity, adequate furniture and equipment). Such structure provides conditions for the physical survival and physical well-being of a person. The second aspect also concerns the invisible reality of a dwelling place, the general well-being of its inhabitant.

This aspect, in contrast to "house", can be called "home". "Home" necessarily is based on "house". "Home" is a "house" expanded with inhabitant's participation. "Home" contains "house" and more. It is in "home" and through "home", through the feeling of being "at home", "chez soi" that a person realises his/her need of belonging, privacy and intimacy, of feeling at ease and free. These needs are rooted in the dignity of each human person. It is within a "house" raised to the status of a "home" that the space for outer and inner safety, dignity and freedom is provided. All this being true for humankind and having a home of one's own is critical for a person who is homeless and who also has mental health support needs.

It is through "having a home" that essential conditions exist for the person to be enabled to recover from a mental health illness and while not an absolute given mental health supports can often be more effective when a person is living in a home.

Main Ideas

Housing as a right

Many EU countries have enshrined in their constitutions the right to "shelter" and right to "home of one's own". This in itself is not a guarantee that those who need a home will be provided with one, and indeed the interpretations in some countries tend to be limited in their effectiveness. However, it is important and consequential for practitioners to start to think about housing in terms of a person's right. It changes the way we view the problem and invigorates advocacy. The CHARTER OF FUNDAMENTAL RIGHTS OF THE EUROPEAN UNION states in article 34.4: In order to combat social exclusion and poverty, the Union recognises and respects the right to social and housing assistance so as to ensure a decent existence for all those who lack sufficient resources, in accordance with the rules laid down by Union law and national laws and practices.

Adopting a Rights-Based approach has its implications:

Immediacy. The notion of right defies barriers. People should be housed as quickly as possible (be it temporarily). Housing should be available for people who present with multiple support needs - meaning that the threshold to accessing housing should be as low as possible. This may concern rules about couples or pets staying in the facilities or more importantly the issues concerned with harm reduction.

Choice. The person we are supporting should be given a choice. This is certainly true for long-term housing. Simply offering an option of "take it or leave it" while not being respectful of the person's preferences is not conducive to promoting his/her well-being and in particular his/her mental health. Even when the choices are very limited, the service user must be facilitated through a process where he/she is involved, fully informed and owns the decision making process. The person must also be "allowed" to change as time passes, as his/her situation can change also.

> **Practice Example:** The SLI Nua Apartments operated by the Midlands Simon Community in Athlone in Ireland provides homes for people that have experienced homelessness and who also need visiting supports to maintain their tenancies. Prior to moving in the service users come to view the apartment, they get time to ask questions, and they have a period of days after visiting the apartment to reflect on if this is suitable to their needs. Even if the service user is living in a hostel and has no other realistic options of a home, this process is followed, and one of the reasons it is followed is the belief that engaging in this way will have a positive effect on the service user's well-being. In 2018 Taoiseach Mr Leo Varadkar T.D (Prime Minister of Republic of Ireland) and Mairead McGuiness M.E.P First Vice President of the European Parliament visited a new housing with support project in Longford Town (which is funded by Department of Housing, Community and Local Government and Longford County Council) where 10 people with a range of support needs and with an experience of long terms homelessness were offered a home of their own; critical to this model is that people are seen as active participants in their own care and not passive recipients of a service and the belief in the right to housing drives this methodology.

Support. There is no proper housing without proper support, adapted to the needs of the person, especially the person with mental health problems. On this depends on the success in housing. Support should be based on the care plan developed with the service user and operated as long as the service user needs it. Support should be case managed and include different disciplines pertaining to the particular case, i.e. mental health, addiction, social care, other health professionals, housing officer, a lawyer. Support should be open-ended meaning flexibility and adaptation to the changing needs of the service user and not time limited. A major challenge is to have the courage to let the person we are supporting " to set the pace". This means the steps that are taken from the street to home and how fast this journey progresses is the prerogative of the service user. This is a challenging position to take, especially when funding of services are often subject to attaining certain targets. It is difficult to square the targets set by funders with the pace that a service user wishes to move with. However, it is vital for the wellbeing and recovery of a person who is homeless and who has mental health problems to be trusted to make his/her own choices at his/her own pace.

> **Practice Example:** Project Udenfor in Copenhagen outline that their core ethos is to "*give assistance based on the individual's needs of the moment, with no strings attached. This means that we do not demand any particular behaviour, nor do we require any specific results from our users.*" Preben Brandt (Founder of Project Udenfor) outlines in his book "Udenfor – Erindringer fra et liv på kanten" that this way of working not only is a respectful and rights influenced intervention, it also leads to sustainable and lasting change.

Quality of accommodation. The quality of homes that are offered to people needs to meet appropriate standards . Psychologically informed housing services (service that takes into account the past traumas and psychological problems of users) should also take into account the physical environment of the shelter, hostels, day service or home. The physical environment of the home or service needs to convey welcoming and empathy as opposed to being functional, cold, impersonal or institutional. At the very least, the housing offered should not re-traumatise people we are seeking to support. Thus often when someone with mental health support needs moves into their new home, there should be a welcome pack, welcoming and appropriate soft furnishings and everything is done to convey warmth, welcome and safety.

Prevention. Prevention must have an important role in any housing strategy, as it is probably the most efficient way to secure people a home.

Check List for using a Rights-Based Approach:

- Have service providers formally adopted the value that people have a right to a home?
- Is there a process where housing options are explored and explained to the service user?
- Are professionals supporting service users participating in training in anti-oppressive practice?
- Once a service user moves into their new homes is the support open-ended?
- Are the homes offered to people meeting minimum standards for leasing?
- Is there a code of conduct for professional standards which people supporting service users are obliged to adhere to ? Is the home welcoming and emotionally warm, i.e. is there a welcome pack for new residents?

Importance of staff training

A key factor in offering relevant support is staff training. A rights-based approach requires training in person-centred interventions. For this staff should be able to demonstrate a high level of empathy and capacity to engage with emotional warmth and have a high competency in active listening. Knowing when to advise and direct when needed but always being able to communicate understanding, unconditional positive regard and emotional warmth. These skills also require reflective practice, f and opportunities to reflect under supervision with a supervisor with the necessary skills and qualifications

Professionals wishing to support people who are homeless or at risk of homelessness and who have mental health problems should participate in training in anti-oppressive practice. This training would ensure there is awareness about how some of one's own beliefs and values can impact negatively on the quality of support offered to service users.

Check List for person-centred intervention:

• Are staff working with service users briefed/trained in using person-centred interventions?
• Are staff competent in basic listening skills?
• Has staff been trained in anti-oppressive practice?
• Is there a reflective practice and opportunities for staff to reflect on this methodology?

Assistance to people with mental health problems should specifically take into account the possible past traumas experienced by them. This is what is often referred to as the trauma-informed care approach. Peter Cockersell, writing the FEANSTA magazine "Homeless in Europe"(Winter 2017) gives an illustrative account for the trauma experienced by people who are experiencing homelessness. He states: "*Anybody who has worked with long-term rough sleepers and the chronically homeless knows that a large proportion of them have experienced very difficult lives, often starting with early childhood experiences of abuse, neglect, parental separation, death or alcoholism, often followed by difficult school histories, maybe trouble with the police, with violence, or drugs, or alcohol, or mental health problems (often undefined), and sometimes with all these things. They then in adult life face social exclusion and the dangers and challenges of rough sleeping. This understanding among homelessness workers of the clear link between compound trauma and long-term or repeat homelessness has been confirmed by a range of academic studies in Britain, Europe, and across the world "*(Maguire et al., 2009; Cockersell, 2011). Cockersell argues not to pathologise or psychologise homeless services but rather that people working in homeless services and supporting people with an experience of homelessness should have a competent awareness of the impact of trauma and gain better insights into how to support the victims.

Checklist for having Housing service that is operating from a Trauma Informed Care Model

• Are Staff trained in the model?
• Do houses and shelters have a standard for letting that is psychologically informed?
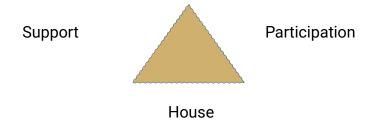• Are the external environment gardens and common areas well maintained?

Training should be offered to staff in:

• the processes of change,
• the impact of trauma,
• ways of motivating,
• involving and supporting people;

There is also a need for regular (at least monthly) formal reflective, practice sessions for staff.

Home triangle

There is a "hard", and a "soft" side to the support offered to a person. Both are indispensable, complementary and intertwined. There is this impersonal, objective, unbending aspect to assistance as well as personal, subjective, adjusting itself to individual circumstances. Both are very visible in housing and very important to take into account when we deal with a person with mental health support needs Hard assistance would be the actual architecture, medical indications, prescriptions, deadlines, social assistance in its official, documentary aspect. Soft assistance would be the space and possibilities for personalisation within given unbending context - human aspect of the interaction between the user and social worker, doctor, psychiatrist, psychologist, social worker etc. This human dimension enables meaningful exchange with a user, fuels mutual relationship, stimulates the user to come into contact with oneself, really make his/her own decisions. "Soft" assistance induces participation on the part of the user. Participation is an indispensable factor in making a house to a home. It is by participation that one starts owning the place where he/she lives. It is owning the place that changes a house into a home. We can picture it in the shape of a "home triangle."

Support   Participation

House

Participation on the part of the user is to a large extent the function of support given to him/her by care-workers.

Housing continuity of care

Let us follow the real world manifestations of housing for homeless persons. While the description progresses from the simple to the more complicated, it should not be understood as preferred chronology for the individual case. Indeed the basic assumption of Housing First, for example, is to defy the chronology. Assistance should not be measured out in schematic ways but be a relevant response to the present day needs and capacities of a person. It is the task of the support worker to make the best use of the available resources for the benefit of the specific person.

Pre-housing. There are in the real world situations where the notion of a "home" is or can be

conveyed. The fact that this is not housing yet does not mean these manifestations are not useful or meaningful in the process of housing a person. The first hint of a home may come in the shape of a street-worker offering a cup of coffee. A warm cup of coffee as a modest token of safety and human closeness invokes that safety and human closeness which constitutes a home.

There are soup-kitchens and drop-in centres. No housing, but already wider space for communicating "home". It comes with a smile of someone ladling out the food, with the quality of food itself, with opportunity to have one's clothes washed and washed in a way that reminds of home (the smell), with invitation to a festive meal at Christmas, with site's welcoming aura, with the possibility to spend time in "one's own" corner. Such unobtrusive, informal, flexible hints of home, warmth and welcome are especially in demand in contact with persons with mental health problems.

Emergency housing. Emergency housing mainly ensures survival. This is especially true for the night-shelter providing roof overhead at night with an obligation to leave for the day. Night-shelter may however also serve an important purpose of connecting a person living in the street with more sophisticated forms of assistance, including housing. That depends on the range of services deployed at the facility (e.g. psychiatrist, social worker), engagement of the personnel and functioning referral pathways.

The day-and-night shelter is the first representation of housing potentially able to contain meaningful doses of a home ingredient for users. The shelter is often looked down upon as an inadequate and obsolete way of dealing with homelessness. While criticism may be justified on the grounds of a typical practice, what is really questionable about shelter has more to do with the way it is run than with the institution itself. Certainly, no form of emergency housing should become chronic. But shelter may play an important role in ensuring physical and psychological survival and stabilisation of a person and in allowing the workers and the user himself to assess his/her actual state and further options. Ideally, the stay should be short but in real life, owing to the scarcity of other possibilities, and also to the user's attitudes, the delays may prove substantial. It has to be mentioned that some persons seem to fare quite well in a shelter. Structured day, tasks to take care of, elements of discipline, manifold interactions with other people – all these things characterising shelter may be in shorter supply in individualised housing. Loneliness, pressure of everyday problems, unwelcoming or harmful environment – shelter protects from this.

There is a right tendency to move towards ever-improving standards of living in a shelter. Ideally:

- Each person should have access to their room without having to share it;
- Showers and toilets should be shared at the maximal ratio of 2:1;
- Users should be consulted about the meals provided and their dietary requirements;
- Users should be allowed to access their rooms 24/7.

Higher standards, however, should not deprive users of incentive to live more independent lives, which is a risk especially in the situation where more independent, long-term housing options are in short supply.

Long-term housing. The dilemmatic choice between – to put it in simple terms - housing conditions with little privacy and housing conditions with little company can be solved by flexibly shaped forms of supported housing. This is where the home triangle can be fully and creatively played out

to suit the capacities and needs of a homeless person with mental health problems.

We can have many solutions based on a threefold muster:

- A centralised block of apartments for individuals or couples with private quarters allowing for privacy, and common spaces for socialisation, where care-workers are present on a workday basis;
- Big, individual apartments, normally dispersed within a town or a city, where every person lives in a separate room, with common sanitary, kitchen and socialising spaces; such apartments may come in all sizes, and they are characterised by a quasi-familial community of life between the users;
- Individual apartments for individuals or couples.

Support may also come in a threefold muster:

- On the spot support by care-workers present on a daily basis (most suited for the block of apartments as described above);
- Support by various relevant care-workers (most suited for the "communities of life");
- Case-managed support on an individual basis with the case manager and the use of generally available services.

There are of course all kinds of possible mixes both as far as living structure, and support structure is concerned. Generally, both living and support structures above musters go from more to less support and control. Whether a person attains any such housing following the line of gradual progress or just "jump in" at the later stage is of secondary importance - only a function of individual needs and capacities as well as objective possibilities and constraints.

> **Practice Example:** Sophia in Ireland has a centralised service in Dublin where it provides homes for 18 couples who had a history of long-term homelessness. These couples would typically not be allowed to access homeless services as a couple and would have been sent to live in different services. Many of the couples have significant and on-going addictions and mental health support needs. The couples are offered a home of their own without pre-conditions with on-site 24-hour support staff. To date of the 36 people that moved to live there in 2015, 32 of the people have successfully maintained their homes.

Housing First. Housing First is an intervention that proposes that people experiencing homelessness should be supported to access a home of their own as quickly as possible and without the pre-conditions of having to be sober or compliant with treatment. Housing First is a paradigm shift in that instead of following a linear model where people progress from the street to a hostel to transitional housing and eventually onto a home of their own, and people are supported as soon as possible into a home of their own. In short, people that are supported through a Housing First service don't have to prove they are housing ready; rather their need for housing is what predated being offered a home. Housing First is especially relevant for people with mental health problems. Of course, "Housing First is not housing only" stresses Dr Sam Tsemberis, (lead international expert on Housing First). In his pivotal work "Housing First : The Pathways Model to End Homelessness for People with Mental Illness and Addiction" Dr Tsemberis outlines in detail the methodologies and interventions that are required to support people with mental

health support needs to successfully progress out of homelessness. There is a substantial body of international research that supports the model as leading to positive and sustainable housing and health outcomes for people with mental problems and experience of homelessness . While this manual doesn't allow for a full treatise on the Housing First Model, service ethos and values can be summarised as:

- Housing as a basic right
- Respect, Warmth and Compassion
- Support is there for as long as needed
- Scattered site housing
- Services leasing and in turn sub-letting to the service user
- Recovery Orientation
- Harm Reduction
- The Art of the Home Visit

The experience of the practitioners that implement this model argues that Housing First excels as an intervention when there is an investment in all the multidisciplinary interventions needed such as a psychiatrist, mental health nurse, housing officers, support workers, addiction specialist, peer specialist.

