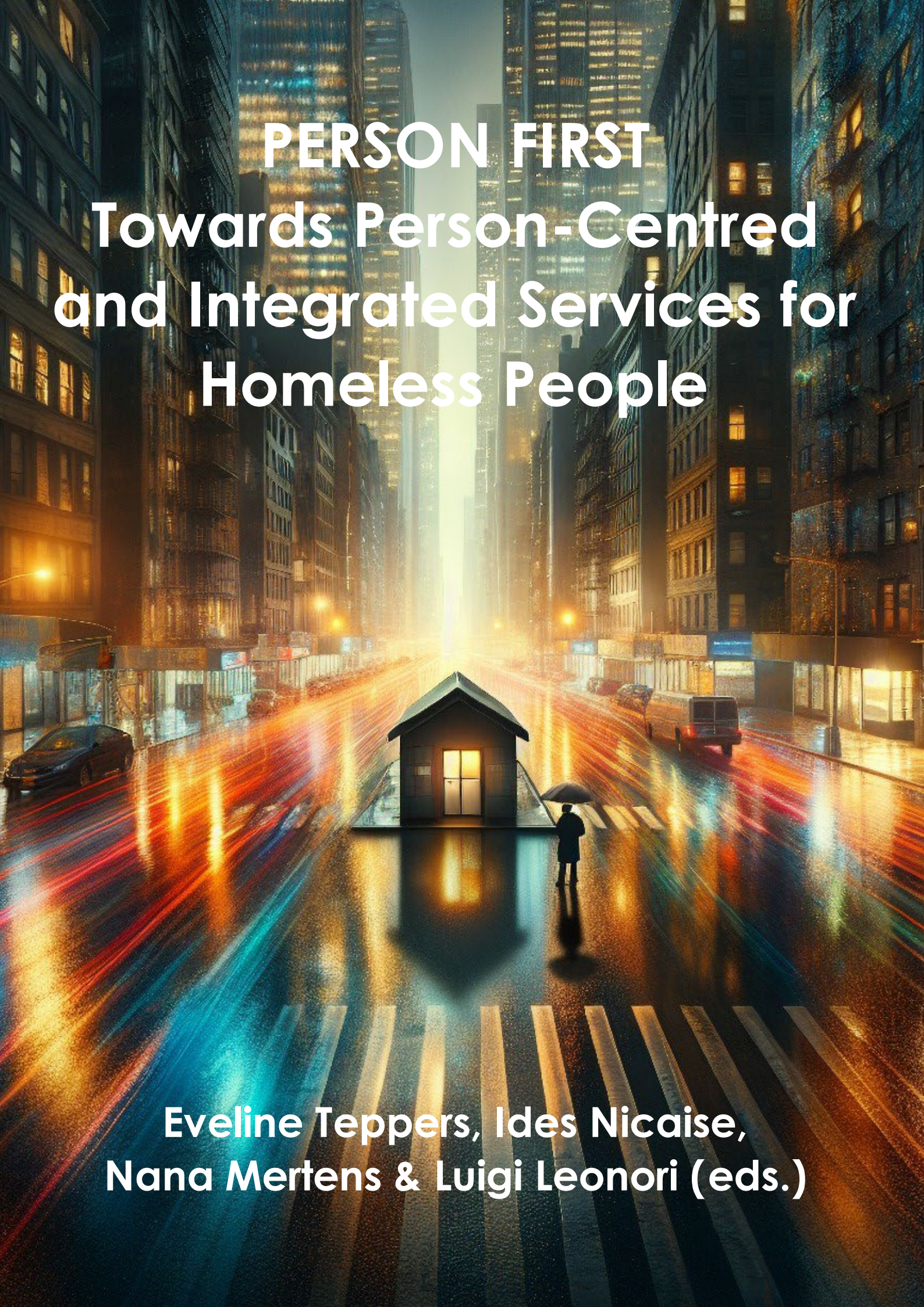

PERSON FIRST
Towards Person-Centred and Integrated Services for Homeless People

Eveline Teppers, Ides Nicaise,
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Abstract

Staff of services for homeless people from 9 European countries participated in this learning network funded by Erasmus+ (2022-2024) upon invitation by SMES Europe (specialised in mental health services for homeless people). The project focussed on quality and integration of services and maximum 'ownership' for users. HIVA-KU Leuven provided scientific support.
In addition to an exploratory survey of 65 services, four study visits took place (Riga, Ljubljana, Helsinki and Athens), alternating with thematic webinars for a wider audience. The present report is a compilation of all these inputs. It is published in a format that can be used for training and professional development.
Some key lessons can be summarised as follows:

- the classic night shelter (bath-bed-bread) should be limited to the first urgent reception,:
- the traditional pathway model (reception - working on behavioural change - reintegration - rehousing) remains inadequate;
- a humane approach must go much faster and further: starting from each user's own story and working with individual plans and provisions that take into account the great diversity of emergency situations;
- building on the well-known Housing First alternative, an approach with at least four pillars is needed: social services, sustainable housing, (mental) health care and rehabilitation. Only networks of services from different sectors can handle this;
- homelessness is the result of a structural crisis in the implementation of human rights. Access to a guaranteed minimum income, affordable and decent housing, high-quality social and (mental) health services;
- the homeless person must be given every opportunity to take up an active role: from chores in the facility itself, over part-time (paid or voluntary) work, up to and including involvement as a paid expert by experience or in advocacy work in associations.

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List of Abbreviations

CAW	Centre for general social work (Centrum Algemeen Welzijnswerk in Dutch).
CMHC	Community-based mental health care
ETHOS	European Typology of Homelessness and Housing Exclusion
GP	General Practitioner
HF	Housing First
NGO	Non-Governmental Organisation
NIMBY	Not In My Backyard
OCMW	Public centre for social welfare (Openbaar Centrum voor Maatschappelijk Welzijn)
SMES	Santé Mentale et Exclusion Sociale (in French)

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Introduction

The phenomenon of homelessness is extremely complex, multifaceted, and pervasive across all European countries. Given its complexity, it is crucial to deeply reflect on this phenomenon and prioritise placing the individual at the core of intervention efforts.

In this regard, the Person First project (funded by Erasmus+ under grant number 21PCP0009) underscores the necessity of prioritising the person within interventions, with each aspect of the intervention tailored to individual needs and profiles, rather than the reverse. This approach is rooted in upholding dignity and ensuring access to human and social rights.

The project facilitated the exchange of experiences and mutual learning among participants from nine European countries, including Belgium, Denmark, Finland, Greece, Italy, Latvia, Poland, Portugal, and Slovenia. It encompasses participation in four study visits focusing on key structural pillars: social assistance and emergency services; physical and mental health; home and housing; and empowerment, rehabilitation, and participation. The study visits showed a diversity of contexts - demographic, cultural, climatic, historical - as well as diverse interventions and responses implemented on the ground to address homelessness. Throughout the study visits, there was a strong emphasis on the active participation of individuals experiencing homelessness. This interaction was guided by the fundamental belief that each person's existence holds significance only when their voice is genuinely heard and understood.

The present report aims to do more than reflect the lessons learned by a small number of professionals from a temporary project. It advocates for the implementation of a more holistic and person-centred approach across all services for homeless people. Specifically, we hope that this report will serve as educational material for students and professionals from various disciplines involved in such services. It is primarily recommended for students in social work, but also for students and in-service trainees in the realm of social psychology, psychiatry, social/mental healthcare, public health, sociology, and social pedagogy. Moreover, given the large numbers of volunteers and peer workers engaged in homeless services, we recommend this report to them as well, as it may contribute to greater efficacy, personal growth, and prevention of burnout. Last but not least, we recommend this report to policymakers and NGO workers involved in the fight against poverty and homelessness.

The chapters are clustered in three parts. Part one (Chapters 1 to 4) sketches the background picture, with a description of the Erasmus+ project within which the Person First approach was developed. Part two (Chapters 5 to 9) summarises the findings from study visits, webinars, and seminars that took place in the framework of the project. Chapters 5 to 8 successively focus on four key service areas- the four 'pillars' of the Person First approach: social assistance, health and mental health, housing, and participation/rehabilitation, while Chapter 9 examines experiences in service integration. Finally, Part three (Chapter 10) synthesises the main lessons drawn from this Person First project and presents a set of recommendations for policy and practice at the EU, national and local level.

PART ONE
BACKGROUND OF THE PERSON FIRST APPROACH

1 | Project outline

1.1 Background

SMES (Santé Mentale et Exclusion Sociale)-Europa[1] is a European network (established in 2001) that addresses the needs of individuals living in extreme poverty, especially those facing mental health challenges. As an international non-profit association, SMES advocates human rights, dignity, and well-being. The network aims to facilitate access to citizenship rights, social and health services, and promote inclusion and participation. It focuses on specific groups, including mentally ill individuals without adequate assistance, at-risk youth, abandoned elderly, undocumented migrants, asylum seekers, and refugees. Through networking with other European bodies, SMES raises awareness and promotes best practices.

In a previous project titled 'Dignity and Wellbeing' SMES-Europa investigated the profiles of approximately 50 individuals living in extreme social and health conditions[2] - individuals who sometimes preferred remaining, and at times, even passing away on the streets rather than accepting solutions offered by available services. The final report of this project was presented at a European conference in Lisbon in 2017. During this event, there was a suggestion to initiate a follow-up project focusing on the profiles of services catering to these individuals. Ideally, these services should prioritise welcoming, respecting, engaging, supporting, and reconnecting with the individual. The central question is whether interventions integrate social and health care in line with the genuine needs of individuals, respecting their dignity, and are accessible, outreach-oriented, and sustainable, especially in emergency centres.

1.2 Objectives

Building on the 'Dignity and Well-being' project,[3] 'Person First' aims to identify models and practices to facilitate homeless individuals' access to services. Additionally, it seeks to enable social and health workers in both public and private sectors to reach homeless individuals with mental health issues where they are.

The specific objectives include:

- promoting and facilitating networking and collaboration among workers in institutions, organisations, and associations dealing with extreme precariousness to achieve effective synergies and transform daily practices into effective networking models;
- building the capacity of each participant through international and intersectoral exchanges, study visits, and workshops, promoting mutual learning about diverse problems and methodologies and seeking adequate and efficient solutions;
- identifying efficient and innovative services and structures capable of preventing the persistence of problems and recommending priorities for prevention and sustainability;
- involving civil society, politicians, administrators, and media, recognising this as a societal issue requiring collective attention, not just a challenge for professional workers;

1 https://www.smes-europa.org/

2 https://www.smes-europa.org/REPORT PROFILES D-&-WB_SMES.pdf

3 https://www.smes-europa.org/DIGNITY_&_WELLBEING.htm

- emphasising lifelong learning and establishing a network that persists beyond the project's completion.

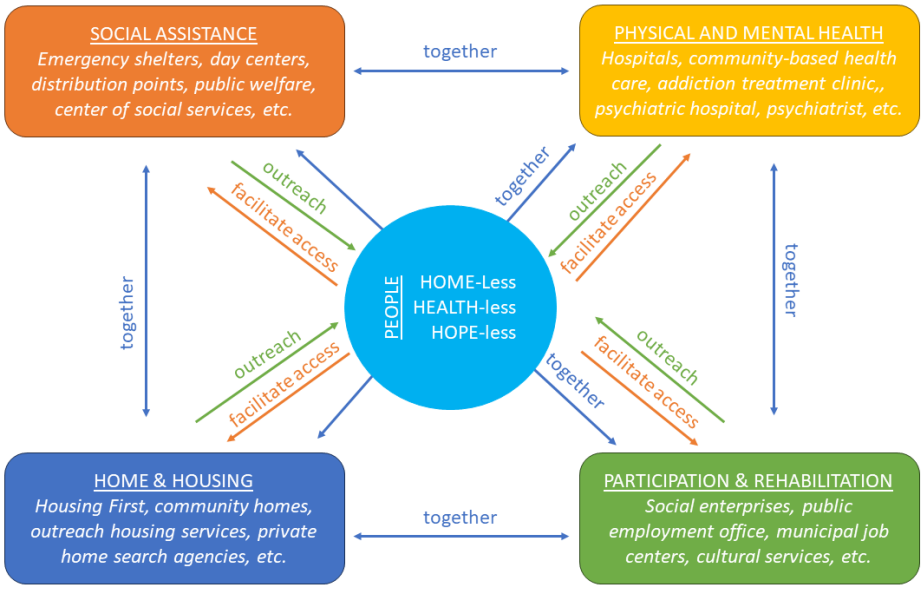
With the Person First project, we aim to achieve the following results:

- enhancing professionals' understanding of complex needs and appropriate responses;
- encouraging the involvement of institutions and policymakers in health and social services;
- fostering the participation of professionals and students in social work in formal and informal training on more person-centred and holistic approaches to homelessness;
- shifting from a charitable approach to homeless individuals to respecting their fundamental rights;
- improving cooperation between public and private services in the health and social sectors.

1.3 A person-centred approach consisting of four essential pillars for dignity and well-being

The Person First project places a strong emphasis on prioritising the voices of homeless individuals, tailoring services to their specific needs. It advocates a holistic, integrated approach that not only provides assistance but actively promotes empowerment. The Person-First model underscores the significance of adopting a person-centred approach that addresses a minimum of four crucial dimensions in meeting the needs of homeless individuals (see Figure 1.1): (1) social assistance, (2) mental and physical health, (3) housing, and (4) participation and rehabilitation through employment or other social activities.

Figure 1.1 The four pillars for dignity and well-being



In line with the Person-First model, it is essential to establish bridges between the four pillars. This involves fostering holistic relationships and engagement, while also promoting collaboration or co-working across various sectors including social services, healthcare, housing services, and rehabilitation services.

Moreover, the Person-First model does not passively wait for individuals to seek help; instead, it actively reaches out to meet them where they are. While proactive outreach is invaluable, maintaining an accessible and welcoming environment for those seeking assistance is equally imperative.

1.4 Method

Within the Person First project, various methods were used:

- **Survey**: An exploratory survey was carried out, targeting both public and private services operating in social assistance, (mental) health care, housing, and rehabilitation across the nine partner countries (i.e. Portugal, Greece, Latvia, Italy, Poland, Denmark, Slovenia, Belgium, and Finland). This survey enabled us to analyse the congruence between profiles of services and the needs of individuals in need, considering factors such as accessibility, welcoming, sustainability, and care. We also strived to develop a nuanced understanding of the multifaceted needs of homeless individuals and determine the most effective ways to address them.
- **Study Visits**: Study visits were made to services in four European countries in 2023, namely Latvia (Riga), Slovenia (Ljubljana and Nova Gorica), Finland (Helsinki), and Greece (Athens). These visits focussed on social assistance, (mental) health, housing, and rehabilitation services, respectively.
- **Webinars**: Four open webinars were held following the study visits for an in-depth exchange of views regarding the quality-of-service delivery.
- **Public Event and Conference**: Two events were organised in Brussels in the first semester of 2024: a dissemination event in collaboration with the European Economic and Social Committee, targeted at NGOs and service providers, and an advocacy event hosted by the Intergroup on the Fight against Poverty of the European Parliament.
- **Production of Vocational Education and Training Materials**: The present report is meant to be used as training material in schools of social work as well as for in-service training of volunteers and professionals working in services for homeless people.

2 | Background

2.1 Definition of homelessness

The ETHOS (European Typology on Homelessness and Housing Exclusion) typology developed by FEANTSA presents a robust conceptual definition of homelessness and housing exclusion, allowing for specific operational definitions tailored to reflect national situations and policy needs[4]. Homelessness, according to ETHOS, is characterised by exclusion from one or more of the three domains constituting a home: the physical, social, and legal domains. More specifically:

- possessing a decent dwelling or space sufficient to meet the needs of the individual and their family (physical domain);
- being able to maintain privacy and enjoy social relations (social domain);
- having exclusive possession, security of occupation, and legal title (legal domain).

The ETHOS light definition, agreed upon at the European level, encompasses individuals living in the streets, residing in specific (emergency or other) accommodations, occupying unconventional dwellings (such as a garage or car), or temporarily staying with friends or family due to a lack of stable housing.[5] The Belgian count (MEHOBEL)[6] introduced an additional operational category to the existing six categories of ETHOS light. This new category encompasses individuals residing in housing situations at risk of eviction, thereby expanding the total to seven categories.

In the literature, a distinction can be made between different types of homelessness (the categories in this report are not exhaustive). People experiencing chronic homelessness are deeply embedded in the shelter system, which functions as a long-term housing solution for this population rather than a temporary or emergency option. This group is often older, underemployed, and frequently dealing with a disability. Transitional homelessness occurs when individuals enter the shelter system for a single stay, typically of a short duration. This group is more likely to be younger and has become homeless due to a significant and often catastrophic event, such as job loss, divorce, or domestic abuse. Occasionally homelessness refers to people who experience regular bouts of being unhoused. Unlike transitional homelessness, they are chronically unemployed and may experience medical, mental health, and substance use issues.

2.2 Causes of homelessness

The profiles of homeless people are extremely diverse, encompassing destitute persons, victims of domestic violence, drugs users, young people who have broken ties with their families, undocumented migrants, and others. This diversity is the result of a complex interplay of causes of social disconnection. Growing up in poverty is a significant factor, but other common contributing factors include failed school careers, conflicts with parents, loss of relatives, negative encounters with social services, and limited access to the housing market.

The risk factors associated with homelessness, as outlined by Edgar (2009), can be broadly categorised into four main dimensions: structural, institutional, relationship, and personal factors.

4 https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion

5 fea-002-18-update-ethos-light-00324174417886874191 54.pdf (feantsa.org)

6 https://www.belspo.be/belspo/fedra/proj.asp?l=nl&COD=BR%2F154%2FA4%2FMEHOBEL

a) Structural factors

The majority of homeless individuals in Europe experience low incomes, often being unemployed or working in unstable, low-skilled jobs. Structural factors like housing shortages, affordability challenges, and specific housing access issues for disadvantaged individuals also play a significant role. Social protection is crucial, as a lack of security in illness or unemployment, coupled with insufficient benefits, increases the risk of homelessness. Certain groups, like immigrants facing legal barriers or discrimination, particularly those excluded from social security and minimum benefits, are at greatest risk. In many cases, people are even excluded from social protection *because* they have no legal residence (see the 'postal paradox' in Section 5.8.4 of this report). The plight of undocumented migrants, marked by undocumented migration and their lack of rights, exacerbates this issue.

b) Institutional factors

Institutional factors contribute to increased vulnerability to homelessness when individuals in need lack adequate support due to unavailable or poorly coordinated services. Policies on resource allocation and gatekeeping practices can also heighten the risk of specific groups becoming homeless. This may occur when individuals are not assessed as priority cases or are explicitly excluded from services, often due to documentation or legal status issues. Institutionalisation itself can exacerbate vulnerability by leading to a loss of independent living competencies. Discharge procedures, particularly from hospitals or jails, may lack preparation for stable housing, resulting in individuals being discharged to the streets. Prison admission or certain long-term hospital treatments can lead to homelessness, with underreporting observed among prison inmates, possibly influencing parole decisions.

c) Relationship factors

Homelessness often stems from escalating conflicts, abusive relationships, separations, or bereavement. Survey results consistently highlight traumatic relationship issues as a prominent trigger for homelessness across countries. Homeless individuals frequently report experiencing prior difficult events, such as domestic violence, early departures from parental homes, or parental deaths during childhood, at higher rates than the general population. These relationship-level risk factors contribute to heightened vulnerability among those affected by homelessness, with variations in the incidence of these critical life events observed between countries and subgroups of homeless individuals.

d) Personal factors

Lastly, personal characteristics play a significant role in determining individuals' vulnerability to the previously mentioned risk factors and can ultimately be the decisive factor leading to homelessness. While mental health problems and addiction are frequently cited as significant personal challenges, long-term illness, disability, and low educational attainment also contribute to increased vulnerability.

It is essential to recognise that not all individuals facing these risk factors become homeless, as economic, social, and cultural resources, along with support from the welfare system, significantly impact the outcome. Success in preventing homelessness often depends on the availability of resources and support systems, which may be lacking for those who ultimately experience homelessness.

2.3 Effects of homelessness

Being homeless leads to a decline in health and life expectancy. While the factors contributing to homelessness may also have adverse effects on health, research indicates that the experience of homelessness and rough sleeping itself has a profound and immediate detrimental impact on health.

Physical health problems can arise directly from the specific risks associated with homelessness, the absence of the usual social support structure for health or worsen due to a lack of access to medical treatment (Erasmus+ Project Dignity & Well-being, 2019). Regarding mental health issues,

homelessness can be attributed to psychosis, multiple traumas, and addiction, while emotional distress, anxiety, and depression may be responses to homelessness (Leng, 2007).

2.4 Figures on homelessness in selected partner countries

2.4.1 Homelessness in Belgium

Since 2020, the King Baudouin Foundation has been actively collaborating with research teams from LUCAS KU Leuven and UCLouvain CIRTES, along with over 100 local authorities, to implement a standardised methodology for counting homeless individuals in Flanders and Wallonia. The KBF aims to extend this methodology across all federal levels to ensure uniform and recurrent counts in Belgium. Based on the standardised counts conducted over the past 4 years (2020-2023) (in no fewer than 227 municipalities and with the help of 900 participating organisations), the research teams have made extrapolations for Flanders, Wallonia, and the German-speaking community:[7]

- in Flanders, an estimated 19,479 individuals are homeless: 13,533 adults and 5,946 children;
- in Wallonia, an estimated 19,055 individuals are homeless: 14,342 adults and 4,713 children;
- in the German-speaking Community, 192 individuals are homeless: 131 adults and 61 children.

2.4.2 Homelessness in Lisbon

In Portugal, approximately 9,604 people were counted as homeless in 2021, with around 3,328 in Lisbon, constituting 0.6% of the city's total resident population. Lisbon alone accounts for 35% of the country's homeless population, indicating a significant concentration of homelessness in the city. Of these, more than 307 individuals live on the streets, representing 6% of the national homeless population.

Despite diverse services and attention dedicated to the issue in Lisbon, an increase in homelessness is expected. There is no more recent data yet, but services predict changes in the profile of homeless individuals, foreseeing a rise in migrants and newcomers experiencing homelessness. Prevention efforts for these groups, particularly newcomers facing homelessness for the first time, appear to be insufficient in Lisbon.

2.4.3 Homelessness in Greece

Greece has faced challenges with homelessness, particularly exacerbated by economic difficulties and the refugee crisis. The economic crisis that began in 2008 hit Greece particularly hard, leading to high unemployment rates and austerity measures that affected various sectors of society, including housing. Homelessness became a significant issue during this time, with reports of increasing numbers of people living on the streets or in temporary shelters. The refugee crisis also placed additional strain on Greece's resources, as many refugees and migrants arrived in the country seeking asylum and assistance. To address homelessness, the Greek government has implemented various policies and programmes, often in collaboration with international organisations and NGOs. These initiatives aimed to provide support services, such as shelters, food assistance, healthcare, and social integration programmes, to individuals without homes as well as families. However, despite the efforts, homelessness remains a complex and persistent issue in Greece. Economic instability, limited affordable housing options, and social challenges continue to fuel the problem.

7 https://kbs-frb.be/nl/dak-en-thuisloosheid-nieuwe-tellingen-onthullen-de-omvang-van-de-problematiek

According to the UN, there would be 22,000 homeless people in Athens and another 20,000 elsewhere in Greece. Most of them are recognised refugees and native Greeks. As regards undocumented migrants, the majority are EU citizens whose residence permit has expired.[8].

According to 2023 data from the Hellenic Statistical Authority (ELSTAT) 26,1% of the Greek population is at risk of poverty and social exclusion. This percentage differs little from the 2022 figure of 26,3%.[9]

2.4.4 Homelessness in Latvia

The homelessness situation in Latvia varies across cities, and available data are limited to shelter statistics. The overall numbers have not seen significant growth, with the figure standing at 5,400 in 2014 and slightly increasing to 5,600 in 2022 for individuals using shelters.

2.4.5 Homelessness in Finland

In contrast to other European countries, Finland has witnessed a decrease in homelessness from over 18,000 in 1987 to less than 4,000 in 2022, thanks to the implementation of permanent Housing First initiatives for homeless individuals. While the majority affected are still male, the number of homeless women has been on the rise, often grappling with experiences of violence and shame. Additionally, there's a growing presence of gender and sexual minorities within the homeless population, particularly among the youth. To address this, tailored support for specific target groups and enhanced aftercare information are crucial.

2.5 Lisbon declaration

Poverty and the rising cost of living are significant contributors to the increasing homelessness crisis, which has grown substantially over the past decade, affecting an estimated 895,000 people across Europe.[10] The Lisbon Declaration on the European Platform on Combatting Homelessness, established by Member States in June 2021, sets a goal to eliminate homelessness by 2030, so that:

> *'No one sleeps rough for lack of accessible, safe and appropriate emergency accommodation; no one lives in emergency or transitional accommodation longer than is required for successful move-on to a permanent housing solution; no one is discharged from any institution (e.g. prison, hospital, care facility) without an offer of appropriate housing; evictions should be prevented whenever possible and no one is evicted without assistance for an appropriate housing solution when needed; and no one is discriminated against due to their homeless.'*

The declaration outlines key objectives, including ensuring accessible emergency accommodation, preventing prolonged stays in transitional housing, offering appropriate housing to individuals leaving institutions, preventing evictions without assistance, and eliminating discrimination based on homelessness.

The declaration recognises that the determinants of homelessness include rising housing costs, insufficient social housing, low income, precarious employment, job loss, aging, family breakdown, discrimination, health issues, and unprepared release from institutions. Variation among Member States exists in the significance of these drivers, influenced by social protection, health, and housing systems.

Addressing these challenges is complex, but the declaration notes growing evidence of effective interventions. There's considerable diversity in how homelessness is conceptualised and measured

8 For more information, https://www.hrw.org/world-report/2022/country-chapters/greece, https://www.statistics.gr/documents/20181/13491320/VNR+2022+Greece+Report.pdf/d0b97502-84b4-866f-e32e-2d91dff2538a

9 For more information, https://thepressproject.gr/hellenic-statistical-authority-report-over-2-6-million-citizens-in-greece-facing-poverty-minimal-relief-from-benefits/

10 Report: 8th Overview of Housing Exclusion in Europe 2023 (feantsa.org).

across Member States, reflecting differences in welfare regimes, funding mechanisms, service delivery, centralisation, and decommodification levels.

3 | Survey of services

3.1 Method

The exploratory survey conducted in the first stage of the Person First project was ethically screened by the Social and Societal Ethics Committee (SMEC) of KU Leuven (see Appendix 4). Initially drafted in English, the questionnaire was translated into native languages by project partners before being administered to potential respondents. Data collection responsibilities rested with the project partners, who committed themselves to collect responses from a minimum of 50 organisations (with at least 6 organisations per country/project partner). Communication with organisations occurred by email, phone, and/or mail, with a preference for in-person, online, or phone interviews in order to eliminate missing answers, provide direct assistance, and yield higher response rates for better-quality data.

The survey took place between May 2022 and October 2022, and all collected data, translated into English, was entered into Excel, and analysed by the Research Institute for Work and Society (HIVA) at KU Leuven. Given the inclusion of numerous open-ended questions, both quantitative and qualitative analyses were conducted. It is important to note that certain responses could be assigned multiple codes (i.e., multiple themes), and organisations had the option to provide multiple answers to each question.

Feedback from project partners indicated that most organisations were contacted by email or telephone. However, the data collection process encountered delays due to several factors, including translation issues for both the survey and responses, overlapping with summer holidays, challenges in engaging stakeholders with a direct interest in the project (such as municipalities and local authorities), and the need for some organisations to secure permission before participating.

3.2 Profile of organisations

We received a total of 65 completed surveys, representing the participation of 65 different organisations (see Table 3.1). Survey distribution varied by country, ranging from 3 surveys (Belgium) to 12 surveys (Portugal), with an average of around 7 surveys per country.

Table 3.1 Number of filled questionnaires received by country (N=65)

	N	%
Portugal	12	18.5
Greece	10	15.4
Latvia	9	13.8
Italy	9	13.8
Poland	7	10.8
Denmark	6	9.2
Slovenia	5	7.7
Belgium	4	6.2
Finland	3	4.6

Approximately two-thirds (63%) of the organisations are subsidised private non-profit organisations, about one-sixth (17%) are public organisations, and one-fifth (20%) have a different status, such as mixed, private non-subsidised, or others (see Table 3.2).

Table 3.2 Category of the organisation (N=65)

	N	%
Private subsidised	41	63.1
Public	11	16.9
Mixed	5	7.7
Private, non-subsidised	5	7.7
Other (religious organisation, association, non-profit community-based)	3	4.6

About half (52%) of the organisations are locally oriented, a quarter (26%) are regionally oriented, and approximately one-fifth (20%) are nationally oriented (see Table 3.3).

Table 3.3 Level of the organisation (N=65)

	N	%
Local	34	52.3
Regional	17	26.2
National	12	18.5
National and regional	1	1.5
National and local	1	1.5

In terms of mission or goals, organisations reported diverse objectives, with around half (49%) aiming to help users or provide them with a better life, 37% focusing on rehabilitation and empowerment, 25% contributing to inclusion in society, and 20% offering health services to homeless persons. Other goals, although less frequently mentioned, include lobbying, advocacy, awareness raising, providing shelter, preventive work, strengthening social networks, employment and education, harm reduction, service improvement, and collaboration with other services (see Table 3.4).

Table 3.4 Mission or objectives of the organisation (N=65)*

	N	%
Better (social) life/support/treatment 'Assistance in the process of overcoming the crisis of homelessness and social exclusion; support in the addiction treatment process; supporting human dignity', 'Help for deprived people (the poor, disabled and socially excluded) easing the problems of everyday life', ...	32	49.2
Rehabilitation and empowerment 'Improvement of adaptation abilities in the environment and support in the process of self-empowerment and social re-adaptation of young people ...', 'Rehabilitation and stabilisation in housing of the most vulnerable homeless people', ...	24	36,9
Inclusion 'The mission is to promote full inclusion and autonomy of people in situations of vulnerability', 'Creating an including setting for marginalised people, particularly people who use drugs, low threshold, ... Building social relations and tolerate guests as they are', 'To build bridges between the street and the rest of society', ...	16	24.6
(Physical and mental) Health 'Recovery and community integration of people with mental health problems', 'Medical assistance for the people in the situation of homelessness – mostly those staying in the street', ...	14	21.5
Lobbying/advocacy/awareness 'Rights protection. Awareness raising on the social marginalisation problem. A contribution to the design of social policies ...', ...	12	18.5
Providing shelter 'To provide shelter to homeless individuals with specific social problems, such as mental illness or substance abuse, who are in need of personal and social support', 'Providing shelter in a crisis situation', 'To provide temporary safe shelter and social rehabilitation for homeless adults or adults in crisis, and to prevent wandering and homelessness', ...	10	15.4
Prevention 'Preventing social exclusion and derailment of young people ...', ...	8	12.3
Strengthening social networks 'Improve mutual relations within the family/partnership/with loved ones', 'Connecting all generations, creating intergenerational coexistence', ...	6	9.2
Employment 'Increasing the level of professional activity of young people at risk of social exclusion', 'The creation of bridges between lack of interest and motivation with the offers of training, employment or occupation which are available but not always used', ...	5	7.7
Harm Reduction 'Harm-reduction in a broad perspective; clean needles, condoms, food, sleep', ...	5	7.7
Service improvement 'Guaranteeing a level of excellence in the services provided; Ensure that the most vulnerable population has access to a network of resources that allow them to improve their stability and decrease their suffering, 'Ensure sustainability of all projects', ...	3	4.6
Education 'Aid, educational and cultural activities aimed at disadvantaged groups threatened with social exclusion', ...	3	4.6
Collaboration with other services 'Establishing contact with partners, governmental and non-governmental, psychiatry, ...	2	3.1

* Multiple objectives or answers possible per organisation.