Some issues of importance

Home visit. A home visit is one of the key interventions in a supported housing hosing with support or housing first model. It is where the person offering support meets the service user in their own home. While it is casual in setting it is focused and is one of the key therapeutic interventions in Housing First as well as any supported housing.

The following points are critical to the successful home visit:

- The visit is scheduled in advance and not an unexpected call;
- The support worker needs to arrive prepared and have the clinical notes read in advance of the visit;
- It should be relaxed and not rushed;
- There needs to be an emotional, warm and authentic tone communicated verbally and non-verbal body language.
- The home visit allows the support worker to monitor the user's well-being. Often the support worker should bookmark their observations and not be expected to raise every observation with the service user.
- The home visit allows the support worker to monitor any repairs and maintenance that needs to be followed up to make the service user remain a comfortable home.

To conclude this section a summary of the home visit by Dr Sam Tsemberis: "The home visit, both in its form and content provides a wealth of information about the client, the client living conditions, the staff, and the conditions of the treatment relationship. It is a microcosm of the entire program. Most of the work of the program takes place during the home visit, the teams continue to visit their client, and they bring them caring and questions "How are you?", "How can I help you ?"….to foster trust team members must convey acceptance and concern-not judgement

(Tsemberis S, 2010 P86/88).

Discharge from hospital, prison or other institutions. This best practice manual proposes that clear protocols be developed between the discharging institution and homeless services to plan discharge and consequent admission into homeless services, so that discharge into the street is prevented.

Women and men in housing services. There are good sides to co-habitation of users of both sexes and varying degrees of deficits and skills in homeless facilities, notably shelters. They complement and help each other. Mutual acceptance dissolves stigmatisation. But there also must be among workers a high level of awareness of the needs and vulnerabilities of both groups. Women's vulnerability, especially within emergency facilities and their experience of gender-based violence means that essential work needs to be done to ensure women feel safe and secure .

Building bridges between users. It is important to introduce the co-habitants of the housing facility based on a degree of collectively (be it a shelter or community of life) to the difficulties of some of the more problematic users in the way that facilitates constructive relationships.

Good Practice

This best practice manual proposes that the ideal model is based on a Service Users right to choose if they want a home of their own such as is ascribed by the principle values of the Housing First model.

The ultimate goal of housing is to achieve the home triangle – to put a person into an adequate living space – a house - and to induce with the support given a degree of participation that will make this space his/her home. It sounds simple; in reality, it is an open-ended process in which the support -worker is not the only and not unconditioned decision maker. The Support -Worker is rather one of the actors, important, but having to reckon with other people's decisions (notably the user, perhaps other persons close to him/her, neighbours, other services, actual architecture etc.). That's why the role of the care-worker is best described by two notions: balancing and flexibility. First of all, he/she has to strike a balance between the user-to-be and the architecture while architecture to some degree presupposes the mode of living. As described in the previous chapter we can have a block of apartments; we can have a community of life within bigger apartments, and we can have individual apartments. We have users-to-be with all their traits, strong and weak points, particularities, deficits, idiosyncrasies. Our actual housing options are almost always restricted. Now we have to strike a balance! Use the available architecture for the best benefit of the person(s) before you. Deliver yourself and/or procure from other services the support needed. No easy act of balancing, the sole comfort is that we can strive for the ideal and achieve only the possible. One suggestion concerning housing where interactions between inhabitants play a big role – especially in communities of life – is to bring together people with differing characteristics. Strong points of one person fit well with weak points of someone else. People who fit together well tend to mutually take care of each other in many small ways, which is meaningful additional support on the top of the professional one. Such mutual, every day, peer-to-peer support is, by the way, an important ingredient of a home — a family of sorts, a company which is a common need among humans.

Striking balance in other forms of housing (individual, a block of flats etc.) is no easier. Everywhere the same wise and well-known principles apply of:

Prevention. It is better to foresee a problem than to quench the fire. A good example for housing is negotiating and planning discharges from hospitals and other institutions to have housing – be it only a short-term one – for the person ready when the time comes.

Reaching out. This takes in housing mostly the form of the home visit, but the question is not the form but the content. How much reaching out in the home visit? How much real contact and dialogue?

Networking. It is good to have partners in striving for goals. All kinds of services are eligible as partners in housing – health services, social assistance, occupational centre, employer, police but especially desirable are neighbours of the housed person. A coalition with neighbours prevents stigmatisation and rejection. It requires, however, reaching out to neighbours.

Person-centeredness is the very centre of meaningful assistance in housing and elsewhere. In practical terms, it means that among all service providers for the housing user there is at least one for whom this he/she is in the centre as a whole person — subject, not an object of assistance. The formal embodiment of person-centred assistance is case-manager – a very appropriate form of service in housing, especially for individual apartments, and especially for the Housing First model.

Being so often faced in the realm of housing with various constraints and scarcity of solutions available, we are asked not to add inflexibility of our thinking to the inflexibility of the reality around us. In general, all good practices are expressions of agile perception, hard and often unorthodox thinking, bold decisions and action making the best of circumstances encountered.

Difficulties

Increase in house prices: House prices rose by 4.3% in both the euro area and the EU in the third quarter of 2018 compared with the same quarter of the previous year. (Source Eurostat) Thus having an impact on affordable housing for people experiencing homelessness.

The lack of affordable rent proprieties: An EU wide trend is the lack of affordable housing and the trend of local government to withdraw from being an active player in building social homes.

Besides the scarcity of living spaces available typical difficulties to cite is prolonged bureaucratic procedures necessary to obtain them, lack of variety in available spaces in the face of very varied needs of the users-to-be. Most probably there will also be other underprivileged groups and their representatives competing for what is available. It is difficult to work in a person-centred way when there is little choice we can offer to the person.

Housing process poses constraints of time. On the one hand, there may be a lot of waiting to go through, on the other some things, especially to do with documents and legal transactions have to be completed sharply on time. This may be especially difficult for some of the persons we focus in this manual on.

There is a tendency to regard a housed person as "done," i.e. the end-result achieved – "homeless person no longer homeless." Even if we are aware of a person's persisting need for support, some services may be less readily available. It is a delicate turning point in the person's situation when he or she is all of a sudden expected to do much more for him/herself than before. This moment requires special attention from the support worker.

The possibility of stigmatisation and rejection on the part of the neighbours is also a problem to be reckoned with.

Case

Best Practice Service

Flat Zero – Arrels Foundation – Barcelona

Low-demand temporary housing for the homeless

Flat Zero is low-threshold temporary housing for people who are chronically homeless in Barcelona. The project aims to provide an alternative way to ensure access to housing; it caters for ten people each night. It is deliberately a small service to respect privacy and build on relationships of trust with Arrels Staff.

A conventional flat was renovated and transformed into a "street flat", it is geared towards people who have rejected other shelter options, the 20% of people that do not adapt to the Housing First model or are unable to adapt to some of the rules they impose regarding behaviour and communal living. The flat has been designed as a half-way spot between the street and home. Service Users can access the flat with dogs, drinks and the bags and packages they normally carry with them.

One innovation worth pointing out as a benefit to the organisation is that the flat becomes a reversible space that acts as a collective dwelling at night and during the day, is used for training Arrels Foundation volunteers and advocates.
They have adapted the space to meet the needs of those they support; they do not aim to change a person in order for them to fit a model, rather they adapt for the person. Aligning it with key elements of best practice, creating a person-centred service, that brings dignity and security to their service users.
Flat Zero Links:

https://www.arrelsfundacio.org/piszero/

https://youtu.be/favwHgzwZjY

https://youtu.be/_OtmYhwVdp0

Case Studies

Housing case history/profile

Jack was a 34-year-old man from Newcastle, a city in the North East of England, who had developed a severe psychotic illness in his late teenage years. He had lived in London, on the streets and in large hostels, for around ten years before he met our team. He moved into a flat in one of our first-stage projects, improved greatly with a small dose of antipsychotic medication and support, and then moved to a long-term high support flat a couple of miles down the road in Bermondsey, a traditionally working-class area in South London. He seemed to be settled in his flat, which was one of 12 grouped around a courtyard, with housing staff on-site 12 hours per day.

However, one day he was talking to his key worker and said that he had been thinking of moving back to Newcastle – in fact, he had thought of just catching the train the following week. He had not made any arrangements but was sure that things would "be alright" when he got back to Newcastle, which he clearly saw as his home town. After some conversation, his keyworker persuaded him not to go back without any kind of preparation but started to help him make arrangements. Over the next few weeks, he managed to contact the Housing Department in Newcastle, a flat was found for him, financial benefits were arranged, and the local community mental health team agreed to take him on.

Before he made the final move, he and the team agreed that it would be good to go up to visit the proposed flat and meet the mental health team in Newcastle. So, Jack, his key worker and the psychiatrist (myself) went up to Newcastle for the day. Now arrangements had been made; he was looking forward to the move.

We got off the train and took a taxi to the flat that had been allocated. It was in good repair but absolutely bare. Jack also did not seem to recognise the geography of the city. We then went to the mental health team, introduced ourselves and had a very positive meeting. After lunch in the city centre, we got on the train back to London. I was aware that Jack had been rather quiet during the several hours we had spent in the city and, after an hour or so, his keyworker asked him if something was wrong. He said, "I don't think I want to go back to Newcastle". He had not felt comfortable there as it had changed so much since he left. In addition, although he had tried to contact his family, they wanted nothing to do with him. So, he had not recognised the place from his past, and he had no relationships or social network left there. The visit had brought home to him the reality of the situation.

So, he stayed in the flat in London, where he was able to stay indefinitely. For myself, it was so helpful to go with him. A lot of time and energy had been invested in his move, and it would have been easy for my team to have felt irritated, or at least disappointed, by the fact that all their work had resulted in – no change. But, being there with him, his sense of disappointment and discomfort was so obvious. It would clearly not have worked for him. And so the relationship between Jack and the team continued on a positive basis.

Profile : Mr D (team : Infirmiers de rue)

We met Mr D in June 2010.

At that time he was 45, homeless, living in the street. He was nearly always under the influence of alcohol and was sometimes aggressive. It took us some time to get his confidence and to be able to open some rights for him (income, medical care,…).

Still, it was very difficult to imagine any solution in terms of housing for him since he was most of the time not accepted in the emergency shelters or temporary housing facilities, and housing first was not developed at that time in Brussels.

In 2015 we managed to propose him a place in our housing first program, and he was very glad to enter his first apartment for nearly a decade. In the first months, it was all well; he had stopped drinking and was investing his new life with enthusiasm.

But then he started again to drink, and the following two years were a nightmare, both for him and for us. We were very worried because we found him often heavily drunk, nearly in a coma, in his home, without any surveillance. Several times he tried to stop drinking, whether alone or in a detoxification program in an institution. The only positive points in these two years were: that his confidence and the relation with our team was never affected, on the contrary, it improved; that he wanted really to continue in an apartment, he was very motivated ; and finally that he choose himself to move to another apartment, smaller (which he liked more, the other seemed too big) and cheaper : he was again in state of making his choices, really.

And then, finally, after one more hospitalisation, he told us that he had realised that it was not good for him to be housed alone. So we proposed him a nursing home, for which he was too young, but where he was accepted, and which he accepted! Since two years that he has been there, he has not drunk any alcohol, and he is happy. He is continuing his progress because now he is thinking about finding another collective housing project where he could be with people of his age.

Questions:

-    What strengths and risk factors do you identify in the interventions described?
-    What could be the critical moments in the process?
-    Starting from your experience can you imagine a different intervention? If yes can you describe it?

Recovery

Introduction

People in a situation of long-term homelessness often went through a long process of social exclusion and compound trauma (Cockersell, 2018).

Research consistently shows that in infancy and adolescence homeless people frequently present indicators of dysfunctional homes, such as histories of physical and/or sexual abuse in infancy, parent substance abuse or mental illness, running away from home, foster care and institutionalisation. In adulthood, homeless people frequently are affected by the loss of jobs, economic crises, poor physical and mental health, substance abuse, exposure to physical or sexual violence and lack of social networks to support or protect them. (Munoz, Vásquez e Panadero in Levinson e Ross, 2007).

This means that working with the homeless is not just a matter of providing answers to the lack of housing, treatment or jobs. It is also a matter of addressing the process of social exclusion and helping to recover a sense of a stable self, a sense of home- a place where one feels welcomed and belonging to- a sense of connectedness to stable relationships and social networks and a sense of personal value, where one feels to have something valuable to share with others and feels recognized by that.

This dimension is so essential that it becomes elusive and challenging to capture in one word. "Participation", "Recapacitation", "Reconnecting", "Empowerment", "Rehabilitation", "Recovery", "Employment" are some of the words that may come up when one tries to think about it.
"Recovery" has the advantage to connect with current literature on the subject but at the same time, it is not entirely suitable. On the one hand, it evokes "illness"- one recovers from an illness, for example. But at the same time, it requires a shift from a medical model to a social model of understanding that focuses on wellbeing, strengths and opportunities rather than deficits and weaknesses.

 On the other hand, it evokes the idea of "return"- returning to the state that preceded whatever the person is recovering from. But it is also important to be aware that one may not have lived in a previous state of so-called "normal" social and economic conditions, which means that it is not often a matter of returning to but of trying to build from" scratch" what was not there before.

According to Repper & Perkins (2006), recovery is a personalised process, which is connected with the growth of future hope, the discovery of a new meaning in life, empowerment, development of personal skills and strategies, a safe economic and social base, supportive relationships and social integration.

So recovery is not something that professionals do but rather a personal journey that has to be understood from the user's point of view. The role of professionals may be best understood to be a role of support, of trying to provide the environment and opportunities that the person can use on his recovery journey rather than hinder that journey with the imposition of solutions and plans designed by professionals that supposed to know better. That requires the abilities to listen, respect the right to choose and to work collaboratively with users.

Main Ideas

Recovery is not treatment: Recovery and Treatment are two different things. Recovery is about gaining self-management. According to this approach, a person takes risks. For example, he chooses to return to work; at the same time, he has strong support from his family (when there is one) and professionals (Chamberlin, 2005). The users themselves must manage their own recovery – it is RECOVERY BY THEMSELVES with support.

Recovery is a process, not a state: It is a process of change, through which individuals improve their wellness, their quality of living and lead themselves to more degrees of autonomy, preferably being able to support themselves and not being dependent on other people. This means being treated as a person rather than as a patient.

It is a personal journey, and everybody recovers at his own pace. Thus, it should be supported by -but not managed by- a professional.

The first reason for that is related to the fact that a person's needs and a professional's opinion for the same individual can vary greatly (Lasalvia al., 2005; Thornicroft & Slade, 2002). In addition, the needs that have been assessed by the service users themselves are much better indicators for the assessment of the quality of life compared with those reported by professionals (Slade, Leese, Cahill, Thornicroft, & Knipers, 2005).

The second reason is related to the individual's right to make his/her own decisions, even if it is proved in the way that it was the wrong choice or that his/her decisions were harmful and risky. The right to take personal risks and regain the control of one's own life, through free will, fits into the broader context of the concept of recovery and should be assigned, even if there is substantial disagreement or concern for the results of this choice (Slade, 2009).

Additionally, we should be aware that:

Engagement and trying to establish a trustful and meaningful relationship between people in a homeless situation and the professionals are central to support the recovery process. Through that relationship choices and options can be given to the persons regarding their needs and will. This is of critical importance in outreach work (see outreach chapter).

The road to recovery is never straight, and there's **no predetermined destination**.
Professionals should be aware of not trying to force their clients into some sort of ideal (ex: get a house, get a job, get a family) regardless of the will and possibilities of the clients. We should also have in mind that normality is a statistical concept, but each one of us has a subjective approach to it, and therefore this has to be taken into account when working with people that have been exposed to severe life events and have created a certain "personal way" to interact with the environment.

The role of professionals working from a recovery perspective is to instil hope and build a positive and realistic view, to support, connect and discover opportunities as well as to respect needs and

choices, focusing on strengths, self-determination and somebody's resources, instead of focusing on symptoms and deficits. It is a holistic approach, facing users as individuals with roles rather than as patients.

For someone to gain or regain self-respect, self-confidence and meaning in life, it is important to feel "included", to feel that he/she belongs in a community and he/she is somebody not only accepted but valued as someone worthy as well. All the above can be gained partly through increased connection with others, being able to participate as a citizen actively and having access to jobs.

Access to jobs may be very important in the process of recovery, as it can lead to self-support, independence and recognition. Besides that, earned money/salary can also be linked to dignity, as it is one kind of exchange. Moreover, through a job homeless people can gain a structure in their life and a purpose. Thus, for some people job can definitely be a step towards recovery.

On the other hand, it is crucial to be underlined that having a job is not everything. There are people for whom having a job is not their priority (i.e. older people or more severely ill), so we should accept diversity and recognise the right to live with dignity without a job. If we consider a job to be prerequisite for a fulfilled life, we may end up blaming and diminishing those who might not be able to work anymore, but who can live with dignity with a pension or other social benefits, and find purpose in life through a hobby and other social and meaningful community activities.

Difficulties

Time-scale: Services often fear the dependence of users and tend to put pressure on professionals in order to produce fast results and have their clients become autonomous as soon as possible. This contributes to an emphasis on short-term solutions and rigid plans where users are compelled to do things under the threat of losing support if they don't. This defensive mode can turn services into a system that readily blames, punishes and excludes people, instead of one that cares, supports and helps people on their needs.

Professionals often have **big caseloads,** making it difficult a **person-centred and a person-tailored approach.** However, dealing with people who suffer from a long process of social exclusion, requires a central focus on the relationship, fostering the development of a close, regular and trustful relationship between professionals and users.

The fear of addressing the **long-term needs** creates the paradox of increasing the **risk of institutionalisation,** where being a service user becomes a "full-time job", and people live permanently in supposedly temporary accommodations, like shelters, hostels and other big institutions.

Professionals may not consider the possibilities of entering into the labour market and tend to use a **step-wise model** where people are asked first to attend occupational activities or professional training courses before trying the job market. This might contribute to trapping people in vicious circles of preparatory training without any access to the job market. This can be prevented by a **"first job approach"** where people are helped to find a "real" job and are supported and trained while they are at their jobs.

More and more, due to the socioeconomic crisis, some European countries face a situation of lack of jobs combined with the exhaustion of family provisions, as well as reduced investment in social welfare, leaving more vulnerable those in need. At the same time, we face a more competitive free labour market where there is only place for the "fittest", leaving out many who could work, even if they are not the fastest or the youngest. (Social cooperative style businesses can be an alternative).

However, **the issue of labour may be controversial**, in the sense that labour can be different from a "job". Very often labour is seen as an inclusive action in the community and not as work, on its own right. As labour/ work is a strong symbolic identity feature, the idea of how labour affects somebody's identity has to be looked at very carefully. If that identity construction is achieved through a specially "developed job", targeted for people with mental illness and homelessness, to what extent do we identify them with their illness and to what extent do they see themselves with that condition and not as citizens with rights and responsibilities?

The staff in institutions and services can get frustrated with the process of recovery if they are not well trained and supported. Stereotypes and misconceptions can lead to constant marginalisation and discrimination, especially for those with mental health problems and/or addictions. Thus, the staff needs to be given the tools to clearly understand that treatment does not equal recovery.

Teams should be given time for reflection, team approach, mentality and culture of networking, communication within and out of the team. This is essential to understand that the recovery process takes time and during this process, we have to deal with frustrations, steps back and forward and at the same time respect people's resources. A team has to be continuously supported to be flexible (see also next chapter about staff care-staff training).

Good Practices

Since we are often facing persons who have been through a long process of social exclusion, it is of the utmost importance to try to build an **environment that people feel safe, stable and containing key figures** that can be trusted enough to turn to when help is needed.

The intervention has to have a **central focus on relationship,** and try to foster continuity, trust, interactivity, an attitude of positive regard, respect, responsiveness, non-retaliation, with a special attention to power dynamics, avoiding the activation of feelings of shame, humiliation and anger by offering alternatives that the person can choose and not imposed solutions with an attitude of "take it or leave it".

It is essential to have access to **stable case managers** and not see a different professional each time they go to services. It is also important that case managers have caseloads that enable them to see their clients regularly and do things together.

A person-centred approach should be the foundational approach style, as it is vital to meet people where they are, listen to and acknowledge their point of views, needs and hopes. At the same time, workers should try to support their aspirations proving information, access to opportunities and mentoring them through a **tailor-made plan** according to the person's choices, potentials and impairments.

Provision of appropriate levels of care according to the individual's needs, avoiding an oversupply of care and treatment, which poses the risk of long-term dependency, gradual loss of autonomy and empowerment — at the same time, being alert for availability and flexibility in crises and relapses.

Networking is also of vital importance, specifically person-centred networking, which means collaboration among the different services based on the special needs of each person every time. The complexity of the problems that homeless people are facing demands progressive assistance and support from various professionals in social services, health services, etc. So, it is important to facilitate with formal and informal associations and community resources, something that requires a high level of expertise among the professionals as well as flexibility and "thinking out of the box".(see the chapter on networking).

Continuity of care: is the process by which the person and the professional are cooperatively involved in ongoing care management toward the shared goal of high quality, cost-effective care. It also facilitates the services by making early recognition of problems possible. Continuity of care is rooted in a long-term partnership in which the professional (or the team) knows the person's history from experience and can integrate new information and decisions from a whole-person perspective efficiently without extensive investigation or record review. In that way, it reduces fragmentation of care and improves a person's safety and quality of care. Continuity of care is strongly connected with the ongoing follow up, whereas it presupposes the existence of a network. **Mutual self-help groups, peer support specialists, peer-run programs:** groups or programs

implemented by persons who have experienced homelessness and sometimes they have also faced addiction problems or mental illness. Through these groups or programs open dialogue, consultation and in some cases even debate is encouraged. Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. A peer is in a position to offer support by virtue of relevant experience: he or she has "been there, done that" and can relate to others who are now in a similar situation. It commonly refers to an initiative consisting of trained supporters (although peers can provide it without training).

Active citizenship: A wide range of stakeholders should be meaningfully involved in policy development and program implementation, delivery and evaluation. In particular, people who have experienced (or still experiencing) homelessness should be included in decisions that affect them and should be allowed to be active in their communities and be able to use the community resources or other means that reinforce human bonds.

Case

"Red Sin Gravedad": A community action and participation project that has been developed by the following associations: Radio Nikosia, Saräu, ActivaMent and Cooperativa Aixec.

The project consists of the creation of a network of workshops and/or laboratories of art, culture, well-being, etc. in Community Centers of Barcelona that are open to the community, and that are meant to create a natural atmosphere of opportunities among people with and without mental health problems. The origin of the Network is in the need to generate "light" community settings, without diagnostic categories, with the aim of opening real spaces for interaction and participation. For further infor
mation: https://redsingravedad.org/
Social cooperatives of Limited Liability (SCLL)

The Social Cooperatives of Limited Liability (SCLL) are Private Law Entities, with limited liability of their members. They have a commercial nature and can develop any economic activity supporting it by vocational training programs for their members, as well as sheltered laboratories, and supported employment pertaining to the Social Cooperative Enterprises. Economic migrants, refugees and mentally ill individuals are among those groups that are being provided for.

The activities of SCLL aim:

To ensure the viability of the enterprise and the continuous creation of new employment positions;

• To be active in the local open market;
• To maintain a balance between the entrepreneurial strategy and the social aims;
• To fight and eliminate the social stigma, through – among others - the creation of a work;
• To provide continuing education and vocational training to its members with psychosocial problems.

For further information:
http://www.socialfirmseurope.org/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846108/

Checklist:

Ask yourself in every intervention or proposal to a client:

1. Who is this for? Whose interests am I trying to serve? The client's, mine, my service, a third party?
2. Does this add to their recovery, their development, their learning?
3. Is it enabling or is it oppressive? Does it encourage trust and a positive interaction or does it contribute to mistrust and mutual defensiveness?
4. What does it say about power? Is it respectful or forceful? Does it allow choices or is a "take it or leave it" proposal?

Case profile 2

N. was born in 1967 in a Greek island, but when he was two years old, he and his family moved to the USA. He is single with no children. He has a younger brother. His mother died 15 years ago; his father has been remarried and lives in the USA.

N. graduated secondary school and lived in the USA until 2014. After his mother's death, with whom he was very close, he started behaving deceptively. He wanted to become rich and independent, as he thought that if his family had money his mother wouldn't have died. But soon afterwards he was arrested for drug possession and use and was sentenced for four years. When he came out of prison he tried to find a job in his uncle's restaurant but he was not paid enough, and he quitted. He started doing illegal things again, and consequently, he passed another six years in prison for carjacking and undeclared labour. When he was released, he was expelled from the country as he had no American citizenship. He didn't inform his father or his brother about that because he was embarrassed and this is how he ended in Greece, sleeping in the streets.

N. visited the Day Center for Homeless (D.C.f.H.) of NGO PRAKSIS in Piraeus in June 2015 for the first time, and his initial request was the use of sanitation services (shower and clothes). At that time he was sleeping at a shelter of UNESCO. He was also under legal advisory and support by an NGO for ex-prisoners named "Epanodos" (=Comeback).

While he was a beneficiary in the Day Center for Homeless of the NGO PRAKSIS in Piraeus, he also visited the Day Center for Homeless of the same NGO in Athens, although this is not allowed. When this was discovered he was asked by the social worker in Athens to leave. He got furious, started accusing the staff that they intended to harm him and finally he had a violent outbreak; he hit a beneficiary in the head with a tether and threatened that he would kill them all. He locked himself in an office and took one of the beneficiaries with him as a hostage. As this was not the only violent incident, the staff called the police, and he was taken first to the police station and then for involuntary admission to a psychiatric hospital.
During his hospitalisation, N. mentioned to the doctors that he was brought and left in the borders of Greece by agents of the FBI. He also expressed paranoid thoughts and aggressiveness. Consequently, he was diagnosed with "Severe psychotic syndrome, drug use inclination (sisha and cannabis) and aggressive behaviour-verbal and physical". Since then he has been under medical treatment.

After a few weeks in the psychiatric hospital, N. returned to the hostel of UNESCO under order to be followed up every month. Additionally, he was under the support of Day Center for Homeless of NGO PRAKSIS and PRAKSIS Polyclinic as well. Unfortunately, soon afterwards he had another violent outburst, in the D.C.f.H. in Piraeus.

But this time, with the intervention of the male nurse and the social worker of the Centre he was persuaded to go for voluntary hospitalisation. In the hospital, he admitted that he didn't take his medication. Therefore auditory hallucinations and paranoid thoughts were still troubling him.
Due to his attitude (he had a few violent episodes in the hostel and an unstable behaviour) he was expelled from the hostel of UNESCO and ended up sleeping at the port of Piraeus. Fortunately, he had built a strong relationship of trust with the male nurse of the D.C.f.H. Therefore he accepted

taking his daily dose from the D.C.f.H. and having a follow up by the volunteer psychiatrist of the Center. Also, thanks to the nurse's continuous and genuine interest, N. eventually started feeling safe and expressing himself.

At this point, the D.C.f.H. started cooperating with the association "Society of Social Psychiatry and Mental Health (SSP&MH)" to provide more efficient and integrated services to homeless people with psychosocial problems. Therefore, a psychologist from SSP&MH had a weekly presence in the D.C.f.H.

With this setting, N. started having weekly sessions with the psychologist from SSP&MH (May 2017 until April 2019), aiming at his psychological support, empowerment and guidance. His clinical situation was gradually improved due to a combination of counselling and medication. Therefore, he became less aggressive and paranoid whereas he was more "open" to talk about himself.

Although he didn't visit the Day Center on a regular basis, he was there on time for the session, and he was looking forward to them. He said that it was the only reference point in his life and made him feel resilient. Meanwhile, with the support and guidance of both the psychologist and the social worker, N. got his Tax Registration Number, applied for a social allowance and started earning some money as a street painter.

The route/path to recovery was never easy for him, and there were many times he lost his courage. Those times he used to say: "Prison is better than homelessness. There you could sleep and eat… However, prison affects you physically and mentally. You feel that you are under a sheet and this keeps you "down". You "forget" you have a body".

Meanwhile, N. participated in a street fiesta that was organised by the D.C.f.H. in 2018 under the umbrella of the municipality of Piraeus and during the fiesta he painted in front of the audience. His painting was impressive and was finally bought by the municipality for a relatively high amount, which made him regain his self-confidence and start seeing himself as an artist instead of a homeless and hopeless person.

At present, after many relapses and steps backwards N. has made considerable steps in his life. His social allowance has been approved, and he has found a job in a Social Cooperative as a cleaner. Moreover, with the intervention of the social worker of the D.C.f.H., he was accepted back to Unesco's hostel. The last months he has even made a relationship with a young woman, and he is pleased about that. He, therefore, is trying to save money to make his dream come true; To rent his apartment, as according to him: "The most valuable thing in life is to have a key and open the door of your own home… In a different case, you feel "lost". Everything seems to be in vain".

N. is considered to be a vivid example for the successful recovery of a person when there is effective collaboration among the professionals, person-centred approach, tailor-made plan and above all the strong will of the person to change his fate.

Questions

-        What strengths and risk factors do you identify in this client?

-        What were the critical moments in the recovery process?
-        What professional interventions added, or not, to the recovery process?

Two outreach practices :

Project UDENFOR   does outreach work on the local and regional plan in Copenhagen and other parts of Denmark in the following fields: homelessness, drug abuse and mentally ill people together with other marginalised groups in Denmark. It is a non-profit organisation registered in the City of Copenhagen, Denmark in 1999.

Our objectives are :

• an improvement in the conditions of the socially rejected in our society by identifying and documenting factors which result in social rejection in order to prevent any further effects. her of (delete)
• to spread knowledge of such factors and spreading knowledge of preventing people from being rejected and ways improving conditions for those already rejected.
• to develop new methods for working with severely excluded persons.
• to try directly, through practical work to improve the conditions of the people already socially rejected.

The activities of Project UDENFOR shall reflect the view that there have always been many different approaches by professionals depending on their educational and professional background.

Infirmiers de rue (Street nurses).

• A medical non-profit working on outreach to and rehousing of the most vulnerable homeless people of the streets of Brussels.
• The organisation has developed a specific approach based mainly on hygiene, medical care, and the valuing of the resources and the talent of people.
• Teams of two nurses, go in the street to meet homeless people, raise awareness of the importance of hygiene for well-being and inclusion, and help them, step by step, in the process to recover good health and self-care.
• At the same time, they respond to demands around medical care, treating people on the spot when needed, but trying as much as possible to bring them back to « normal » medical structures, and helping them to get enough confidence to get back by themselves.
• During their contacts with the people, a lot of attention is paid to actively discover their talents, resources and wishes, in order to promote self-esteem.
• Training is given regularly to professionals, around the importance to work on health and self-care, how to speak about it, and how to do it. Basically, the training aim at having the professionals see health as a useful tool, in their work, rather than as an obstacle.