3.3 Profile of staff

Examining the personnel in different organisations reveals that approximately half of them (53%) have fewer than 20 paid staff members (see Table 3.5). However, a subset of organisations has significantly more paid staff members, with 13% having over 100 paid staff members (up to a maximum of 1,860). Due to extreme values, the average of 82 paid staff members is considerably higher than the median[11] of 18 paid staff members in our sample. The median, being less affected by extreme values, serves as the most informative measure for the central tendency of the distribution.

Table 3.5 Total number of paid staff in the organisation (N=63)*

	N	%
0-19	33	52.4
20-39	10	15.9
40-59	7	11.1
60-79	1	1.6
80-99	4	6.3
100-1,860	8	12.7
Median	**18**	
Average	**81.8**	

* 2 missing values.

Apart from paid staff members, many organisations rely on volunteers, with 80% within this sample (see Table 3.6). Conversely, 20% do not rely on volunteers. The total number of volunteers varies significantly, with an average of 94 and a median of 14. The median, being less influenced by extreme values, serves as the most informative measure for the central tendency of the distribution. Additionally, a strong positive correlation (r=0.91) is observed between the number of paid staff members and volunteers. Higher numbers of paid staff members correlate with higher numbers of volunteers.

Table 3.6 Total number of volunteers in the organisation (N=61) [1]

	N	%
0	12	19.7
1-19 [2]	26	42.6
20-39	9	14.8
40-59	3	4.9
60-79	2	3.3
80- 2,459	9	14.8
Median	**14**	
Average	**93.5**	

[1] 4 missing values.

[2] 1 organisation consists only of volunteers and no paid staff.

Organisations also reported the proportion of staff with specific qualifications (see Table 3.7). The average proportion of staff with social qualifications is 40% (median of 30%), the highest among the surveyed qualifications. General medical personnel follow with an average proportion of 12%

[11] The median is the middle value of a group of numbers ranked by size.

(median of 3%), while the average proportion of staff specialised in mental health is the lowest at 8% (median of 0%).

Table 3.7 Proportion of staff by type of qualifications in the organisation

	Median	Average
Social qualifications (N=60)	29.5	40.1
General medical workers (N=61)	3.3	11.8
Mental health specialists (N=61)	0.0	8.1

3.3.1 Project partners' insights and recommendations

In discussions with the project partners regarding the results concerning the profile of staff, several key considerations have come to the fore.

Firstly, there is a recognised need for greater diversity in education or training background, as the current majority of staff consists of social and medical workers. It is emphasised that organisations could benefit from a more varied skill set, such as individuals with backgrounds in psychology, communication sciences, or other fields.

Secondly, the shortage of staff is identified as a significant challenge. Interestingly, it is noted that the issue is not solely a lack of qualified staff but also a turnover problem The turnover of staff, reinforced by shortages, creates challenges in building trust, as experience is crucial in connecting with individuals experiencing homelessness. The temporary nature of staff employment contributes to tensions within the organisation. Additionally, there is a cautionary note about the risks associated with large-scale organisations in terms of safety.

To prevent staff drop-out and burnout, several key strategies are crucial:

- provide support and supervision: ensure staff receives regular support and supervision, including weekly intervention and monthly supervision sessions;
- promote healthy relationships: encourage positive relationships and cooperation among colleagues while emphasising the importance of sufficient rest;
- avoid overwhelming expectations: avoid - and temper if needed - a mindset of 'rescuing all people', as it can lead to overwhelming and unsustainable efforts;
- offer competitive compensation: provide well-paying jobs and opportunities for career advancement to motivate and retain staff;
- emphasise attitude and passion: acknowledge the essential role of staff attitude, passion, and interest. Genuine care for the people they serve is crucial;
- relying on security personnel can have adverse consequences. Achieving a balance between the number of staff and service users is vital for establishing personal connections. This might involve reducing the number of users to avoid the need for security personnel. Furthermore, the security and working conditions of staff are paramount, and individuals should not be working alone, especially in challenging conditions (refer to the violent incident in the day centre for drug users in Ljubljana). In Denmark, such practices are prohibited by law.

The organisation of work is underscored as a critical factor affecting the effectiveness of addressing homelessness. The responses suggest that the way work is structured and managed plays a pivotal role in the success of homeless shelters.

ŠENT, a Slovenian organisation (see appendix 2) dedicated to providing quality services, faces a persistent challenge in securing adequate funding. The requirement for co-financing public funds,

typically around 20%, proves to be a challenging hurdle. While staff shortages are partly addressed through voluntary work, ŠENT acknowledges the limitations, emphasising the need to strike a balance where voluntary contributions complement, not substitute, professional expertise.

Furthermore, there is a consensus on the necessity for additional in-service training, particularly in handling mental health issues and addressing cultural differences. Moreover, it is emphasised that all staff in homeless shelters, including volunteers, should undergo trauma-informed training. This highlights the multifaceted nature of the challenges faced by homeless individuals and the importance of ensuring that staff are well-equipped to provide effective support.

Finally, the importance of staff attitudes cannot be overstated:

- firstly, adopting a person-centred approach is crucial. This ensures that everyone's unique needs, circumstances and aspirations are considered and addressed;
- secondly, implementing a 'psychologically informed practice' is essential. Understanding the psychological aspects of individuals, particularly those who have experienced trauma, provides a vital window of access to their needs, and enables more effective support;
- lastly, there is a clear need for flexibility. Over-regulation and excessive specialisation can hinder the ability to respond dynamically to the diverse and evolving needs of those being served. Flexibility allows for more responsive and adaptable support systems to be implemented.

3.4 Profile of users

The responses to inquiries about the total number of users per year and per day reveal significant differences attributable to variations in Organisational scale, type of organisation, and operational level (local versus national). The median for the number of users per year is 460 (see Table 3.8), while the median for the number of users per day is 48 (see Table 3.9). Notably, there is a positive correlation (r=0.75) between the number of users per year and day. As the annual number of users increases, so does the daily count.

Table 3.8 Total number of users per year in the organisation (N=59)*

	N	%
15-114	9	15.3
115-214	7	11.9
215-314	10	17.0
315-414	3	5.1
415-514	3	5.1
515-180,014	27	45.8
Median	**460**	
Average	**9,081.0**	

* 6 missing values.

Table 3.9 Total number of users per day in the organisation (N=51)*

	N	%
3-102	41	80.4
103-202	3	5.9
203-302	2	3.9
303-4,402	5	9.8
Median	**48**	
Average	**258.9**	

* 14 missing values.

In the survey, organisations were also asked about the average and maximum length of stay for their users (see Table 3.10). Approximately half of the organisations (48%) either reported that users did not stay or did not respond to this question, often due to unavailable information on average length. For the other half, the average length of stay was 200 days, with a median of 120 days.

Table 3.10 Average and maximum duration of stay in days of the users

Duration of stay	Average in days (N=35) [1]	Maximum in days (N=42) [2]
Minimum	0.04 (1 hour)	2
Maximum	730 (2 years)	5,110 (almost 14 years)
Median	120	720 (almost 2 years)
Average	199.9	1,246.0 (3.4 years)

[1] Out of 65 organisations, 31 (48%) either reported that users did not stay or did not respond to this question.
[2] Out of 65 organisations, 13 organisations (20%) did not apply a maximum duration of stay and 10 organisations (15%) did not respond to this question.

One-fifth of the organisations reported no maximum duration for user stays, and 15% did not respond. Among the remaining organisations (65%), the average maximum length of stay was around 3.5 years, with a median of almost 2 years.

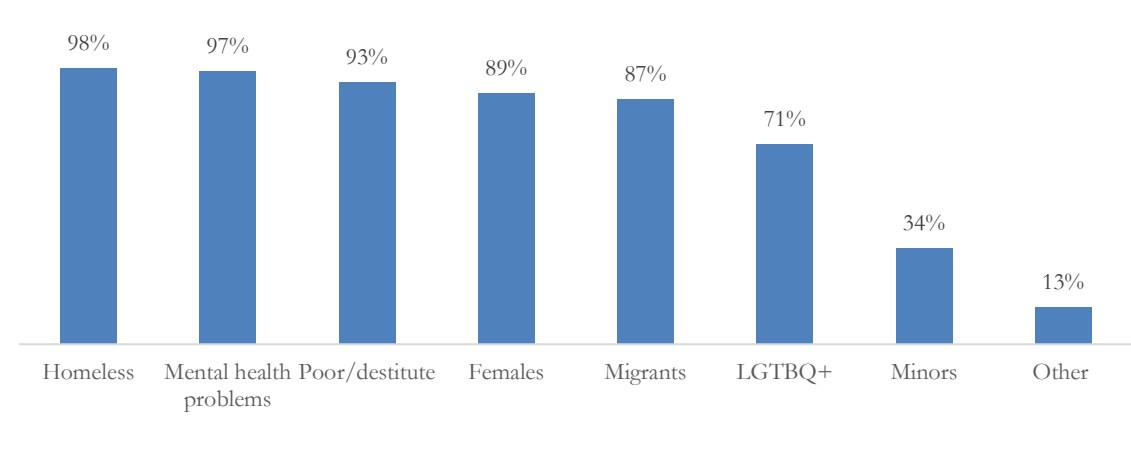
Table 3.11 and Figure 3.1 offer additional insights into the various categories of users within the organisations. Almost all organisations assist homeless individuals and those with mental health problems. Approximately 90% of the organisations provide services to poor individuals, women, and migrants. Around 70% of the organisations have LGBTQ+ individuals as users, while one-third mention the inclusion of minors among their users. Other mentioned categories encompass refugees from Ukraine, extremely vulnerable homeless people, drug users, Roma, and sex workers.

Table 3.11 Categories of users according to the organisation (N=65)

	Organisation where category is present			Approximate % of category in the total user group			
	N	%	Missing values	N	Median	Average	Range
Homeless	63	98.4	1	57	90.0	71.1	1.5-100
Persons with mental health problems	62	96.9	1	44	62.5	58.1	1.5-100
Domestic violence	37	60.7	4				
Mental suffering (loneliness, anxiety, ...)	48	78.7	4				
Psychiatric disorders	54	88.5	4				
Addiction (alcoholism, substance abuse)	58	95.1	4				
Poor/destitute	56	93.3	5	53	99.0	88.7	20-100
Female users	54	88.5	4	52	25.0	33.7	0.2-100
LGTBQ+	37	71.2	13	30	4.0	6.3	0.1-40
Minors (< 18 years)	21	34.4	4	20	5.0	17.2	0.1-50
Migrants	53	86.9	4	46	34.2	41.2	0.3-100
Legal residents	44	89.8	16				
Asylum seekers	27	55.1	16				
Undocumented migrants	35	71.4	16				
Other*	7	13.2	11				

* Examples: 'refugees from Ukraine', 'most vulnerable homeless people', 'people who use drugs', 'Roma', 'sex workers', ...

Figure 3.1 Percentage of organisations where the category of users is present (N=65)



When examining the proportion of each user category within an organisation's total user group, we observe that the highest average share is attributed to poor people (89%), followed by homeless individuals (71%), and those with mental health problems (58%). Conversely, the average shares of LGBTQ+ individuals, minors, women, and migrants are notably lower, at 6%, 17%, 34%, and 41%, respectively.

Although women are users in nearly 9 out of 10 organisations, their representation is not as pronounced as that of men. Literature also indicates that women are often considered 'hidden homeless', constituting a minority (Erasmus+ Project Dignity & Well-being, 2019). This suggests that while they may have a roof over their heads by being in a relationship with a man, they could be experiencing

physical and sexual abuse and are unable to leave due to the lack of alternative housing options. Homeless women are also more likely to face severe mental illnesses, presenting complex needs that necessitate specific support. Moreover, they often have a highly negative self-image, viewing themselves as losers or inadequate mothers.

As illustrated in Table 3.11, not all user categories are represented in each organisation. Moreover, organisations have specific reasons for refusing admission to certain individuals. In the survey, respondents could select several reasons for non-admission (refer to Table 3.12). Approximately half of the organisations state that they deny admission if the organisation's rules are not adhered to. Additionally, reasons such as age and family composition, violent or risky behaviour, pet ownership, and the use of drugs or alcohol are mentioned by 40% to 30% of organisations. Less frequently cited reasons include psychiatric issues, lack of legal residence, and gender-based refusal. On average, an organisation cites 2.3 different reasons for refusal. One in eight organisations lists more than five reasons, while one in six admits everyone and does not specify any reasons for refusal.

Table 3.12 Reasons for non-admission of applicants according to the organisation (N=65) [1]

	N	%
Age/family composition (e.g., presence of minors)	28	43.1
Sex (e.g., no men)	11	16.9
Lack of legal residence (undocumented migrants)	8	12.3
Violent/risk behaviour	23	35.4
Psychiatric disorder	5	7.7
Pet animals	20	30.8
Use of drugs or alcohol	19	29.2
Non-compliance with the rules of the organisation [2]	28	48.3
Other [3]	10	15.4
Number of non-admission reasons per organisation		
None	11	16.9
1	14	21.5
2	14	21.5
3	7	10.7
4	11	16.9
5+	8	12.3
Median	**2**	
Average	**2.3**	

[1] Multiple reasons or answers possible per organisation.
[2] 8 missing values (old version of survey used).
[3] Examples: 'Being not vulnerable enough', 'lack of space', 'not in the target group', 'non-paid rents', 'when the user's behaviour is dangerous to the safety of other users, staff, and volunteers, ...'.

The finding that one-third of users are denied access due to aggressive or risky behaviour implies that such incidents may be occurring within organisations. The Erasmus+ Dignity & Well-being project emphasises that professional training should equip staff to anticipate and prevent aggression, although sometimes aggressive behaviour can be sudden and unpredictable. Effectively managing aggressive and violent behaviours poses a significant challenge for social professionals. Frequently, they may feel unequipped to handle such situations, leading to burnout and a high turnover of staff (Erasmus+ Project Dignity & Well-being, 2019).

3.5 Project partners' insights and recommendations

During discussions with the project partners concerning the user profile results, several reflections emerged:

- The larger numbers of users pertain to regional/national umbrella organisations with numerous local branches. Drawing conclusions about the scale from this data is challenging, but a reference to the overall need for small-scale accommodation is desirable. On the other hand, significant (umbrella) organisations have the advantage of ensuring a broader range and more integrated service delivery.
- The average maximum duration of stay is 3.5 years (a median of 2 years), indicating that some crisis services are not short-term. Some services prioritise respect for individuals, providing a temporary home in a shelter. This reflects tension but is not necessarily negative.
- Minors are typically not permitted in shelters: instead, they receive care through a separate system, although they may still end up in shelters or domestic violence shelters.
- Migrants, particularly those who have become homeless in significant numbers due to war, constitute a distinct group that is not well served by the current system, such as short-term rented flats. Additionally, there is a notable discrepancy between Ukrainian and Syrian/Middle Eastern refugees within the existing system. Among staff, there is also a significant need for language training.
- LGBTQ+ individuals show above-average risks of homelessness, mainly due to rejection by their family or peers. This issue became acute during the COVID crisis as young people could not 'hide' their sexual identity during lockdowns.
- Women, especially single mothers who have experienced violence, have specific needs such as childcare. It is very difficult for them to find shelter together with their children.

4 | Aligning services with the needs of homeless people

4.1 Needs of the users

4.1.1 Information from the survey

Research indicates that individuals facing homelessness and mental health challenges have increasingly complex and diverse needs, influenced by changing economic conditions across Europe in recent years, altering the demographic profile of those at risk of or experiencing homelessness (O'Sullivan, 2012).

To assess the alignment of services with user needs, organisations were asked to report on the most frequent requests for help or support from their users. The responses, detailed in Table 4.1, reflect a broad spectrum of needs. Common requests include housing support, legal or administrative assistance, support of care, medical examinations, basic necessities (such as food, clothing, and hygiene), access to drop-in centres, aid with job search, educational support, assistance with substance abuse, help with integration, and participation in social activities.

Table 4.1 Most frequent requests that organisations receive from users (N=59)*

	N	%
Housing 'Assisted housing (disabled persons, refugees, people in a homeless crisis) and housing training (leaving the foster care, disabled persons)', 'Housing first services', 'Housing counselling', ...	26	44.1
Administrative/legal help 'Assistance in gaining access to social support and social security benefits', 'Legal aid', 'Help with renewing documents, registering as a person in need, other formalities', ...	24	40.7
Support or care 'Due to the very wide spectrum of activities undertaken, the requests for assistance concern various needs. The need for material help is certainly predominant, but many people also look for counselling and help in solving life problems', ...	22	37.3
(Physical) health 'Medical and specialist examinations, general health activities, dental, physical therapy, psychiatric, blood and instrumental examinations, and assistance in accessing physical and telematic services', 'Health problems (cancer, dialysis, female genital mutilation consequences, etc.)', ...	21	35.6
Primary needs (food, clothes, hygiene, medical equipment, ...) 'Food, toilets, aluminium foil and syringes/needles, phone charging, clean clothes and shoes', 'food, shower, washing', 'Various services (soup kitchen, laundry, showers, internet, refills)', 'Clothing, footwear, hygiene products, etc.', ...	18	30.5
Shelter 'Provision of shelter', 'A place to sleep', 'Housing shelters and drop-in centres', ...	15	25.4
Job/employment 'Job orientation and job placement support', 'We receive requests for help with job search', ...	12	20.3
Education/training 'Educational support (children, adolescents, and adults)', ...	6	10.2
Drugs/Harm reduction 'Drug harm reduction intervention', 'Stop using drugs', 'Stopping consumption', ...	5	8.5
Rehabilitation 'Adaptation after release from prison (declaration of residence, opening a bank account, health checks, etc.)', 'Integration (people, including children of disabled persons)' and 'Request for a field visit and help - prevention against loss of housing/possibility of living'.	3	5.1
Companionship 'Low-threshold meeting activities' and 'Companionship'	2	3.4

* Multiple services or answers possible per organisation.

The order of the pillars based on the most common user requests aligns with the order of the pillars based on the most frequently offered services: social assistance ranks first, followed by home & housing, (physical) health, and finally empowerment & rehabilitation. However, a notable difference exists regarding the themes within the four pillars (see Section 4.2).

Organisations were queried about latent needs among their users, referring to those needs that users have but do not express. 74% (N=48) of organisations recognised the existence of latent needs among their users, with the need for mental healthcare notably being unexpressed (mentioned by 46% (N=22) of these organisations). Additionally, according to some organisations (10-19%, N=5-9),

users may have a need for access to specialised or more tailored services, even if they do not consistently articulate these needs themselves.

Table 4.2 Total number of organisations that see latent needs among users and experience a mismatch between the users' needs and the services offered (N=65)

	N	%	Missing values
Latent needs among users	48	73.9	0
A mismatch between users' needs and the services of organisation	34	59.7	8

Organisations were also asked whether there was a mismatch between user needs and the services provided. 60% (N=34) reported a discrepancy between user needs and the services offered. Among the organisations reporting a discrepancy, 55% (N=18) state that services can be insufficient or inefficient, citing challenges in referring to mental health services, a need for prolonged shelter hours, and the requirement for psychiatric care for shelter users or those living on the streets. Another 27% (N=9) report differences in perspective or goals, with users having varying priorities or requesting solutions that maintain their existing problems, such as money for substances, apartments without accountability, success in school without learning, and approval of harmful behaviours.

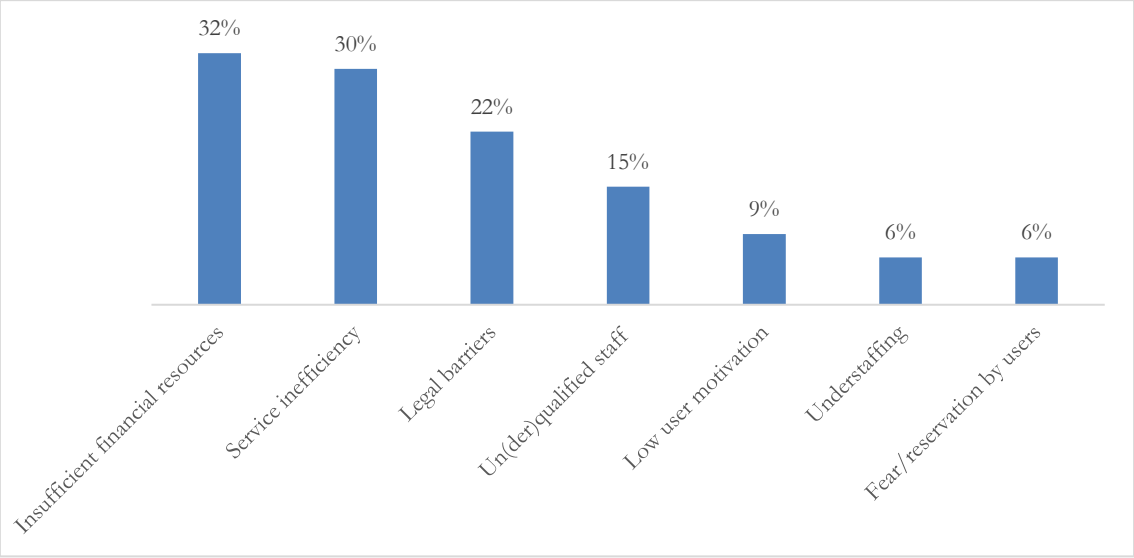
A quarter of organisations (24%, N=8) identify a shortage of (affordable) housing as a significant cause of the mismatch. Additionally, 9% (N=3) of organisations note that specific user characteristics, such as not accommodating couples or pets, and not admitting victims of domestic violence into emergency shelters, can hinder assistance.

In addressing user requests, organisations face various difficulties (See Figure 4.1). Insufficient financial resources pose a challenge for 32% of the organisations, impacting project financing, staff employment, building maintenance, and long-term financial support. Another 30% mention service inefficiency, including accessibility problems, barriers in access, long waiting lists, and complex procedures. Legal barriers are reported by 23%, citing complexities in the regularisation process for undocumented migrants.

Personnel-related challenges are also mentioned, with 15% highlighting the availability of un(der)qualified staff and 6% noting understaffing. These issues range from a lack of training opportunities and funding to attract specialists to staff shortages due to illness and limited resources for hiring.

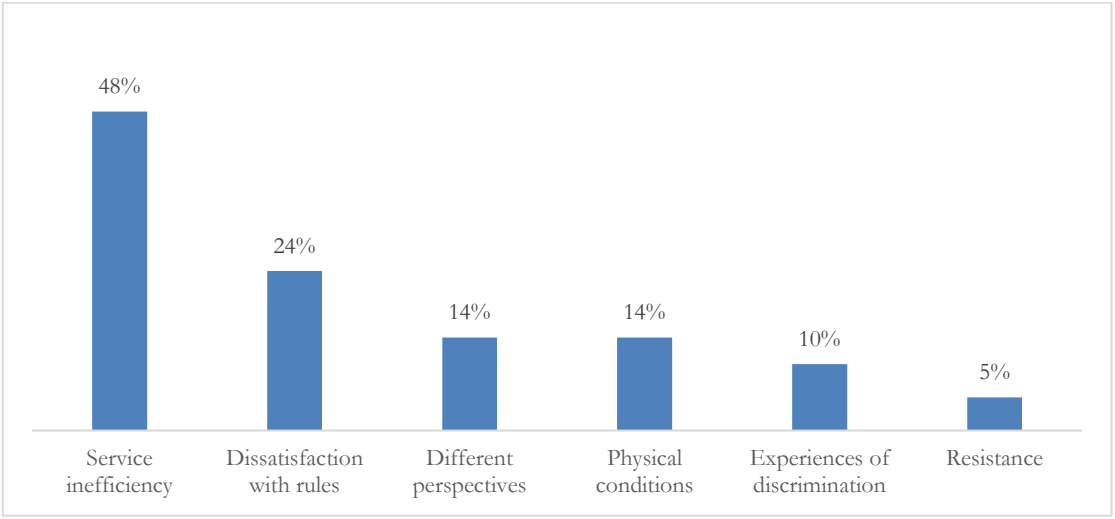
Finally, difficulties related to low user motivation (9%) or fear/reservation (6%) are identified. Intrinsic motivation may be lacking, and retaining users in intervention plans proves challenging. Users may also experience shame about their difficulties and fear of stigma. The literature suggests that building a strong relationship with users requires sufficient time, and rejections should prompt continued expert services to monitor the situation (Report 50 People Profiles, 2017).

Figure 4.1 **Difficulties in responding to requests of users according to the organisations (N=53)**



To further understand service shortcomings, organisations were surveyed about the most common complaints from service users (see Figure 4.2). Around half of the organisations (48%) reported complaints related to service inefficiency, including issues such as the inaccessibility of public or specialised services, restrictive operating hours, extended waiting times for critical services like housing, and inadequate shelter availability. Roughly a quarter of the organisations (24%) mentioned dissatisfaction with rules and regulations, such as limited operating hours, restrictions on partner visitation, the ban on alcohol consumption in the shelter, and rent payments. Additionally, user complaints sometimes arise from differing perspectives (14%), as some users may not fully comprehend their living situation or believe that the services do not adequately address their needs. There are also complaints related to physical conditions (14%), such as a lack of personal private spaces. Additionally, to a lesser extent, it is reported that users experience discrimination (10%), and some users show resistance (5%), for example, by refusing to engage in activities outside their comfort zone.

Figure 4.2 **The most received complaints from users according to the organisations (N=42)**



4.1.2 Why do some homeless individuals prefer sleeping on the streets in freezing conditions rather than in night shelters?

In an online news article in Belgium, an attempt was made to answer the question of why, even during icy days with temperatures below freezing both day and night, homeless individuals consciously avoid night shelters. According to Brussels Street worker Filip Keymeulen from the Diogenes non-profit organisation, there are several reasons for this.[12]

First and foremost, there are insufficient spaces in night shelters for the number of street residents in Brussels. Additionally, there is an influx of people from outside Brussels who know they have a better chance of finding shelter in a larger city. Moreover, street residents have the freedom to decline the offer and refuse it. There are, however, several obstacles associated with the offer:

- **Scale, insecurity, and lack of privacy**: Keymeulen notes from experience that the large scale, insecurity, and lack of privacy in night shelters deter some street residents. 'People are assigned beds in large dormitories. You might end up next to someone you distrust or do not know. A lot of people together in a big space creates a feeling of insecurity. You also must call every day for a spot, so you end up in a different bed every day. In an environment like that, especially for people with mental health and anxiety issues, it can exacerbate discomfort. I would not feel at ease either.'
- **Non-admission rules**: Rules such as not allowing drug and alcohol use in shelters result in the avoidance of such facilities by groups of individuals struggling with addiction.
- **Administrative procedures**: For example, in Brussels, application for a bed occurs through a strict procedure. 'You must call precisely at 2 p.m., not earlier. Then you must wait until you get someone on the line to address your specific request: not everyone has the capabilities to handle such arrangements. When someone is left out in the cold because all the spots are filled, it can be frustrating. Some street residents are inherently suspicious of official institutions because of past disappointments, leading them to stop seeking help after a while.'

4.2 The range of services offered

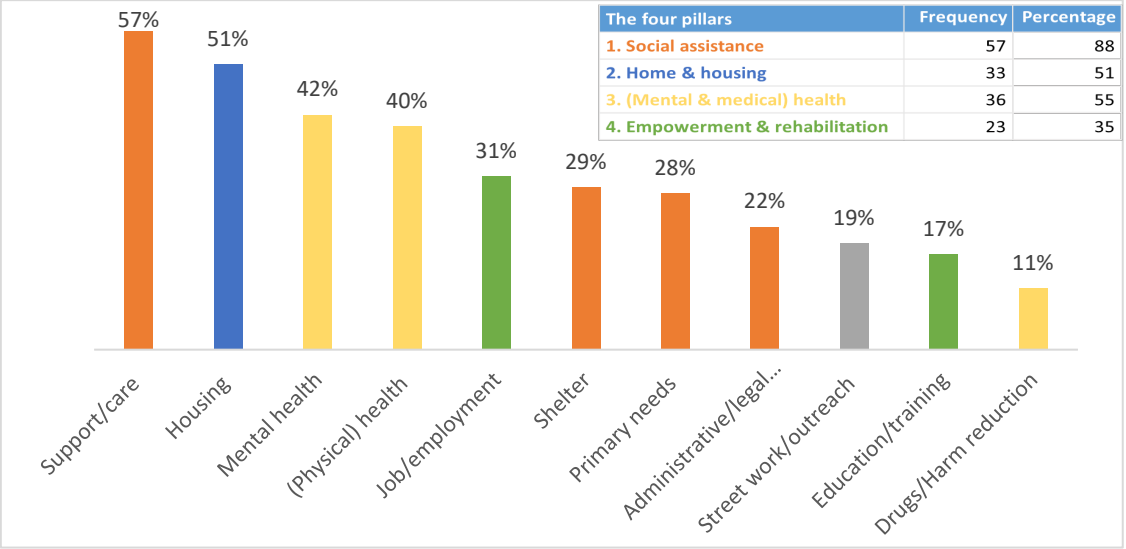
4.2.1 Information from the survey

The 65 different organisations provide **a range of services**, which can be categorised into the four pillars as follows (see Figure 4.3 and Table 4.3):

- social assistance includes support/care (e.g., social services), shelter (e.g., emergency shelter), services for primary needs (e.g., food, clothes, hygiene), and administrative/legal help (e.g., social benefits);
- home and housing include housing services (e.g., Housing First);
- health includes mental health (e.g., psychological counselling), physical health (e.g., medical/nursing support), and drugs or harm reduction (e.g., rehab programmes);
- empowerment & rehabilitation include job/employment (e.g., job orientation) and education/training (e.g., language courses).

[12] https://www.vrt.be/vrtnws/nl/2024/01/10/waarom-slapen-daklozen-niet-in-de-nachtopvang/#:~:text=Sommige%20straatbewoners%20hebben%20sowieso%20al,liever%20weg%20uit%20de%20nachtopvang.

Figure 4.3 Percentage of organisations who offer the different services (N=65)



The four pillars	Frequency	Percentage
1. Social assistance	57	88
2. Home & housing	33	51
3. (Mental & medical) health	36	55
4. Empowerment & rehabilitation	23	35

Street work or outreach work is not part of the four pillars but is used by 19% of organisations as a service method. Most organisations (88%) offer services within the social assistance pillar, with 57% focusing on social support or care. Approximately 20% to 30% provide shelter, services for primary needs, and administrative help. Health and home & housing pillars are offered by 55% and 51% of organisations, respectively. Within the health pillar, 42% focus on mental health, 40% on physical health, and 11% on drugs or harm reduction. The least represented pillar is empowerment & rehabilitation, covered by 35% of organisations, with 31% focusing on work and 17% on education and training.