Outreach

Introduction

Institutions and associations have, for centuries, offered basic help – food, shelter, clothing - to people living on the streets. But, in the past, such poverty was seen as an unavoidable condition of life. Homeless people were seen as unfortunate examples of extreme but individual poverty, not as the consequence of specific deficits in health or social provision.

Today, poverty is increasing everywhere in Europe. More than 22.5% of the European population is at risk of poverty or social exclusion (Eurostat 2018), and more than 4 million European citizens are homeless (FEANTSA estimation). Homelessness has become a political priority, even if only at the level of rhetoric rather than concrete actions which require the allocation of specific resources.

Studies in England, Germany and other EU countries have demonstrated the excessive prevalence of mental disorders in homeless people.

Apart from the increasing numbers of people affected by homelessness and mental illness, there are major problems for such people in accessing appropriate services. These can be administrative, a result of mental illness, or arise from personal experiences of helping services.
Outreach initiatives in the past were focused on providing for basic needs, distributing food and blankets to those living on the streets. Such volunteers had often had no specific training in the social or health sector, just a desire to make themselves useful. However, faced with the particular challenges faced in doing this sort of work, during the 1980s many of these organisations reorganised and offered a range of increasingly professional and skilled services – sometimes within NGOs but also existing health, housing and social services.

Originally it was thought that such services could significantly impact the number of homeless people on the street (1) – and for a while, they did. The principles of outreach have also been found to be effective with people who have a home to live in but are « cut off » from other people, for whatever reason. However, the era of austerity has fostered the recent increases in homelessness. So, instead of becoming less necessary, such services have become more essential than ever. Hence the importance of this Erasmus project – to enhance the skills and experiences of people engaged in providing service to homeless people.

The following proposals are grounded in practical experience and intended to clarify the skills and practices needed to meet homeless people, to hear their voices, and to understand their situation – so that they can, as much as possible, gain access to their fundamental rights - to social and health services, to a home, and to the support to live there.

Outreach Description

The idea of Outreach is used to describe programmes and schemes that locate people who need help or advice, rather than waiting for those people to come and ask for help. (Dictionary Collins)

Bringing medical or other services to people at home or to where they spend time
(Dict. Cambridge)

It is to **provide services** to any group of people **who might not otherwise have access to those services.** Such services go to meet those in need of their services where they are, rather than expecting them to come to an office or clinic. (Wikipedia encyclopaedia)

Outreach is more than a specific pillar in our scheme – it is the common element that links the other service pillars and creates a pathway from exclusion on the streets to social inclusion and connection with health and social services.

Different definitions of outreach share some ideas:

1. **To find, to meet, and engage with people** who need help
2. **To identify and provide assistance** for basic needs.
3. **To build bridges** with social & health services to facilitate both access to services and continuing contact with them.

It's not easy to find an exact literal translation of the word 'outreach' in other languages. For example, in French, we find 'aller vers'… (to tend towards) and 'aller à la rencontre' (to go meeting).

In the past, outreach initiatives were focused on providing for basic needs, such as the distribution of food and blankets. The new element in outreach is the involvement of those with professional skills and specialist knowledge – doctors, nurse, psychologists, social workers – going out beyond their usual professional setting to meet people where they are.

Main Ideas

a.   **Outreach is an attitude:** More than a method, and it requires that the practitioner is:

* **Open**
* **Attentive**
* **Accessible**

to people who do not have access to health and social services.

b.   **A good outreach service is:**

* Offered where the person lives or spends their time - streets, shelters, squats, the home - whether or not the location is familiar to, or comfortable for, the worker.
* Offered if accessibility is a problem.
* Open to the client, without any request necessary from the client.
* Open to the client, without needing a referral from any other service.
* Informal, offered within the context of a personal relationship.
* The worker's position is more alongside the client, rather than looking at the client — a non-hierarchical and relationship-based approach.
* Partnership based, where the client and service work together.
* Normal - outreach work is seen as an integral part of work rather than as an exception.
* Accessible - this is seen as more important than specialisation.
* The first priority is to establish a person-to-person helping relationship – and where time and resources are allocated for this.
* Offered purely for the benefit of the patient, to facilitate their progress towards social inclusion - not to satisfy political or bureaucratic aims.
* Respectful of the client's dignity, their right to be different, their right to be heard, of their space and their time.
* Able to consider all possibilities, both in terms of the individual, but also in terms of other significant actors and service providers.

c.   **Changing practice to an outreach model**

We, as service providers, are used to predictable, organised (perhaps comfortable) environments that, in some sense, we feel we "own". However, effective outreach work takes place in less-planned, more spontaneous ways in other people's space.
Greater emphasis is placed on establishing a helpful relationship with a client than on making a diagnosis or gathering information.

Outreach work requires that a worker can listen to a person's concerns, be attentive to their body language, be flexible enough to accommodate their feelings and desires and can respect their voice before acting.

This is characteristic of good mental health practice anywhere but can make extra demands in less conventional, less private and (possibly) more hazardous surroundings such as the street.

Homeless people tend to have needs in multiple domains at a single point of time, which reinforce each other – so no one service can act effectively. This applies to all homeless people who live on the street. So, collaboration and coordination are absolutely essential for an outreach model to work effectively. In order to avoid competition between services, or clients "falling between" services, this needs to be mandated at managerial level by service providers.

Social and Health Outreach

A.   Phases of outreach work:

Identification of a person in need:

You, or a member of your outreach team, may see someone on the street who seems to need assistance. But you may equally be told about such a person by a family member, the police, private persons, or a shopkeeper in the neighbourhood.

Establishing contact:

Introduce yourself – as yourself, saying who you are and why you are there and asking permission to talk to the person. You can then sit down with them and start to work out how much they are willing to talk – if at all.

It may be that you don't need to talk much at first but can just spend time with the person, perhaps over a coffee or a cigarette, allowing both of you to become comfortable with the other. If he or she tells you that they don't want to talk, or moves away, just try another day again, don't take it personally. It can take some time, and it can be lonely to work on your own with clients. Working in pairs has some advantages, but can be perceived as threatening by a homeless person.

You may want to establish informal contacts with other people involved with the client, perhaps even their family.

Clarification: Getting to know the person

Meeting someone several times, even if only for a short time, can create the basis for establishing trust and mutual understanding.

These meetings can be as short as your client wants, on a bench, in a park, in a café. You can sit together and chat or smoke a cigarette and drink a cup of coffee. After some time, you can clarify what kind of help the person needs.

This can elicit conflicting thoughts and feelings in the worker. Any homeless person with severe mental illness will want to live as good a life as possible, even given their difficult circumstances. It may seem, sometimes, that this way of life has been freely chosen, and so one does not want to interfere. But, at the same time, we know that a person can be trapped in their homelessness by symptoms of mental disorder.

Interventions: Establishing the right form of help

This can start with an offer of the simplest form of help that will be accepted. This will often be practical, such as supplying clothing, food, or a sleeping bag. Or it could be a physical health problem, where a worker can offer simple treatment for skin sores.

Gradually, more substantial issues can be addressed, such as obtaining welfare payments, a health insurance card obtained, or housing applied for.

If mental health problems are evident, these can now be discussed. You can ask for permission to contact the welfare office, psychiatric hospital, family, or other help organisations. A comprehensive plan can be made, preferably involving both the individual concerned and the responsible institutions and organisations.

Support: maintaining support and contact

As the person comes off the street and moves into more settled and appropriate accommodation, their support needs will change.
The conditions of deficit or conflict that first contributed to social exclusion can easily happen again – and need to be addressed, if possible. It's important to maintain contact to ensure early intervention if problems should arise.

Conclusion:

The art of ending the helping relationship at the right time. This needs to take account of the fact that the relationship with the client may be the only substantial relationship they have had in many years. So, the ending of contact with the client needs to be planned well-ahead, giving the client time to get used to the idea, to grieve (perhaps) and to adjust to their new situation.
A good ending can help to ensure that what has been gained from this contact and work will not be lost.
Contact may, for some, need to continue at a lower level of intensity for many years. For example, in the form of visits a couple of times a year or the possibility to contact the team by telephone.
The team should try to slowly phase out support and interventions while others take over.

B.   Roles of healthcare workers in street work:

All those working with people on the street must be aware of the principles of outreach work and engagement, and be familiar with the practical ways of developing a positive, helping relationship with a client.

Nurses:

- Can work directly with a person's hygiene, care, motivation, evaluation of any medical problems, assessment of capacity and vulnerability.
- Can work as intermediaries between the person and medical staff (hospital, GP- medical doctor), particularly to clarify/translate medical language" for the patient.
- Can support follow-up treatments and medical appointments, by both accompanying and by helping to negotiate bureaucratic processes.
- Will meet with the person regularly.

Mental health nurses:

- Will meet the person regularly
- In addition to the role of generalist nurses, MH nurses work in a specialist role with people experiencing and/or affected by mental disorder, in whatever setting they may be (street, shelter, etc.)
- Bridge-building for health care services through the mutual trust relationship established with the person
- The guidelines are to follow the person's demands, desires and needs (with no preconceived objectives and no time limit), using a proactive approach and trying to deliver holistic attention and sense of dignity.

Medical doctor (GP): Will meet the person on the street, to:

- Enhance the person's engagement with the whole service
- To break down any barriers of mistrust that exist due to previous bad experiences with medical services.
- Give clinical advice in non-urgent cases.

Psychiatrist: Will meet the person on the street to:

- Enhance the person's engagement with the whole service.
- Establish a psychiatric diagnosis and formulation.
- Provide non-urgent and urgent (compulsory) interventions, where possible.
- Facilitate access to psychiatric resources, whether in hospital or not.

Psychologist: Will meet the person on the street to:
- Help to establish a working relationship with the patient.
- To establish a psychological diagnosis and formulation
- Support and advise the team in the psychological aspects of their daily work with the patient.

Social workers: Like nurses, will often function as case coordinators and will see the person regularly to:
- Provide social work interventions
- Facilitate access to healthcare and social services.

Issues to address in re-housing:
- To be proactive in maintaining contact with clients.
- To be aware of the paradoxical dangers of moving into fixed accommodation – e.g., lower levels of activity can make thrombosis more likely.

Increased risk of overdoses (alcohol or other drugs) because of:
- The ability to stock drugs or alcohol.
- Increased privacy (desirable in most senses) making overdoses less visible, and so reducing the possibility of intervention.

Loneliness at home.

To create, inform and support a network of health professionals from the "normal system" that are able to follow these patients and provide both continuing and urgent help when needed.

Difficulties

In relation to homeless people:

a.   **Fire-fighting:** It is common for services to focus on immediate and urgent need, without tackling underlying issues. The danger is that the homeless person merely becomes dependent on the service, without any change in their underlying situation.
b.   **Repeated s**ocial or health emergencies without any resolution of the underlying causes for the individual.
c.   **Refusal of service** by people sleeping in the street - even a refusal to meet or to speak.
d.   **"Urban hygiene":** Interventions, usually by police or cleaning services, to remove homeless people from certain areas without improving their predicament.
e.   **Widespread fear and distrust** (of homeless people) towards those in any kind of authority.

In relation to workers :

a.   **Discouragement:** In spite of great efforts, the homeless person disappears or dies.
b.   **Institutional barriers to access:** - clinic opening hours, physical accessibility etc.
c.   **Competition and individualism of NGOs and statutory services:** tendering culture discourages collaboration and encourages organisational self-aggrandisement
d.   **Lack of reciprocity** in giving and receiving.
e.   **Time, urgency and lack of resources** limit options for more permanent solutions.
f.   **The stigmatisation of homeless people on the street:** they can be seen as unhelpable – or as not deserving of help.

B.   Co-working and Coordination:

Networking and cooperation are essential, both at an organisational level and in each individual case. Unfortunately, funding is organised in such a way that agencies that should be working together are, instead, competing with each other.

<div align="center">

Competition   Collaboration   Coordination

</div>

Competition

This is the "natural" state of organisations, competing for funding and customers/clients. It can lead to improvements in standards, particularly where professional standards are involved. However, most of the issues surrounding homelessness are not susceptible to effective intervention by one organisation or team, and so competition has the potential to limit the effectiveness of help given by excluding other, potentially helpful, sources of assistance.

Collaboration

Collaboration is the most rational response to complex problems, such as those generated by homelessness and mental illness. Ideally, a collaboration between two or more entities (people,

departments, associations, institutions) both public and private, will produce joint working which can achieve results that individual agencies would be unable to accomplish on their own.

Good collaboration produces better quality, facilitates project execution, improves team efficiency, creates better work environments, and makes organisations grow.

By collaborating, people share skills, knowledge, talent, information and resources to achieve a common goal.

Given that collaboration will go against normal organisational instincts, it cannot be assumed to be happening. It needs to be formally acknowledged and valued at the highest level in any organisation. Collaboration needs to be planned, well-structured and monitored – and focused on results.

Coordination

Coordinating the actions of different agencies can focus attention, avoid needless duplication of effort, and achieve complementarity. It allows the deployment of diverse approaches to a common problem.

Good Practices

Specific outreach practices

Phases of outreach

1.   **Preparation** (prior to meeting with someone on the street)

•   The collection of as much information as possible before planning any intervention or first contact.
•   The use of a multidisciplinary team composed of (at least) a coordinator, health and social workers, with both salaried & volunteer workers.
•   To plan a "program" of interventions.
•   To assign the ' case ' to a member of the team who will take continuing responsibility for the person concerned. It can be helpful to have two people allocated in this way, to allow for sickness, leave etc.

2.   **Planning the first meeting on the street:**

•   A meeting should be held to assess risks, opportunities and the objective of the proposed meeting with a potential client.

3.   Continuing recovery: Regular meetings to monitor and plan the progress of social and/or health reintegration.

Good practices in outreach work

Time: One may need to manage time differently from that used when working within more structured systems. In more formal systems you may be able to plan to get a job done within a specific time, to make and keep appointments, and "use" time optimally (or, in the eyes of the organisation, "efficiently". In outreach work on the street, time is far less under your control – most often, the needs of the person will determine how long a particular task or intervention will take.

Patience: It can take weeks and months to get close to another person - quick results can be achieved, but usually take a while. Again, it is important to make any timetable contingent on your client's needs and, as far as possible, let the other person decide the tempo. A rejection does not need to be a rejection – if you can wait and allow the person to establish trust with you over time.

Recognise and respect the client's needs and desires.

Trust/credibility: must be earned. It is not enough to work on the streets with good intentions alone. People living in the streets have met many well-meaning people in their lives – in institutions, from social work departments, NGOs, etc. – and yet, they are still on the street.
For someone who has suffered a great loss the process of developing trust in others can take a much longer time than in mainstream health or social work. You need to demonstrate that you are

punctual, reliable, honest, can act effectively and that you are a safe person to be with.

Timing: The right time to make contact is when the homeless person wishes it; the right time to apply for a pension is when the person wants it. One must have provisional plans, but these need to be adjusted according to the ability of the client to tolerate them – one often needs to wait until the client is ready.

Resilience: You may have to do uncomfortable things – such as approaching, several times, a person who rejects your attempts to establish contact with them.

Reject hierarchy: To lay aside any professional status and to relate to the client, first and foremost, as a person, to create as equal a relationship as is possible.

Curiosity: Be curious, genuinely want to understand another person's world.