Table 4.3 Services of the organisations (N=65)*

	N	%
Support or care 'Guidance', 'Social services', 'All kinds of social services', 'Psychosocial support', ...	37	56.9
Housing 'Housing First', 'Social Residence and Shared Apartments', 'Comprehensive housing support (for people in a crisis of homelessness, people with disabilities, leaving foster care, refugees)', ...	33	50.8
Mental health 'Psychological assistance in the street', 'Psychological counselling', 'Therapeutic help', 'Psychiatry Pediatrics', 'Services range from psychological counselling to career and business counselling', ...	27	41.5
(Medical) health 'Medical assistance in the street', 'Health services (free FibroScan- is a type of liver elastography/linking patients to health care facilities/free HCV, HBV, HIV test to prisoners)', 'Nurse services and appointments with doctors, including GPs, as needed', ...	26	40.0
Job/employment 'Job orientation and job placement support (curriculum, training, job search, etc.)', 'Project of returning women to the labour market after childbirth', 'Referrals to other NGOs and public structures for housing shelters and employability services', ...	20	30.8
Shelter 'Emergency shelter', 'Shelter for the homeless', 'Temporary shelter', 'Shelter for adults under the influence of alcohol', ...	19	29.2
Primary needs (food, clothes, hygiene, medical equipment, ...) 'Soup kitchens', 'Personal hygiene', Food (5 meals/day), clothes and laundry', 'Social meals service, social pharmacy, social grocery, etc.', ...	18	27.7
Administrative/legal help 'Legal aid', 'Generally, make sure that the women have basic- and civil rights', 'Advice on paperwork and obtaining social benefits', ...	14	21.5
Street work/outreach 'Medical assistance in the street and psychological assistance in the street', 'Social – Outreach Team', 'Outreach (street units targeted on homeless and addicted people)', ...	12	18.5
Education/training 'University courses for inmates who are currently detained', 'Training projects (Italian, English, elderly assistance, digital literacy, etc.)', 'English language course', 'We promote the right to education by building or rebuilding schools, training teachers, and promoting educational activities in humanitarian crises', ...	11	16.9
Drugs/Harm Reduction 'Harm reduction and prevention, rehab programmes, rehab communities', 'Linkage to public health care units, like HIV clinics, but also mental health care services including drug addiction treatment units', ...	7	10.8

* Multiple services or answers possible per organisation.

The survey inquired further about the provision of emergency services and (mental) health services by organisations (see Table 4.4). Respondents were asked to specify the services they offer, with approximately three out of five organisations reporting the provision of emergency services, such as 'First aid and prevention of overdose', 'Crisis centre service', 'Emergency care (including emergency food aid)', and 'Emergency night shelter'. According to Figure 3.1, half of the organisations provide health services, such as 'Services of a psychiatrist (office with community psychiatry)', 'Consultations

of clinical psychologist', and 'Accompaniment to guests in approaching medical and/or psychiatric services'. The examples highlight a distinction between direct and indirect health services, where the latter involves evaluating users and referring them to (specialised) health services if necessary. About 45% of organisations offer direct health care, while around one-fifth provide indirect health services (further analysis reveals that 18% of organisations offer both direct and indirect health care).

Table 4.4 Emergency services and (mental) health care in organisations (N=64)

	N	%
Emergency services 'Emergency care for users of drug consumption and addiction space in municipal shelter and mobile methadone programmes', 'We have 7 beds for emergency filed with the Social Security', 'Emergency night shelter', 'First aid and prevention overdose', 'Crisis centre service', 'Emergency care (including emergency food aid)', ...	39	60.9
Specific (mental) health care	32	50.0
Direct (mental) health care (N=60, 5 missing values) 'The mental assistance activity takes place in our clinics, is free of charge, and managed by specialised staff (psychotherapists and psychiatrists)', 'Services of a psychiatrist (office with community psychiatry)', 'Consultations of clinical psychologist. If a client has mental disorders, he is referred to psychiatrist', ...	27	45.0
Indirect (mental) health care (N=60, 5 missing values) 'The mental health response includes the following services: evaluation consultation and referral to specialised services with a psychiatrist', 'Regarding medical care, the team streamlines participants' access to local public health centres or specialised medical services whenever needed', 'Accompaniment to guests in approaching medical services and /or psychiatric and/or in job placement paths', ...	13	21.7

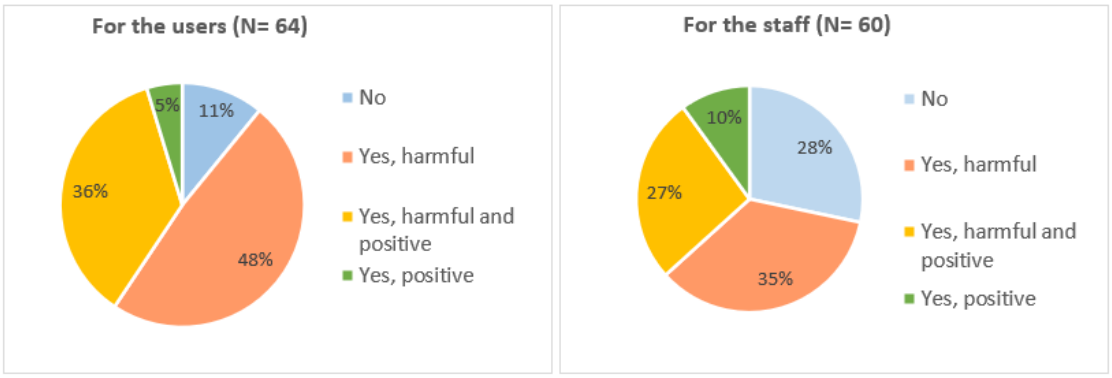
4.3 Assessing the effects of COVID-19 on homeless populations and services

4.3.1 Information from the survey

The Person First project started during the COVID-19 crisis, in February 2022. Therefore, one of the survey objectives was to assess the impact of COVID-19 on both services and users, examining innovative changes and organisational transformations, as well as drawing lessons from the pandemic.

Approximately half of the organisations (48%) reported a negative impact of the COVID-19 crisis on their users, making it the most commonly reported response (see Figure 4.4). The second most common response (36% of organisations) was that the crisis had both negative and positive impacts on users. About one in ten organisations (11%) reported no impact on users, while a small minority (5%) reported only a positive impact. In summary, around four-fifths (84%) of the organisations reported a negative impact on users. Of these, 57% stated that these negative consequences are still being felt. On the other hand, approximately two-fifths (41%) reported a positive impact on users, with 52% stating that these positive consequences are still present.

Figure 4.4 The impact of the COVID-19 crisis on users and staff



The impact on service personnel differs from that of users. Although a negative impact is still the most reported (35% of organisations), approximately the same number reported that the crisis had both positive and negative impacts on staff or no impact at all - 27% and 28%, respectively. The proportion of organisations reporting no impact on staff was higher than those reporting no impact on users (28% versus 11%). Moreover, the proportion reporting only a positive impact on staff was higher than that for users (10% versus 5%). In summary, about three-fifths (62%) reported negative consequences for staff, with 44% indicating that these negative consequences are still present. Just under two-fifths (37%) reported positive consequences for staff, of which 74% indicated that these positive consequences are still present. Compared to the impact on users, there are more reports of no consequences for service personnel and fewer reports of negative consequences. The proportion reporting positive consequences is the same, but for service personnel, these positive consequences appear to be more enduring.

The consequences of the COVID-19 crisis for users were detailed by organisations in the survey,[13] see Figure 4.5 and 4.6. A majority (55%) of organisations identified limited accessibility of services as a major barrier caused by the crisis. This resulted in restricted access to shelters, emergency services, and other essential services such as medical, nutritional, and housing services.

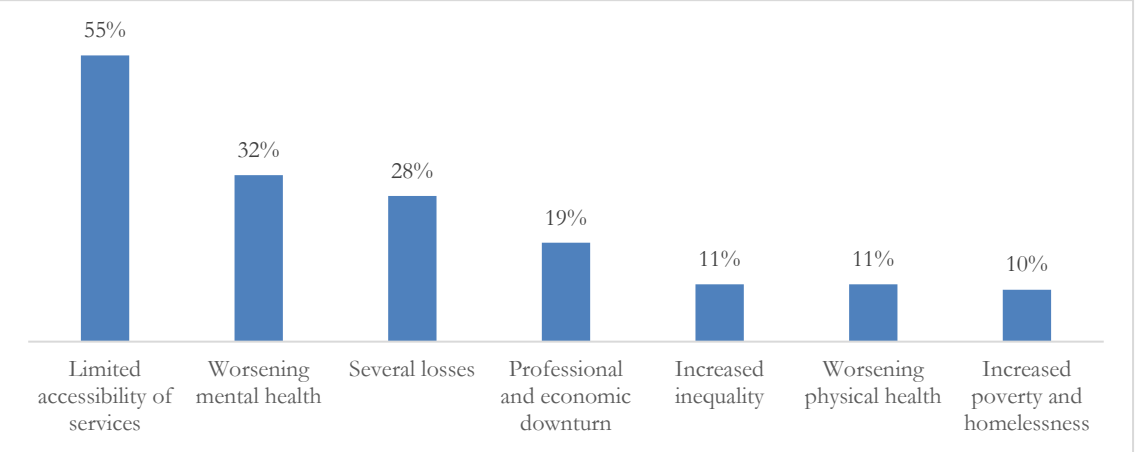
Around one-third of the organisations reported that the pandemic had a negative impact on the mental health of service users (32%) and led to experiences of loss (28%). Examples included increased drug and alcohol abuse, higher rates of double diagnoses, medical issues, losing loved ones, coping with anxiety and uncertainty, interruption of activities (such as jobs and social activities), and removal from support networks.

Additionally, one-fifth (19%) of the organisations reported that the crisis resulted in a professional and economic downturn for many service users due to job loss and the absence of informal sources of income, such as daily paid activities. Finally, about one in ten organisations reported that the crisis caused increased inequality (11%), worsening physical health (11%), and increased poverty and homelessness (10%). Examples of these impacts included disadvantaged groups experiencing larger, longer-lasting shocks, and having to adopt coping mechanisms that affect their economic prospects and ability to endure future shocks, increased risk of COVID-19 infection among those living in shelters (an average of 10-12 people per dormitory), and an increase in unemployment and poverty.

In summary, the COVID-19 crisis had significant negative impacts on service users, including limited accessibility to services, mental health deterioration, loss of experiences, professional and economic downturn, increased inequality, worsening physical health, and increased poverty and homelessness.

[13] In total, 53 organisations responded to the question about the description of the negative impact, while 26 organisations provided insights into the positive impact.

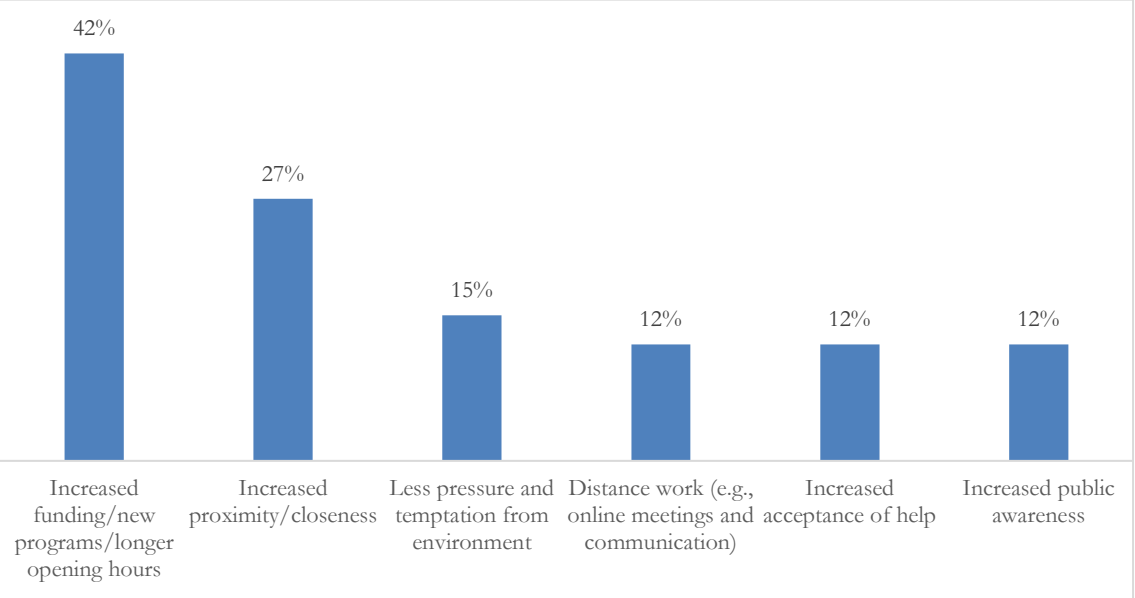
Figure 4.5 The negative (direct or indirect) consequences of the COVID-19 crisis for the users (N=53)



Organisations that mentioned positive outcomes of the COVID-19 crisis for service users highlighted increased funding, new programmes, or expanded opening hours as significant benefits (42%). This included financing for additional shelter beds and establishing housing facilities for homeless individuals who use drugs. In certain cases, night shelters transitioned into 24/7 shelters.

A little over a quarter of organisations (27%) reported 'increased proximity of closeness' as a positive impact on users, including the establishment of closer relationships between staff and users or a reduced number of users. Other positive outcomes included less pressure and temptation from the environment (15%), distance work (such as online meetings and communication) (12%), increased acceptance of help from the users (12%) and increased public awareness (12%). Examples included courts and related services operating on a limited scale, allowing people to breathe a little easier, services embracing email and scanning to speed up processes, being contacted by individuals who were previously hesitant to seek help and a slight increase in public awareness toward homeless individuals with psychiatric disorders.

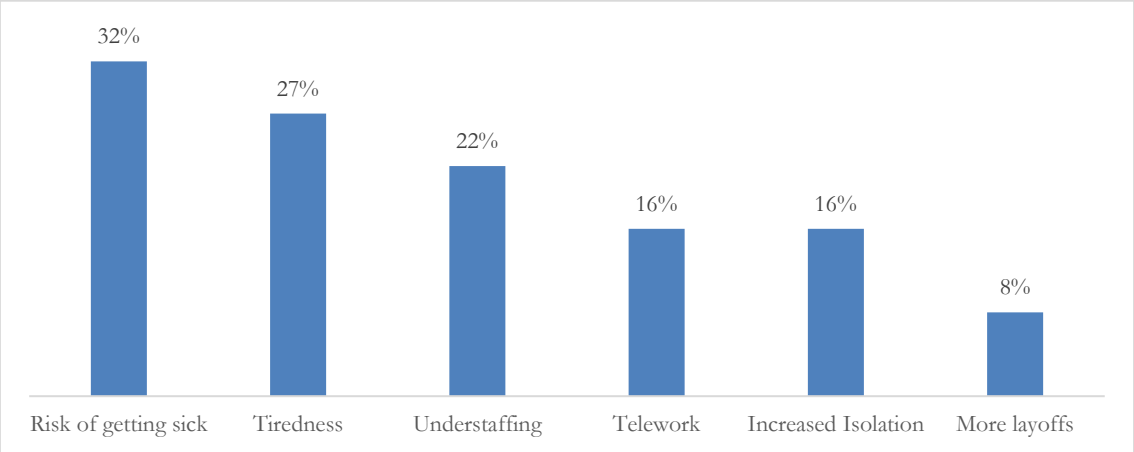
Figure 4.6 The positive (direct or indirect) consequences of the COVID-19 crisis for the users (N=26)



The consequences of the COVID-19 crisis for the staff of organisations were also detailed by organisations in the survey,[14] see Figure 4.7 and 4.8. Approximately one-third of the organisations mentioned the risk of becoming sick themselves (32%) and the additional workload caused by the COVID-19 crisis (27%). The pandemic induced more stress and emotional exhaustion among staff due to factors like an emphasis on physical health and mask mandates, as well as prolonged sick leaves of colleagues. Keeping the organisation open for extended hours while being understaffed was incredibly stressful, and staff experienced stress and fatigue while dealing with users who were not always compliant with social distancing and mask usage.

About one in five organisations (22%) also indicated that understaffing was a negative consequence of the pandemic. For instance, some volunteers no longer came to serve, and workers were often absent due to illness. Other negative consequences included telework (16%), increased isolation (16%), and more layoffs (8%). Although telework can have a positive impact on staff (see below), the nature of their work is based on relationships and trust, making working remotely with users difficult. Furthermore, not only the lives of users but also the personal and professional lives of staff were affected by the pandemic, resulting in concerns about social isolation. The increased (temporary) layoffs, for example, affected staff working in the outreach context. In addition to involuntary departures, voluntary departures were also reported, as some staff took advantage of the epidemic to leave the organisation.

Figure 4.7 The negative (direct or indirect) consequences of the COVID-19 crisis for the staff (N=37)

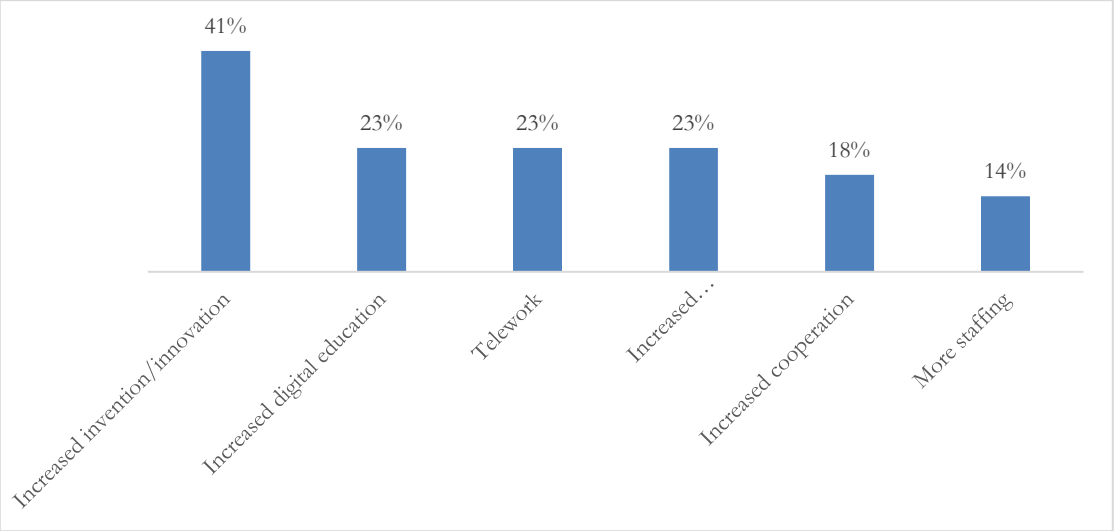


Looking at the positive consequences of the COVID-19 crisis on personnel 'increased invention of innovation' is mentioned most frequently, by 41% of organisations. Examples of this include finding innovative solutions to connect with guests and utilising distance meetings and training to better manage time. The innovation is mainly related to a new (digital) and more efficient way of working. This is also reflected in other responses, such as 'increased digital education' (23%) and 'telework' (23%). Some examples include video meetings, online work (e.g., setting up a shared drive), and employees working from home for additional training and professional literature reading.

Additionally, it is reported that the COVID-19 crisis has led to increased cohesion and togetherness (23%) and increased cooperation (18%). Strengthening relationships between colleagues or with users can be explained by being labelled as an 'essential service', which had a positive effect on morale and brought organisations closer together. For some organisations, the COVID-19 crisis also provided an opportunity to cooperate with other organisations or authorities more closely.

14 In total, 37 organisations responded to the question about the description of the negative impact, while 22 organisations provided insights into the positive impact.

Figure 4.8 The positive (direct or indirect) consequences of the COVID-19 crisis for the staff (N=22)



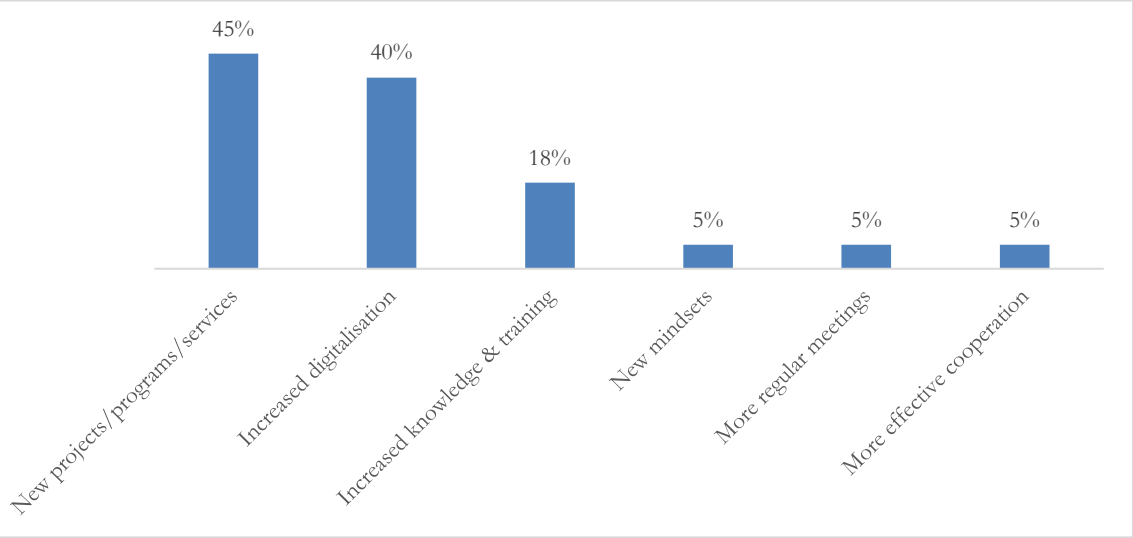
Although understaffing was a significant negative impact of the COVID-19 crisis for some organisations, a few organisations (14%) were able to receive help from increased personnel. This was due to more funding for, for example, an expansion of the Housing First programme. Additionally, some young people wanted to volunteer during the COVID-19 crisis.

The consequences of the COVID-19 crisis for the organisation were also detailed by organisations in the survey,[15] see Figure 4.9. Just over three out of five organisations (64%) reported undergoing transformation or innovation in response to the COVID-19 crisis. The most common initiatives included the initiation of new projects, programmes, or services (45%), and an increase in online communication and digitalisation (40%). Examples of new services encompassed integrating homeless families with babies and children, as well as transgender individuals, into a programme, scaling up a Housing First project from 30 to 120 units, establishing an outreach team specialising in the screening and treatment of Hepatitis C, launching two social businesses to enhance the employability of vulnerable populations, converting a night shelter into a 24-hour facility, and delivering more flexible and effective services under crisis conditions. Online communication examples not only involved utilising digital channels with colleagues or other partners but also with users, thereby enhancing the digital skills and competencies of users. Moreover, conducting online meetings allowed for more time to be available for direct contact with users.

Other forms of innovation included increased knowledge and training (18%), adoption of new mindsets (e.g., the care philosophy has shifted from making individuals uncomfortable to emphasising their comfort, allowing for rest, fostering self-esteem, and enabling a positive mindset to face the world) (5%), more regular meetings (5%), and more effective cooperation (5%). The expansion of knowledge, for instance, resulted from addressing the increased diversity of participants and support needs, frequent communication with the community, and the development of social networks, websites, and newsletters. The introduction of online meetings positively impacted information exchange, leading some organisations to organise more frequent meetings.

[15] In total, 40 organisations responded to the question regarding opportunities for transformation and innovation within their organisation arising from the COVID-19 crisis.

Figure 4.9 **The opportunities for transformation and innovation in the organisations due to the COVID-19 crisis (N=40)**



4.4 Project partners' insights and recommendations

According to the project partners, mental health care often revolves around counselling, with companionship and guidance being more crucial than formal treatment. However, addressing the mental needs of homeless individuals can be challenging for several reasons:

- **Time constraints**: Service providers may lack sufficient time to address mental health concerns during brief interactions with homeless individuals.
- **Shame**: Some homeless people may feel embarrassed or ashamed about their mental health issues, making them hesitant to discuss them.
- **Lack of awareness**: Some homeless individuals may not recognise the need for mental health assistance and/or motivation to change.
- **Other priorities**: Homeless individuals may prioritise immediate needs like shelter, food, and safety, considering mental health a lower priority in comparison.

According to the project partners, to better tailor services to the real needs of homeless individuals, it is crucial to:

- **Adopt a listening attitude**: Invest enough time in good intake interviews, prioritise understanding and addressing the needs of homeless people themselves, rather than focusing solely on the service on offer. In some cases, individuals may not be aware of their needs or may be hesitant to share them. Confidence and building a trustful relationship with the person are of utmost importance. Building such a relationship might be time-intensive, taking months or even years. It is the responsibility of the service workers to invest in people and respect their decisions if they choose not to confide in them.
- **Address accessibility issues**: tackle challenges related to accessibility, particularly those faced by undocumented migrants, homeless families, and individuals with disabilities.
- **Foster collaboration**: encourage collaboration and partnerships between mental health and social services, public and private organisations, and policymakers. It is important that each partner should maintain their identity while working collaboratively for the benefit of homeless individuals.
- **Establish a comprehensive resource hub**: create a one-stop-shop for homeless individuals and related organisations, featuring a comprehensive assessment of homeless needs and a dispatch system to connect them with appropriate services.

The aftermath of COVID-19 brought about temporary innovations in homeless shelters, such as reduced bed capacity to ensure adequate spacing between beds and living areas to comply with social distancing guidelines. This often meant reducing the capacity of shelters and utilising alternative spaces such as community centres or hotels to accommodate individuals while maintaining safe distances., improved sanitary conditions by enhanced cleaning protocols, ensuring that high-touch surfaces were regularly disinfected and providing access to handwashing stations and hand sanitisers., increased accessibility to clients, and enhanced integrated services, implemented rigorous screening protocols for new arrivals, including temperature checks and symptom screenings, to identify individuals who may be at risk of COVID-19 and provide appropriate care and isolation if necessary. Overall, the aftermath of COVID-19 prompted homeless shelters to adapt quickly and implement innovative measures to protect the health and safety of residents while continuing to provide essential services and support. However, these advancements have regressed, and most shelters are now reverting to their pre-COVID practices.

In Spain, amidst the COVID-19 pandemic, the government took the initiative to provide shelter for all individuals experiencing homelessness, a measure that was previously considered unfeasible. Certain shelters extended their accommodation to active consumers, and this practice continued even after the pandemic. Moreover, the collective situation of providing shelter to everyone created an opportunity to engage with these individuals, inquire about their needs, and explore potential solutions. Regrettably, due to staffing shortages, this opportunity was not fully realised.

Reflections from the project partners based on survey data:

- COVID-19 has blurred the line between work and personal life;
- alternative ways of working, such as digital communication, have emerged, benefiting both the organisation and users;
- while more online education has been implemented, migrant children face significant barriers to access due to a lack of equipment capable of participating in online education or services, underscoring the importance of equal access to digital education;
- there is a growing awareness that vulnerable groups require specific plans in times of crisis. Providing care for these groups is crucial, and municipalities lacking plans struggled to offer even the most basic services. Health-related stigmatisation of vulnerable populations (as being spreaders of contaminations) must be avoided, as it contributes significantly to their poor treatment during a crisis;
- the crisis has prompted a shift in awareness from a mentality of 'get out as soon as possible' to 'invest in rest';
- prevention remains essential despite health risks. However, a forward-looking approach is necessary, as large-scale shelters are once again being implemented.

PART 2
THE FOUR PILLARS OF PERSON FIRST

In each of the next four chapters, we focus on one of the 'pillars' of the Person First approach: social assistance, health and mental health care, housing, and participation/rehabilitation). Each chapter consists of a set of 'pictures' of existing services that were visited or presented in the context of the Erasmus+ project, followed by reflections by the Person First team.

The practices described in these chapters are not analysed in depth, leaving room for personal reflection and assessment to the reader. Nor do we aim to classify them as good, bad or best practice, as none are perfect, yet each offers valuable lessons. Thus, these case descriptions can serve as raw material for analysis and discussion by students or trainees. An overall normative assessment can be found in Chapter 10.

An important quality feature of the Person First approach concerns the integration of services. This is the focus of Chapter 9, where a similar method based on a set of case studies is used.

5 | Social assistance

5.1 Comprehensive support for Athens' homeless population: A spotlight on PRAKSIS open day centres and peer workers' stories

The open day centres for the homeless operated by PRAKSIS in Athens and Piraeus serve as direct access structures to meet the basic needs of the homeless population. These centres provide essential services such as primary health care, personal care, hygiene services, and liaising with other support services. Beneficiaries are empowered through daily accommodation, personal hygiene, clothing provision, food and beverages, storage for personal belongings, basic health care and medication, and participation in individual or group meetings for problem management. In addition to these services, long-standing volunteer initiatives such as Imathiotheque, Lending Library, Film Club, and Children's Corner operate at the Homeless Day Centre in Athens.

The day centre in Athens, established in 2012 in an impoverished area, operates as an NGO and emphasises community integration. Before the COVID-19 pandemic, the centre received 100-120 daily visits, but post-pandemic, this has diminished to 80 visits per day. The centre caters to both migrants (50%), legal and undocumented, and homeless individuals (50%), creating a familiar and supportive environment. The facility provides laundry facilities, showers, medical care, coffee, snacks, and occasional lunches based on donations. There are spaces for socialising, including a lobby and a children's room. The team comprises nine social workers, a psychologist available one day per week, and peer workers actively engaged in a street work project. The centre collaborates with PRAKSIS Community Centre[16] (where specialists can be consulted), pharmacies, local hospitals, and engages in advocacy efforts.

The centre faces challenges such as legal and licensing issues, impacting services like a volunteer-led haircut service, which had to be discontinued. However, coupons for other haircut shops are now distributed. PRAKSIS also provides housing solutions by letting apartments to refugees. In the past decade, the day centres have received 280,000 visits, with 25,000 meals distributed in the first 8 months of 2023.

Despite the mayor's commitment to create a shelter, the municipality lacks experience in addressing homelessness, leading to a preference for outsourcing services. Structural solutions remain elusive. Athens has confronted various crises, including the financial crisis in 2009/2010, the migrant crisis in 2015, and the ongoing COVID-19 pandemic, exacerbating housing problems. Currently, the local Greek population, restricted in accessing credit, struggles to reimburse mortgage loans. Affordable housing is further challenged by the prevalence of Airbnb in the city.

Personal stories from peer workers highlight the challenges and experiences of homelessness and drug addiction. One peer worker, who spent 15 years homeless, found motivation to overcome drug use for stable employment, a home, and companionship with his dogs. Knowledgeable about various

[16] Health care services are delivered by a team comprising a general practitioner, a gynaecologist, a neurologist/psychiatrist, and a dentist. The centre's social pharmacy administers pharmaceuticals when available. The medical department aims to provide therapeutic interventions, health counselling, and education on the proper use of medication. As part of its Public Health activities, the centre offers information and conducts rapid tests for HIV, hepatitis B & C.

drugs, including methadone[17] and the alarming misuse of sisa or shisha[18] in Athens, he serves as a specialist and liaison for other workers. Despite encountering conflicts in his role as a peer worker, he is widely accepted and praised. He also provides a form of protection and support within the street work team. Another peer worker, born in Germany and residing in Greece for 28 years, shares the struggles of drug use in a country where even a single pill can lead to imprisonment due to conservative societal norms. Both peer workers advocate more supervised drug-use spaces, drug decriminalisation or legalisation, and legal prescription of drug substitutes like methadone.

5.2 The Caritas Warsaw night and day shelter strives to be a home for homeless people

According to Andrzej Czarnocki, the director of the Caritas Warsaw night and day shelter for homeless people, the most crucial factor in a person's recovery process is their relationships with others. These relationships serve as the foundation that gives meaning to all other forms of assistance. However, this important reality sometimes is neglected, forgotten, or underrated. The shelter in Warsaw strives to be a home for its residents, however inadequate or temporary such home may be. It strives to be an environment where individuals can feel secure and welcomed enough to solace, regain composure, and experience fair and kind interactions with others, following many hardships in life. The Person First principle is interpreted here as the 'home principle', wherein the staff aims to create a homely atmosphere through relationships built on respect, dialogue, and active participation.