Team working: Roles and functions are clear, but workers are flexible enough to share assignments and to work beyond their roles where necessary.

Supervision: Street work is demanding. It can be lonely, and it can easily leave the worker without the collegial support that is usually part of working together. Therefore, no street-level project carrying out work with homeless mentally ill people living on the street should be without a well-organised structure for regular supervision.

Case

Context: This happened during a winter period of municipal emergency cold alert (November-March). This increases the number of night beds available for homeless people, and the number of mobile units for street outreach.

Report: The urban police reported to the municipality's social service the presence of a woman of a certain age and under ' pitiful ' conditions, who rejected any form of contact and dialogue

Mobile Unit : **The Coop Soc X mobile unit, composed of a volunteer (driver), social worker and** educator, was sent to evaluate the situation,

First meeting: The social assistant discreetly tried to establish a contact, a few words. The woman was in a visible state of self-neglect, with an infected leg wound. She refused to talk, did not acknowledge their greeting and gave no reply to any questions. She did not respond to the offer of a hot drink, so it was just left next to her. The team said good night and that they would come again tomorrow.

Evaluation and brief report

Observations from this first contact suggested that her predicament needed to be dealt with urgently. She was without money or appropriate clothing or accommodation, she was in poor health and not receiving proper treatment (leg infection), she had not been able to keep herself clean and was not equipped to be sleeping out on a cold night. This information was shared with other night services that operated mainly in the central station, an area frequented by the homeless.

Team meeting at the shelter, with the participation of a physician. The case was classified as urgent and was allocated to the social worker. The immediate objective was agreed to be to create enough of a relationship with this lady to try to convince her to come off the street and accept treatment for her leg.

Plan: A frequency for subsequent meetings was proposed, to enable the social worker to gain the trust of the lady, and hopefully to help her to accept dressings for her leg from the hostel infirmary, to avoid gangrene and possible amputation.

Results & Synthesis: After the next meeting she accepted dressings from the hostel infirmary – and then stayed to sleep in a chair. She then moved to a four-bedded room – and, ironically, complained that the other guests weren't clean enough.

So, in spite of her original indifference to the outreach team at their first meeting with her, the lady was subsequently able to accept medical treatment for her leg and accommodation in the hostel after roughly ten weekly visits.

Conclusion The primary process of outreach and engagement – meeting, listening, taking care, providing basic help (the hot drink) – enabled an alienated woman to re-engage with helping services.

Questions:
- What strengths and risk factors do you identify in the intervention described?
- What could be the critical moments in the process?
- Starting from your experience can you imagine a different intervention? If yes can you describe it?

Networking

Introduction

To be homeless, in most cases, means to have multiple needs that require multiple answers to be coordinated and that can hardly be met by a single agency: housing, bureaucratic, working needs, physical or mental health problems.

Furthermore, the way most of the homeless persons ask for help is not usually direct and explicit: very often the necessities emerge because the person "breaks" the fragile balance between the social context and his exigencies.

It is significant that third parties mainly convey the help's requests: ordinary citizens, volunteers, social operators, and police officers.

Being urgent and not specific are therefore two additional characteristics of such requests, although the need that is detected in immediacy is usually of a health nature or to defend the public peace.

Complexity

We may refer to a typical experience to highlight the complexity of the phenomenon: a citizen sees a person with characteristics easily attributable to a homeless (particular neglect, lack of hygiene, rough clothing, presence of backpacks, bags, cartons) in a severe physical difficulty, probably even in a state of chronic alcoholism or in a state of mental alteration, such as to determine disturbing, dangerous or disruptive behaviours.

In such a case, the first institution involved is usually the health care system, which, once resolved the emergency (mostly a state of poisoning or a psychiatric acuity) tends to avoid, for several reasons, a more comprehensive sanitary takeover of the person.

One of the reason may be represented by the lack of a further level of care in case of a hospitalization, consisting of a response to basic needs: clothing, changing of linens, toiletries, as well as company, encouragement and support, is usually supported by relatives, are missing or absolved in a discontinuous and not exhaustive way by the most various figures (nursing, medical, volunteer).

In addition to the issues strictly related to healthcare, this is often interfered by bureaucratic and administrative irregularities, a phenomenon that is increasingly present as a result of the large migratory flows affecting Europe in recent years: migrants, in fact, compose a significant part of this population.

Going back to the example, suppose that instead of calling for a health emergency to assist the person in trouble, the Social Services were directly involved: in the luckiest case, they will provide a more or less temporary shelter to the person until his recovery, in compliance with the legal requirements and the legal status of the person.

Rarely, however, the matter is exhausted through a solution of the housing order: it is very likely that the same reasons that led to the call, will occur again in the short time and that the situation will be repeated in a vicious circle that makes the failure of interventions an element of deep frustration for the person in need and for those who are in charge .

Actors involved

As seen in the previous paragraph, in a typical situation of an intervention for a homeless person, we may need to refer to the following agencies:

- healthcare workers
- municipal police
- law enforcement
- social workers
- embassies
- volunteers

 It is interesting to underline that none of these actors is the only and directly responsible for the situation and each of them are therefore in the position to delegate towards other institutions.
For all the above, in some European realities, it has come to the constitutions of networking, that is, of meta-organizations including all the formal and non-formal institutions, which in various ways deal with this phenomenon.

Networking as a multi-layered approach

Networking is a "process which fosters the exchanges of information, ideas and practices among

Individuals or groups that share a common interest" (https://www.investopedia.com/terms/n/networking.asp).

Networking, in our case, means to optimise resources and competencies and to avoid contradictory or overlapping interventions.

Creating a network may allow to build a better diagnosis of the problem and to design the intervention and share it at the presence of all the involved entities; to organize the intervention in a procedural and organic manner granting the continuity of care; to overcome each institutional limitation and the different timing between organizations; to take part in the difficulties, not feeling to be solely responsible or, even worse, getting out and avoiding any responsibility.

Structural and operative networking

Talking about a network implies to contemplate two different levels, strictly interrelated: the structural and the operative.

We indicate with structural, the entire range of the organisation participating in a network in an explicit and agreed way. The network may be constituted in this case both by formal and informal institutions, governmental and non – governmental, public and private.

We define operative, the network strictly constituted by the persons, belonging to the different organisation represented by the structural network, directly involved in the specific case management: a front-line level, that designs tailored intervention and follows the process, case by case, on the field.

As said, these two levels should be interrelated, which means that in a certain way, the operative level should be a kind of output of the structural one, the concrete expression of the values and projects shared by the parties.

Reasons for networking:

A.   Reasons related to the patient:

The principal reason is that the person is not in a situation, for various reasons, of being himself in charge of making its network and going to one place to another. The person needs someone else to make the connection between the different actors, that are necessary to help him and respond to his needs, to transmit information, to coordinate, to refer him, to accompany him, as long as the patient is not able to do that himself.

Additionally, a very good reason is that the patient needs to have access to different people or institutions, in order to recreate its own, personal network.

B. Context reasons:

- Patients have multiple needs that no institution can respond to alone (general medical, specialised medical, social, psychological, practical, housing, educational, …)
- From the beginning of the care, patients need support at multiple different times, and will need it for a very long period: you cannot bear that alone
- The situation of the person is often very hard, difficult, complicated, sometimes critical, so it's good that several institutions share the burden of those difficulties and persons.
- The recovery of these patients takes a very long time. Therefore, it's crucial that several institutions support that process together.
- The different institutions have to make an effort to be able to work together without doing two times the work (complementarity), without doing contradictory work (coherence) and ensuring that all the needs are covered (sufficiency).

Main Ideas

Main ideas

Networking as an opportunity

To be part of a network should be an opportunity to:

- overcome the feelings of solitude and disqualification that too often are part of these disadvantaged situations,
- become more aware of each other missions, values, languages, skills and difficulties
- feel in turn recognised and appreciated
- leverage over proactive elements even dealing with a complex reality as homelessness
- prevent the defensive occurrences of delegating operations
- reduce the burnout phenomena
- avoid the recurrence and overlapping of interventions (unsuccessful admissions due to lack of planning distribution of essential goods to the same person by several contemporary operators; paperwork being taken and never concluded; impossibility to access to a safety valve for insufficient documentation)

To build a network

To build a network is not a spontaneous process: it underlies willingness and a specific effort and may take a long time and care.

First of all, it is necessary to "detect" the knots of the net, those sharing with us the same "problem".

It is important to know the role of each "player": missions, specific competencies, limitations, inspirational values. To deeply respect the identity and values of each participant, even the "free players", for instance volunteers whose contribution may become really significant but is rendered on chance, for free and out of any structured organization, is the first step of a process that should lead to share common goals and to design appropriate and coordinated tasks.

In this first phase of contacts, the most common feeling may be of fear and suspiciousness: not to be understood or recognised in our efforts or limits; to be those who will receive most of the duties and responsibilities; to lose our decisional power. It is a very delicate moment, in which the aim should be to create the conditions for mutual trust and to build a "win/win" playground.

A "win/win" approach rests on strategies involving: going back to underlying needs; recognition of individual differences; openness to adapting one's position in the light of shared information and attitudes; attacking the problem, not the people. Where both people win, both are tied to the solution: they feel committed to the plan because it actually suits them.

A. **Networking inside the institution:**

It's not always evident, but inside the institution, it's sometimes difficult to network while it is

necessary, and generally for the same reasons as outside. For example, in a hospital, you need different competencies, and different exams and further on. In medical practice, you can have various competencies which should work together, but they don't always do it, or do it in a very fragmentary way.

Several skills contribute to the ability to network and work together in the same institution:

1. Speaking together:

This implies a place - there must be a place where meetings and discussions can take place; it can not only be in the corridors. And possibility- there must be a possibility, as a rule, for the people of different competencies, to speak to each other; it must be something normal, not an extraordinary initiative taken by an individual (example: nurses or social assistant should be able to ask a doctor to speak about a patient). Also respect- there should be total respect and confidence between the different competencies that they are a part of the solution and that their view on the patient's situation is legitimate.

2. Establishing common objectives towards the client:

This means that both parties can agree implicitly or explicitly on objectives. These objectives are both general (« for the patients in our service we expect to reach that or that ») and very specific (« for this patient, we agree that we should aim specifically at that, but renounce at this moment, on that »).

Sometimes we can hold objectives for the patient if he is unclear about his goals until he reaches a point where he has more clear ideas about agreeing or not with us.

3. Sharing information:

There is a need to share information, the necessary information, which doesn't mean all the information. It means the information required for each competency to act accurately towards the patient.

4. Patience together:

All professionals have to agree on what time they are ready to spend and to wait on the resolution on the case. This also allows to work on a relay-mode: when one competency or person is out of patience another can take over for a while.

5. Complementarity:

 Collaboration works better when it is very clear for all the parties what complementarity there is between them.

6. Leader or case manager:

 There is better collaboration and progress when there is someone who takes responsibility for the

advancement of the case

Networking between institutions:

Networking outside an institution is more evident but probably more difficult and time-consuming. It is an everyday task, takes time and energy, confronts the workers with competition, misunderstanding and prejudice.

Institutions should be aware of the advantage it is to take this task seriously and explicitly inside there day-by-day working. To have a person in the team specifically responsible for networking helps the institution to devote enough time and resources to this task, and will be time-saving at certain points.

Helping factors in networking and working together with other institutions:

1.Good information about possibilities: knowing what partners can do what, where they are, when they work and how to contact them. It can take a long time before to know exactly all the possibilities of the network.

2. Ability to share information: there must be an agreement about what information can be shared or not, or will be shared or not, especially because we speak of dealing with an external organisation. Often there is a meeting needed to clarify that. It should also be remembered to always share only the necessary information.

3 Clear view of everyone's job: it must be clear for everyone involved in the partnership what is it's task and contribution to the care to the patient.

4. Shared objective: it's easier to coordinate efforts and actions if the specific objective is shared (e. g. to get the person followed by a doctor).

5. Win-win operation: it is an ideal situation when both services have a (different) interest in the collaboration. This happens specifically when there is clear complementarity between the services. A "win/win" approach rests on strategies involving: going back to underlying needs; recognition of individual differences; openness to adapting one's position in the light of shared information and attitudes; attacking the problem, not the people. Where both institutions win, both are tied to the solution: they feel committed to the plan because it actually suits them.

Difficulties

Networking as a problem

Several issues can undermine the set-up of the proper functioning of a network.
Different values, cultures and languages between different professionals or roles, may represent a barrier in terms of sharing a goal or in the way this is reached.

To be a public organisation or a private, as well as to be an official or unofficial one, can raise the feeling of a power imbalance between the institutions and threaten the identity of the parties.
In some cases, it may occur that the persons representing the organisation to which they belong to, do not have any decision making power, a condition that could weaken the specific role or function.

The number of participants too can represent a problem: being "too many on the boat", may affect the decisional and operational processes, creating the condition for a role blurring phenomenon.

A poor communication flow, a fragmentation or a lack of information, the absence of coordination between operators, may seriously affect the continuity even of a good plan, but especially of the long-term ones.

Another issue often disturbing the positive functionality of a network is the tendency to convert the role of the "facilitator" of the meta-organization, into a "coordinator" as the only responsible for the integration of the entire process, the only entitled to take decisions or, even worse, the only responsible for the outcome.

On the other hand, the lack of a "case manager", that should be not the first and last responsible for the person in charge, but the facilitator of a fluent process may cause the collapse of the project, whenever any difficulty is encountered, due to a discharge of responsibility.

In some cases, the gap between the so said "structural" level and the "operative", may become an obstacle to the agility of the process and the good results of the outcome. The structural level should be a frame, that grants the awareness to be in the position to overcome limits otherwise insurmountable, thanks to the presence of other institutions. Whenever the structural network prevails through requests of bureaucratic commitments, power struggles, lack of a co-working culture, lack of a common training, this may become a severe threat to the whole functioning of the net, in particular may affect the operative level whose main duty will become to be a function of the structural level, instead of being an efficient enactment.

Last not least in a list that might be longer due to the complexity of the subject, is the handling of all is related to the personal data protection (General Data Protection Regulation, UE 2016/679) a complex matter to manage, being many the agencies involved and the data shared between different professional figures and agencies.

Preventing difficulties

Building a network, as seen, is a process that foresees several steps.
The mutual knowledge of the parties, as a first step, not only is a necessary, but is also a very delicate phase: it is mainly about building relationship and any initiative that has to do with the promotion of social situation, is highly recommended in order to meet and better know each other, even in an informal way.

Especially for what concerns the so said "operative networks" it will be a must to plan meetings with the attendance of all the parties, to organise the activities and be debriefed on the developments of the different cases. A detailed follow up of the activities is also necessary, in order to check achievements, monitor results, share difficulties and implement recovery plans.
It may happen to have "extra – meeting", due to the urgencies that arise dealing with human "material": to be flexible is always a good way to cope with difficulties and complexity.

A good communication, based on shared Information is the basis of the network functioning: not only to provide the updates on every single case that the network is caring for but also to have common access to the information and the resources shared in the net.

Communication and commitment should follow the top - down and bottom – up way, and this is also why it is necessary that the persons in charge for each organisation, should have the decision-making power of the institutions they represent and feel in a peer to peer condition.
It is a good practice to agree on a Memorandum of Understanding, which should not sound like a strict and mandatory contract, but as document fine-tuning each entity, duty and responsibility.
The more the mutual understanding develops, the more will become a necessity to make experience of joint training, which means for instance to visit the places in which each member of the networks and operates: on the street for nurses, doctors, social workers; in some "war room" for the coordinators of the outreach team; in hospital wards or clinics; inside the houses of our clients; in some soup kitchen or shower service; in some government office, etc. etc.
To experience in real life and real time the way the other partners work and the problems they have to deal with daily increases the mutual understanding and tolerance and improves the esprit de corps.