The shelter operates on three crucial key principles:

- *Respect*: It is expected that both staff and residents demonstrate respect in all relationships, by being non-judgmental, attentive, understanding, and willing to assist. Any lack of respect, including a superior attitude or aggression, is regarded as a significant issue.
- *Dialogue*: Dialogue does not shy away from tough questions. It is neither naive nor afraid to set boundaries or conditions. By its very nature, it involves negotiation between two free individuals. It listens and seeks to accommodate the preferences of the other person as long as they do not cause harm. It enables the recognition of each person's specific needs, limitations, and strengths. Establishing a culture of ongoing dialogue and negotiation is essential for nurturing relationships. Dialogue includes addressing struggles with addiction, exploring therapy options, and engaging in shelter activities.
- *Participation*: Active involvement in shelter activities is considered a sign of respect towards others. Residents are encouraged to contribute to tasks such as preparing and serving meals, organising clothing, and maintaining shared areas. These activities not only improve the functionality of the shelter but also foster a sense of collaboration and support among residents, enabling them to actively participate and form meaningful relationships.

The challenges faced by this approach can be broadly categorised as follows:

- *Conflicting regulations*: These often arise externally and may present contradictory directives. For instance, there may be regulations prohibiting the presence of substance abuse on the premises, while simultaneously advocating for a person-first approach that accommodates all individuals, including those with substance abuse issues. Such discrepancies between regulations and real-life

[17] • Methadone, recognised by its green pills, serves as both a tranquillizer and an opioid painkiller. It is prescribed for individuals addicted to heroin or morphine to prevent withdrawal symptoms.

[18] Sisa or shisha is a psychoactive drug originating from Greece. Its primary component is crystal methamphetamine, supplemented with additives like battery acid, engine oil, shampoo, and salt. Notably, it is extensively misused by numerous homeless individuals in Athens, leading to hazardous side effects, including insomnia, delusions, heart attacks, and violent tendencies. Administration methods involve smoking, snorting, and intravenous injection. Unfortunately, many individuals have already lost their lives to its effects. There are also cocktails (Tai) combining shisha and heroin available in the market.

situations can hinder the implementation of a person-first approach. These restrictions or prescriptions that hinder adequate solutions often stem from ideological differences. For instance, while the Housing First procedure may have its advantages, it may not be suitable for every individual at every stage of the recovery process. It is crucial to evaluate everyone's unique preferences and capabilities at any given moment, as well as the organisation's capacity to provide the necessary supportive environment.

- *Balancing rights*: Striking a balance between the rights of all individuals residing and working in the shelter, including both residents and staff members, presents an ongoing challenge. Daily conflicts arising from shared living and working spaces are common occurrences, such as noisy behaviour at night or differing preferences during television viewing. While private rooms would be preferable for many, they may not be suitable or feasible for everyone.
- *Staff attitudes*: In any relationship, the assisting person assumes a leading role, responsible for fostering a positive relationship with the assisted individual. The term 'assisting person' encompasses all shelter employees. Maintaining standards of respect, particularly when interacting with a 'difficult' resident, demands continuous effort, dialogue, and above all, respect from staff members.

Despite these tensions, shelters, with their opportunities for building relationships, play a crucial role in the recovery process, particularly for the most vulnerable individuals who struggle with specific mental health issues or severe addiction. For these individuals, shelters can serve as a valuable temporary or permanent residence, depending on their needs. It is essential to maintain a focus on creating a sense of home and dignity for them within the shelter environment.

5.3 Santa Barbara (Lisbon) emergency shelter: Embracing the Person-First principles through resident relationships, participation, and empowering voices

The municipal emergency centre in Lisbon, Santa Barbara, operates 24/7 and accommodates 128 individuals, including 95 males, 17 females, and 8 couples prioritised by the Street Technical Teams. The centre, centrally located, offers numerous services, including a 24-hour accessible dispatch providing integrated health and psychosocial support.

Children and minors are not allowed in Lisbon shelters, and a specific protocol is in place for families with children. For instance, if a child is found sleeping rough, authorities are legally obligated to intervene.

Santa Barbara provides:

- individualised psychosocial follow-up for a personalised life project;
- basic needs satisfaction and preparation for integration into more restorative interventions for autonomy and social integration;
- intervention focused on individual needs, risk reduction, and damage minimisation for atypical cases;
- a partnership network for daily engagement, diverse activities, and investment in training/employment;
- a dedicated space for occupational activities fostering skills development in sports, leisure, cooking, education, etc.;
- participation in city events and visits to museums, concerts, fairs, etc.;
- a homeless journal (CAEM Santa Bárbara) with opinion articles, activity records, and various themes;
- nursing service 365 days a year, with internal medical consultation twice a week, including screening for various conditions;

- accommodation for visitors' pets;
- a support service for individuals with drug addiction, offering spaces for smoking, intravenous consumption, and alcohol consumption, with referrals to medical and social services.

The centre adheres to the Person First principle, maintaining a horizontal relationship with residents. This not only creates a safe space but also aids community relations by discouraging substance use outside the shelter. Protecting vulnerable residents from relapse is crucial, leading to referrals for more protective services when needed. The centre collaborates with other shelters, providing daily transfers for tailored support. The municipal plan facilitates an overview of available services in the city.

Santa Barbara employs a medical protocol for new service users, offering pre-approved medication to alleviate withdrawal symptoms. Some individuals reduce or quit drinking, and a low-threshold methadone programme is integrated, eliminating the need for mobile van visits. The centre continually introduces new procedures, tools, and perspectives to address substance use within the shelter.

Furthermore, Santa Barbara actively encourages resident involvement and participation in decision-making processes. This inclusive approach aims to empower individuals and foster a sense of community within the centre.

5.4 Shelters and day centres in Helsinki

5.4.1 No Fixed Abode's day and night centre

No Fixed Abode's day and night centre serves as a community hub for homeless individuals, offering activities, peer support, and essential supplies such as clothes and hygienic products. Peer workers are responsible for the day-to-day life of the centre, emphasising the importance of lived experiences in supporting the homeless community. The centre operates during extended hours, providing a warm lunch and coffee throughout the day. Visitors, often facing mental health and substance abuse challenges, can access help for practical issues and seek assistance anonymously (only a first name or a chosen nickname is required for registration).

In the summer, the centre opens from 9 am to 7 pm, while in the colder months (October-April), it operates at night as well, accommodating approximately 100 visitors daily. Visitors have the option to sleep in the centre, although the absence of beds is due to bureaucratic limitations. The centre caters to individuals aged 18 and above, with a majority facing challenges related to mental health and substance abuse. While visitors are permitted to enter the centre under the influence of drugs or alcohol, the use of substances within the centre is prohibited. Violation of this rule results in a one-day prohibition from entering the centre. Serious or repeated violations of the rules will result in longer prohibitions.

The primary objective is to secure housing for individuals. Those without a residence permit in Finland are in a very precarious situation in the housing market but the centre offers guidance. A specialist in this field is available to provide personalised assistance. In connection with the day centre a housing counsellor and a floating support worker are available by appointment

The night shift is staffed by two workers, preferably one of whom has personal experience of homelessness. At the moment the team consist of three professionals and one peer support worker. No Fixed Abode's outreach team, consisting of two nurses, addresses life-threatening situations during harsh winter conditions. Operating at night, the team reaches out to those sleeping rough, offering first aid, shelter transportation and building relationships that can take up to six months to establish.

5.4.2 Hietaniemi service centre for the homeless

The Hietaniemi service centre for the homeless operates around the clock, encompassing emergency services, temporary housing, and a day centre. The centre employs a robust security system, including 24/7 surveillance in public areas, although private rooms remain camera-free. A dedicated guard ensures the safety of residents, with reported incidents of violence considered relatively low given the large number (more than 100) of occupants.

The centre employs a diverse staff, including nurses, doctors, social workers, and social instructors.[19] These professionals offer comprehensive care, from medical assistance to support services outside the centre. Despite the demand for their services, staff members work on relatively permanent schedules, contributing to the centre stability.

a) Emergency services

In this section, individuals seeking overnight accommodation, aged 18 and older, can secure a bed by calling the centre. Reservations are made daily between 5 pm and 9 am, with a cap of 60 beds available. Some residents have opted to stay in the emergency services for more than a decade, choosing not to pursue permanent housing of their own.

Residents are allowed to be intoxicated but must be residents of Helsinki, identified by their social security numbers. Individuals lacking a residence permit are not eligible to stay in the emergency centre. In situations where individuals with children require accommodation, the city is responsible for providing for their housing needs.

Women and men are housed separately, with three rooms dedicated to women. However, there is a shortage of rooms for women, and these spaces are frequently fully occupied. The centre provides lockers, meals at a nominal fee, and enforces strict rules to maintain order.

Finland's policy primarily emphasises supported housing over emergency services with the main goal of eliminating homelessness. However, due to the increased demand for accommodation during COVID, emergency centres are essential, despite being far from ideal, as the waiting lists for Housing First accommodation are excessively long.

b) Temporary housing

The temporary housing segment offers private rooms within a communal setting. With separate blocks for men and women, the facility comprises 52 rooms (9 rooms for women), each equipped with shared bathrooms, kitchens, and a designated smoking area. The cost for one night is a maximum of 14.6 euros, subject to income variations. Residents sign agreements adhering to rules such as no violence or substance use inside the premises. Staff conducts nightly room checks, and visitor access is restricted to specific cleaning days (i.e., Monday and Saturday and not during nighttime).

c) Day centre

Operating until 6 pm, the day centre provides meals (at the cost of 1 euro), computer access, sauna facilities, and laundry services. Charging nominal fees for certain amenities aims to instil a sense of responsibility among visitors. Social workers are available for appointments, and residents can undertake paid chores.

5.5 Shelters and day centres in Ljubljana

5.5.1 ŠENT day centres: Fostering mental well-being and community resilience

Day centres, initiated by ŠENT to address the unmet needs of homeless individuals, play a pivotal role in promoting mental health, rehabilitation, and community integration. With a commitment to

[19] A social worker has a master's degree and can make decisions, a social instructor has a bachelor's degree.

destigmatisation and personalised growth, these centres serve as crucial hubs for support and empowerment.

Currently managing 16 day centres in Ljubljana and Nova Gorica with a team of 17 employees, ŠENT serves approximately 1,300 users annually. While initially balanced, the user demographic is evolving with an increasing proportion of men. The majority (80%) come from a low socio-economic background and are typically referred by social services, community psychiatric teams, treatment coordinators, GPs, or psychiatrists. The centres actively collaborate with other organisations to enhance visitor conditions.

Day centres focus on rehabilitation, destigmatisation, and helping visitors learn to live with their conditions. Collaboratively designed individualised action plans prioritise autonomy and personal growth. Activities, ranging from life skills training to creative workshops and arts and crafts, contribute to holistic well-being. Complaint boxes provide an avenue for anonymous feedback, and family members engage in supportive self-help groups.

Access to day centres is unconditional and free, Subsidised by the Ministry of Health (90% salary costs). Additional funding comes from FIHO and local municipalities. Private fundraising is not a common practice in Slovenia, although occasional contributions from major corporations, such as Bayer, are made to NGOs.

The dedicated team at the day centres includes psychologists, social workers, theologists, and other professionals. During operating hours, both the Ljubljana and Nova Gorica centres are staffed by a clinical psychologist and a social worker, vouching for a multidisciplinary approach to support visitors.

5.5.1.1 Nova Gorica day centre

Established in 2020 and organised by a psychiatric hospital, the Nova Gorica Day centre is a beacon of community-based mental health care. It not only provides vital support to individuals facing mental health challenges but also strives to destigmatise and innovate. The centre promotes self-activity, personal responsibility, and self-help, with an additional focus on educating the public about mental health.

The day centre's goal is to address mental health and life challenges, fostering daily structures, life skills, social bonds, and preventing loneliness. Individual treatments and diverse group activities, such as communication workshops, arts, crafts, and trips, contribute to visitors' holistic development. The participatory approach involves visitors in planning activities, with a transparent complaint system taken seriously by the centre.

The day centre operates for 12 hours a week, from 8 am to 1 pm, providing an opportunity for active engagement. Open to all in Slovenia aged 18 and above, the centre welcomes visitors for specific activities or social interactions, averaging 10-15 visitors daily, totalling around 120 different individuals annually.

During the COVID-19 pandemic, the day centre temporarily closed, prompting the social workers to provide counselling over the phone. While other organisations paused aid, ŠENT continued supplying essentials to the homeless. Increased tensions, heightened alcohol abuse, and pandemic-related anxiety led to a surge in mental health issues. Unfortunately, one young individual dropped out of school, highlighting the profound impact on their community.

With one social worker, one assistant, and seven volunteers, the day centre navigates challenges in recruiting qualified personnel. The sector's struggles with workforce shortages and tough-to-fill vacancies, emphasising the critical need for skilled professionals.

5.5.1.2 ŠENT day centre Ljubjana

Originating three decades ago, the ŠENT day centre in Ljubljana stands as one of the organisation's pioneering services, specifically tailored for individuals discharged from psychiatric hospitals. Before its establishment, a void existed for those transitioning from psychiatric care.

The day centre warmly welcomes individuals facing mental health challenges, along with their friends and family. Upon arrival, visitors encounter a voluntary and free programme. A nominal yearly membership fee symbolically exists at 4 euros. An initial interview with a social worker evaluates individual needs and expectations.

The centre offers both individual and group treatments. Individual plans, tailored to each person's unique circumstances, aim at fostering independence and personal growth. Daily counselling on mental health matters is available, complemented by group activities focusing on social and basic life skills. Visitors are encouraged to extend their interactions outside the centre, nurturing personal networks.

With a dynamic weekly programme and monthly meetings to assess skill needs, the day centre places a strong emphasis on visitor participation. Visitors can contribute as volunteers, sharing their skills in activities like aroma therapy or language instruction. The programme is designed collaboratively, allowing visitors to voice concerns and submit complaints, which are earnestly addressed by ŠENT.

5.5.2 Nova Gorica shelter for homeless people

Established in 2016, the Nova Gorica Shelter for homeless people operates as a private nonprofit organisation dedicated to addressing homelessness. While the overarching goal is to facilitate permanent exits from homelessness, the immediate focus is on providing a safe haven for individuals experiencing homelessness. Open from 9 pm to 9 am, the shelter offers practical support, such as personal hygiene assistance, and facilitates meaningful conversations with its visitors.

The shelter opens nightly due to resource constraints, and daytime access is limited. Referral to the day centre is encouraged, but a perceived 'culture gap' with the youngsters hinders the transition for some residents. The shelter provides facilities for washing clothes and socialising. Doors are locked after 11 pm, and visitors can leave at any time. Residents wake up at 8 am, have breakfast, and must leave the shelter by 9 am. Those with jobs, like working in a vineyard, spend their day working, while others engage in leisure activities. In the evening, individuals return to the shelter. During the visit of this shelter, some were seen sitting below the stairs at the centre's entry.

There are 12 beds and 2 emergency beds distributed across 6 twin rooms, with plans to expand to 18. Emergency beds are allocated based on perceived need. If deemed unnecessary or if the individual can afford it, alternative paid accommodations (25 euros/night) are recommended.

The shelter accommodates both men and women, with separate rooms and exceptions for couples or emergencies. The majority of visitors are males aged between 40-50 years. Residents in the shelter tend to have stable stays, with no specified time limit. Some individuals have experienced homelessness for over 30 years. Visitors can stay up to four nights initially, with the option to extend. However, if individuals fail to show up without notice, their spot in the shelter may be assigned to someone else. Belongings can be stored during the day.

To be eligible for the shelter, individuals must meet three criteria: (1) be homeless, (2) be 18 years or older, and (3) be from the municipality. In cases where social workers perceive a person to be at substantial risk, individuals from outside the municipality may be accommodated for one night. Upon entry, visitors complete an entrance sheet, providing their name and acknowledging shelter rules, including restrictions on bringing alcohol or drugs, smoking in the room, engaging in violence, and

having pets. Violations are subject to sanctions by a commission, though these instances are infrequent. The shelter accepts individuals under the influence of alcohol, and visitors can remain anonymous during their initial visit(s). Social workers will verify homelessness with the centre for social work but only after a few days.

The day centre, open from 2 pm to 8 pm, serves shelter residents. However, not all shelter visitors participate. All shelter visitors are referred to the centre for social work. Connections with employment and housing services are sought externally. Therapeutic counselling is not provided within the shelter, and referrals are made to appropriate external services.

Despite shelter operations ending at 9 pm, complaints from neighbours persist. Open house events are organised to foster understanding, and neighbours have direct contact with the manager. A volunteer at ŠENT, who is a visitor to the shelter, has taken on cleaning responsibilities and now regards the shelter as her second home after a year of being there. Other users manage their own laundry and are responsible for maintaining the cleanliness of their rooms.

Regarding human resources, only one staff member is present during the night; security services are hired if this person is unavailable. In emergencies, the manager can be contacted by phone. While staff are informed about incidents through visitor reports, such as violent occurrences, recognising mental health problems or dual diagnoses among visitors is challenging as the staff lacks medical training.

5.5.3 The low threshold shelter for alcohol and drug users in Ljubljana

Established in 2012 in the city centre, the shelter for drug users operates on a 'low threshold' approach, welcoming individuals under the influence of drugs or alcohol. The facility, uncomfortable with 15 spots for both male and female users, accommodates approximately 50 individuals annually.

The shelter provides sleeping arrangements, showers, washing machines, meals, and community work opportunities within the facility. Psychosocial and legal support, counselling, and access to syringes for drug consumption are also offered. Regular health monitoring and monthly screenings of alcohol/drug consumption are mandatory. Plans for user rooms are in progress.

Open daily, operating from 9 pm to 9 am in summer and 6 pm to 9 am in winter, residents spend their daytime at the Metelko day centre or in designated city spots. Some visitors engage in shelter responsibilities such as kitchen work or bathroom cleaning. Activities cease at 11 pm, and visitors retire to bed, waking up at 8 am and leaving by 9 am.

The shelter provides material support along with healthcare, community work, harm reduction, psychosocial, and legal assistance. No time limit for stay accommodates varying needs. Some rely on long-term shelter use, while others await access to 'high threshold' shelters for detoxification and rehabilitation. This shelter focuses on offering a transitional stay.

Staffed with 2 professional social workers and 2 regular workers, the personnel ratio of 1 worker for 12 clients falls below the norm of 1 to 8. Security concerns arise, especially during the night, as one worker manages the facility, exposing them to potentially violent incidents mostly triggered by alcohol. The lack of a nighttime security guard necessitates reliance on the police for safety, highlighting inadequate working conditions in the shelter.

5.6 Shelters and day centres in Riga

5.6.1 Riga Shelter Day Care Centre: Addressing homelessness and promoting Inclusivity

The Riga Shelter Day Care Centre emerged as a response to changing societal dynamics following the fall of the Iron Curtain, adapting to new economic conditions and family structures. Established in 2009, the centre initially aimed to make homeless individuals less visible, housed in a building originally constructed as a youth centre.

In its early years, the Riga Shelter Day Care Centre had an inclusive open-door policy, serving a diverse range of individuals, including the healthy, those with employment opportunities, and the elderly. However, a significant shift occurred in 2018 when the centre decided to narrow its focus, concentrating efforts on individuals facing specific challenges like mental health issues, disabilities, and substance abuse - particularly alcohol or drugs. This strategic pivot led to a reduction in overall clients but brought forth new challenges, requiring a heightened emphasis on daytime activities to address the more severe problems of the individuals served.

With approximately 1.8 million inhabitants in Latvia, there is no precise count of the homeless population. However, there are two categories observed: cooperative individuals who become invisible as homeless by engaging with available services and non-cooperative individuals living close to central markets and railway stations, often begging and perceiving homelessness as a lifestyle.

Society's perception of homelessness remains unchanged, with a desire for it to be invisible. Mobile teams receive requests to remove homeless individuals, highlighting societal attitudes. Some people misuse public transport for rest without payment, possibly due to the high cost of using electricity at home. Notably, there are long waiting lists for social flats in Riga.

The day centre, theoretically accessible only for night shelter guests, practically extends its services to other citizens. Operating from 9 am to 5 pm, with weekend services during winter, it accommodates around 65 visitors daily, primarily men.

Operational since 2009, the Riga shelter day care centre emerged in response to the aftermath of the financial crisis, characterised by high unemployment and over-indebtedness. While recent times have seen some improvement, homelessness predominantly affects specific demographics, including the elderly, disabled individuals, and those struggling with addiction. The centre also caters to Russians without a certificate of knowledge of Latvian, facing challenges in finding employment in government services and lacking social security coverage. Non-citizens of Riga, brought in by mobile teams or police, utilise the centre's facilities for basic needs like showers, with some residing in squats or garages.

To maintain a conducive environment, the centre imposes restrictions, barring intoxication by drugs or alcohol, with staff empowered to enforce these rules. The main problems faced by visitors include unemployment, isolated lifestyles devoid of friends and family, mental health issues, and disabilities.

Specific challenges arise for individuals who speak only Russian and lack proficiency in Latvian. Alcoholism, often rooted in family histories, poses a significant issue, while drug-related problems are more prevalent among the younger population. The breakdown of vulnerable family ties is also observed, especially in cases where individuals, particularly men around 50 years old, depend on their mothers. The death of a mother can leave them feeling lost. Similarly, unmarried women face challenges in legal status when their partners die, lacking a testament or property rights. These complexities highlight the multifaceted nature of the issues faced by the centre's visitors.

The centre follows a '50% social/50% cultural work' approach. Cultural activities aim to activate guests, including film screenings, table games, creative workshops, and library readings. Social work focuses on providing clean clothes, tailored guidance, information on services and rights, and rebuilding emotional bonds. Additionally, the centre offers voluntary work opportunities, incentivised with non-monetary rewards (e.g., snacks).

Addressing unemployment, isolation, mental health issues, and disabilities, the centre offers a combination of social and cultural services. Efforts include rebuilding emotional bonds, language teaching, and basic administrative skills. The centre collaborates with external organisations for celebrations and provides support for those seeking rehabilitation into work.

While not directly responsible for mental health services, the centre ensures client protection during crises. Cooperation with hospitals is effective, providing access to necessary care and treatment. Pathways for clients involve initial social care, access to Samaritan's Centre (social service centre), application for social housing, and potential autonomous exits.

The centre is staffed with a physician, nurse, social workers, and a psychologist. The psychologist, initially part-time, transitioned to full-time during the 2009 crisis. Some former clients return for ongoing psychological guidance.

5.6.2 Comprehensive support for women in need at Riga Shelter Women's department

The Riga Shelter Women's department has a rich history of providing essential services to women in vulnerable situations. Initially funded by the city government and supported by donations from individuals and companies, including contributions like chocolate from M&M, this facility transformed into a women-only shelter in 2015.

Services at the shelter encompass both day and night care, with a dedicated day centre catering specifically to women requiring special attention due to multiple problems or physical disabilities. Social workers carefully assess eligibility for daytime stay based on various factors such as medical needs, psychological issues, financial constraints, and the requirement for food support.

Upon entry, clients undergo checks for alcohol consumption, followed by decontamination and showering. The facility offers a selection of second-hand clothes, allowing women to choose items individually. Workshops, donated tickets to cultural events, creative activities, weekly food preparation sessions, and festive celebrations during holidays contribute to a holistic approach to well-being. The inclusion of fun and humour in activities is considered crucial.

The shelter comprises rooms with varying bed capacities - 5, 12, or 17 beds. The dedicated staff includes 5 social workers, a director, a nurse, and a doctor, with three individuals working throughout the day. The staff's approach emphasises finding solutions, creativity, and maintaining a free and humorous relationship with clients. Ongoing supervision, 24-hour training, and regular team meetings contribute to a dynamic and supportive work environment.

The shelter serves approximately 95-100 clients, with the first floor accommodating women with physical disabilities, often pensioners who prefer this intermediate solution to hospitalisation (which is too expensive). The second floor caters to women with psychological problems. The shelter has established rules, including restrictions on alcohol and drug use, designated smoking areas, and permission for cats but not dogs (too dangerous). The women are permitted to bring personal belongings, and family members are allowed to meet with them.

Many clients at the shelter face complex challenges, often rooted in trauma, debts, homelessness, or isolation. While some return to the centre after temporary periods away, others remain under care day and night.

5.6.3 Riga Shelter Men's department: A crucial haven for individuals in need

Funded by the City Council, the Riga Shelter Men's department has been a crucial haven for individuals in need. Primarily operating as a night shelter, the facility opens its doors from 5 pm to 8 am (no breakfast served). Clients, queuing from 4:30 pm, undergo a sanitary check before being served dinner between 5 pm and 8 pm. Social services, available from 9 am to 10 pm, offer assistance with administrative tasks, passports, financial affairs, housing searches, and family liaisons. Riga citizens are permitted to stay at the shelter, while individuals from other Latvian cities can stay for a duration

of 5 or 10 days. In such cases, the shelter initiates contact with the social services of the respective cities.

Spread across various floors, the shelter accommodates different needs. The first floor houses a nurse, while the third floor caters to men with alcohol problems. The fifth floor is designated for working men. This floor offers better conditions with fewer beds per room. Unemployed men who exhibit good behaviour are also accommodated on this floor. With a capacity for 170 individuals and 27 staff members, the shelter provides essential support. Clients may stay during the day based on health conditions (e.g., after surgery, because of heavy addictions), and some can work on (non-paid) shelter tasks during the day.

Access involves a registration process (a harmonised registration system between shelters in Riga) and sanitary checks, while restrictions include a zero-tolerance policy for alcohol (some tolerance on third floor) and violence (sanction is a 6-month exclusion). The shelter lacks leisure activities because of limited space, and clients are restricted to carrying very few personal items. The maximum duration of stay was initially set at 3 months, with exceptions allowing for up to 6 months. However, the current policy has removed this limit, as individuals tend to rotate between shelters. Additionally, the shelter includes an isolation room, utilised, for instance, when addressing issues such as theft among clients.

In the event of violence against staff, the first rule is to prioritise personal safety by seeking refuge in the staff room and promptly calling the police. Staff members are encouraged to maintain a realistic outlook while fostering hope for a better future. Additionally, emphasising humour and enjoying positive interactions with clients is considered crucial in the shelter environment.

The shelter caters to a diverse clientele, primarily aged between 50 and 60, including ex-prisoners seeking a fresh start. Pathways to the shelter often involve encounters with the police, street life, hospitals, and concerned neighbours.

Challenges include issues related to alcohol consumption and the complex needs of clients. Ideas for improvement include smaller groups to address diverse mental health problems and the inclusion of more specialised nursing staff. During the COVID-19 period, a positive experience emerged as clients testing positive were granted a 2-week stay at the shelter, including daytime accommodations.

5.6.4 Zilais Krusts (the Blue Cross): A haven of transformation and faith

Founded in 1996, Zilais Krusts (the Blue Cross) stands as a testament to resilience and recovery. Initially established as a religious congregation, the shelter has evolved into a beacon of hope under the guidance of its manager and pastor. A former client who triumphed over alcohol addiction, the pastor's personal journey of transformation fuels his mission to help others find a similar path. Acquiring the current building in 2003, once dilapidated Russian military barracks, the shelter underwent a renewal process in collaboration with its guests.

At its core, Zilais Krusts serves as a sanctuary for those facing crisis situations. Operating primarily as a night shelter from 5 pm to 10 am, the facility provides essential meals and offers a work rehabilitation programme. Men within the shelter actively participate in chores, woodworking, and maintenance, contributing to their rehabilitation journey. Men actively participating in work at Zilais Krusts can stay in the shelter during the day, including individuals with (mental) disabilities for a continuous

24-hour period (the ground floor is for men in wheelchairs). Additionally, some prefer work outside the compound, typically unofficially to avoid immediate repayment of loans or debts, ensuring greater financial flexibility.

Religious activities, such as Bible studies and optional Sunday services (while attendance is voluntary, staying for the optional Sunday service ensures access to coffee and tea; otherwise, departure is expected by 7 am) in the chapel adorned with paintings by clients, add a spiritual dimension to the rehabilitation process. Social services are also extended to provide support with paperwork and address individual needs.

Going beyond the shelter's walls, Zilais Krusts extends its impact to a family farm. This unique venture, featuring alpacas, llamas, rabbits, and camp sites, serves as both a regional tourist attraction and a source of revenue for the shelter. The farm also offers camping sites for children's camps, fostering a wholesome environment for growth and connection.

Guided by a team of eight paid staff members, the shelter accommodates approximately 140 clients, primarily consisting of ex-offenders. Some individuals have found solace within the shelter for more than a decade, highlighting the enduring support provided by Zilais Krusts. During the summer months, the client numbers may fluctuate, reflecting the dynamic nature of the shelter's engagement.

Zilais Krusts maintains a strict alcohol-free and smoke-free environment. Sanctions for alcohol or substance abuse include a 12-month exclusion, reinforcing the commitment to an encouraging and transformative atmosphere.

5.6.5 V.E.L.G. shelter: Navigating homelessness challenges with caring support

V.E.L.G. emerged from the consolidation of various shelters and received municipal support for establishing a day centre. Housed in a former sailors' hotel, the facility maintains positive relations with the neighbourhood, addressing concerns like designated smoking areas (inside instead of outside). Operating 24/7, V.E.L.G. accommodates clients in shared rooms on the 2nd floor and social flats on the 3rd-4th floors, funded by social services. The maximum stay is 6 months, individually assessed and potentially extending beyond a year. In 2022, V.E.L.G. accommodated a total of 220 guests, among them 76 women, with some being couples. The shelter enforces access restrictions, prohibiting alcohol consumption within the centre and ensuring a violence-free environment.

Services offered include assistance with paperwork, social flat applications, addiction treatment referrals, job applications, CV writing, and legal advice. Work rehabilitation faces obstacles due to financial traps, including the loss of benefits such as free transport and housing allowances.

Clients facing homelessness, financial difficulties, and health issues, including undiagnosed mental health problems, seek refuge. Commonly, they lack family support, struggle with societal integration, and exhibit alcohol addiction, which clients do not recognise.

The five clients present diverse challenges: a 70-year-old man facing health and financial distress with a very low pension, a 62-year-old woman dealing with material issues and low social benefits before retirement, a recently displaced 46-year-old man with a diploma seeking employment, a 37-year-old man in the second disability group navigating disability status complexities and seeking social housing, and a 37-year-old woman victimised by online scams determined to overcome her losses.

While clients express satisfaction with the welcoming atmosphere and living conditions at V.E.L.G., the organisation prioritises individual counselling over collective action by NGOs. The journey out of homelessness is often tied to personal motivation, although persistent alcohol use remains a significant challenge for many.

5.7 La Fenice: homeless day centre in Florence

La Fenice day centre, established in 2013 and managed by Coordinamento Toscano Marginalità, serves as the sole day centre for the homeless, operating through a diverse array of desks and services. These services, provided by different organisations specialising in specific areas of need, aim to offer tailored solutions to the multifaceted challenges faced by the homeless population.

Accessible either directly or through referrals, the centre begins its support at the reception desk, where an experienced educator assesses individuals' vulnerabilities and needs. Immediate assistance is available for those in urgent situations, followed by a comprehensive First Contact Interview to initiate a personalised support plan.

Both low-threshold and second-threshold services are offered in the La Fenice Day Centre.