In the light of the above, once the network is well structured, and that suspicion of subjugation or dominance by any party have been dispelled, and mutual trust is acquired, to provide a common training could strengthen the links and the mentality of the group.

To share a common space, in which contacts and communication may happen in a fast way, and the intervention may follow in an easier way the possibility to be tailored for the person in need, may be a big challenge for many European realities, but a good solution for many reasons.

Good Practices

Suggestions:

- **Feed-back,** when the patient gets better, feedback given to the partner can motivate him to continue the collaboration for other cases.
- **Concessions** are often necessary to facilitate collaboration, but still: good collaboration works on equality between partners.
- **Responsibility:** each partner should feel totally in charge and responsible for his part, and also for final success.
- **Coordination** of the care is a service provided to all partners, not a way to control the situation.
- **Necessary information** and only necessary information should be shared
- **Confidence:** a reasonable level of confidence between partners is necessary.
- **Win-win situation:** maximises the involvement of each partner.
- **Presentation:** it is useful to take time take by the different services to present themselves to the different partners in a particular situation.

Who to involve:

A good collaboration with a few services is probably preferable to a large number of nearly unknown partners, but:

- **a certain amount of partners are needed,** because of the risk of saturating one service with the most difficult cases.
- **diversity is needed** because the same solution will not be fitted for all patients.
- **new ways, new services are to be explored continuously.**

Case

A concrete example: NPISA in Lisbon

The idea of NPISA (Núcleo de Planeamento e Intervenção com Pessoas Sem-Abrigo) was made explicit in the National Strategy for the Homeless published in 2009 by the Social Security Ministry. With this document as a guide, several NPISAS were created in different regions of the country. The NPISA of Lisbon was created in 2015. It took several years of preparation, requiring the will of the Municipality of Lisbon, Santa Casa da Misericórdia de Lisboa and Social Security, together with NGO's and associations working with the homeless in the city.

 NPISA has a building where all the organizations are represented and where the homeless can be assessed. The work of outreach teams from different associations was organised and planned in an articulated way: attribution of territories, responsibilities, case managers. There is also a sharing of information and resources.

The person who addresses to its social services is welcomed and listened to, by a social worker and a psychologist simultaneously. Starting with this meeting, an agreed and shared plan for caring corresponding to the needs takes shape, whether these needs are of a physical, psychic, housing, or working nature. The recovery process is supported by all the partners of the network according to the individual's needs and is facilitated by the partners being able to communicate directly and plan their interventions together.

By doing so the operational times and costs are enormously reduced, as well as the bureaucratic obstacles: it is evident that the opportunity to draw up an assistance through the establishment of a network shall then determine effectiveness or even success to a large extent and makes the eventual failure more tolerable as it becomes less frequent and widely shared.

CASE PROFILE

Filipe was a 40-year-old, tall, black, homeless man that had been living in the street for years in the neighbourhood where he had grown up and where his sister and brother were still living in the family house. His parents had passed away. The sister was the only functional member of the family. She was a physical therapist (their father had been a practice nurse), and single-headed took care of a teenage son and two brothers, Filipe and another brother that had been unemployed for years. While Filipe refused to go home and slept on the streets, his brother refused to go out and had closed himself in his room for years.

Filipe was a big concern for all the community of the neighbourhood. He drank heavily and was so careless with himself that was often seen defecating while walking! He was later on diagnosed a long term course of schizophrenia, with significant deterioration.

The staff working at the psychiatric hospital, that was used to have regular meetings (every 2 weeks) to discuss difficult situations with particular concern for the homeless with mental health problems, first heard about him through an outreach team belonging to the city council and

therefore started to visit, on a regular basis, also this family.

Also, a local church group was very much involved in the case and tried to help Felipe and his family. They called for the city outreach team which eventually also asked us to evaluate Filipe's brother since nobody understood why he was isolated at home. So our team, a psychiatrist and a psychologist, paid a visit to their home. We had the chance to talk to his sister and Filipe' s brother. He was also an impressive tall man (he had worked as security), although he talked to us while lying down in the bed. His room exhaled a strong smell, and he talked very little as he was evidently suspicious and tense. His sister told us he refused to eat any of her food and didn't take a bath for a long time. We got out of this visit with a strong suspicion that Filipe's brother was dealing with a psychotic breakdown, and talked with his sister about her options.
Right after this visit, we heard that Filipe had surprisingly accepted to go to sleep in a small nice shelter downtown, with very good conditions and staff. The ladies of the church that had been looking after him for years, together with an outreach team, had managed to persuade him to leave the streets. Everybody was happy and hopeful.

But this joy didn't last for long. After a few days, Filipe became violent at the shelter, breaking a lot of windows. Amid his rabid outburst, he managed to hurt himself, by falling and breaking a leg. He was sent to a big general hospital in the city, where he was taken care of his leg and psychiatrically examined. Within a few days, he was discharged back to the shelter.

The staff of the shelter was quite scared of Filipe coming back so soon after he was admitted to the hospital and felt that the opportunity of giving proper psychiatric care to Filipe was not being used. So the responsibility for the shelter called the head-director of our service, which was also the psychiatrist who had visited Filipe's home. They planned that Filipe would come directly to our service after being discharged from the other hospital. So he did, by taxi!

Filipe stayed as an inpatient in our service for three weeks. During this time he was diagnosed and treated for schizophrenia, exhibiting a very discreet, peaceful behaviour that caused no problems whatsoever at the unit. At the same time, the social services found a nursing home specialised in serious mental health problems. So, when the time came to get out of the hospital, a nice solution had been found. We must say that the costs for this nursing home were a little higher than usual, but the social services managed to obtain special permission to go a little higher than the regular budget because they were conscious that Filipe needed specialised care.
A few weeks later, our team paid him a visit at his nursing home. He was more communicative (in his deficient kind of way), greeted us, and showed us his new home. We found out that his sister was visiting him regularly, and that he was going out daily from the nursing home to the neighbourhood, without trying to escape.

This was a very difficult situation that seemed impossible to change for many years. With the cooperation of several partners (family, local community, outreach team, social services, psychiatric hospital, nursing home) that were able to put together their efforts and expertise, a synergy of actions converged for a final outcome that was much better than previously was thought to be possible.

This case highlights the fecundity of joint action and reflection.

Regular meetings to discuss difficult cases between professionals of the social and mental health sectors can be fruitful and change situations that have been stuck for years.

At the same time, it is important to have the means to intervene and the trust between partners. For example, in this case, the trust that social services would support the patient once he was discharged from the hospital, enable the psychiatric team to open the doors and admit him as an inpatient (without the fear of having no other solution afterwards). Similarly, the social services were not afraid to find unusual and expensive solutions (nursing home) because they trusted that the mental health team would continue to give all the necessary support and felt that this was an adequate solution from the technical point of view.

Five main ideas from the Profile:

1.   Are there impossible cases?

The case presented had been stuck for years in the streets, and a lot of different actors felt helpless to help. This profile suggests that even the apparently impossible cases can be transformed and it is useful to try to research what makes some cases seem impossible to intervene, and what are the factors that open a possibility to a useful intervention.

2.   What seems impossible can become possible by cooperation

This case brought together a diversity of actors, both from the private and public sectors, as well from the social and health fields, that started to work together. This intervention was possible because trust and openness to cooperate had been built. Instead of an attitude "it's your job to do this…", a different attitude was displayed: "if you'll help me here, I will be able to do that". In this case, hospitalisation also enabled social services to find a more adequate solution (nursing home).

3.   It is useful to have regular meetings to discuss difficult cases that bring together professionals from the social and mental health fields.

The regular meetings between an outreach team that belonged to the municipality and a psychiatrist and a psychologist, with experience with outreach for the homeless and working in a psychiatric hospital, proved useful to several difficult situations. From these meetings came out the idea to go and visit Filipe, his sister and brother, and because of this first-hand knowledge, it was much easier later to cooperate for the hospitalisation.

4.   It is critical to evaluate which situations need hospitalisation or mental health consultations, which situations need a good social support that fits the individual needs, or both.

This case highlights the importance of a good evaluation and intervention that takes care of both social and mental health needs.

Hospitalisation opened the possibility to plan and find a better housing solution.

5.   A successful intervention is everyone's success

In the end, everyone involved in the case felt like a winner, and no one felt that success was especially his doing.

Questions

-        What strengths and risk factors do you identify in this client?
-        What were the critical moments in the networking process?
-        What professional interventions added, or not, to the networking process?

Staff Care

Introduction

Working with homeless people can be demanding. It requires a wide range of skills and can be emotionally challenging, as workers are often faced with traumatic situations.

Homeless people, and especially homeless people with mental health problems and/or addictions have multiple needs. They experience not only social exclusion but often also exclusion from services and/or stigma, even from professionals. Front line staff are repeatedly confronted with the suffering and trauma of those who have (often severe) mental health needs and have no home. People with such needs are likely to improve slowly – this can be frustrating for staff and lead to pessimism and less personal investment in the work. In addition, the environment is often unpredictable and somewhat chaotic.

Specialist work with homeless people is often marginalised within mainstream services, leaving specialist staff – and teams - feeling isolated and unsupported, and sometimes stigmatised themselves. These problems are further compounded by the lack of service coordination and networking.

There is an obvious burden, and a sense of continuous pressure, as staff try to meet the multiple needs of homeless people with mental health/addiction problems. This can be compounded by the additional strain of trying to deal with inflexible, fragmented and uncoordinated health and welfare systems. These strains are likely in the short term, to distress staff – who can become distracted and unable to maintain focus on the client's needs. In the longer term, staff can experience burnout, a defensive reaction in which staff can no longer effectively engage in the work.

So, there is a clear need to take care of the staff who work with homeless people.
The purpose of staff training and staff care is to:

•	Increase resilience
•	Maintain – and, hopefully, improve performance
•	Help staff to deal with the stresses and frustration of work.
•	Help staff to maintain a balance between the job and personal quality of life.

Specific objectives:

•	To improve knowledge of the needs of homeless people with multiple and complex needs, including mental health problems and/or addiction or dual diagnosis
•	To develop the various skills necessary for working with homeless people with multiple and complex needs.
•	To facilitate multidisciplinary working and awareness of complementary roles in a team.
•	To foster collaborative networking across services and organisations, trying to overcome the system's gaps

Main Ideas

Training

The importance of the helping relationship and a client-centred approach needs to be built into team functioning; it cannot be assumed.

Training motivates, activates and reinvigorates staff. It should be preventative and not reactionary. Organisations should be able to plan for the future training needs of their staff and put training in place - not train in reaction to a situation which they could have predicted and planned for. This gives staff the tools with which to effectively deal with events and situations before they happen, making them more effective and in control of their work.

Staff training comes in many forms - essentially it can be **formal** or **informal.**

Informal training is casual and incidental, not usually planned. One trains and learns by experience while doing the job.

Training sessions taken by staff members in an organisation might also be considered as informal training - where a staff member, who has strong skills or knows much about a particular area can provide ad-hoc training to co-workers on the job. This form of training can often be effective because it occurs naturally on the job, with real-time examples and solutions to learn from. It also reduces the risk of miscommunication between learner and trainer. But – one needs to confirm that such informal training reflects the values of the organisation.

Formal learning is a set program in which the goals and objectives are defined. It is structured and designed and may result in a formal certificate or qualification for the learner.
Training should be strengths-based, to help staff to develop the skills they already have, building on existing knowledge and abilities. Such an approach acknowledges and affirms the capacity, skills, knowledge and potential of staff members.

Training needs assessments should be carried out to ensure that any training is relevant to staff needs, and the needs of their clients. Work with people with complex needs will demand quite specific skills and tools, so specialist trainers may need to be found. In addition to basic training for all staff, specialised staff should receive targeted training to enable them to address their key responsibilities.

Training should be **checked** against job specifications to ensure that it is relevant.
Rotations between posts can allow staff to experience other ways of doing things.
Experts by experience – people who are or have been homeless and who have experienced mental disorder – should be encouraged to contribute as trainers.

Values and Vision

Team function/goal needs to be clear and explicitly defined. This provides some boundaries and

definition to work.
:
Values Any team should be clear about its values. In work with homeless people, these values include:
- Needs - the focus on the needs of the client as a person. The person is the centre of the team's activity.
- Respect - the client as a person of equal value and interest to anyone else in society. This implies the values of Diversity, Dignity and Equality.
- Optimism and persistence should be core values for the team.

Roles

Staff need to be clear about their roles within an organisation - clarity of role and vision creates more effective organisations.

Team culture

Every member should feel that their knowledge and views are heard and taken seriously.
A "no blame" culture should be encouraged so that problems/mistakes can be shared without penalising the individual worker. Mistakes are excellent learning tools, so should not be treated as failures, but incorporated into a process of active eliminating things that don't work, and developing new, more effective ways of working.

This attitude allows staff to be supported and to learn. Moreover, this is an area where conventional ways of working have been shown to be ineffective. If staff make no mistakes, they may well not be working creatively enough.

Team Function

Space for reflection before decisions are made.

Practical ways of achieving this:

- Planned, regular sessions where staff discuss individuals and their follow-up.
- Both concrete decisions and emotions should be discussed.
- Staff should have enough time to explore the situation thoroughly and to allow any member of the team to express herself and contribute ideas.
- Everybody should be able to give an opinion from their function/role in the team, and all contributions treated as having value.
- A daily morning planning can help to ensure that information about clients is exchanged freely and in a timely fashion.
- Staff should feel free to express their feelings about the work, individual cases – and each other.
- An exploratory style of reflection / "thinking together" is essential to create adequate solutions to the complex problems faced in this environment.
- Regular time/space is needed to allow reflection with other team members about difficult situations or problems.

- A common glossary can facilitate communication between different professions and support a common approach, which is enriched by the different skills, personalities s and professions within the team.
- Clearly-defined tasks, duties, communication system, support system, roles and limits, obligations and rights.

Difficulties

Limited resources, time or even a place to train- organisations which provide services to homeless people are usually under-financed and under-resourced. To provide the necessary level of staff support and staff training is often outside the reach of such organisations.

Time has to be scheduled to allow staff to make time for supervision, self-care and training. However, working patterns can make it difficult to schedule such time.

Priority - Staff training and staff care can often be a low priority for organisations, especially if they have arisen from a charity tradition.

Organisational Burden - training can be seen as putting excessive strain on the resources of the organisation.

Large case-loads can restrict the ability of staff to access training and limit their time to look after themselves appropriately.

Past inappropriate or irrelevant training can put off staff from taking part in training.
Staff may feel unsafe – that if they are told that they need training, that they are seen as not being competent - or feeling unable to share experiences for fear of negative consequences from other team members or management.

Prejudice about mental illness within the organisation can also be inhibiting for staff and create obstacles in free discussion– where does that leave a staff member if they become depressed, for example?

Lack of organisational commitment to staff care.

Combined clinical and managerial supervision can inhibit staff from freely expressing concerns freely.

Lack of external supervision to explore both issues regarding individuals, relationships and working within the team. Reflection, supervision and team support are particularly needed in cases that are frustrating or difficult – here staff feel frightened, worried or where they feel that they are not "getting anywhere" with a client. External supervision can help staff to elaborate on feelings and difficulties. Access to such supervision can help staff to act professionally and flexible, even in difficult situations. These could include the death of a client, over-involvement with a client, or where there is splitting in the team.

One-off training, where there are no follow-up sessions to evaluate or reinforce the training, or to decide whether there is a need for further training.

Compulsory training may not apply to the work done by each staff member. Rather than having the service user as its focus, it is more likely to address health and safety policies rather than staff

training or staff care policies

The trainer/facilitator needs to have credibility with the team. Some teams have a powerful sense of their competence which can lead staff to think that they don't have anything to learn from anyone else.

Team narcissism: This is most often found in demoralised teams, where staff have a "circle the wagons" mentality, externalising all problems to other agencies and preserving a sense that "we know what we are doing, no-one else does".

Inappropriate training: Any training must be practically relevant to the everyday work of the team.

Presentism. Staff are tired, unwell, distressed or physically ill, are unable to function well – but still, come into work.

Good Practices

Having the r**ight staff - who have** not only the basic knowledge and ability to perform well but also have an enthusiasm and commitment to work in community service with homeless people.

Confirm that the **attitudes and values** of the person consistent with those of the organisation.
A good example is of adhering to a non-judgemental human rights approach rather than a philanthropic/charitable approach, incorporating values of dignity and respect.

Commitment to **outreach and engagement** values.

Confirming that the individual has the right skill set, training and experience for the job
Allowing individual staff to play to their strengths – to do the things they are good at – rather than insisting that everyone does everything.

A clear structure, but with the capacity for flexibility, so that urgent situations can be addressed quickly.

A **multidisciplinary team,** with a range of complementary approaches. Homeless people have multiple needs and so may need various skills/professions to resolve their situations.

Teamwork is emphasised, with encouragement to perform with **enthusiasm and motfvatio**n. One of the most motivating things is the sense that one has been effective, that one has done some good – and, being a self-critical bunch of people, we tend to forget or ignore the times we have been effective. So, we all have a responsibility to remind each other of the times when we have been effective. The team has a specific role in being the "memory" for such things.

Provide resources, tools, a clear management and support system (i.e. to whom they call when they have a difficulty) and protocols to react, i.e. when they are in danger, how to protect themselves and the clients, are supportive functions.

Reliance on other team members. We have to reduce feelings that staff can, or should, deal with everything on their own. Team members should be encouraged to rely on each other, both in terms of tasks but also in terms of learning.   This is more likely if staff feel able to **share informally** with each other, and feel ready to ask for their opinion/advice.

Exploration of problems, rather than personalising them and blaming – both for staff and service users.

Multidisciplinary team meetings. Regular, at least once a week, for discussion of cases and difficulties, decision making, sharing perspectives and responsibility.

All situations should be **openly discussed. All members should have equal status** in the team so that they feel able to express their opinions and problems. Open and reflecting team meetings are the basis for teamwork.

It is essential to provide **regular clinical supervision and support, both for the team and individual workers. External facilitators** are necessary. Supervision is a crucial part of reflective practice and an integral part of the work done by front line staff. Not all supervision sessions take the same style or structure. Some organisations may be understaffed or overloaded with cases and are unable to provide well-balanced supervision. Supervision should not only be for front line staff but for entire organisations and incorporate management, supportive and educational functions.

Provide institutional/organisational and administrative supervision

Actively elicit staff feedback on the organisation - and act on it!

Exchanges of experience with other teams.

Cross-team supervision.

Joint training with other organisations – especially powerful where it is cross-sector, e.g. statutory / NGO. It can also reinforce networking.

There should be a **staff care policy and culture**. Staff should feel valued and supported from all levels of an organisation with a culture that staff can identify with and feel supported by.
Staff should be given the **time and space to reflect.**

Staff must be given the space to be fully fit to work and to be able to reflect on the work they do. Person-centred care for clients is linked with person-centred care for staff.

Regular and constructive evaluations will help to motivate staff to continue developing and improving their work.

A clear understanding of the relationship between trauma and homelessness, so that staff can better understand the problems, difficulties and behaviour of the patients.

Reflective practices and sharing culture.

This can be facilitated by:

* An externally facilitated group.
* Shared working spaces – no individual offices.
* Modelling by senior staff

Case

Case study 1: Staff care- Infirmiers de rue

The key idea is to combine staff training and staff care, through teamwork, peer to peer exchange and a focus on reflection. External facilitators and supervision are important.
Working with homeless people can be hard, so it makes sense to reinforce the positive aspects (results of the work, environment, working conditions, team spirit). If this is not done, staff may focus too much on the negative aspects of their work – although, of course, these must still be discussed.

The team is multidisciplinary. Having a range of competencies means that the team is more likely to be able to address complex situations. For example, at any point in time, a client may have had social problems, mental health and legal problems.

- The team has two weekly meetings. One is devoted to patients and the planning of clinical work - each patient is discussed regularly, irrespective of whether they have problems or not. The other meeting is concerned with the team and organisational issues.
- A monthly session is held to discuss problems or situations encountered by the field teams. An external supervisor leads the discussion but doesn't offer solutions ("opening doors"). These monthly meetings have proved to be useful and refreshing.
- Good news moment: Once a week, just before the team meeting, a slot is devoted to sharing successes and progressions – large or small – made by patients and the team. The staff prepare for this during the week by entering items into the 'good news diary' - a large register where everyone sticks coloured notes about the good news. Workers then present and explain them to the rest of the team.
- Later in the meeting, bad feelings or problems concerning team topics can be discussed. Problems concerning individuals are discussed in the specific meeting.
- In team meetings, there are dedicated moments for sharing both positive and negative feelings. This is designed so that such feelings do not erupt unexpectedly, or that they do not express themselves insidiously as cynicism or rigidity.
- There is a daily time, for the team, to reflect upon the last 24 hours. Staff can express feelings and emotions of any kind (job-linked or from private life). This allows team members to understand each other's emotional situation. More time is available for a face to face meeting with a supervisor if needed.
- We encourage reflection, with peers, about any situation, without any expectation, necessarily, of a resolution.
- A shared, easily updated database means that information is easily accessible when needed. Staff diaries and contact details are shared so that that team members can contact each other easily.
- We take two days per year to discuss and reflect on how the team is functioning. This helps to motivate the team and to see the work from different perspectives.
- We encourage staff to take leave regularly, rather than accumulating it.
- We support staff in their career development – even if that is going to take them out of our team. After five years of fieldwork, there is a three-months paid career break, to allow people

to think freely about their job and their career.

Alternative Practical Case

Case study 2: Staff care and training services of the Society of Social Psychiatry and Mental Health

The Society of Social Psychiatry and Mental Health has, from its outset, combined the provision of community-based mental health services and the provision of high-quality training (both in-service training for the employees and training for other professionals).
At the beginning of each "academic" year, the Scientific Directorate prepares a common training programme for all the staff, at all levels. It is based on regular needs assessments - questionnaires completed by the staff.

At the same time, each Unit constructs a specific training programme, adapted to the needs and demands of that unit's team. This training is designed both to reinforce the knowledge and to improve the skills of the staff. Service users are involved as trainers, especially those who live in protected housing and rehabilitation services. They participate in specific training events and in joint reflective teams, called "communities", held regularly.

The emphasis on sharing the same vision and values of the organisation, develop a strong emotional bond with the user, listen and understand his/her multilevel needs as a whole person and develop a person-centred approach, system navigation and networking, mainstreaming human rights, community awareness raising, crisis intervention, management skills.

The whole organisation's approach is psychodynamic, community-based and person-centred. This allows us to understand the psychological needs and conflicts which lead to certain behaviours. We are in a continuing collaboration with local communities.

In parallel with the ongoing in-service-training, we organise specific training seminars whenever this seems necessary, for example when the team faces a new, unfamiliar challenge.
Team and individual supervision are offered at least once a month. We have external professionals for the supervision teams. The emphasis is given in staff care and support, avoidance of burn-out, guidance to self-care.

There are regular reflective teams once a week, discussion about both the clients and the collaboration within the team.
Clear guidelines, job descriptions, protocols are included so that the staff understand how to act in any case (i.e. in case of emergency etc.).

Networking, the participation of the staff in EU projects for exchanging experience and effective practices are part of the organisation's culture and staff care.

Another staff care tool is the option to work in different units (i.e. hostels, protected apartments, day centres, mobile mental health units. Of course, we try to balance staff needs, team and organisational needs and the need for continuity of care and stability in therapeutic relationships. The evaluation of the organisation's Educational Program was carried out using a self-completed

questionnaire which was created for this purpose. The analysis of the data revealed that 67% of the participants felt that the training program was very useful on the subject of their work, 70% declared satisfied with the general organization of the training program, and the 85 % were very pleased with the speakers, while 55% felt that the link between theory and practice was very effective.

Case study 3: the PIE and TIC approach for working with homeless people.

Trauma Informed Care (TIC) and Psychologically Informed Environments (PIE)
"[…] *both approaches aim to address the psychological wellbeing of people using services by implementing a framework in which their psychological needs are considered.*

Psychologically informed environments (designed in the UK) and trauma-informed care (a US innovation) also consider the psychological wellbeing of the staff providing the service. They focus on staff development and support, positive and empowering relationships, and improving wellbeing through the environment and support provided to both service users and providers.
However, neither approach expects support staff to be quasi-therapists or to start delving into someone's trauma history with them. Instead, they promote the creation of safe and empowering environments based on an understanding of repeated experiences of trauma, which often started in childhood […]"

This becomes feasible through basic training and awareness of the staff working with homeless people, regarding the psychological factors which are linked with his/her situation and maybe leads to the difficulty to engage to relationships and help. Through this basic awareness and training the staff can better manage the relationship with the person, be more effective in approaching him/her and manage his/her own emotions about this role.
Data above from:

http://www.homeless.org.uk/connect/blogs/2015/aug/19/do-you-know-your-tic-from-your-pie

TRAINING CURRICULUM

Providing Dignity and Wellbeing to Homeless People with Mental Illness

1.   Rationale

Working with people in a situation of homelessness and mental illness is a demanding job for which no one is well prepared from the start. The multiple issues involved (health, social, housing, recovery, outreach, networking, staff care, etc.) make it difficult for a single professional, discipline or service to be prepared for all the challenges and needs of this population. It is very common that professionals starting to work with this population are confronted with their limits and feel the need to go beyond their usual ways and knowledge, developing new skills to become more sensitive to people needs and network with others.

A recurrent observation is that what one has learned from regular university and professional curriculum is not enough to face the challenges of the work with this population.
Learning from experience, learning from other's experiences, developing a reflective practice that searches for adaptive solutions for unique contexts, rather than copy readymade solutions, is of the utmost importance in this field.

This training curriculum aims at helping professionals to develop skills to better approach the needs of this population, proving a context where future professionals may become more aware of the challenges and dimensions as well as the good principles of practice when one works with people in a situation of homelessness and mental illness.

2.   Target Audience

Health and social professionals working with homeless people.

3.   Objectives

1. 1. Strengthen the skills of professionals working in the social area and of mental health to understand and respond appropriately to the needs of homeless people with mental health problems.
2. 2. Improve professionals' abilities to listen and understand the voice and needs of homeless people, to design and propose more adequate answers that increase their physical and psychical wellbeing as well as their dignity and access to rights.

3.   Training methodologies

Every module will start with an introduction to the topic and with a theoretical approach. To stimulate the active participation of participants, the methodology applied in the second part of the modules will use dynamic activities, such as discussions in small groups and plenary or case studies.

Each module may be complemented with a visit to the field with a minimum duration of two hours.

Modules

Module Name	Introduction		
Duration	2 hours		
Contents to be addressed	- Overview of the Training Curriculum - Introduction to the seven modules - Presentation of the structure and methodology of each session		
Learning Objectives	- To provide an understanding of why this selection of topics - To sensitise for the weaving and interconnectedness of the topics - Sensitise to the focus on the practice of this training		
Session Plan	**Theme**	**Method**	**Activities**
	1. Overview of the Training Curriculum	Presentation	Ppt presentation
	2. Presentation of the structure and methodology of the sessions	Presentation	Ppt presentation
	3. Why these topics and how they interconnect	Presentation and group discussion	Group discussion of topics following a ppt presentation
Pedagogical Materials	Supporting documentation (templates, etc.) and PowerPoint presentation		
Evaluation	Self-assessment questionnaire at the end of the session		

Module Name	Social
Duration	5 h
Contents to be addressed	- Introduction: Social rights, social protection, social prevention, social assistance - Main ideas: Social professionals as mediators to the services; rights and individual will; Reconnection to individual's safety net - Difficulties: Poverty; Difficulties in detection; Lack of cooperation between health and social services; Gender; Undocumented people: stigmatisation; aggressive behaviour - Good practices: Curiosity; Choosing a method, measuring quality and documentation of results; proactive attitude and anticipation; Communication and visibility; choose, enlarge choices; tailored services; Relationship
Learning Objectives	- Sensitise to the importance of social factors and social protection related to homelessness - Learn about the role of social professionals as mediators - Raise awareness of the importance of rights and individual will in social interventions - Learn to identify difficulties that contribute to higher levels of vulnerability - Raise awareness of the attitude and sound principles of social outreach and tailored services

Session Plan	Theme	Method	Activities
	4. Introduction	Presentation and group discussion	Group discussion of topics following a ppt presentation
	5. Main ideas	Presentation and discussion (Section 1 and 2 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
	6. Difficulties	Presentation and group discussion	Group discussion of topics following a ppt presentation
	7. Good practices	Presentation and discussion (Section 3 and 4 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
	8. Case profile	Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min)	Group discussion

Pedagogical Materials	Supporting documentation (templates, etc) and PowerPoint presentation Case Study Profile (ex.)
Evaluation	Self-assessment questionnaire at the end of the session

Module Name	Health
Duration	5 hours
Contents to be addressed	- Introduction: Mental and physical health needs of homeless people - Main ideas: Health outreach, emergency services, hospital admission and discharge, outpatient services, compulsory treatment; networking and collaboration with social services Difficulties: Difficulties in engagement, street assessments, compulsory assessments, communication and cultural differences - Good practices: on outreach, health services accessibility, hospitalisation, work with colleagues, prevention and staff support
Learning Objectives	- Sensitise to the mental and physical health needs of homeless - Learn about the role of health interventions in the street and within services - Learn about the role of collaboration and networking between health and social services - Learn to anticipate difficulties and prevent them - Identify good practices of health care to the homeless

Session Plan	Theme	Method	Activities
	1. Introduction: the connection of health problems to homelessness	Presentation and discussion	Group Discussion of topics following a ppt presentation
	2. Main ideas to highlight	Presentation and group discussion (Section 1 and 2 can be grouped: 45 min for presentation + 45 min for discussion)	Group discussion following a ppt presentation
	3. Expected difficulties and barriers	Presentation and group discussion	Group discussion following a ppt presentation
	4. Good practices	Presentation and group discussion (section 3 and 4: 45 min for presentation + 45 min for discussion)	Group discussion following a ppt presentation
	5. Case profile	Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min)	Group discussion

Pedagogical Materials	Supporting documentation (templates, etc) and PowerPoint presentation Case Study
Evaluation	Self-assessment questionnaire at the end of the session