Low Threshold Services: These services provide essential support to address the immediate needs of homeless individuals, laying the groundwork for trust-building between users and staff. These services encompass:

- Breakfast service: Offered to all attendees, breakfast fosters a sense of belonging among long-term guests actively engaged in their journey out of homelessness.
- Shower service: Accessible to all, this service provides essential hygiene items and facilitates a sense of community among regular attendees.
- Smartphone and device recharging: Recognising the importance of digital connectivity, the centre offers a charging station to facilitate communication and access to services.
- Social health prevention and awareness: In response to the COVID-19 pandemic and other health concerns, the centre conducts health screenings, raises awareness about health risks, and provides access to information and resources.
- Awareness-raising meetings: Periodic meetings address various challenges faced by the homeless population, including addiction, hygiene, and infectious diseases.
- Psychological support: Recognising the mental health challenges prevalent among the homeless, La Fenice offers both group sessions and individual counselling to address psychological distress and promote emotional well-being.
- Self-help groups and orientation services: Through self-help groups and multifunctional orientation services, individuals receive support in navigating their challenges, fostering mutual support and empowerment.

- Housing orientation service 'One step away from home': Specialised staff assist in housing-related matters, including guidance on independent living and shared accommodation, and offer support throughout the housing search process.
- Street unit and harm reduction desk: This service bridges street support with structured interventions, offering assistance for substance abuse issues and distributing vital harm reduction resources.

Second threshold services: These services recognise the multifaceted challenges faced by homeless individuals, stemming from experiences of trauma, social exclusion, and systemic barriers. These services aim not only to address immediate needs but also to foster personal growth, empowerment, and social inclusion. Key components include:

- Understanding root causes: Acknowledging the complex backgrounds of homelessness, including childhood trauma and adult struggles such as job loss and substance abuse, underscores the importance of holistic support.
- Emphasis on social reintegration: Beyond basic care, the focus shifts to restoring a sense of self-worth, belonging, and stability. This involves establishing trusting relationships and empowering individuals to take charge of their lives.
- Personalised emancipation projects: Tailored services allow for flexibility in addressing individual needs and aspirations, fostering a sense of ownership and agency in the journey towards autonomy.
- Active engagement and support: Operators actively engage with individuals, building networks of support and connecting them with relevant services and resources to facilitate social inclusion.
- Document regularisation assistance: Recognising the practical barriers posed by lack of identification documents, dedicated support is provided to help individuals navigate bureaucratic processes and regain their legal identity.

Through its holistic approach and personalised care, La Fenice day centre aims to not only alleviate immediate hardships but also to empower homeless individuals to reclaim control over their lives and sustainable reintegrate into society with dignity and purpose.

5.8 Project partners' insights and recommendations

5.8.1 Listening and understanding

As we contemplate the foundational nature of individual biographies, a critical question arises: do shelters act as spaces dedicated to attentive listening and understanding the voices of those in search of refuge, or do they unintentionally play a role in rendering these individuals invisible? This dilemma gains complexity within overcrowded shelters, where the sheer numbers might overshadow the distinct voices longing to be recognised and acknowledged.

Understanding the dynamics between visitors/users and professionals leading 'normal' lives can be challenging, as there may be a perceived superiority of professionals who are assumed to know better. The difficulty is compounded by a chaotic environment, emphasising the need for focused settings. Creating environments conducive to understanding involves both formal methods, like conversation tools that encourage dialogue from different perspectives, and informal settings, such as shared activities like driving or collecting material items together.

Listening to diverse needs, adopting an open approach, and acknowledging the complexity of experiences and needs underscore the importance of case managers. Tailoring rehabilitation pathways on an individual basis is imperative. Creating meaningful connections among individuals, professionals, and the structural framework is crucial for successful intervention. The re-establishment of

connections is vital for the rehabilitation of homeless individuals. The significance of listening, maintaining respectful attitudes, both from individuals and professionals, and the involvement of institutions such as schools (e.g., PROLEPSIS organisation) are key components in this process.

5.8.2 Strengths and challenges of homeless shelters and day centres in Riga

The homeless shelters and day centres in Riga exhibit several strengths:

- *Adequate facilities*: The absence of waiting queues and shelter shortages is a notable strength, although it raises the concern of a potentially hidden segment of the homeless population, including those residing in garages or squats.
- *Sufficient staffing*: The presence of sufficient staff is a significant strength, with no serious issues of burnout, turnover, or exits. The staff exhibits passionate and optimistic thinking. Staff members emphasise the importance of fostering hope and engaging in enjoyable interactions with homeless individuals. The multidisciplinary composition, including psychologists, social workers, nurses, doctors, etc., facilitates integrated services and rehabilitation efforts.
- *Free of charge*: The provision of beds without charge is a commendable aspect, ensuring accessibility to those in need.
- *Well-organised facilities*: The facilities are characterised by cleanliness (e.g., clean walls, plants) and effective organisation, contributing to a conducive environment.
- *Flexibility*: Some shelters display flexibility by accommodating individuals with disabilities or destitute elderly people, extending their services beyond the traditional target group of homeless shelters. The Red Cross shelter, for instance, caters specifically to persons struggling with alcohol addiction. Also registering in the social register for shelters brings about positive aspects, primarily enhancing flexibility and accessibility for individuals seeking shelter services.
- *Employment opportunities*: Certain shelters provide opportunities for residents to engage in work, such as woodwork, building renovation, cleaning, and maintenance. This not only serves practical purposes but also represents a crucial initial step toward rehabilitation.
- *Peer worker relationships*: The close relationships between peer workers and clients, formed through shared life experiences, can enhance the support system within the shelters.

However, these facilities also face certain **challenges and areas for improvement**:

- *Persons without documents*: The issue of individuals without documents and undocumented immigrants poses a significant challenge. Decentralisation, particularly when funding is tied to municipalities, may also limit access for individuals from outside the municipality. Due to the war between Ukraine and Russia, Ukrainians receive specialised support through a specific law, including housing assistance for the initial three months, followed by ongoing support in the form of food and other provisions.
- *Shelter organisation*: Larger shelter units are associated with more problems, suggesting that smaller, more focused units might be more effective. Scaling down the size of the shelter will enhance the privacy and individual experience of its users. The strict separation between men and women and the clear distinction between day care centres and night shelters are viewed as potential obstacles to successful reintegration. When shelters operate exclusively at night, individuals experiencing homelessness are required to leave during the daytime. Nevertheless, in cold weather, Riga municipality shelters remain open 24/7.

  The separation between night shelters and day centres, observed not only in Riga but also in Ljubljana, particularly in cases with gaps in the day structure, proves to be ineffective. This inefficiency was vividly demonstrated by men lingering aimlessly under the staircase at the entrance of the night shelter in Nova Gorica. The rigid division between daytime and nighttime services often results in pushing homeless individuals back onto the streets, leaving them without meaningful

activities or a structured routine during parts of the day. This highlights the need for a more integrated approach to support homeless populations.

- *Negative perception of homelessness*: There persists a negative societal perception of homelessness, shared even among shelter staff. Most staff members appear to be convinced of the lack of motivation among homeless people. This perception may contribute to a lack of motivation among clients and instances of relapse, acknowledging the complexity of the issue.
- *Non-admission rules*: Some shelters implement strict non-admission rules, such as restrictions on personal belongings and pets (while harm reduction with animals is reasonable), and a six-month exclusion for offenses against staff. Furthermore, the disposal of alcohol when guests are intoxicated may cause distress, especially if guests have spent all their money on it and feel unwell without access to it.
- *Long-term shelter stays*: Ideally, shelters should facilitate short stays, but the reality often involves long-term residency, pointing to a need for a re-evaluation of shelter practices. Emergency services play a crucial role, but there is a need to address the ongoing emergency as it is deemed unacceptable in a developed society where many lack basic necessities. Shelters, initially designed for emergencies, face challenges due to an unacceptably large proportion of people relying on them for extended periods. The goal is to provide a dignified, quality shelter that offers more than survival assistance, emphasising welcoming, observing, listening, supporting, and connecting. This can be better achieved with smaller units. There is a tension between the ideal image of shelters and the actual limitations faced by both guests and available services, requiring collaboration and new responses to fulfil societal responsibilities.
- *Social case work versus the bigger picture*: While social case work focuses on the individual, there is a recognised need to consider the broader political landscape. This includes implementing fundamental rights, adhering to the European Pillar of Social Rights, ensuring protection, establishing a decent minimum income, and addressing challenges related to affordable housing.
- *Community-oriented actions*: Limited efforts are observed in terms of reintegrating individuals into the local community, suggesting a potential area for improvement and increased community engagement.
- *Underserved fundamental rights*: Advocacy for human rights and political reform is crucial, encompassing the right to protection, a decent minimum income, and access to mainstream institutions such as those catering to disabled individuals or nursing homes for the elderly. This reflects a broader fight for human rights and systemic changes.

5.8.3 Accessibility of services

Psychiatrist Victor Soto, affiliated with the Psiquiatra Programma ESMeSS in Barcelona, emphasises that evaluating the accessibility of services, a major barrier highlighted in the 'Needs of the Users' section, requires a comprehensive assessment from both subjective and objective perspectives. On a subjective level, individuals facing homelessness may decline services for various reasons, including negative past experiences with overly strict rules, leading to discontinued participation in programmes, ultimately reducing service accessibility. Additional factors contributing to refusals may include feelings of insecurity within shelters, mental health challenges, and suspicion. Recognising the diverse reasons for refusals is crucial, as no one actively chooses to live on the streets. Services should adopt more open approaches, free from stigma.

Objectively, there is an insufficient availability of services for people experiencing homelessness, underscoring the need for additional support. Moreover, comprehensive follow-up is crucial. Programmes should integrate robust follow-up procedures for various scenarios, emphasising that while securing housing is essential, ongoing support is critical for individuals even after they have transitioned into permanent housing.

5.8.4 Postal paradox

The 'postal paradox' in the context of homelessness refers to a cycle where the lack of a fixed address contributes to the difficulty that individuals experiencing homelessness face in accessing social rights and services (see Figure 5.1). The paradox lies in the fact that not having an address can perpetuate exclusion, as access to essential services often requires a verifiable address (Byrne, 2018).

Figure 5.1 The postal paradox: how having no address keeps people homeless

Source Byrne (2018)

In contemporary society, an address serves a broader purpose than its original function for postal services and tax authorities. It has become a critical element for establishing one's identity and proof of citizenship. Institutions may use an individual's street address or domicile as a key identifier, and the absence of a fixed address can result in a lack of recognition or existence in the system. The 'postal paradox' refers to the fact that, in the current societal structure, citizenship is closely tied to having a fixed domicile or address. Without an address, individuals may face barriers in accessing fundamental rights and services, perpetuating the cycle of homelessness.

Furthermore, solutions such as providing a reference address in Belgium are not without hurdles (Robben *et al.*, 2023). Administrative burdens, characterised by bureaucracy, intricate paperwork, and regulations, pose challenges for homeless individuals with a reference address in Belgium. These burdens not only impact accessibility but also undermine fundamental rights and influence the efficacy of public programmes

Homeless individuals face intrusive screenings, intricate forms, and strict conditions, designed at the municipal level to discourage the use of a reference address, despite its formal recognition as a right for citizens without a residential address. The role of street-level bureaucrats in shaping or mitigating these burdens is often overlooked, and their construction can stem from political and institutional factors. Addressing these burdens is vital for ensuring equitable access to rights and services for homeless individuals.

Within this section, it is also important to note that the challenge of 'legal residence' extends beyond its initial context; similar issues arise with undocumented migrants (in Greece, Belgium, etc.) and even residents from other cities (in Latvia).

5.8.5 Stigmatisation and criminalisation

'Society's response to homeless deaths should mirror the empathy shown when someone close to us passes away, rather than blaming others.' (Julia Wygnanska - Vice-President of the Housing First Poland Foundation).

Various policies, laws, and local ordinances act as barriers and pose challenges for unsheltered individuals, rendering it illegal, difficult, or even impossible for them to engage in routine activities that most people take for granted. Measures like the 'No sit, no lie' laws, which prohibit individuals from sitting or lying down in public spaces, are perceived as a form of criminalising homelessness. Additional examples include bans on camping in public spaces, sleeping in parks, begging, and the removal of personal belongings from tent encampments, all of which compound the difficulties faced by those already struggling with homelessness. Such measures taken by public authorities echo the NIMBY ('not in my backyard') attitude of citizens who lack any sense of empathy and solidarity. More and more often, they culminate in violence against homeless people, as exemplified by aggressive police interventions in cities such as London, Paris and Brussels.

A related article in The Guardian,[20] illustrates how UK Home Secretary Suella Braverman defended her decision to restrict tent use by homeless individuals, describing rough sleeping as a 'lifestyle choice.' Braverman targeted 'disruptive' tents in urban areas due to a rise in rough sleepers and perceived antisocial behaviour, proposing potential fines for charities providing tents. Expressing her concerns, she warns of British cities mirroring the challenges faced by US cities like San Francisco and Los Angeles due to weak policies leading to crime and squalor. Her focus is on preventing nuisance and distress caused by tent pitching, aggressive begging, stealing, drug use, and littering in public spaces. What about compassion and support to the homeless themselves?

Rejecting this idea that individuals experiencing homelessness have willingly chosen this path is essential, as criminalising them is counterproductive and exacerbates the issue. Efforts to assist them should be viewed not merely as acts of charity but as essential steps toward tackling a complex societal problem. There is a critical need to cultivate an inclusive culture within cultural spaces, institutions, and among citizens.

[20] https://www.theguardian.com/society/2023/nov/04/suella-braverman-says-rough-sleeping-is-lifestyle-choice

6 | Physical and mental health care

'There is no health without mental health.'
(World Health Organisation)

6.1 Homelessness and mental health issues

6.1.1 Stigma and discrimination of people with mental health problems and disorders

Dr. Vesna Švab, a psychiatrist and president of the Association ŠENT in Ljubljana, reports on two incidents in Europe that highlight contemporary challenges in the international mental health care community: (1) in Belgium, a patient was killed by police officers in a psychiatric hospital under the mistaken belief that he was attacking them; (2) in Italy, a psychiatrist was killed by a chronic psychiatric patient.

These incidents shed light on the underfinancing and understaffing of mental health services, not only in Europe but globally. Mental health issues, plagued by stigma and discrimination, often find themselves at the bottom of healthcare agendas, contributing directly to the shortage of mental health professionals. It is alarming that individuals lacking psychological qualifications, such as police officers, are involved in operations within psychiatric hospitals, taking on roles where qualified staff (including mental health care professionals and social workers) should have been present to respond.

Moreover, when incidents occur from the patient's side, as in the case of Italy, it is a consequence of inadequate patient care and insufficient attention. Questions arise about who was responsible for following up on the patient and providing appropriate care. Both incidents underscore the need for guidelines in mental health reform.

Slovenia has addressed this need by creating a new mental health action plan, placing a significant emphasis on care provision. The plan also addresses stigma and discrimination, linking insufficient quality care, understaffing, and inadequate funding to put an end to the mistreatment of individuals with mental health problems. The World Health Organisation's 'Comprehensive Mental Health Action Plan 2013-2030'[21] stresses the importance of improving mental health services, psychiatric care, fostering interdisciplinary collaboration, and reducing stigma and discrimination through attitude shifts. It emphasises that the issue of stigma and discrimination is fundamentally a human rights problem, necessitating increased funding and resources for mental health services.

The plan advocates a balanced approach between community-based health care and hospital care, acknowledging the need for diverse services in mental health care. However, the primary focus should be a commitment to upholding the human rights of people in psychiatry. Combatting stigma and discrimination requires the active involvement of individuals with mental health problems in decision-making processes related to services and programmes. Additionally, improving mental health care extends beyond medical treatment; it involves enhancing the social conditions of individuals with mental health problems.

In conclusion, individuals with mental health conditions and psychosocial disabilities often encounter substandard care and human rights violations. The new action plan seeks to significantly enhance

[21] https://www.who.int/publications/i/item/9789240031029

the care for people with mental health problems, aligning with the latest international literature guidelines.

6.1.2 Mental health care challenges for the homeless in Slovenia

In Slovenia, the landscape of mental health care comprises 6 psychiatric hospitals and 20 community mental health centres (CMHCs). Funding in Slovenia's mental health system is heavily skewed, with psychiatric hospitals receiving the bulk of resources and housing 70% of the country's psychiatrists. Prof. Švab, a psychiatrist with 25 years of experience, has been at the forefront of the 'de-institutionalisation' movement since its initiation in 2016.

For homeless individuals grappling with mental health challenges in Slovenia, accessing care involves a referral from a GP. While GPs are readily accessible and a basic state-funded health insurance covers primary care, complications arise when more specialised services are required. Specialised care often necessitates additional insurance, linked to employment contracts or self-funding, and requires a permanent residence posing significant hurdles for the homeless population. Currently, the Slovenian government is working towards discontinuing the additional insurance requirement and instead implementing a tax on supplementary mental health services.

CMHCs, adopting a policy of 'open doors', offer a more accessible alternative. In theory, everyone has access to psychiatric hospitals, yet also practical barriers such as referral requirements and prolonged waiting times challenge this inclusivity. Children, for instance, cannot consult a child psychiatrist without a referral, and the waiting period for admission without one can be substantial, contradicting the principle of universal access.

The integral link between mental health and social circumstances underscores a critical challenge in hospital-based mental health care - its focus on treatment often overshadows attention to the broader social context, including issues like poverty and exclusion. A considerable proportion of individuals with mental health problems face concurrent social challenges, complicating their overall well-being.

The COVID pandemic has further strained mental health care services, leading psychiatric hospitals to limit admissions. The surge in demand for admissions post-pandemic has intensified pressure on an already burdened system. Slovenia is currently undertaking health care reforms to enhance psychiatric hospital accessibility, although community health centres have managed to avoid long waiting lists.

6.1.3 The importance of community-based mental health care

The study visits in Ljubljana highlighted the significance of community-based health care and demonstrated how it functions in practice. Six characteristics distinguish community-based mental health care from institutional care:

- *Avoidance of long-term hospitalisation*: Emphasis on small-scale, intensive services integrated into a community to minimise the need for extended hospital stays. Housing projects with permanent support for homeless individuals were observed, promoting community living.
- *Continuity of Normal Daily Activities:* Rehabilitation involves ensuring that individuals can engage in regular daily activities, such as cooking together, maintaining the house, attending school, or working. Day centres play a vital role in organising social activities when sustained engagement in regular day-to-day activities becomes challenging. Additionally, when individuals need to be removed from toxic environments, these centres provide alternative settings in other communities. This approach aims to prevent isolation and, if feasible, facilitates the reconnection of individuals with their original community over time.

- *Networking with other community service*s: Adopting an integrated approach that includes housing, sports, social work, and more. Collaboration with diverse services is crucial for the comprehensive rehabilitation of individuals with mental health problems.
- *Holistic view and systemic approach*: Promoting a holistic view and a more systemic approach to mental health care is crucial. Hospitals, unfortunately, tend to isolate individuals from their environment and often concentrate solely on the individual. This artificial separation overlooks the essential support individuals need from friends, family, their neighbourhood, school, and other community elements.
- *Relying on mutual support*: Encouraging mutual support among homeless individuals. Projects were visited where young adults lived together, forming friendships and empowering each other.
- *Importance of collective action for destigmatisation*: Acknowledging the role of individuals with mental health issues in collective action. They become advocates their peers, participate in user councils, and organise activities to improve services for their community, contributing to destigmatisation efforts.

6.2 Mental health care for homeless people in general

6.2.1 Outreaching and care for homeless people with mental health issues: The case of Leuven

Gunther Hannot, a psychiatric nurse from the mobile team in mental health care at UPC[22] Leuven, provided valuable insights into their comprehensive approach to outreach and care for homeless individuals facing mental health issues. Established in 2012, the mobile team, consisting of two part-time caretakers, including Gunther, focuses specifically on addressing mental health challenges within the homeless population in the city of Leuven.

The structure of the team involves two mobile units, each with a supporting psychiatrist and an assistant, which operate on a rotational basis. Caretakers maintain essential connections with two psychiatric hospitals in the region to facilitate collaborative efforts.

Referrals come from diverse sources such as social housing, CAW,[23] police, and OCMW[24], covering a selection of cases involving psychiatric problems, often intertwined with drug use. The emphasis is on small-scale living arrangements and establishing emergency services within general hospitals, albeit with limited capacity (a maximum of 5 days and 10 beds). The team faces the challenge of navigating the complex procedures associated with compulsory treatment, with a concerted effort to reduce the number of forced hospitalisations.

Regarding drug use, individuals are referred to the crisis ward as part of the process. The initial step involves a physical check for emergency situations. Admission to the ward follows a staged process, requiring individuals to meet specific criteria, including being relatively clean and demonstrating motivation for addressing their situation.

The team engages in proactive outreach work, maintaining a flexible schedule and conducting initial contacts crucial for building relationships, especially with 'care avoiders'. The initial contact is vital, emphasising an authentic approach and a focus on motivating individuals, especially those resistant to care, with the primary goal of understanding their needs and fostering ongoing engagement through subsequent meetings. The outreach locations vary, including parks and winter shelters.

Gunther touched upon the challenges faced by the team, including the difficulty of distinguishing crises from homelessness. Psychiatric services may reject patients based on their housing situation, prompting a proposal for a crisis ward within psychiatric facilities to address this issue instead of

22 University Psychiatric Centre.

23 Centre for General Welfare Work.

24 Public Centre for Social Welfare.

relying on a month-long stay at a crisis centre at CAW. This tension illustrates the need for a Housing First approach as a necessary condition for effective psychiatric outpatient care.

Gunther highlighted regular contact with individuals in winter shelters, including shared breakfasts twice a week. This approach aims to foster connections with both individuals experiencing homelessness and the staff at the shelters.

Gunther's presentation underscored the multifaceted challenges inherent in providing mental health care and support to homeless individuals, emphasising the need for flexibility, understanding, and collaboration between various services.

6.2.2 Babel Day Centre: Bridging mental health gaps for migrants in Athens

Since 2007, the Babel Day Centre, under the auspices of the Syn-eirmos Social Solidarity NGO (www.syn-eirmos.gr), has been dedicated to delivering mental health services to migrants. This encompasses support for individuals, families, children, adolescents, and groups in Athens and Kipseli, Greece. Babel's primary mission is to offer mental healthcare to migrants, irrespective of their legal or residence status. The centre focuses on addressing the unique challenges posed by the triple scheme of the migrant or refugee condition, diverse ethno-cultural backgrounds, and experiences of mental disorders.

Babel strives to create a supportive home environment, including assistance with material conditions, where individuals and groups can be heard, understood, and supported in their mental health. The centre places a significant emphasis on a personalised approach, crafting individualised treatment plans through consultations between professionals and beneficiaries. A person-centred network is established to meet a diverse range of needs.

The recent influx of arrivals overwhelming the islands, coupled with the closure of migration routes, has resulted in individuals living in controlled camps. Some have chosen an alternative route, bypassing Greece to reach Italy via Lampedusa. This shift in circumstances has altered the landscape of their needs. Additionally, the existence of camps outside Athens has contributed to a decline in individuals seeking services within the city. Rejected asylum seekers, particularly evident in places like Lesbos, face restricted access to essential services, with the shortage of medical professionals further exacerbating the situation. Furthermore, the conclusion of the Helios programme,[25] designed to integrate refugees, leaves them awaiting new initiatives, adding uncertainty to their future.

Despite facing numerous challenges, refugees demonstrate resilience and assert their right to dignity. The complex interplay between vulnerability and strength emerges as a paradox, especially as individuals, once healed, may lose the right to stay. This raises the question of unconsciously perpetuating dependency instead of empowering them to care for themselves.

Trauma, though lacking a universally agreed-upon definition, is prevalent among refugees, influencing their reactions to stressful situations. While vulnerabilities are evident, so too are strengths, forming a part of their identity exploration that involves dreams, expectations, and perspectives. The energy and courage refugees possess can be blocked, leading to imbalances, a normal response to their circumstances. Statistics indicating a high prevalence of PTSD (Post-Traumatic Stress Disorder) in Lesbos need to be understood in the broader context of living conditions.

Acknowledging the existing fragmentation in services, Babel's goal is to establish person-centred networks that transcend simple referrals, connecting individuals with a range of services. Comprehensive plans address not only immediate needs but also more complex challenges, fostering a holistic approach to mental health support for migrants and refugees.

A touching personal narrative underscores the pressing challenges faced by refugees. In August 2022, a pregnant refugee, fleeing violence in a camp, sought refuge in a hospital for the imminent birth of her baby. While the baby could stay in the hospital after delivery, the mother grappled with the daunting task of securing shelter for herself. Reuniting with her newborn hinged

[25] https://www.infomigrants.net/fr/post/52911/greece-future-of-refugee-support-program-helios-in-doubt-as-eu-pledges-extra-funds

on her ability to find suitable accommodation. In a conversation with a Babel employee, the mother expressed an additional challenge – the need to pump milk for her baby. Although the hospital was willing to provide accommodation, it was not authorised to do it. This illustrates the necessity for collaborative efforts with other services. Fortunately, Babel was able to leverage its connections with other organisations to secure a place for the woman and her baby.

6.2.3 PROLEPSIS: a decades-long commitment to health equity and social justice

The PROLEPSIS Institute, a non-governmental organisation, has been actively engaged in medical research, health promotion, and environmental and occupational health since 1990. Embracing the belief that health is an essential, non-negotiable right for every individual, the institute envisions a society that fosters physical and mental well-being and prosperity equally and justly for all, with special consideration for the most vulnerable populations, including migrants, refugees, Roma, and children. Upholding human freedom and environmental preservation for future generations is at the core of Prolepsis' vision.

The institute's mission revolves around addressing prominent public health needs in Greece and Europe through rigorous academic research, translating findings into action through education, advocacy, and direct services. PROLEPSIS is dedicated to promoting health and health equity for all Europeans, recognising health equality as a vital prerequisite for broader social justice. The organisation is unwavering in its commitment to equality, social inclusion, and respect for individual differences and choices.

PROLEPSIS is actively involved in European research and training projects, such as improving access to vaccination for newly arrived migrants, training health professionals on mental health in culturally diverse environments, early detection of cancer among homeless individuals, and implementing whole-school approaches to promote healthy lifestyles among school children through the Schools4Health initiative.

Humanitarian aid is a significant part of PROLEPSIS' work, addressing issues like loneliness among elderly individuals in isolated rural areas, food insecurity following natural disasters, and preventive healthcare and empowerment training for Roma women living in camps. The organisation collaborates with various entities, including municipalities, NGOs, charitable foundations, companies, the EU (Horizon, Erasmus, Structural Funds), and foreign universities.

Despite challenges arising from the financial crisis and bureaucratic hurdles in Greek public funding, PROLEPSIS has continued its vital work with the support of private donations. One of its flagship programmes, DIATROFI, launched in 2012 during the height of the financial crisis, focuses on providing food support to socially vulnerable areas in Greece. The programme, initially funded by the Stavros Niarchos Foundation, has now transitioned to receive support from prefectures.

6.2.4 Médecins Sans Frontières (MSF)/Doctors Without Borders - Greece

MSF founded in 1971 in Paris by a group of journalists and doctors, stands as an international, independent non-profit medical humanitarian organisation. Dedicated to offering medical assistance to those affected by conflict, epidemics, disasters, or exclusion from healthcare, MSF operates globally with nearly 68,000 individuals bound together by a charter emphasising medical ethics and the principles of impartiality, independence, and neutrality.

In Athens, MSF responds to the unique needs of migrants and asylum seekers residing in both formal and informal accommodations through three clinics. The Athens Urban Day Care Centre provides sexual and reproductive healthcare and mental health support, with an outreach unit reaching migrants where they live. A clinic in Victoria Square offers basic and mental healthcare on a walk-in basis, conducting over 4,055 medical consultations between February and December. In Kypseli, a dedicated team provides interdisciplinary rehabilitation to victims of torture and ill-treatment, with

the monthly average of new cases increasing since the EU-Turkey agreement (from 10 to almost 40 cases).

MSF extends basic healthcare services to Eleonas camp, Korinthos detention centre, and Piraeus port, performing 6,734 consultations during the year and accompanying 623 patients for specialised medical services. In Elliniko camp, the team offers sexual and reproductive healthcare and mental health support to refugees.

The medical services provided by the Athens Urban Day Care Centre are tailored to meet the healthcare needs of individuals excluded from the formal healthcare system. This includes those without documentation, refugees, and migrants. MSF's commitment to addressing unmet healthcare needs is particularly evident through its focus on serving victims of sexual violence and individuals with chronic diseases.

The day centre operates with an interdisciplinary team, available from 9 am to 5 pm, catering to the healthcare requirements of approximately 50-60 visitors. MSF places a strong emphasis on language diversity to ensure that the diverse needs of the visitors are accommodated, fostering an inclusive and accessible healthcare environment.

The centre collaborates with private services and refers those with access to public services accordingly. However, challenges persist, especially in the availability of medications despite the presence of a pharmacy. Despite its NGO status, MSF faces regulatory restrictions that constrain its operations, prompting the organisation to engage in advocacy and lobbying efforts to secure more space.

The resurgence of the refugee crisis underscores the importance of halting pushbacks and allowing continuous travel for seamless integration. MSF emphasises the visibility of individuals in the system, advocating against forced placement in camps, which can lead to disconnection rather than integration, causing individuals to disappear from the system.

6.2.5 Médecins du Monde (MdM)/Doctors of the World – Greece

MdM-Greece, established in 1990, is a non-governmental organisation that forms part of Médecins Du Monde International, comprising 17 delegations worldwide. Operating with a small team of salaried workers and a large group of volunteers, MdM-Greece focuses on delivering medical and other essential services to marginalised populations facing barriers to healthcare.

The Open Polyclinics of Doctors of the World in Athens and Thessaloniki aim to provide primary healthcare, social, and psychological support to vulnerable social groups. This includes the homeless, those in need, the uninsured, immigrants, refugees without administrative documents, and individuals with limited or zero access to the National Health System. The polyclinics offer free laboratory tests through referrals to collaborating organisations, and after medical monitoring, patients receive necessary medications.

MdM-Greece extends its services to address homelessness, offering night shelters for women and families. The main night shelter accommodates 40 beds, employing a comprehensive approach for homeless individuals. Upon arrival, users meet a team comprising a social worker, psychologist, and/or doctor. After an initial assessment, individuals receive meals and shower access. The next morning, they receive social and administrative support. Residents gain free medical screenings after two days, underscoring the organisation's commitment to immediate and long-term health needs. The shelter allows a stay of up to 6 months, providing a secure environment. However, some residents opt not to stay due to imposed rules and communal living in large dormitories. MdM-Greece also involves street corner workers who reach out to homeless individuals and drug users in Athens, offering medical services that occasionally yield life-saving results.

However, numerous and complex obstacles are encountered:

- *Limited health insurance access*: Homeless individuals, particularly undocumented migrants, face challenges accessing health insurance. Uninsured individuals can obtain consultations for 10 euros with a referral from a social service or another clinic.

- *Conditional minimum income (KEA)*: The minimum guaranteed income (KEA) is barely 200 euros/ month and comes with stringent conditions. Homeless applicants face stringent criteria, including police signalling, job unavailability, and the submission of income tax declarations from the previous year, excluding newly arrived migrants.
- *Lack of political will and financial support*: There is limited political will and financial support for services aiding homeless people. The reduction in community support due to the government's lack of backing with annual support applications hinders the provision of quality services (e.g., 1 social worker per 40 homeless people).
- *Police brutality and violence*: The police, particularly in Omonoia area, have a reputation for their brutality and violence against homeless people.
- *Challenges in Lesbos*: Despite initial solidarity from the local population, there is growing fatigue among migrants and NGOs due to overcrowding and campfires.
- *Project challenges with Roma people*: Opposition from the local government poses obstacles to a project with Roma people. Additionally, there is a lack of support for a university professor of social work who sends students to work in Roma settlements, discouraging their involvement.

These multifaceted challenges highlight the need for systemic changes, increased financial support, and collaborative efforts to address homelessness effectively.

6.3 Supportive services for substance users

6.3.1 Red Cross centre in Riga: Emergency aid for vulnerable individuals

The Latvian Red Cross organisation in Riga plays a crucial role in supporting individuals facing challenging circumstances through a variety of services. One notable offering is a 24-hour sobering-up shelter designed for those under the influence of alcohol, narcotics, or toxic substances. Beyond the sobering-up shelter, the Red Cross centre provides additional assistance through various services:

- *Food distribution*: Individuals with a monthly income below 317 euros (with a certificate from the municipality) or those experiencing sudden crisis situations can access dried food items, including rice and condensed milk.
- *Clothing, toys, and shoes distribution*: Free distribution of second-hand clothing, toys, and shoes to those in need.
- *Shelter services*:
  - Downstairs: Four rooms equipped with 12 plastic mattresses each, supervised by two staff members, cater to individuals brought in by the police under the influence of alcohol or drugs. Operating day and night, guests have the flexibility to leave at any time. After cleaning, disinfection/pesticide spray is used to eliminate lingering odours. The Red Cross shelter is the sole facility in Riga that accepts people with addiction problems, providing one-night shelter.

- Second floor: Features rooms for 4-5 persons (free of charge) with a total of 30 beds. This floor also includes a 'health room' for consultations and a room with books and PCs equipped with internet access. A long-term resident assists other guests with computer usage.
- Third floor: Offers 'private' studios with a bathroom and kitchen for short stays (4 euros/night), often sponsored by the municipality when no other rooms are available.

The centre serves approximately 3,500 individuals annually, providing over 28,000 nights of accommodation.

6.3.2 STEKI 46: Pioneering supervised use space in Greece

STEKI 46 stands as Greece's inaugural Supervised Use Space (SUS), located in Athens. The establishment of SUS marks a significant step in providing a secure environment for active substance users, effectively mitigating health risks and the transmission of diseases. Operating under a government license (Ministerial Decision D2a/64914/5-11-2021), this fully equipped facility is manned by an interdisciplinary team.

In its holistic approach to support, STEKI 46 prioritises the well-being of active users through health promotion and offers comprehensive primary healthcare, including overdose management. The facility actively contributes to disease prevention by supplying safe-use materials, thereby curbing the spread of communicable diseases. Outreaching towards hard-to-reach populations, integration into treatment programmes, and congestion reduction at gathering points are integral parts of its mission. Furthermore, STEKI 46 provides psychological and counselling support, addressing the emotional and psychological needs of its visitors. The facility extends its support to cover basic needs like hygiene, nutrition, and clothing, particularly for homeless substance-dependent individuals.

Operational procedures at STEKI 46 involve an initial medical assessment, vitals checks, and anonymous reporting of substance use. The facility ensures a clean supply of items for sniffing, smoking, and injecting, promoting a safe and hygienic environment. Additional services include storage for medication, laundry facilities, and assistance with basic needs. Substance use is supervised during operational hours from 9 am to 10 pm, with effective communication with law enforcement for a safer environment. In cases of violence or threats, a person-centred approach is adopted, focusing on understanding and providing assistance rather than exclusion.

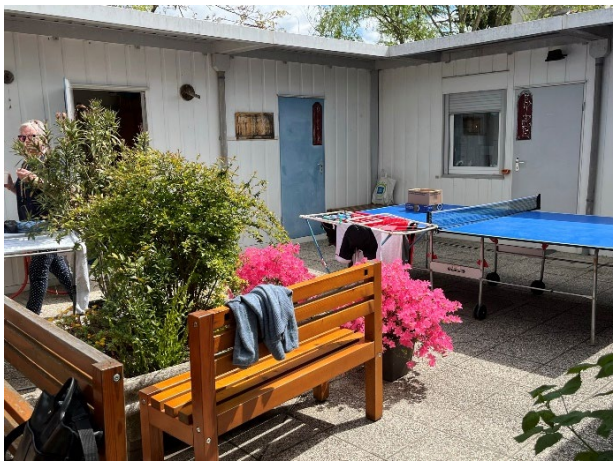
STEKI 46 actively seeks visitor feedback through observation and direct communication, fostering a responsive and person-centred environment. As a publicly funded organisation under the Ministry of Health, the facility is committed to future developments, awaiting legal frameworks for mobile

units and emphasising the role of Methadone in overdose prevention. The facility recognises the importance of building connections, establishing relationships, and effective communication with other services, considering these elements crucial in providing comprehensive support to active substance users. Through its unique and innovative approach, STEKI 46 strives to understand and address the diverse needs of its visitors, contributing to the well-being of the community it serves.

6.3.1 The day centre Nova Gorica for users of illegal drugs

The day centre Nova Gorica for Users of Illegal Drugs, a harm reduction project launched in 2006, operates for seven hours daily (8 am – 3 pm) and caters to individuals dealing with drugs. It enforces a policy prohibiting drugs, alcohol, dealing, and violence, with smoking allowed. On average, the day centre receives 100-150 visitors annually, with a daily fluctuation of 20-25 unique visitors.

Pre-COVID, the centre saw higher numbers of visitors due to increased group activities fostering connections among visitors. Entry involves signing an agreement to abide by rules and develop a goal-oriented plan with a centre employee, focusing on skill development rather than detoxification. Limited drug-related services exist in Slovenia,[26] with the day centre planning to establish a user room, a pioneering initiative in the country.



The day centre prioritises networking with other services and destigmatisation efforts, such as street cleaning. Despite being located next to the police station without issues, the relationship with the community remains complex, gradually improving. The day centre's strong outreach team (see mobile team for users of illegal drugs) actively promotes the organisation for public recognition. Human resources data is sparse, except for a mention of security concerns and a past incident where a worker was threatened with a knife while working alone.

6.3.2 The mobile team Nova Gorica for users of illegal drugs in Ljubljana

The mobile team Nova Gorica focuses on outreach and accessibility for individuals actively using illegal drugs, including those with mental health issues, homelessness, adolescents, and physical disabilities. Established in 2006 due to some individuals not accessing the day centre for users of illegal drugs, the mobile team aims to reach hidden and vulnerable groups, offering needle exchange, syringes, and health care materials (no drugs).

The mobile team prioritises reaching those hidden and vulnerable individuals, respecting their autonomy and right to make decisions. Inclusion is not conditional on abstinence. Covering a wide, mountainous region with sparse population, the team rotates locations daily and interacts with around 300 users annually, primarily in Nova Gorica.

The team distributes flyers and relies on recommendations from other users for effective engagement. By introducing themselves and explaining the offered help, the team respects individual decisions on continuing conversations. The programme is anonymous, emphasising informal exchanges to build relationships. The team also organises sports activities and tournaments, occasionally seeking donations for events like rafting.

[26] Drug users have access to methadone, but it is exclusively available in outpatient clinics and not within hospital settings.

Comprising two social workers and one nurse, the team addresses social and health harm. The nurse provides medical support and referrals to doctors. While instances of verbal violence have occurred, physical violence is rare. A panic button is available but has never been used. The team advocates better understanding of drug users among social workers, suggesting direct training with target groups.

The mobile team aims to connect users with municipal services, given their prevalent health and financial issues. Collaborating with social services, hospitals, police, and other entities, smooth referrals are facilitated. Users seeking rehabilitation often face a waiting period (on average 1,5 – 2 months), and the team sometimes advocates quicker admissions to the sole rehabilitation centre in Ljubljana.

6.4 Advocating for health and rights

6.4.1 ŠENT users' board (Slovenia)

The users' board at ŠENT in Slovenia, led by Andreja Stepec, offers a crucial perspective on mental health care. Comprising individuals who have personally faced or are facing mental health challenges, the board serves as an advisory entity within ŠENT. Their primary role involves providing insightful advice on programmes and governmental policies, fostering positive relationships with professionals, and collaborating with other NGOs. Currently, the board is actively engaged in crafting proposals for a mental health care law.

The establishment of the users' board was a response to the marginalised position of individuals with mental health problems in society. Many lack awareness of their rights, including the right to social support, and remain uninformed about available programmes. Since 2019, the users' board has expanded its influence by creating a centre for social advocacy, welcoming members such as social workers, peer workers, and relatives of individuals with mental health challenges.

Officially recognised as a member of the National Health Council, the users' board actively participates in negotiations concerning new measures and laws. Their initiatives include providing peer support, facilitating peer-to-peer discussions, forming support groups, and raising awareness about mental health issues. The users' board at ŠENT is ambitiously working towards employing peer workers to enhance the recognition of peer support work. Depending on their ability to raise the necessary funding, the intention is to combine this employment with specialised programmes to train peer workers as professionals.

The users' board engages in advocacy efforts to defend the rights and interests of service users and promote more and higher-quality mental health programmes. They aim to empower their target group by amplifying their voices, recognising the challenges of exposing oneself while sharing personal experiences.

6.4.2 Positive Voice (Athens): Defending dignity, fighting stigma

Positive Voice, established in 2009, defends the rights of HIV-positive patients and addresses the impact of HIV/AIDS in Greece. The association focuses on prevention, treatment, and social care, emphasising the importance of acceptance and support for affected individuals. Volunteers actively engage in three key projects, offering counselling, administrative assistance, and legal support. While medical practitioners are not on-site, collaborations with organisations like MSF and MdM ensure access to medical services. The housing programme, informative sessions, and street projects (distributing free condoms and disseminating HIV information) tackle challenges such as homelessness, the necessity of trust-building, the need for more comprehensive follow-up and the rise of new, cheap and more dangerous drugs.

6.4.3 Ref CHECKPOINT (Athens): Testing and counselling for refugees and migrants

Ref CHECKPOINT serves as a Prevention & Testing Centre, offering fast, cost-free and anonymous HIV and Hepatitis B and C testing for refugees, migrants, asylum seekers and people without legal documents. The centre aims to provide testing services in various native languages, ensuring accessibility. Beyond testing, discussions on sexual education and health issues contribute to a comprehensive approach, promoting confidence and knowledge about sexual health without stigma and discrimination.

6.5 Project partners' insights and recommendations

6.5.1 Trauma

Trauma, whether stemming from past or present experiences, plays a significant role in the lives of many homeless people. This trauma can result from various sources, such as the loss of caregivers, domestic violence, or witnessing the death of peers while living on the streets. However, homeless people often perceive these traumatic events as routine occurrences, overlooking their profound impact. Dissociation from these experiences is common, and there is often a lack of awareness about trauma and its far-reaching effects on overall functioning. Unfortunately, the knowledge of workers in this domain is often insufficient, posing the risk of re-traumatisation during the recovery process.

A focus on trauma can become a significant window into understanding an individual's experiences, transcending the confines of diagnosis. It involves a profound journey to reflect on a process that a person has endured, offering a pathway to break down barriers and foster genuine understanding. By focusing our attention and approach on the individual's experiences and trauma, we can ensure a more holistic and effective delivery of care and treatment.

SMES-Europe also emphasises the critical importance of understanding trauma, and acknowledging its impact on the brain, often causing a split in individuals. This division may lead people to act without reflection, independently of economic stress or psychosis. A significant aspect of trauma response is the self-protective refusal of help. To address the complex consequences of trauma, the project partners advocate establishing a supportive network and implementing positive interventions. Initiating the process with small steps can provide a way forward. In some cases, basic necessities like

a bed, shower, and breakfast can be sufficient, considering the individual's limited capacity to aspire to more. Subsequently, reconstructing one's biography, possibly through a diary, serves as a virtual means of reconnection. Social workers or psychiatrists can use this life history to identify the elements that have remained resilient in the person. Therapy involves reflecting on past experiences within the context of one's history, uncovering strengths that helped overcome barriers.

6.5.2 Drugs and alcohol consumption in services

In Slovenia, particularly in Ljubljana, there is an approach to providing safe spaces where individuals can consume alcohol or drugs during intake. Legal methadone is available, while efforts are ongoing to address illegal substances like heroin. This contrasts with other shelters that maintain a high-threshold approach.

For instance, in Poland, there is a stringent no-tolerance policy toward drugs and alcohol (0.5% promille) within shelters. While some individuals use alcohol to numb emotional pain, the system usually offers shelter under the condition of sobriety. Andrzej Czarnocki emphasised the delicate balance between ensuring safety within shelter environments and the tolerance with respect to with alcohol use. He suggested that individuals who have consumed alcohol can be accommodated in separate areas for a short duration to sober up. This approach aims to safeguard both the individual and the well-being of others within the shelter.

In Finland, the issue of substance use and inebriation on facility premises is influenced by state regulations that prohibit restrictions on individual freedom in this regard. Residents are granted the freedom to use substances on the premises, and staff cannot enforce restrictions on this behaviour. However, this approach has faced criticism, particularly at a Housing First facility in Helsinki. Staff members at the facility have raised concerns about the adverse effects of substance use and abuse happening in proximity, impacting individuals living nearby who are also dealing with substance-related challenges. These concerns are particularly pertinent in multiple housing facilities, such as blocks of flats. The staff's viewpoint is that the regulation is impractical and seems to be motivated more by ideology than feasibility. Consequently, there is a plea to strike a reasonable balance between an individual's rights to engage in substance use and the rights and well-being of other individuals residing in the same vicinity. Achieving this balance is crucial to addressing the concerns and challenges stemming from substance use within the facilities.

Tiina Aitta highlighted the perspective that substance use should be regarded as an individual problem. This viewpoint underscores the importance of addressing substance abuse issues on a case-by-case basis, recognising that each person's situation is unique and may require tailored support and interventions. Unfortunately, in Finland if you are a drug addict you cannot have any mental medical assistance. You have first to be rehabilitated and then you can be treated for any mental illness.

6.5.3 Continuity of care and In-reach

In Italy, particularly in Florence, there appears to be a concern about psychiatric individuals returning to the streets without proper care, highlighting a lack of continuity in psychiatric services. In Portugal, there are efforts, such as meetings with directors of psychiatric hospitals through NPISA (see Chapter 9), to raise awareness and establish 'fast track services' for homeless individuals.

In addition to traditional outreach efforts, the concept of 'in-reach' also holds considerable significance. Unlike outreach, which typically involves reaching out to individuals in the community, in-reach involves community teams entering hospital settings to continue providing support and follow-up care to patients who are hospitalised. This concept refers to the integration and continuity of care and support across different healthcare settings. The term 'in-reach' highlighting its relevance in ensuring ongoing assistance and engagement with individuals regardless of their location or circum-

stances. Ultimately, the concept of in-reach underscores the commitment to accompanying individuals throughout their journey, whether it pertains to mental health, healthcare interventions, or other aspects of well-being.

6.5.4 Strengths of community-based mental health care

The study visit to ŠENT highlighted the robust strengths of community-based mental health care. In contrast to psychiatric hospitals, community-based mental health care is characterised by its accessibility, multidisciplinary approach, and a more 'systemic' methodology that involves families, employers, social services, and local communities. The smaller scale of services contributes to a warmer, more humane atmosphere. ŠENT showcases creativity and flexibility in tailoring services to diverse target groups. Moreover, the concept of 'community-based therapy' extends to healing community relationships. For instance, in the housing group for young people, efforts are made to reintegrate individuals into their family and neighbourhood after a period of separation from a 'toxic environment'. This underscores the importance of interdisciplinary collaboration between psychologists and social workers, a crucial aspect often overlooked in clinical psychiatry within a hospital setting.

Whereas the 'de-institutionalisation' policy is relatively recent (implemented in 2016), a significant imbalance persists between the psychiatric hospital sector and community-based mental health care. It's essential to recognise that these sectors are complementary, not competitive, with community-based mental health care relying on psychiatric hospitals for specialised care when needed.

De-institutionalisation remains a persistent challenge in Europe, marked by a concerning reversal of the trend towards increased inpatient care and the resurgence of outdated treatment practices, such as the resurgence of electro-shock therapies. This troubling shift is particularly evident among immigrants who, despite their significant engagement in social services, tend to inadvertently 'import' and perpetuate these regressive practices. The struggle against institutionalisation persists, demanding continued efforts to uphold progressive and humane mental health care practices.

7 | Home and housing

7.1 Finland: Embracing the Housing First approach

Through sustained collaboration, homelessness has remarkably decreased in Finland. Over the past 15 years, Finland has undertaken persistent efforts, dating back to 2007, to combat homelessness. This endeavour has fostered a network encompassing major urban regions, service providers, and organisations dedicated to addressing homelessness. The outcome has been a tangible decline in the number of individuals experiencing homelessness, even amidst challenging pandemic circumstances, with effective intervention strategies identified. Nonetheless, approximately 3,429 individuals still find themselves homeless, underscoring the ongoing need for action.

The most recent governmental initiative, spearheaded by the Ministry of the Environment, is particularly focused on eradicating long-term homelessness. By 2027, the aim is to completely eliminate instances of long-term homelessness. According to a report from the Housing Finance and Development Centre ARA, as of 2023, over 1,018 individuals were classified as long-term homeless in Finland.

7.1.1 The housing finance and development centre for Finland (ARA): Preventing evictions through housing advice

Sina Rasilainen, senior expert in housing policy and homelessness at ARA and lecturer at LUT University, shared insights into Finland's housing policy with the Person First team. ARA plays a vital role in implementing government housing policy, focusing on sustainable and affordable housing. ARA grants subsidies, guarantees, and guidance related to housing and construction, overseeing the use of ARA housing stock and engaging in housing development projects.

In 2022, ARA allocated 2.3 billion euros in loans and 280 million euros in grants for social and affordable housing. A total of 5,300 new apartments were established, contributing to ARA's mission of providing housing for those in need due to social or economic reasons.

ARA housing, allocated based on urgency, income, and wealth, targets individuals facing homelessness or those at risk, as well as special groups like the elderly, disabled, and students. In ARA housing, rental contracts are consistently permanent, and the allocation process operates without queues, with tenants selected based on urgency. ARA does not own apartments but collaborates with various providers, such as municipality-owned companies, NGOs, and foundations like the Y-Foundation.

The rent in ARA housing follows a cost-recovery principle, ensuring affordability for tenants. This approach means that the rent is specifically determined to cover the costs of providing and maintaining housing, with no intention of generating profits for the housing company. ARA rents are equalised between cities, which means that in 'high-demand cities' they are significantly cheaper than market rents, providing an average savings of 325 euro per month in Helsinki.

A crucial aspect of ARA's strategy is the employment of housing advisors, aiming to prevent evictions through early intervention. In 2023, ARA granted funds for 69 housing advisors across Finland. The goal of ARA housing advice is to ensure that everyone, regardless of their location, is entitled to receive housing advice.

Housing advisors, often possessing a bachelor's degree in social services, work collaboratively with clients, housing providers, NGOs, and social work. Their role as 'bridge builders' involves addressing various issues, such as rental payment problems, housing disorders, and eviction threats. The effectiveness of housing advice is evident in its cost-effectiveness, preventing evictions and associated

costs. A study on eviction costs in Finland revealed a range from 1,600 to 21,400 euros, with an average cost of 6,300 euros and an average rental debt of 4,300 euros. This implies a substantial income loss of 10,300 euros for the housing company. Additionally, the entire process, from the first rental debt to eviction and securing a new tenant, can span up to 8 months.

As part of Finland's strategy to combat homelessness, ARA supports housing advisors through training sessions, facilitating a network for peer support, and organising training for newly hired advisors. ARA's proactive approach aligns with the government's goal to improve the availability of housing advice, as outlined in the 5-year law drafted by the Ministry of Environment for 2023-2027.

In conclusion, ARA's comprehensive strategy, encompassing affordable housing initiatives and the deployment of housing advisors, underscores Finland's dedication to preventing evictions and homelessness through strategic housing policies. While housing advice currently operates on a voluntary basis for municipalities, reflecting a societal commitment to homelessness prevention, there are worrying trends. The number of housing advisors is declining, with national grants set to reduce by 50% from 4 million euros to 2 million euros next year. Furthermore, 20% of the funding burden will shift to municipalities. Recent changes, including a new programme in June 2023, lean towards a right-wing approach, signalling a departure from the Housing First philosophy.

7.1.2 The Y-Foundation: Management of affordable housing provision in Finland

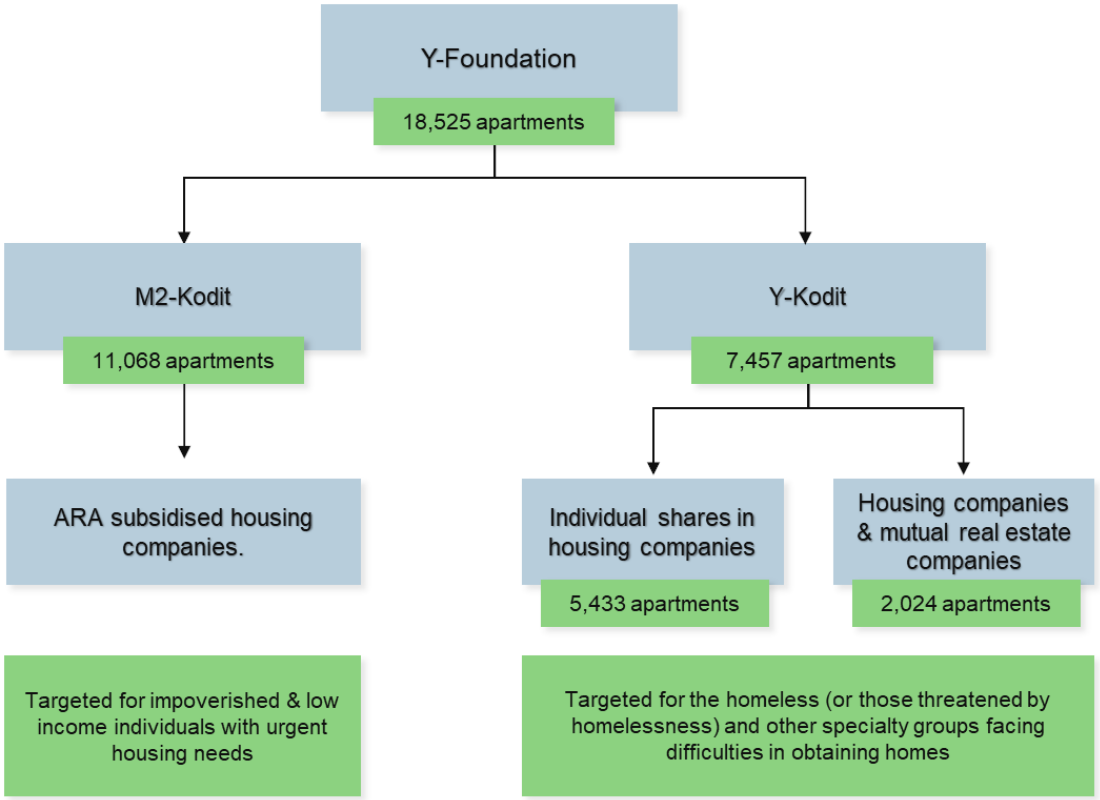
Sari Timonen shared insights into Finland's Y-Foundation. The Y-Foundation, Finland's fourth-largest residential landlord, plays a crucial role in providing affordable rental housing and addressing homelessness. Established in 1985, this non-profit, politically non-affiliated foundation operates with a dedicated focus on social justice and the overall well-being of its tenants.

Comprising Y-Kodit and M2-Kodit (see Figure 7.1), the foundation stands as the largest nationwide non-profit residential property owner in Finland, with governance from top Finnish municipalities, institutions, associations, and trade unions.

With 200 employees overseeing 18,525 apartments, the majority of which are situated in southern Finland, the Y-Foundation plays a crucial role in promoting social justice, preventing homelessness, and enhancing the economic and social well-being of its tenants. This involves increasing the availability of affordable rental housing in growth centres, acquiring individual apartments for specialty groups, and providing comprehensive solutions for construction, living, and tenant welfare.

The Y-Foundation's strategic goals include improving tenants' well-being, achieving carbon neutrality by 2035, and eliminating homelessness in Finland by 2027. These efforts are expected to eradicate homelessness locally and contribute globally through the Housing First model. Anticipated outcomes include enhanced tenant well-being, with both the Y-Foundation and M2-Kodit working towards reduced emissions and carbon neutrality by 2035.

Figure 7.1 Organisational structure of Y-foundation at the end of December 2022



In terms of housing initiatives, the Y-Foundation provides rental flats tailored for impoverished and low-income individuals. The Y-Foundation's rental flats are integrated into regular blocks, designed to closely resemble other flats, providing residents with the comfort, safety, and privacy of a typical home. This includes Y-HOMES, offering over 7,400 flats for special needs groups, and M2-KODIT, providing over 11,000 flats based on ARA-conditions (see Section 7.1.2). The encouragement of tenant committee participation fosters community building.

The foundation also manages specialised housing units like Väinölä, offering supported housing for 35 residents since its establishment in 2014. Another initiative, the Housing First unit Wäylä, combines rental houses, a day centre, and scattered housing.

Development initiatives involve a dedicated team of researchers working on the evaluation and, prevention of homelessness, and promoting carbon neutrality and sustainability. The Y-Foundation acts as a coordinator in national and international development networks, emphasising Housing First principles and working towards ending homelessness.

The Uuras Programme, a notable aspect, offers the possibility to pay off rent debt through employment opportunities for tenants, facilitating gigs, and business cooperation for job placement.

In addition, the Y-Foundation provides housing services, including property maintenance, renovations, cleaning, and gardening services, aligning with its over-arching goal to support employment objectives and enhance the well-being of its tenants.

7.1.3 Optimising support in Housing First: The role of small housing units

Housing first is tailored to individuals needing substantial assistance to transition out of homelessness. However, sometimes this model is implemented too passively for those with wide-ranging and acute support needs. Large housing units, accommodating approximately 100 residents, may pose challenges to the Person First principle.

With fewer residents per unit, it becomes easier for staff to establish genuine, trust-based relationships with each resident, crucial for identifying and addressing individual needs effectively. Small units foster an intimate and personalised approach, enhancing support effectiveness.

Many homeless individuals have experienced social isolation and lack support networks. Therefore, Housing First units must focus on fostering social interaction and community. In smaller units, creating a sense of community is more manageable, providing residents with a supportive environment to connect with others who understand their experiences. This support network assists in navigating challenges, sharing resources, and offering emotional support, promoting feelings of safety and security. Additionally, individuals with lived experience (e.g., experts-by-experience) can contribute to building community spirit.

The next subsections illustrate the diversity of Housing Units and Housing First in Helsinki

7.1.4 Alppikatu Housing Unit by Salvation Army: A shelter in transition to Housing First

The Alppikatu Housing Unit, a former shelter, underwent renovation to become a Housing First unit under the Salvation Army. With a history dating back to 1908, the Salvation Army has evolved to provide more structured and safer accommodation. In 2009, in alignment with Helsinki's shift to Housing First, the Salvation Army's shelter transformed into a supported housing unit.

The housing service, comprising two units, welcomes approximately 80 individuals who were previously homeless. Access to the accommodation has minimal prerequisites, requiring only a valid ID and a residence permit. Each resident enjoys a private room, and the unit strives to secure permanent housing for them. While one unit provides temporary accommodation, the Housing First principle allows residents to stay as long as they wish. Shared kitchen facilities and varied room arrangements are available. However, a lack of rules inside the rooms regarding substance use has led to challenges, with reports of violence and difficulties for those striving for sobriety.

Residents engaging in activities and chores receive a fee of 8-10 euros and a discounted lunch (1 euro). Participation in chores comes with a no-substance-use policy. Those who opt not to participate receive lunch at 2 euros and complimentary porridge and coffee from Monday to Friday. Activities include cleaning, gardening, crafting items for sale, bike repairs, printing on various materials, and furniture restoration. Rules within the unit are discussed bi-weekly with residents, and breaking them may lead to exclusion, with the option to return after a stay in the shelter. A peer worker, present weekly, plays a crucial role in connecting residents to healthcare, groups, and serves as a positive role model since the peer worker has their own apartment.

The housing unit has 30 instructors, and night shifts are overseen by a staff member per unit, with alarm and security measures in place. Mutual support among coworkers is emphasised, serving as a significant source of assistance. Mental health support is limited by the Finnish policy requiring sobriety for assistance, creating challenges for individuals with interconnected substance abuse and mental health issues. For instance, a resident facing suicidal thoughts could not be admitted to a hospital due to intoxication.

7.1.5 The House of Fellows (no fixed abode)

The traditional 'ladder' approach[27] was in use in Finland until 2007. The House of Fellows (HoF) was the first piloting project in 2007 for Housing First model in Finland. It was found that users were stuck in loops, some with severe health problems due to difficult living conditions. To address this, HoF adopted Housing First, focusing on permanent housing as a more effective solution that provides security, ensures rights, and enables individuals to take responsibility.

Homeless individuals access HoF after an assessment interview about their housing history, with a minimum threshold of 1.5 years of homelessness or very acute circumstances. Despite initial resistance from neighbours and traditional services, HoF has become a success in Helsinki, offering smaller-scale accommodations (maximum 20 rooms or studios) to long-term homeless people, many of whom are aged 65 and above. The neighbours also noticed that the streets became quieter and more secure. Out of approximately 100 residents (2007-2023), only four had to be excluded from the Housing First project in Helsinki due to severe violence against staff or deliberate arson. Some heavy drinkers (5%) returned to the streets and sought help in therapeutic communities. However, there were also success stories, with individuals securing flats in the open housing market. Another inspiring case involved a resident who began collecting and selling empty bottles, using the earnings to prepare meals for others in the community.

The studios, with a surface of 25 m², include a separate bathroom, kitchenette, and living space, with a monthly rent of 900-1000 euros all-in. Residents receive a minimum income, housing allowance, and a service fee from the City of Helsinki.

The HoF staff primarily consists of housing instructors (who have a training of a practical nurse or a social worker), including cleaning staff, one nurse for two blocks, and housing management. Service integration is achieved through collaboration with local services in the neighbourhood, though in-house services are preferable for better accessibility and expertise.

Challenges include potential eviction due to the organisation that owns the building intending to use it themselves, tightening conditions for access by the City's housing service, and difficulties in maintaining community life within the building as residents age. HoF faces alcohol-related challenges, but collective HF accommodation experiences less prevalence than individual apartments.

Despite these challenges, HoF has successfully addressed homelessness for older individuals, fostering a quiet and peaceful community. The NIMBY (Not In My Backyard) mentality is less prevalent among neighbours due to the older and quieter nature of the residents.

7.1.6 Vartiosaari Island (no fixed abode): Building a community by and for the homeless

Founded in 1989 by individuals experiencing homelessness, the Vartiosaari community is a unique project initiated by No Fixed Abode. Starting with a single ruined building on the island, homeless individuals collaborated to renovate structures, including a sauna, and construct new facilities. Throughout the island's reconstruction, No Fixed Abode received material support from a prominent psychiatrist.

[27] The ladder approach in addressing homelessness involves a staged progression through different housing levels, starting with emergency shelters or temporary housing and progressing through transitional housing programmes before reaching the final step of obtaining permanent housing. Each step on the ladder represents a transitional phase that provides individuals with increasing levels of support, services, and independence. However, there is a shift towards Housing First models, which prioritise immediate and permanent housing without requiring individuals to complete transitional stages.