Module Name	Housing		
Duration	5 h		
Contents to be addressed	- Introduction: House; Home - Main ideas: Housing as a right; the importance of staff training; house, support and participation; emergency housing; long-term housing; Housing first; home visit; women and men in housing services: - Difficulties: Housing market; access to housing; follow-up - Good practices: Prevention; Reaching-out; networking; person-centeredness - Case study: Example s of services and case profile		
Learning Objectives	- Increase awareness of the importance of housing and the establishment of a home - Learn about working from a perspective of housing as a right - Learn about the role of emergency and long-term housing - Increase awareness to difficulties of accessing and adapting to housing - Learn about the sound principles of work in housing		
Session Plan	**Theme**	**Method**	**Activities**
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 1 and 2 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 3 and 4 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min	Group discussion
Pedagogical Materials	Supporting documentation (templates, etc) and PowerPoint presentation Case Study Profile (ex.)		
Evaluation	Self-assessment questionnaire at the end of the session		

Module Name	RECOVERY		
Duration	5 h		
Contents to be addressed	- Introduction: Principles and concepts of recovery - Main ideas: The process of recovery - recovery by themselves, autonomy, the role of professionals - Difficulties of the process of recovery and how to manage them - Good practices: stable case managers, person-centred and tailored services; continuity of care, the role of peer groups - Case study and case profile		
Learning Objectives	- Increase awareness of the specificity of the recovery process - Learn about the differences between recovery and treatment; - To identify difficulties of the process of recovery and the appropriate solutions - Identify good principles of practice that foster recovery		
Session Plan	**Theme**	**Method**	**Activities**
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 1 and 2 can be grouped together: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 3 and 4 can be grouped together: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min	Group discussion
Pedagogical Materials	Supporting documentation (templates, etc) and PowerPoint presentation Case Study Profile (ex.)		
Evaluation	Self-assessment questionnaire at the end of the session		

Module Name	Outreach
Duration	5 h
Contents to be addressed	- Introduction: the concept of outreach - Main ideas: outreach is an attitude; a service; a model; phases of outreach work; roles of healthcare workers in the street; issues to address in re-housing - Difficulties: concerning homeless people; regarding workers; co-working and co-ordination - Good practices: Specific and good practices in outreach work - Case profile
Learning Objectives	- Raise awareness of the value of outreach work to homelessness - Learn about outreach as an attitude, a service and a model - Learn about professional roles in street outreach - Identify difficulties in outreach work - Learn about the phases and good practices of outreach

Session Plan	Theme	Method	Activities
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 1 and 2 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 3 and 4 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min	Group discussion

Pedagogical Materials	Supporting documentation (templates, etc) and Power Point presentation Case Study Profile (ex.)
Evaluation	Self-assessment questionnaire at the end of the session

Module Name	Networking		
Duration	5 h		
Contents to be addressed	- Introduction: complexity; actors involved; networking as a multi-layered approach; structural and operative networking; reasons for networking - Main ideas: Networking as an opportunity; to build a network; networking inside the institution; between institutions - Difficulties: networking as a problem; preventing difficulties - Good practices: Suggestions; who to involve; case study - Case profile		
Learning Objectives	- Raise awareness of the importance of networking - Learn about structural and operative networking - Learn about how to build and sustain a network - Identify good practices of networking		
Session Plan	**Theme**	**Method**	**Activities**
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 1 and 2 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 3 and 4 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation of a case profile and questions for discussion in small groups (45 min) Plenary session (45 min	Group discussion
Pedagogical Materials	Supporting documentation (templates, etc) and PowerPoint presentation Case Study Profile (ex.)		
Evaluation	Self-assessment questionnaire at the end of the session		

Module Name	Staff care		
Duration	5 H		
Contents to be addressed	- Introduction: the role of staff training and staff care - Main ideas: training; values and vision; team function - Difficulties in staff care and training - Good practices that foster the care and development of teams - Case studies		
Learning Objectives	- Sensitise to the importance of staff care and training - Learn about the role of training, team culture and team functioning - Identify difficulties and obstacles to good care to teams - Identify good staff care and training practices		
Session Plan	**Theme**	**Method**	**Activities**
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 1 and 2 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation and group discussion	Group discussion of topics following a ppt presentation
		Presentation and discussion (Section 3 and 4 can be grouped: 45 min presentation+ 45 min discussion)	Group discussion of topics following a ppt presentation
		Presentation of a case study and questions for discussion in small groups (45 min) Plenary session (45 min	Group discussion
Pedagogical Materials	Supporting documentation (templates, etc.) and PowerPoint presentation Case Study Profile (ex.)		
Evaluation	Self-assessment questionnaire at the end of the session		

5.   Trainers Profile

Professional experts with experience working with homelessness and mental health, and who have a degree or specialisation related to these fields of work.

Glossary

Social

Homelessness: In Europe is mostly used the ETHOS definition. ETHOS categories cover all living situations which amount to forms of homelessness, as:
1) rooflessness (without a shelter of any kind, sleeping rough)
,2) houselessness (with a place to sleep but temporary in institutions or shelter)
3) living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence), 4) living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).In this text, we are only focusing on homeless people sleeping rough.

Social service: The social service offered by the public system or by Non-Government Organizations to people in social need.

Casework: Social work that is case processing

Mental illness: Also called mental disorder or psychiatric disorder, is a behavioural or mental pattern that causes significant distress or impairment of personal functioning.

Humanism: That man should show respect to man, irrespective of class, race or creed is fundamental to the humanist attitude to life. Among the fundamental moral principles, he would count those of freedom, justice, tolerance and happiness...the attitude that people can live an honest, meaningful life without following a formal religious creed. (Pears Cyclopaedia, 87th edition, 1978)

Social Psychiatry: The field of interest for social psychiatry is the life of the mentally ill person as it comes out in the dialogue and contact between individual persons and between the individual and the surrounding society. Social psychiatry must deal with the question of "what is the good life", and must be an analysing, critical and active partner in the public debate.

It is a supplement to the biological-medical and the psychotherapeutic psychiatry

Poverty: "*Poverty is hunger. Poverty is a lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty has many faces, changing from place to place and across time, and has been described in many ways. Most often, poverty is a situation people want to escape. So poverty is a call to action -- for the poor and the wealthy alike -- a call to change the world so that many more may have enough to eat, adequate shelter, access to education and health, protection from violence, and a voice in what happens in their communities.*" (The World Bank Organization)

Multidisciplinary team: Refers to social activities that involve the efforts of individuals from several relevant disciplines.

Health

Accessibility: Direct access to care and resources.

Networking: Essential due to the multiple health and social problems, multi-morbidity.

Continuing care: (See outreach chapter)

Bridge building Advocacy and emotional support through various health and social systems have an important role.

"Soft" skills: Paying attention to interpersonal and relational aspects.

Inreach: Community services and professionals must take the initiative in communicating with and sharing information with in-patient staff.

Admission plan: Succinctly setting out the reasons for admission, what has worked in the past and what the anticipated outcome for the admission could be.

Street assessments: Assessments carried out in the street

Compulsory assessments: Carrying out an assessment to evaluate a possible compulsory admission to hospital

"Hard to engage.": Homeless people can be seen by mainstream services as difficult to engage, but this will usually have much to do with access to basic rights, social security and language barriers

Revolving door: Multiple admissions to hospital

Open door services: Mainstream services should increase access for homeless people, therefore without an appointment or waiting lists are good ways to achieve this.

Pre-discharge meetings: Involving the hospital team and the homeless team (with a social worker) to plan future accommodation, and organise a discharge / follow up plan.

Prevention
Primary: Improving the overall health of the population.
Secondary: Improving the detection of disorders.
Tertiary: Improving treatment and recovery.

Housing

Active Listening
Is to fully concentrating on what is being said rather than just passively 'hearing' the message of the speaker. It is listening attentively while a person speaks, reflecting back what they said and without judgement or advice.

Housing

Housing, with regard to it being a social issue or human right, can be defined as a house, other dwelling or shelter which gives safety and warmth as well as providing a place to rest. It is one of the most important components of living a secure life.

Housing First: Housing First, is an approach to ending homelessness that focuses on moving a person from homelessness to a home of one's own as quickly as possible. It is recovery orientated with additional supports and services given as needed.

Housing Officer: Manages housing and related services on behalf of housing associations, local authorities and NGOs. The role involves managing housing and keeping in regular contact with Service Users, looking after rental income and dealing with repairs and neighbour nuisance issues. Housing Officers often work in a team which includes tenancy support officers, case / key workers etc.

Interventions: Intervention refers to actions taken by services to support service users in their recovery journey. These can be extremely wide-ranging and often involves providing less dramatic means of helping an individual.

Psychologically Informed Environments Psychologically Informed Environments are services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals using them. It is a complementary approach to service delivery for people with complex needs with Trauma Informed Care.

Person-centred care: Person-centred care means putting Service Users at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.

Being compassionate seeing and making decisions from a Service Users point of view and being respectful are all important. Consideration is given to a person's values, social circumstance and lifestyle when making shared decisions with Service Users.

Rights-Based Approach: A rights-based approach places an obligation on Service Providers to ensure that their services uphold and promote European and international human rights standards. Such an approach places the focus on the right of an individual rather than the need.

Under a rights-based approach, the plans, policies and processes of development are anchored in a system of rights and corresponding obligations established by international law.

For example, Article 25 Universal Declaration of Human Rights states that: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Service User: A service user is a generic term for any person who uses a homeless, health or another social service

Trauma: Trauma is an emotional response someone has to a negative event. The effects of trauma can interfere with an individual's ability to live a normal life. Someone who has suffered trauma may develop emotional issues such as anger, sadness, anxiety, PTSD, survivors guilt etc. They may develop on-going problems with sleep, physical and emotional pain and have trouble with their personal relationships. People who have suffered a major trauma are more likely to have an addiction support need.

Trauma Informed Care: Trauma Informed Care is an approach which aims to improve awareness of trauma and its impact on Service Users, to ensure that the services provided offer effective support and, above all, that they do not re-traumatise those accessing or working in services

Anti-oppressive practice: Is a method and model for challenging actions of both individual and institutions that have an impact of being oppressive of individuals and groups in society and these discriminatory actions are based on prejudicial and invalid attitudes and values.

Recovery

-Co-construction: the delivery of public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. (Boyle and Harris, 2009).

Connecting: joined or linked; linking two things

Empowerment: to take their lives into their own hands an opportunity to control their own life. There was much discussion on the use of the word empowerment. Empowerment is an external action, but it is also a two-way relationship, it can drive someone to recovery, but recovery can also lead someone to empowerment.

Establish relationships: create and maintain a connection of mutual trust, transparency and respect between a professional and a client (in our case a homeless person with mental difficulties). This is the basis for any further planning and cooperation. Confidentiality and honesty from the professional. A caring attitude but also set limits.

Institutionalisation: Harmful effects such as apathy and loss of independence arising from spending a long time in an institution.

Network: a group or system of interconnected people, services or organisations. They interact with others to exchange information and develop professional or social contacts. It may be formal (see the example of NPISA in Lisbon for homelessness) or informal.

Personal Choice: involves decision making. It can include judging the merits of multiple options and selecting one or more of them. One can make a choice between imagined options ("What would I do if...?") or between real options followed by the corresponding action. It is associated with free will. (through Wikipedia).

Recapacitation: To facilitate the capacity to recover.

Recovery: see the definitions given at the beginning of this chapter.

Step by step approach: The method in which does something carefully, gradually and in particular order (Longman Dictionary).

Outreach

Client: a person who makes use of supportive services, whether professional or voluntary. Other phrases used to describe clients are, in different settings, patients or service users.

Home: a place where a person feels they belong and that they have a right to be there. A place of affections and emotions, protection and security, where a person feels welcomed, recognised and supported,

Housing: a place where people can live in quietly.

Homeless and mentally ill people: people who are homeless who also have a mental disorder which may have precipitated the homelessness, but almost certainly serves to perpetuate homelessness and social exclusion.

Institutionalisation: The process by which an individual becomes dependent on an institution, to the detriment of their independence and ability to make decisions for themselves.

Psychiatric deinstitutionalisation: A cultural and scientific process that recognised that mental illness and psychological suffering is not best helped prolonged isolation in psychiatric closed institutions. The alternative is community-based treatment, which involves a substantial investment in personnel and services.

De-hospitalization: The closure of hospital beds. Although carried out under the guise of "constructive" deinstitutionalisation, it is often carried out for financial reasons rather than therapeutic ones.

Compulsory health treatment: If a person's mental disorder means that they become a risk to themselves or others, or just cannot look after themselves adequately, they may be detained in hospital against their will (or, at least, without their expressed permission), using the laws applicable in that particular country.

Undocumented migrant: A foreign-born person who does not have a legal right to be or remain in one specific country, but who has – as a human person – the basic entitlements recognised by the Declaration of fundamental human rights.

OutREACH : go outside to meet people

InREACH : welcome inside to access services

Networking

Complexity: characterises the behaviour of a system or model whose components interact in multiple ways and follow local rules, meaning there is no reasonable higher instruction to define the various possible interactions. (https://en.wikipedia.org/wiki/Complexity)

Facilitator: someone who helps a person or organisation do something more easily or find the answer to a problem, by discussing things and suggesting ways of doing things.
(https://dictionary.cambridge.org/dictionary/english/facilitator)

Meta – organisation: is defined as organisations which are formed of other organisations, rather than by individuals
(https://en.wikipedia.org/wiki/Meta-organization)

Networking: A process which fosters the exchanges of information, ideas and practices among Individuals or groups that share a common interest.
(https://www.investopedia.com/terms/n/networking.asp)

Win-win position: the "win/win position" is about changing the conflict from adversarial attack and defence, to co-operation. It is a powerful shift of attitude that alters the whole course of communication: I want to win, and I want you to win too.
(http://www.consultpivotal.com/win_win.htm)

Staff Care

Staff: Anyone that directly delivers an organisation's projects and programmes, and to whom an organisation has a duty of care. Staff could be full time or part time workers; they could also be volunteers or outside contracted workers used to help an organisation deliver its function.

Staff training and staff care: The effectiveness of an organisation depends on well-qualified and well- trained staff who have good morale. The simple answer to having an effective organisation is to ensure that all paid and voluntary staff get enough training to develop the right skills to fulfil their responsibilities.

Staff training comes in many forms, but mostly it can be formal and informal. Informal training is somewhat casual and incidental; it is training and learning through experience while on the job.

Formal learning is a set program in which the goals and objectives are defined; it is structured and designed and results in certification for the learner.

Staff care includes support and supervision both regarding cases and regarding dynamics in the team and the organisation.

Reflective practice - Where practitioners reflect on their knowledge and experiences and express their thoughts and feelings about them. There is no pressure for an immediate answer, but this may arise after a period of discussion and reflection.

All these help to prevent burn-out, which is a common phenomenon, as working with traumatised people such as homeless people (with mental health problems) affects staff.

Burn-out *"Occupational burnout is thought to result from long-term, unresolvable, job stress. In 1974, Herbert Freudenberger became the first researcher to publish in a psychology-related journal a paper that used the term burnout. The paper was based on his observations of the volunteer staff (including himself) at a free clinic for drug addicts.[1] He characterised burnout by a set of symptoms that includes exhaustion resulting from work's excessive demands as well as physical symptoms such as headaches and sleeplessness, "quickness to anger" and closed thinking. He observed that the burned-out worker "looks, acts, and seems depressed"*

(https://en.wikipedia.org/wiki/Occupational_burnout)

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Multidisciplinary team: A group of people who work together in a team, who have the same aims and objectives, but who come from different but complementary professional backgrounds and life experiences.

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