The island caters to the needs of homeless individuals or those with a history of homelessness. The place is run by peers and volunteers, with no paid staff present on the premises. Visitors can stay for varying durations, from a weekend to several weeks. For those lacking alternative accommodation, a two-week stay is provided. The island can host up to ten people, requiring a fee of five euros for food. Emphasising a substance-free environment, visitors must refrain from alcohol and drugs during their stay.

Staying on Vartiosaari has proven to have a calming effect on many, with some individuals spending entire summers on the island and successfully maintaining sobriety. This unique experience has contributed to an easier transition to finding permanent housing after their time on the island.

7.1.7 Blue Ribbon Foundation's Ruusulankatu Housing First unit

The Blue Ribbon Foundation is a social enterprise specialising in housing services, actively operating in Helsinki, Uusimaa, Turku, and soon in Tampere. In Helsinki alone, they manage 324 apartments, part of a total of 731 apartments across Finland, with both rented and owned properties.

The Ruusulankatu unit is dedicated to Housing First principles, with 92 apartments spread over 7 floors. While residents have permanent contracts, the average duration of stay is 2.5 years. The majority of residents are young (under 30), and one-third are women.

Residents undergo a comprehensive intake process, including information on rights, obligations, and surveillance systems. Personal counsellors are assigned to monitor residents and their apartments. The unit ensures timely rent payment, offers budget assistance, and supports residents in maintaining their living spaces and living together.

The unit accepts referrals from the city's housing service and allows substance use within apartments. Couples have access to only one apartment, and no pets are allowed. Despite some residents not showing up after renting, these apartments are quickly reallocated to others in need.

The unit is staffed with dedicated professionals, including 6 housing counsellors, 3 service counsellors (bachelor social workers), 4 night-time counsellors, 2 work coaches, 1 occupational therapist, 1 head of the unit, and 1 cleaner.

Each resident is provided with a personal counsellor and a customised service package. Weekly and daily activities are available, including community meetings and meal gatherings. The unit also offers the distribution of clothes, books, DVDs, musical instruments, and a fitness facility. Nevertheless, both the musical instruments and the fitness facility are currently underused.

Initially faced with a negative local reputation, the unit has successfully improved relations with the neighbourhood. Recent donations from a nearby school highlight the positive shift in attitudes.

Counsellors are present around the clock in the building. Outflow incidents are tracked, with recent cases primarily attributed to aggression or substance abuse in common areas. Other outflows result from residents achieving sobriety and transitioning to regular apartments.

7.1.8 Liisankoti: Empowering women through supportive housing

Liisankoti, a supported housing unit for women operated by NGO Suur-Helsingin Valkonauha ry, has been providing women-specific support and housing options since its establishment in 1928. The women's home within Liisankoti has been offering supported living for women dealing with substance misuse issues since 1961.

The organisation expanded its services in January 2022, becoming a Housing First supported housing unit. Prior to this, the principles of Housing First were already being implemented without the label. In 2022, the organisation added scattered housing and two specialised units: Minna, offering housing with less support, and Mathilda, providing more intensively supported housing. The aim is to offer diverse living possibilities for residents, allowing them to transition between units based on their needs and progress.

Living in a women-only environment has had a positive impact on residents, fostering a sense of safety, relaxation, and personal identity. It also allows staff to focus on women-specific issues such as pregnancy and domestic abuse. Residents reported improvements in their lives, including reduced loneliness, increased decision-making capability, enhanced quality of life, and a greater sense of safety. Liisankoti's team comprises housing service managers, senior social care workers, social care workers, social care assistants, a nurse, and a part-time cleaner.

Liisankoti offers communal supported housing for homeless women, with 21 residents having their own rooms and communal areas. Housing First principles are applied, providing permanent rent contracts, allowing residents to stay as long as needed. A multidisciplinary team offers holistic support, focusing on helping residents identify boundaries and recover from traumatic events. Lissankoti operates with minimal rules, treating it as the residents' private home. The only condition is no substance use in communal areas; breaking this rule does not result in eviction. Relapses are recognised as part of the substance misuse journey, prompting increased staff vigilance and presence. While children are not permitted to reside in the home, they are welcome to visit. Additionally, pets are allowed. Staff is available from 8 am to 4 pm, with a social worker present during the evening and night.

The homeless women actively participate in the organisation through weekly community meetings where both staff and residents address issues over a meal. Although attendance is not mandatory, strong encouragement from staff emphasises residents' voices being heard, fostering transparency and awareness of home affairs. Lissankoti integrates rehabilitation work and provides a daily structure, collaborating closely with Helsinki city Social work for homeless people.

Launched in 2022, supported housing in scattered housing provides nine apartments with permanent rent contracts. Staff collaborates with residents to understand their needs, focusing on building relationships and trust. The NGO partners with the Y-Foundation to search for and lease apartments.

The Matilda-Community and Minna's House accommodate 25 women facing substance misuse challenges, providing a home-like environment (they all have a private room). The Mathilda community provides more intensive support with daily tasks. Residents are transferred to these units through Helsinki city substance misuse services. Despite residents being female only, the staff includes both genders to ensure normal relationships with men are established. The importance of having both male and female staff is emphasised by both residents and staff.

7.2 Housing First in Poland: Emphasising the importance of a Person First perspective

Julia Wygnanska, Vice-President of the Housing First Poland Foundation, discussed the effectiveness of Housing First in Poland, emphasising the importance of the 'person-first' perspective. The advocacy for Housing First in Poland began in 2010. The approach places a strong emphasis on the concept of 'home' rather than just addressing homelessness.[28] The philosophy centres on the principle of 'person first', tailoring solutions to meet the unique needs of each individual, addressing mental health concerns, and providing therapeutic support, as necessary. Housing is seen as a central piece of the puzzle.

Julia Wygnanska highlights a common misconception that shelters are vibrant communities. In reality, these settings may well host 60-80 individuals while personal connections are minimal. People frequently move in and out, and residents do not have the liberty to choose their fellow residents. Transitioning to individual apartments can be challenging, as individuals may feel anxious about interactions with neighbours or the responsibility of apartment living. Many people have experienced loneliness and isolation even before facing homelessness. However, within Housing First, there are more opportunities to cultivate relationships and regain a sense of belonging within the community.

Securing employment for those with a history of long-term homelessness can be challenging due to exacerbated health conditions. Mental health and trauma are growing concerns, and Housing First teams in Poland consist of well-trained therapists in mental health, trauma, and harm reduction. Julia Wygnanska emphasises that empowerment and participation are integral aspects of their approach in Poland. They engage in individual work with clients, supporting their decision-making processes and respecting their choices for the next steps in their journeys. Experts-by-experience also play a vital role in their programmes.

In conclusion, they advocate the principles of Housing First and aspire to expand such programmes as much as possible. These principles encompass supporting recovery, harm reduction, and fostering the motivation of stakeholders to align with these values.

7.3 Small-scale housing groups: the housing group for young people in Nova Gorica (Slovenia)

In the landscape of mental health and social care, traditional institutions have been the hallmark. Psychiatric hospitals and specialised social facilities, predominantly established by the State, have been the norm. However, a paradigm shift has been witnessed with the emergence of small-scale 'housing groups', initiated by the NGO sector with support from the Ministry of Social Affairs. These groups,

[28] https://najpierwmieszkanie.org.pl/o-metodzie/

categorised as either 'closed' permanent setups or 'open' transitional ones, aim to provide professional assistance to individuals facing occasional or prolonged hardships and mental health challenges.

Coordinated by multidisciplinary teams, these housing groups set a residence limit of 18 months. The challenge arises in finding alternative accommodation within this period, compounded by a 500-euro registration fee and a requirement for a six-month rent guarantee deposit and furniture purchase. Municipal social services may partially cover these costs, but mental health issues are still unfortunately often stigmatised. A unique fundraising effort through a radio broadcasting company, collecting funds through music-on-demand, adds an innovative touch to address financial challenges.

The Nova Gorica housing group, initiated in 2020 amid the COVID-19 pandemic, stands as ŠENT's first housing group for youngsters, the sole one in Slovenia. Tailored for adults in need of support due to mental health struggles and lacking a suitable living environment or social network, the group focuses on providing a home-like atmosphere, promoting independent living, offering work rehabilitation, and implementing a mental health programme to reintegrate young people into society.

The Nova Gorica housing group has hosted 14 young people in the past year and currently (2023) accommodates 6 residents. These individuals, aged between 19 and 27, come from diverse backgrounds, often with separated parents. Residents stay for an average of 3 months to 1 ½ years, with the state funding the group only for those aged 18 to 26. Upon reaching 27, alternative accommodation is sought for departing residents.

Residents, referred by psychiatrists due to unsuitable or toxic living situations, come from across Slovenia. The housing group provides an individualised plan focusing on basic needs and personal goals, guiding residents towards independence, personal hygiene, ...(basic needs) and education, employment, obtaining a driver's license, doing voluntary work, ...(personal goals).

The housing group maintains strict rules: no drugs or alcohol allowed, and residents using them are expelled. Prospective residents must be drug-free for at least a year before entry. A 10 PM time limit mandates residents to be in their rooms with lights off. Visitors require pre-registration, and any form of violence is prohibited. Residents actively participate in meal preparation and planning, clean their own rooms, and handle grocery shopping together. These guidelines aim to foster a responsible and harmonious living environment.

Beyond offering a home and work rehabilitation, the housing group facilitates connections with psychologists and doctors. Collaborations extend to the day centre in Nova Gorica and local shops, offering housing group residents discounted groceries.

Residents face occasional or prolonged hardships, including depression, schizophrenia, autism, and personal disorders resulting from trauma, such as (sexual) violence. Notably, only a fraction of the residents is homeless in the strict sense, with three out of fourteen having faced homelessness in the past year. Nevertheless, the reality that these young people had to be removed from their home environment should also be recognised as a form of homelessness. One of the positive aspects of this housing group is its role in preventing homelessness by providing a home for adolescents in unsuitable living situations.

Employees work in shifts with a 4-hour overlap, engaging in individual and group work. The team includes a licensed social worker and a mentor. Collaboration with the day centre and psychiatrists ensure comprehensive mental health coverage.

Started in 2020, the housing group secured 50% of funding from the ministry even after the project's completion in 2021. The remaining 50% is covered by participants and their municipality, with individualised pricing for residents based on their specific circumstances. The rented house, maintained through a friendly relationship with the private owner, has become a sanctuary for the young individuals seeking support and a fresh start.

7.4 Local authorities grappling with homelessness: the case of Leuven

Cornelis Kint, advisor on homelessness to the city of Leuven, shed light on the social housing situation in Leuven: with a waiting list exceeding 6,000 households and an inaccessible real estate market, as social housing construction progresses at a slow pace. Available plots for construction are underutilised, and private property developers are increasingly acquiring housing stock. In response to the scarcity, the City has devised a three-pronged approach as part of its housing strategy.

Firstly, there is an imperative to augment the available housing stock. Three avenues for achieving this are:

- collaboration with AG Stadsontwikkeling Leuven, a public property developer that acquires buildings for individuals in dire circumstances, offering them for rent at a rate 20% below the market price;
- emphasis on vacant homes, with measures to force owners to rent them out;
- encouragement of private property owners and developers to let apartments to vulnerable target groups as 'solidary landlords', despite the absence of legal leverage.

The city also aims to provide support to those on the waiting list for social housing. While regional rent subsidies are currently accessible after 4 years on the list, the proposal is to expedite this allowance after just 1 year.

Finally, the city plans to initiate new social housing projects in collaboration with sectoral stakeholders. In conclusion, despite the significance of even small-scale initiatives, it is imperative to recognise that the prevailing challenges necessitate the implementation of a national strategy. Such a comprehensive approach is indispensable for achieving a sustained and lasting impact on the issue at hand.

Cornelis Kint also provided insights into the housing and homelessness context, detailing the City of Leuven's Action Plan against homelessness and the Housing First project. The Leuven intersectoral network, established in 2018 and the first of its kind in Flanders, collaborates with entities such as NMBS (national railway operator), police, and the university.

The 2020 homelessness count identified a diverse group of 466 individuals, including 90 children, primarily composed of young individuals, and with a male majority (72%). The focus of the Housing First project is on individuals who have experienced homelessness for over 2 years. This relatively novel approach emphasises an intersectoral collaboration, involving social, health, addiction, and family support services. As of 2023, there are 7 Housing First units, and there are plans to add five more units each year. The project operates under a 15-year agreement, with each unit allocated 60,000 euros in funding.

The local action plan adopts a human tights approach with a broad definition of homelessness, emphasising housing, an integrated approach, and the continuity of measures. Ten strategic objectives encompass prevention, housing-led/first initiatives, assistance (outreach), access to rights, temporary accommodation, basic facilities, participation, collaboration, and monitoring through a new homeless count every 3 years. Furthermore, targeted measures address specific groups such as the elderly and children.

7.5 Modular housing: A flexible approach to marginalised homelessness in Brussels

Maxime Bonaert from Infirmiers de Rue in Brussels provides detailed insights into the 'modular housing' initiative, a flexible solution for marginalised homeless individuals. Initially the organisation focused on securing permanent housing, but the staff felt that for some marginalised homeless people a 'low-threshold' form of private housing is more suitable. Infirmiers de Rue rents land from private or public land owners for a minimum duration of 2 years to 4 years with a view to installing individual housing modules. They commit themselves to engaging in social work for the benefit of residents.

Termed as 'modules', these housing units are akin to tiny houses, standing at a height of 2.5 meters. Equipped with essential amenities and meeting legal standards, these modules provide a temporary occupation without being merely a transitory housing arrangement.

Residents are charged a rent ranging from 60 to 200 euros, depending on their specific living circumstances within the module. The entire process, from setting up these homes to making them fully functional, takes approximately two months. The cost amounted to 60,000 euros per unit.

Currently, there are 11 modules on 2 properties of land, with a focus on fostering social control and mutual assistance among residents. Support services are readily available for individuals in these modules. The project's flexibility in establishing rules and regulations is highlighted, despite facing challenges during the first months as some users caused property damage. Despite these difficulties, the project persevered successfully. The selection of residents involves careful consideration, aiming for social diversity to facilitate mutual support.

Key insights from this initiative offer a comprehensive understanding of the project's dynamics. These learnings will serve as a guiding force in efforts towards the development of sustainable and inclusive solutions:

- *Living environment comparison*: the experience of residing in these modules closely resembles life on the street, given their open visibility, numerous windows, and a strong connection to the outdoors.
- The 'Four Walls Syndrome' challenge: individuals with significant street-living experience may struggle with adapting to the comfort of a traditional house. The modules serve as an interim solution to address this challenge.
- *Success of temporary housing*: temporary housing, typically lasting from 6 months to 1 year, has proven successful for some residents. However, it is noteworthy that around half of them express a desire to continue living in the modules, prompting an active pursuit of long-term solutions.
- *Community integration*: initial concerns from neighbouring communities have been effectively addressed. The modules' insulation and their separate structures mitigate issues like cockroach infestations, ensuring minimal impact on nearby residences.
- *Diverse resident mix*: to counteract potential 'ghetto effects', the providers wish to diversify the project's resident mix by including groups like students. However, securing additional land for expansion is challenging.

7.6 Project partners' insights and recommendations

7.6.1 The effectiveness and challenges of the Housing First approach

Engaging in conversations with the workers responsible for these housing structures provided the opportunity to gather direct testimonials about the notably positive outcomes, as well as some challenges, associated with the Housing First approach in Finland. The data itself speaks volumes, revealing a significant and consistent reduction in the number of individuals living on the streets over the past 15 years.

However, when discussing the difficulties encountered, they were primarily linked to the established habits and perspectives of individuals who have experienced long-term homelessness. One

notable aspect highlighted by the workers is that a small portion of the population, having lived in homelessness for an extended period, may exhibit feelings of hopelessness. Even when provided with a secure place to stay, they may act in ways that suggest an expectation of losing their dwelling sooner or later, such as inviting acquaintances met on the streets to gain social credit for potential future homelessness.

Another risk factor identified is the potential for individuals to exploit the provided space for storing larger quantities of alcohol or drugs, increasing the likelihood of substance abuse and potential overdosing. It is crucial to note that, despite these challenges, a housing facility like Sällikoti – The House of Fellows has only expelled three individuals for inappropriate behaviour in its 15 years of operation.

Despite these complexities, the model has proven effective for the majority of the homeless population, while underscoring the importance of a substantial investment at the beginning of the social reintegration process for greater success in achieving that purpose.

7.6.2 Multi-optionally in housing

The concept of multi-optionality in housing involves exploring various housing facilities, including blocks of flats, large houses, small-scale housing groups and scattered housing. Differences exist among housing facilities, with some adhering more closely to the 'social mix' principle of Housing First, while others may serve more specific user populations, such as those exclusively catering for women. Staff members emphasise the enhanced cost-effectiveness and care efficiency of having a range of housing facilities. This diversity is beneficial, considering the diverse capacities, situations, and limitations of users. Consequently, efforts should be made to offer as wide a variety of housing opportunities as possible, without pitting one type against another. Even housing conditions resembling shelters (though with small bedrooms and in a 24/7 rather than overnight setting) can be acceptable, provided they offer some security and privacy to residents, the interiors are spacious enough, well-organised, and the atmosphere is positive. The crucial factor influencing the acceptability of such housing is the quality of relationships.

For instance, the Module project in Brussels serves as a temporary solution, recognising that a traditional home may not be the ideal choice for everyone, highlighting the importance of embracing diversity in housing options. The key lies in fostering a sense of belonging, nurturing stable relationships, and maintaining connections. Ensuring the availability of suitable housing, cultivating positive attitudes, and having dedicated staff with the right mindset are crucial elements that contribute to stability in this context.

Housing groups appear to offer the best alternative to shelters. In the Nova Gorica housing group, for instance, group dynamics play a crucial role in the therapeutic process, with young people providing mutual support. This highlights the strength of small-scale, family-like housing solutions.

7.6.3 Fostering true homes

The concept of 'home' extends beyond mere shelter; it intertwines intimately with health and overall well-being. Similarly, the notion of 'housing' transcends mere accommodation; it becomes intricately linked with employment opportunities and social participation. Both elements are indispensable components in the journey toward recovery, each playing a vital role in restoring individuals to a state of stability and fulfilment. Offering a house is easier than providing a true home, where one feels safe and connected. 'A true home' transcends being merely a physical space or structure; it is a space where individuals share affective connections. Homeless individuals experiencing extreme exclusion may paradoxically find a better sense of home on sidewalks or within the confines of a psychiatric hospital rather than in a lonely studio, away from their familiar environment.

Comparing homeless and non-homeless individuals reveals that those who have experienced homelessness tend to undergo more adverse life events and face traumatic difficulties (compound trauma:

continually dealing with challenging situations while still recovering from previous trauma). They often feel insecure, lack stable relationships, and perceive the world as unsafe. Services should be less punitive and judgmental, adopting a more democratic, empathic, and respectful approach.

The prevalence of loneliness within apartment buildings underscores a broader societal shift towards individualised living experiences. Concurrently, the phenomenon of 'homeless at home' highlights the stark reality that even within the confines of one's dwelling, individuals may still experience profound isolation and disconnection from society. These trends reflect a deeper cultural transition towards a more individually-oriented societal climate, where personal connections and communal bonds are increasingly strained or fragmented.

7.6.4 Prioritising housing for substance users: Addressing substance abuse and homelessness separately

Throughout this project, a recurring theme has been the connection between substance abuse problems and homelessness. Although these challenges frequently overlap, it is crucial to tackle them as distinct issues. The primary focus should be on providing housing as a top priority. Following this, with support from both peers and professionals, individuals can then address their substance dependence concerns.

Reflecting on the visit to Helsinki, where some participants questioned the gratitude of service users receiving Housing First services despite substance use issues, a fundamental question arose: If housing is a basic right, should people have to be grateful for it? This philosophical inquiry opens up avenues for exploring the intersection of housing rights, gratitude, and the complexities of supporting individuals with substance use challenges.

7.6.5 Urgent call for affordable housing

In their 2023 edition of the 'Overview of housing exclusion in Europe', Fondation Abbé Pierre and FEANTSA (2023) reiterate the hallucinating estimates of housing exclusion indicators in the EU. More than 15 million households experience an excessive burden of housing costs in relation to their household budget (i.e. they spend more than 40% on housing-related costs) Approximately the same number are not able to keep their home adequately heated during winter. 34 million live in overcrowded dwellings, and at least 895 000 are homeless.[29] The recent energy crisis and subsequent inflation have boosted housing prices and rents beyond the overall inflation rate, affecting low-income households most severely. Despite efforts from the European Commission to support investments in housing (mainly through the Housing Partnership Action Plan[30] and the Affordable Housing Initiative[31]), the glaring shortage of affordable and adequate housing remains alarming. One of the root causes must be sought in the growing concentration of land and real estate in the hands of super-rich people and speculative investment funds.

Urgent action is needed to address this fundamental imbalance, with comprehensive national and EU-wide investment plans and public policies to prevent the abuse of monopoly power in the property sector. It is unacceptable that vulnerable groups are systematically priced out of inner cities, while homeless people have almost no access to adequate and affordable housing.

[29] According to Ethos classification, categories 1-2-3.

[30] final_action_plan_euua_housing_partnership_december_2018_1.pdf (europa.eu)

[31] Affordable housing initiative - European Commission (europa.eu)

8 | Participation and rehabilitation

8.1 The capability approach as a guide for participation and rehabilitation

In Amartya Sen's capability approach developed in the 1980s, human beings are characterised as receivers (i.e. vulnerable beings in need of support and having rights), doers (i.e. actors able to contribute to society), and judges (i.e. political beings with aspirations, values, and desires) (Bonvin & Laruffa, 2022). Reflecting on these dimensions, even the receiver aspect is seen as an active role, or at least it should be.

As concerns the position of the homeless person as a receiver, the focus is on basic rights to services that extend beyond emergency relief such as a bed in a large dormitory or a roof over their heads. This approach involves creating opportunities for negotiation, tailoring individualised pathways, and offering choices in the services they receive. The emphasis is on delivering services of sufficient quality while acknowledging the dignity of those seeking assistance. It is also crucial to recognise that even refusing a service can be an active decision. Limited choices may force individuals to either accept substandard services or have none at all. To ensure dignified treatment, the criteria for quality services include creating a welcoming atmosphere, providing diverse and customised offers, enabling individuals to express their needs, negotiating solutions, and fostering a perspective for long-term rehabilitation rather than mere survival for the night.

The 'doer' dimension extends beyond the receiver role, as homeless individuals express a desire to actively contribute to their well-being and to society at large. This involves a spectrum of activities, ranging from participating in occasional chores, managing the daily housekeeping activities, engaging in social economy projects, generating income through product sales, to serving as peer workers - utilising personal experiences to assist others.

Amartya Sen's third dimension of being a judge highlights the importance of individuals having their own views and expressing opinions about their situations and the future of society. This top layer of participation involves e.g. periodic interviews with shelter residents to assess service quality, representation of peers in external negotiations, and self-organisation of homeless individuals engaging in advocacy for better policies.

Within this approach, services can address several key questions:

- Receiver perspective:
  - To what extent do service providers recognise homeless individuals as rights-holders to basic services rather than passive recipients?
  - In what ways do service providers ensure the dignity and well-being of homeless individuals in accessing basic services?
- Doer perspective:
  - How do services empower homeless individuals to play an active role in their well-being and support to their peers?
  - Are there opportunities for homeless individuals within services to engage in activities contributing to societal improvement?
  - How do service providers foster a sense of purpose and self-efficacy among homeless individuals despite challenging circumstances?

- Judge perspective:
  - How do homeless individuals assess the effectiveness and quality of services in meeting their specific needs?
  - What mechanisms allow homeless individuals to express opinions and concerns about policies combating homelessness?
  - Are there self-organisation and advocacy practices within the homeless population, and how do service providers engage or support these initiatives?

8.2 Homeless people as actors within services

Slovenia stands out for its strong expertise in social pedagogy, acknowledging the significant role of community interaction in shaping individuals' lives. Social pedagogical methods are widely utilised in Slovenia and are particularly evident in initiatives addressing homelessness and mental health. Day centres serve as vital hubs for individuals struggling with housing challenges, providing a supportive environment for collective problem-solving amid societal stigma. Beyond meeting immediate needs, these centres foster communal activities such as sports, arts and music, cooking, cleaning, hiking and camping, adapting practices to align with community preferences. Leveraging social-pedagogical guidance facilitates community development by empowering individuals and providing necessary resources. This approach promotes active participation and empowers individuals to engage meaningfully in their lives.

8.2.1 Kralji Ulice homeless help and self-help association in Slovenia

Kralji Ulice homeless help and self-help association, founded in September 2005, stands as an independent non-governmental humanitarian organisation with non-profit goals. Bringing together experts, service providers and those experiencing homelessness, the NGO is a pivotal force in Slovenia, focusing on research, prevention, and practical intervention in the field of homelessness.

Kralji Ulice began as a study project in December 2004, evolving into an NGO dedicated to homelessness. Starting with a night spent by students with homeless individuals for research, the organisation initiated a newspaper, mirroring 'The Big Issue' in the UK. The paper, authored by homeless vendors, has become a significant advocacy tool. Subsequently, a day centre and a resettlement programme were established, following a bottom-up approach based on the needs of the homeless.

The organisation continues to issue a newspaper authored by homeless individuals, celebrating its 200th edition in February 2023. This initiative not only generates revenue but also serves as a platform for homeless individuals to share their stories, providing valuable insights into their needs and aspirations. Kralji Ulice also offers diverse training activities under 'University under the Stars', encompassing computer courses, photography, arts, music, theatre, and creative writing.

With a focus on the resettlement programme, Kralji Ulice rents 11 apartments to homeless individuals, guaranteeing good management to landlords. Tenants can stay in the apartments for 18 months, acknowledging that the needs are more extensive than available funding allows. The association provides professional help, facilitating involvement in various assistance programmes, and improving access to social resources, including outreach work, addiction prevention, community initiatives, social enterprises, mental health support, and eviction prevention. Note that, at the time of writing, Housing First remains non-existent in Slovenia.

The eviction prevention programme has transformed into community action, addressing families in disadvantaged neighbourhoods. Activities are demand-driven, including debt management counselling, early childhood education, recreational activities, technical services, a second-hand shop, and sports activities.

Kralji Ulice emphasises self-organisation and user participation. Peer workers are present in supporting groups for women, and there is a desire to expand peer work despite resource challenges.

The activities involve many students engaged in voluntary work, providing valuable internship training.

Funding for Kralji Ulice is diverse, sourced from municipalities, the Ministry of Health, Ministry of Labour, Ministry of Social Affairs, Foundation FHO (Foundation for Helping the Homeless), public housing funds in Ljubljana and Maribor, etc.

8.2.1 St. Luke Group's resocialisation programme in Riga

St. Luke Group, named after the renowned painter and doctor, undertook the restoration of its building, once owned by the Riga Municipality. A testament to their dedication is the thorough four-month effort invested in handcrafting the ceiling in one of the rooms. Despite the challenges, the facility now boasts a warm ambiance achieved through innovative heating solutions (infrared heating combined with stoves).

The resocialisation programme, funded by the city government, blends structured workshops in woodworking, clay crafting, and painting with mandatory cultural events every Saturday. Clients, numbering around 15, embark on a year-long journey of self-discovery and skill development. Mental health services, including group and individual therapy, self-help groups, and pastoral counselling, are integral components. St. Luke's has transformed into a social enterprise, operating a bakery that seeks not only to provide sustenance but also to change lives, attitudes, and values.

The programme is offered free of charge. In cases where clients are unable to attend services, an alternative expectation is set - they are encouraged to volunteer or contribute financially to underscore the significance of their participation. This approach fosters a sense of responsibility and reciprocity within the resocialisation programme.

The dedicated team includes social workers, a psychologist, a business counsellor (sometimes they want to start their own business), and a pastoral counsellor. Clients participate in weekly sessions with a psychologist and a social worker, complemented by bi-weekly meetings with the pastoral worker. Peer workers contribute by managing cleaning and gardening tasks, creating a supportive environment for the clients. Monthly supervision and weekly staff meetings are conducted to ensure effective operational oversight and team collaboration.

Primarily comprising ex-prisoners facing the challenge of reintegration, St. Luke Groups' serves individuals dealing with crises, loss of social skills, addiction, and other complexities. Ex-prisoners, often burdened with debts upon release (due to divorce and the obligation to pay alimony), find a haven in the resocialisation programme. The clientele, all from Riga city, typically aged 40-45, join the programme through probation or word of mouth. Ex-prisoners often come from different regions, and returning to their own area involves a risk. While internal and external factors can deter some, a majority display motivation to complete the resocialisation programme, with a commendable 97% success rate.

8.2.1 Meander Stories: Giving the floor to visitors

Jeroen Dewilde from CAW Leuven, the regional welfare service, presented a comprehensive network of services for homeless individuals in Leuven. Meander, a central component of this network,

encompasses various services such as a drop-in centre (around 30-50 visitors per day), street work, and Housing First facilitators. The approach is characterised by an 'open house' concept, fostering shared care with a focus on building relationships and establishing connections that serve as a bridge back to society.

The Meander centre adopts a person-first approach, emphasising a warm welcome, an open-door policy without appointments, and a communal atmosphere around a large meeting table. Offering free coffee and tea, as well as reasonably priced meals, the centre allows individuals to engage at their own pace. Services cover basic needs like laundry, food, and showers, with volunteers who have firsthand experience in poverty working alongside professionals to run the centre. Volunteers, 80% of whom have experienced homelessness or extreme poverty, come from the visitors' group, fostering understanding among peers. The remaining 20% comprises a mix of individuals with different experiences. However, hiring volunteers is not always successful and may create tensions; readiness and training are essential.

The 'Meander Stories' initiative gives visitors a platform to share their experiences, fostering a sense of community. The centre operates on a multifunctional basis, aiming to empower individuals through both individual and group work. The focus is on establishing connections within oneself, with others, and with society, creating an environment where feelings, burdens, and joys are shared.

The Meander centre operates 'as long as needed', serving as a stepping stone to society, and is not bound by time constraints. The approach is inclusive, requiring no papers or keys, providing an accessible and supportive space for individuals. The Meander operates with a few house rules, such as a restriction on drug use inside, but intoxicated individuals can come in if they can respect others. Violent behaviour is deemed unacceptable in the drop-in centre, particularly to (former) victims. The response to violent incidents prioritises safety (calling the police if needed) while subsequently attempting a reconnection. The centre places trust in people and maintains minimal house rules as a preventive measure. Peer workers, with their connections, play a crucial role in addressing issues.

The team of Meander invites volunteering groups to meet with staff and organises a monthly 'Our Voice' meeting to discuss organisational matters, experiences with other services, and various topics. The broader CAW strategy aligns with the principle that activities suit the most vulnerable individuals, indirectly influencing the wider CAW strategy with the most vulnerable group as a touchstone.

8.3 Pathways to paid employment

8.3.1 Income generating projects for homeless people: Shedia (Athens)

Homeless newspapers or magazines can play a role as a stepping stone in empowering the homeless by offering low-threshold employment opportunities as magazine vendors. Additionally, Shedia strives for the restoration of self-esteem and the acquisition of knowledge and skills through training courses, rehabilitation therapy, and other initiatives. Collective empowerment takes shape by establishing local networks in solidarity with these magazines in other cities and countries and building an international homeless community. This collective strength reinforces these initiatives and encourages activities aimed at social change.

The organisation Shedia in Greece is named after 'raft people' symbolising survivors of shipwrecks. It began by organising non-competitive football for homeless people and has since expanded its initiatives. The organisation employs five permanent staff members in Athens.

Shedia's projects include a street journal, a café, crafts workshops, and 'invisible tours', along with social work. The street magazine, launched in 2013, serves as an employment and income-generating project for homeless individuals, with around 200 vendors currently active in Athens and Thessaloniki (over the past decade, there have been a total of approximately 1.000 vendors). Shedia provides (assertiveness) training, starting packs of 10 copies for free, and assigns weekly tours to ensure equal selling opportunities. Some elderly vendors continue selling the magazine as a permanent job due to challenges in finding regular employment for individuals over 55. Shedia supports these vendors by covering sickness insurance and pension contributions, though this assistance is limited to legal residents.

The content of Shedia's magazine takes a unique approach, steering away from focusing solely on the lives of the homeless. Instead, it addresses significant societal challenges through the lens of 'positive journalism,' highlighting encouraging stories. Besides, each issue features a portrait of a homeless vendor, and occasional contributions are made by homeless individuals. Shedia is part of an international network of street journals, facilitating the sharing of the best articles. Financially, the magazine achieved self-sustainability within 5 months, initially supported by voluntary contributions from journalists and commercial advertisements. Presently, journalists are compensated for each article they contribute.

The Shedia café, the only café in Athens designed for accessibility to wheelchair users and visually impaired persons, offers unique cocktails and serves as an exhibition space. Shedia provides housing programmes, distributes food and clothing, and collaborates with other organisations for medical and legal assistance. The crafts workshop, using recycled materials, trains homeless and interested individuals in crafting. Invisible tours involve homeless guides showcasing 'invisible' Athens. Successful housing and job mediation efforts are acknowledged by hanging symbolic houses and boats in the café.

During the COVID-19 pandemic, Shedia creatively adapted, with the restaurant offering takeaway food and the magazine continuing street sales. Shedia's resilience and diverse initiatives highlight its commitment to addressing homelessness and empowering individuals in need.

8.3.2 ŠENTPRIMA: A holistic approach to mental health, rehabilitation and education

Established in 2005 by ŠENT, ŠENTPRIMA aims to integrate individuals with mental health challenges into the open labour market and education. Operating in Ljubljana and the Primorska region, it boasts multiple employment centres with multidisciplinary teams (occupational medicine, psychiatry, psychology, social work, sociology, occupational therapy, pedagogy) holding European quality standard EQUASS accreditation.

ŠENTPRIMA's comprehensive services encompass:

- employment-based vocational rehabilitation accredited by the Ministry of Labour that focuses on individualised pathways with a strong psychosocial component, coaching for employers and on-the-job mentoring;
- supported employment;
- pathways for school leavers with special needs, including internships;
- adult education;
- project development, such as manuals, employer training, and a diversity charter.

Focused on client preferences, ŠENTPRIMA's rehabilitation emphasises workplace training, allowing clients to learn through experience at their own pace. With strong support from the institute, clients undergo an employability assessment, with 15% successfully securing open labour market employment within 2 years. This is a success as the target group consists of individuals with substantial mental health issues and disabilities (30-70%). For those unable to work, social inclusion programmes are offered, and re-entry into the employment programme is always possible.

Recognising employer concerns and prejudices, the institute actively works to reduce the stigma associated with mental health challenges. It offers training and creating manuals for employers and strives to foster positive experiences that encourage the hiring of individuals with mental health problems. Efforts also extend to the training of coworkers, for example by explaining potential obstacles and the institute's approach.

Addressing the gap between education and the labour market, ŠENTPRIMA initiated a project in 2017, collaborating with schools and employers. Given its preventive potential for young people with mental health challenges, this collaboration has been continued and is still running.

Referrals from employment services, NGOs, or other centres are mandatory for programme entry. Psychiatric tests assess individuals' functionality in a working environment, with additional connections to necessary services, such as housing assistance for homeless individuals.

ŠENTPRIMA employs multidisciplinary teams and has received subsidies from the European Social Fund for diverse projects, including training for employers and managers in the social economy, support for various vulnerable groups, and mentoring initiatives.

8.4 Involvement of homeless people in advocacy

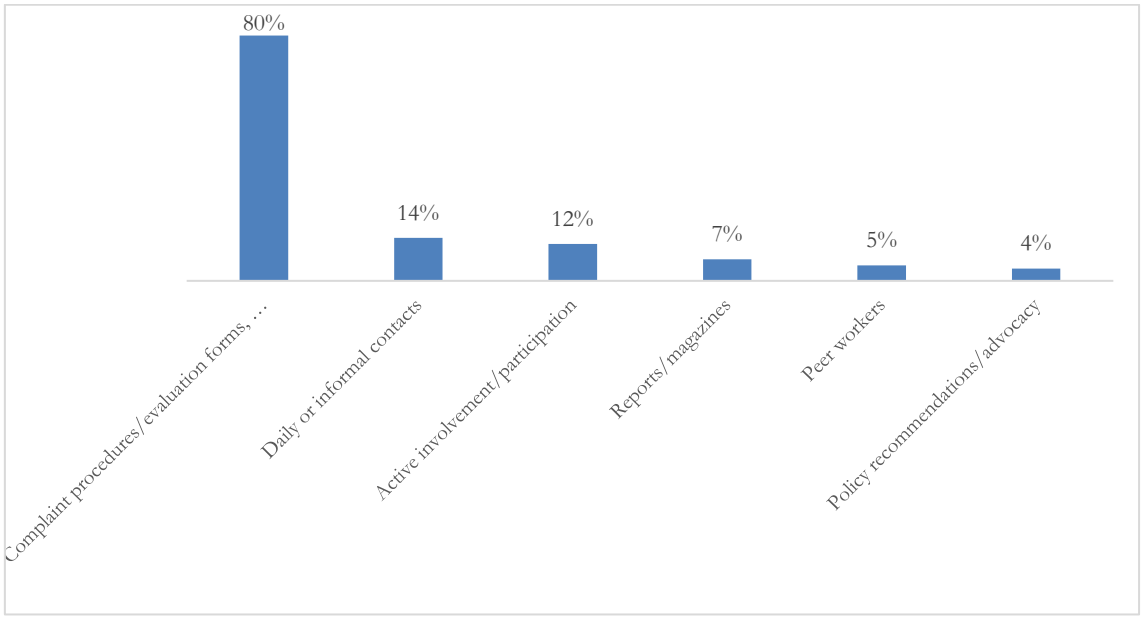
8.4.1 Information from the survey

In the survey analysed in Chapters 3 and 4, organisations were allowed to indicate their efforts to influence public authorities, the media, and public opinion to combat poverty and homelessness, along with details on their lobbying methods. Empowering users involves various methods, such as providing employment opportunities, offering training courses, facilitating access to rehabilitation therapy, and ensuring their voices are heard. The survey also explored whether organisations provide a platform for user input in service development and, if so, how.

According to the responses, 83% of the responding organisations actively try to influence public authorities or public opinion. They use various methods (see Figure 8.1), including participating in

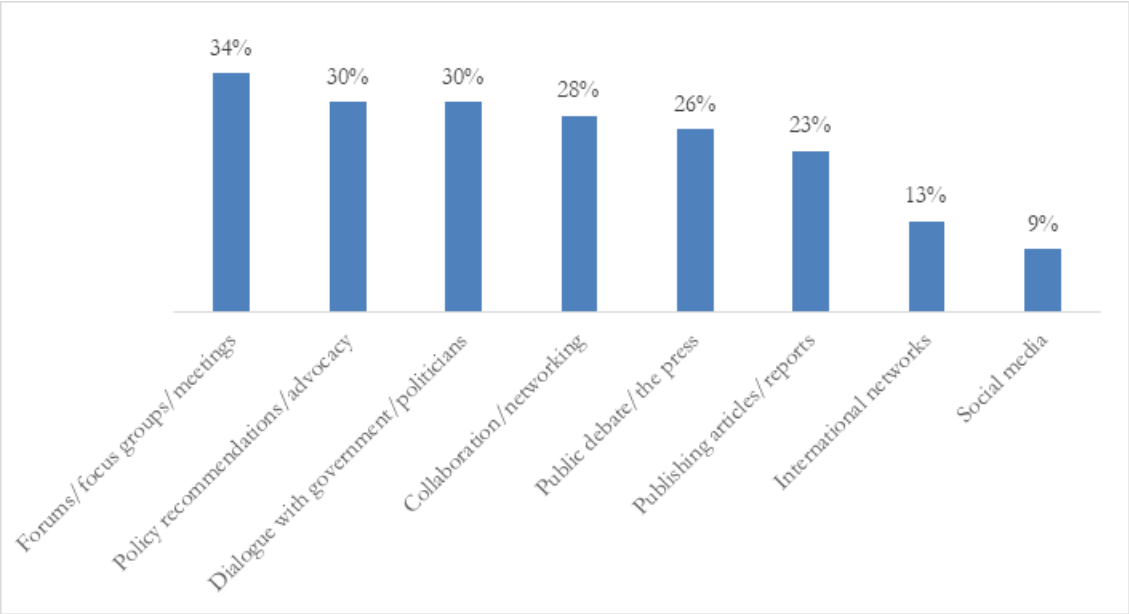
forums, focus groups, discussion groups, or meetings (34%), providing policy recommendations or advocacy (30%), engaging in dialogue with government or politicians (30%), collaborating with other organisations (28%), participating in public debates in the media (26%), writing articles and reports (23%), being involved in international networks or projects (13%), and using social media (9%).

Figure 8.1 The way organisations influence public authorities/public opinion (N=53)



According to the survey responses, 91% of organisations confirm that they provide users with a voice in service development. While there are various methods to involve users, the majority of organisations (81%) do so through complaint procedures, evaluation forms, meetings, interviews, or surveys (see Figure 8.2). Approximately one in seven organisations (14%) adapt services to user needs through daily or informal contacts. Some organisations (12%) take a more involved approach, emphasising active participation through regular User Assemblies, where users' agency is emphasised, and decisions are made collaboratively. Less common methods include users writing reports or magazines (7%), involving peer workers (5%), and including users in advocacy efforts (4%).

Figure 8.2 The way organisations give voice to users (N=57)



8.4.2 Red Umbrella: Empowering sex workers in Athens

Red Umbrella Athens, initiated in 2015, stands as an empowerment centre for sex workers, created in collaboration with Positive Voice, Checkpoint, and Prometheus. Operating under non-discriminatory principles, Red Umbrella advocates equal rights and the improvement of the legal framework concerning sex work. The centre actively participates in international networks, promoting the social inclusion of sex workers in Greece. The centre's social worker takes on the requests of sex workers and liaises with other services to find safe housing when needed or to support their other needs, such as hormone therapy and other medical appointments and applying for benefits. Open one day a week, Red Umbrella also provides testing, legal support, and empowerment activities (such as a nail salon and creative projects), fostering a sense of community.

In Greece, while laws prohibit the operation of sex workers, engaging in individual sex work is not deemed a criminal offense. Nevertheless, strict restrictions and regulations apply to the operation of brothels or prostitution businesses. These include prohibition of work within 200 meters from public places, schools, squares, churches, and other designated areas. Organisations such as Red Umbrella Athens actively advocate legal rights, drawing inspiration from models like that of New Zealand to push for reforms and improved conditions for sex workers.

8.4.3 Participatory advocacy against homelessness: the Blue Ribbon Foundation in Finland

In the realm of homelessness advocacy, Pauliina Liukkonen, a key figure in the Finnish Blue Ribbon Foundation, shares profound insights into the transformative power of participatory advocacy. The Blue Ribbon Foundation, established in 1957, is dedicated to ending homelessness and assisting vulnerable individuals through innovative models and services. Comprising the non-profit Blue Ribbon Foundation and the societal enterprise Blue Ribbon Ltb, the Blue Ribbon Foundation group boasts a team of over 230 social and healthcare experts.

Their support encompasses a range of services:

- supported housing in 6 Housing First units;
- in-home housing support;

- outpatient services, including opioid replacement therapy;
- three low-threshold day centres;
- support for young homeless individuals;
- advocacy work;
- migrant and harm reduction services;
- neighbourhood engagement.

The Blue Ribbon Foundation Group engages in advocacy work targeting structural and systemic issues contributing to homelessness and the challenges faced by those experiencing it. They fight for policy changes, legal reforms, and systemic shifts to foster inclusive and equitable systems, aiming to reduce homelessness, improve conditions for the affected, and diminish associated stigma. They operate on four fronts: (1) information dissemination, (2) promoting attitude change, (3) fostering inclusion, and (4) engaging in justice work and political advocacy.

The group facilitates participatory advocacy, encouraging active involvement from individuals and groups in decision-making processes. Their approach seeks to ensure that diverse perspectives influence policies, promoting inclusion, democracy, and social justice. Participatory advocacy involves various forms: (1) advocacy 'for' based on experiential and professional knowledge, (2) advocacy 'with', empowering those with lived experiences, supported by the Blue Ribbon Foundation Group, (3) allyship (of other citizens) amplifying voices of individuals who have experienced homelessness, and (4) independent self-advocacy, providing resources for expressing needs, navigating systems, and demanding change.

Participatory advocacy, while holding significant promise, also involves risks:

Possible pitfalls:

- *Dead-end empowerment*: Focusing too narrowly on empowerment of individuals may obscure and perpetuate structural deficiencies and result in disillusionment.
- *Masked participation*: 'Participation' of homeless people is often misused by just extracting their lived experiences to support predetermined decisions. In reality, the measures conceived by outsiders may turn against the target group instead of emancipating them. This highlights the importance of addressing power dynamics.
- *Participation requires funding*: Facilitating participation necessitates long-term and sustained presence among homeless people, which is a costly but invisible investment. Resource demands for participation may create challenges at political and organisational levels. Policy makers are usually reluctant to finance critical voices.

Opportunities:

- *No one wants to be a target*: Advocacy work focuses on systemic flaws, creating a sense of empowerment within marginalised groups.
- *Wake-up effect*: Lived experiences can generate a new level of interest among politicians, emphasising the effectiveness of face-to-face meetings.
- *Putting 'your own house' in order*: Advocacy for policy reforms necessitates a reflection on internal dynamics in the organisation to encourage active solidarity and ensure a supportive working culture.

8.5 Self-organisation for advocacy

8.5.1 Empowering expertise in Helsinki: Opportunities for impact in services and politics as an expert-by-experience

Jenni Eronen, affiliated with the project partner organisation No Fixed Abode, fulfils multiple roles, serving as a peer worker, peer mentor, and expert-by-experience. In her capacity as a peer worker, she engages directly with visitors, adopting a dual role as both a peer and a mentor when supporting peers. When interacting with social and health professionals, Jenni transitions into the role of an expert-by-experience, bringing the perspective of service users into decision-making processes. Her professional journey started in the Peer Support and Volunteering Centre, followed by her involvement in the Omat Avaimet development project, where she collaborated with residents to plan a new housing building. At events organised by the Ministry of the Environment and participating in the Aune action programme's coordination group, Jenni actively provided insights to align services with the needs of visitors. She plays a crucial role in proposing future priorities for homelessness services within the Asunto ensin 2.0 change laboratory initiative. Throughout, her focus remains on amplifying the voices of service users and ensuring services adapt to evolving needs.

Sanna Tiivola, manager of No Fixed Abode, provided further insights into the organisation during the online seminar on participation. No Fixed Abode's paid staff includes individuals with personal experiences of homelessness, distinguishing between 'peer workers' engaged in frontline services and 'experts-by-experience' who represent and voice concerns in public forums, discussions with other services, and engagement with policymakers.

The organisation's focus, spanning over 30 years, revolves around advocacy and participation work. Initially operating as a voluntary organisation, it was founded by individuals who had experienced homelessness with a vision to eliminate shelters and enable independent living. With a current staff of 45, a quarter of whom have lived through homelessness, the impact of No Fixed Abode has significantly expanded. The organisation's executive manager, who has a personal experience of homelessness, plays a vital role as a bold advocate, shaping services from outreach teams to night cafés and the Own Keys project in the grassroots field. Activist work, providing a platform for self-advocacy, is a key aspect.

Since 2011, the organisation has had its own expert-by-experience team. The Vartiosaari Island holds special significance, functioning as a summer cottage for homeless individuals and those awaiting housing (see also Section 7.1.3). The island catalyses community-driven actions. Projects like 'Carry On' challenged misconceptions about rough sleeping, and the establishment of housing units involved individuals with lived experiences in planning and decision-making. No Fixed Abode emphasises the transformative impact of advocacy, community-driven efforts, and the inclusion of those with lived experiences in shaping policies and initiatives.

Sanna provided examples of participatory and advocacy work, including exhibitions, the establishment of the House of Fellows, and the transformation of the bus of an outreach team into a mobile cafe. The participation working group has engaged in various activities, such as a European Parliament seminar, with members receiving recognition, authoring books, and participating in events like the Homeless Market. The organisation actively involves individuals, while avoiding the term 'service users'.

8.5.2 The 'Common Front of Homeless People' in Belgium

The Belgian 'Common Front of Homeless People' (Front Commun des Sans-abri/ Gemeenschappelijk Daklozenfront) stands out as a unique self-organisation comprising activists with firsthand experiences of homelessness. These individuals are passionately advocating for the rights of their peers, with specific efforts directed at enhancing access to the minimum income for those without a fixed address and lobbying for improved housing policies to address the challenges faced

by homeless individuals. Notably, the association actively engages in European networks and contributes to endeavours aimed at establishing a European Union of Homeless, highlighting its commitment to addressing homelessness at a broader, international level.

During the webinar on participation (November 10, 2023), Philippe De Craene provided a detailed overview of their work: Firstly, two organisations were involved. DAK (Homeless Action Committee), established in 1997 in Antwerp, Flanders, operates locally. The second is a federal organisation, the Common Homeless Front, active across all of Belgium since its establishment in 1997. These organisations, founded by individuals with lived experiences of homelessness, function as legally recognised non-profit entities.

In 2003, Philippe joined DAK as the coordinator, leading projects that encompass a wide spectrum. Initiatives include occupying empty public buildings for temporary housing, shelter, goods collection, food and clothing distribution, drug reduction, computer access, job support, and diverse cultural activities such as music, visual arts, theatre, and events like concerts. They also operate a bicycle repair shop, a summer camp, and an annual street party on December 26th, known as 'the girl with the matchsticks'. DAK holds weekly meetings. The Front, as the federal organisation, primarily serves as an information-sharing platform. Monthly meetings, resembling a university-like setting, delve into topics such as representations, law, and rights. The organisation engages in lobbying efforts targeting federal politicians, local administrations, and institutions. Some members focus on providing social support, acting as personal advocates in areas like income, housing, and access to health services.

In addition to practical projects, they engage in legal and rights-related activities, lobbying with federal politicians, and working against administrative sanctions, fines, imprisonment, and the criminalisation of those facing homelessness. One recurring challenge addressed is the issue of the reference address - a proxy address for those without a fixed address to gain access to social allowances and official mail. Unfortunately, this has become a complex form of social assistance with stringent conditions, leaving many homeless individuals without essential civic and social rights.

Both organisations conduct various actions, including publications, websites, press releases, opinion articles, flyers, and newsletters, emphasising their commitment to independence and goal-oriented cooperation. The focus is on implementing fair and inclusive policies to combat homelessness, poverty, and social exclusion. The organisation adheres to the latest definition of homelessness, considering it strongly intertwined with poverty and social exclusion. Recognising this interconnectedness, their approach encompasses a holistic understanding addressing not only the lack of housing but also the broader issues of poverty and social marginalisation.

Their organisational principles emphasise independence, accepting subsidies without attached conditions, and providing opportunities for all individuals to join projects and initiatives. There is no distinction between receivers and contributors; everyone is encouraged to participate. Their goal-oriented approach emphasises cooperation, maintaining a balance of instruments in their favour.

Collaboration extends to numerous associations in Flanders and federally in Belgium. They exemplify their work partnership with the Free Clinic, focusing on drug use and harm reduction. Over the years, they have engaged in various projects and partnerships, both locally and internationally. Their involvement in European networks, attempts to create a European Union of Homeless, and participation in international conferences highlight their dedication to influencing policies and creating positive change. However, challenges persist, especially in the face of the current housing crisis and the criminalisation of homelessness – with accusations of social fraud instead of helping them. Despite challenges and changes in political climate, they remain committed to their advocacy and social support initiatives.

Their organisation boasts a rich history of projects, publications, and collaborations, recognising the dynamic nature of their work. Although certain projects have come to a close, their focus remains steadfast on advocacy and political involvement, ensuring that their voices resonate in matters that impact them. In the face of changing times, their dedication to assisting individuals at the grassroots level and advocating their rights remains resolute.

8.5.3 The SOMOS association: A self-managed and self-organised organisation for women in Lisbon

Luisa Gomes, the vice president of SOMOS, has personally experienced homelessness, drug use, and is a survivor of oncological cancer. SOMOS is a self-managed and self-organised organisation for women with a history of domestic violence, addiction, and/or homelessness. The association was officially legalised in September 2022, with the primary goal of creating a safe space for women who have faced violence and life on the streets, ultimately aiming for social inclusion.

SOMOS conducts various activities, including weekly meetings for sharing experiences, referring women to suitable entities, distributing hygiene kits (specifically menstrual hygiene kits), advocating better health and housing policies, and working towards securing their own space to provide essential services. SOMOS employs a horizontal and informal, relationship-based work model that aims to eliminate feelings of shame when individuals seek help. By building trust and addressing the complexities of accessing services, SOMOS prioritises basic needs like housing to establish a foundation for stability, recognising the interconnected relationship between securing housing and obtaining employment as a key strategy to break the cycle of challenges faced by individuals.

The challenges that SOMOS faces include finding funding, establishing new partnerships, and acquiring their own dedicated space. In terms of policy making, SOMOS recognises the importance of political commitment for positive change. The organisation leverages connections with influential figures, engaging with the president of the Republic of Portugal, the minister of social security, and the mayor of Lisbon to effectively convey their messages and advocate change. Despite not directly belonging to NPISA, SOMOS collaborates with them, sharing common goals and working together on strategies, outreach teams, and services, including shelters.

8.6 Project partners' insights and recommendations

Regarding employment, securing a job can be a tough journey for those who have experienced long-term homelessness. Prolonged homelessness tends to exacerbate health conditions, making it physically and mentally challenging to maintain employment. Factors such as social interaction, punctuality, and managing various aspects of daily life become difficult. In some cases, individuals may find greater support from government benefits, as obtaining a job that provides a stable income can prove to be unrealistic for those facing the complexities of long-term homelessness.

There is a need for sustainable solutions, acknowledging that it is fair for individuals to become dependent temporarily but with the goal of achieving autonomy. This means that the right to live a dignified life applies to all (including those who are exhausted or vulnerable), and projects should not solely focus on the healthiest and most resilient individuals.

Part-time and flexible *income-generating activities* such as vending street magazines or handicrafts or guiding 'invisible tours' can be adequate stepping stones towards more stable employment, provided that such informal activities are tolerated by the tax and social security regulations. *Social enterprises* also play a key role in providing tailored employment and serving as bridges towards regular employment. *Voluntary work* (linked with decent social protection) may be less attractive from a financial point of view but often more attractive in fulfilling the latent functions of work (strengthening a sense of citizenship, facilitating integration into social life, and fostering self-realisation) without putting too much stress on vulnerable individuals.

The exploration of various types of formal employment or voluntary work that valorises the own lived experience of (former) homeless people has been one of the most interesting aspects of the Person First project. After 'scratching the surface', we have discovered many forms of *peer work* (mainly in the 'frontline' of organisations) or *peer mentoring* (personal guidance of peers). Experts-by-experience are those who combine their personal experience with a formal or on-the-job training and have specialised in a particular field (such as substance abuse, housing policy or mental healthcare). They do invaluable work, whether as professionals in fieldwork (e.g. in outreach teams), or as experts in advisory boards or in project management teams.

Throughout discussions held on various occasions, there has been a consensus that developing methods to better listen to the voices of service users could lead to more informed and effective solutions to various challenges. For example, in Lisbon, workshops for user feedback, facilitated by an external facilitator, provide a platform for participants to express themselves openly while maintaining anonymity. The collected feedback is then transferred to the service provider. In organisations such as No Fixed Abode (Helsinki), SOMOS (Lisbon), or the Joint Homeless Front (Belgium), advocacy based on the self-expression of people with lived experience is embedded in the DNA of the organisation. Moreover, joint training sessions between workers with and without personal experience of homelessness is an additional guarantee for the 'representativeness' of their advocacy work.

9 | Integrated service delivery and networking

9.1 Information from the survey

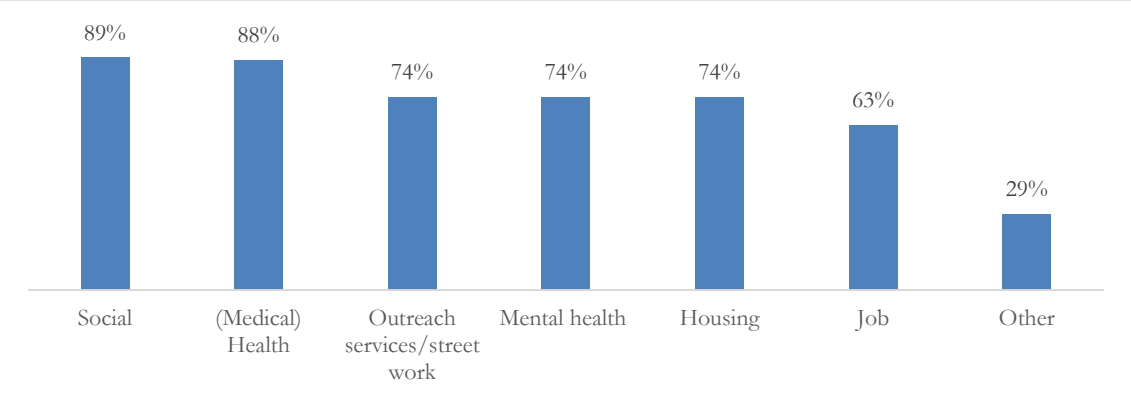
The organisations were queried about their **collaboration with other organisations or services** to address the needs of users. Prior research has emphasised the significance of a support network capable of responding in an integrated, coordinated, and complementary manner, given that homeless individuals often have multifaceted and intertwined needs. No single organisation, professional, or actor can declare itself self-sufficient, and there is a need for a continuum of care (Report 50 People Profiles, 2017)****.

As depicted in Figure 9.1, nine out of ten organisations collaborate with social services such as centres for social services and social security services. Similarly, a high percentage of organisations collaborate with (medical) health services, including hospitals, general practitioners, health centres, outpatient clinics, and emergency services. Three-quarters of the organisations indicate collaboration with outreach services or street work, mental health services, and housing services, encompassing a range of entities from municipal street work to psychiatric hospitals.

Among the various types of services, job services show comparatively less collaboration. Nonetheless, three-fifths of the organisations collaborate with entities like municipal job centres, public employment offices, and local entrepreneurs. Additionally, nineteen organisations (29%) mentioned collaborating with other services such as those for immigrants, lawyers, cultural services, volunteer associations, and civil society (e.g., police).

The survey also allowed organisations to elaborate on *how* they collaborate with other services, although responses provided limited information. In most cases, the collaborations primarily involve referrals, the exchange of experiences or observations, and guidance and physical accompaniment of users to other services.

Figure 9.1 The type of organisations or services with whom they collaborate (N=64)



According to the project partners, collaboration takes diverse forms. For instance, in Slovenia, social workers in the social care system ensure continuity of care, while in Italy, a municipal social worker serves as the first point of contact. These contacts may be both informal and formal, and they are not mandated by law.

Cooperation practices among organisations may vary, but they are not necessarily implemented at the individual case level and are mostly limited to inter-service consultation. The degree of cooperation is influenced by the seniority of staff members involved. In Portugal, there is a national strategy for homeless individuals, and each person experiencing homelessness is assigned a case manager who oversees their case.

One effective approach to cooperation involves a tandem outreach and case management model, where a designated case manager acts as the focal point of contact between different service providers. Social services often serve as the initial contact point for homeless individuals, roofless individuals, or individuals without legal residence. Overall, building and maintaining robust networks and collaboration is crucial for effectively addressing homelessness. This requires continuous communication, coordination, and cooperation among service providers, policymakers, and community members.

9.2 The municipal platform NPISA

In Lisbon, the Homeless Planning and Intervention Centre (NPISA) acts as a collaborative platform that brings together both public and private organisations involved directly or indirectly with homeless individuals. It includes shelters, emergency services, food distribution, street teams, specialised services for people coping with addiction, medical teams, a psychiatric hospital and other mental health services, Housing First projects, community action, vocational training and job placement services. Housed within the NPISA offices is the entire emergency care infrastructure for the city of Lisbon (UAPSA). Its oversight lies with the Santa Casa da Misericórdia de Lisboa (SCML), which incorporates case managers from various institutions into its team, providing access to a common computer system for the allocation of financial or non-financial support. NPISA also manages initiatives such as cold weather protocols, vaccination campaigns, and other vital actions for this population. Furthermore, it operates through adaptable working groups tailored to identified needs, with current areas of focus including resource guidance, accommodation, street outreach teams, food distribution, healthcare, and employability.

9.3 A holistic approach: Insights from Dr. Pierre Ryckmans, co-director of Infirmiers de Rue in Brussels

The organisation 'Infirmiers de Rue' (Street Nurses) initially focused on providing basic nursing care to homeless individuals. However, a grim reality unfolded as they witnessed people succumbing to the harsh conditions of street life. This prompted a shift towards a more comprehensive and holistic approach, recognising the interconnectedness of physical, mental, and social health.

a) Streetwork 2006 – 2010

During the initial years of 'Infirmiers de Rue' from 2006 to 2010, the organisation operated with only two nurses. Their primary focus was on providing essential nursing services on the streets, with an emphasis on direct assistance without scheduled appointments or follow-ups. The goal was to engage with individuals on the streets, offering guidance, addressing their queries, and informing them about existing healthcare services. The organisation sought to leverage the available healthcare infrastructure rather than creating a new service. However, it became evident that this approach was insufficient.

In 2008, recognising the limitations of their initial strategy, the organisation introduced follow-up services after initial street interventions. Despite these efforts, the team witnessed several tragic deaths among the individuals they had assisted. The provision of basic aid, follow-ups, and referrals to existing services proved inadequate in preventing the detrimental effects of street life. Subsequently, in 2010, 'Infirmiers de Rue' underwent a significant shift in their approach. Their new objective became actively supporting individuals to transition from street life to housing, with the long-term

goal of establishing a stable home. This transformation acknowledged housing as a fundamental component of the overall treatment, a facet often overlooked by policymakers and other service providers.

b) Housing 2010 – 2018

With the revised approach, the organisation dedicated significant efforts to addressing housing challenges. Initiating the process of finding suitable housing revealed the complexities involved, requiring substantial investments in various aspects. This encompassed allocating resources to dedicated staff, gathering pertinent information, implementing housing schemes, and fostering extensive networking. Combining the tasks of securing housing and providing healthcare posed a notable challenge.

In the pursuit of rehousing individuals experiencing homelessness, the organisation encountered an additional hurdle. The transition into housing necessitates careful consideration of potential health and mental health risks. This shift entails a drastic lifestyle change with implications for immunity (increased vulnerability to illnesses), consumption (individuals may store substances privately), loneliness (potentially leading to increased substance consumption), and mental health. Additionally, some individuals may opt to continue living on the streets for a few weeks even after obtaining housing due to the significant adjustment. Consequently, housing requires specific follow-up measures, extending beyond the mere provision of housing. Typically, individuals need 1-2 years to stabilise after being rehoused.

Furthermore, health encompasses more than just medical support; it involves the restoration of both work-related and personal networks. Social relationships, appreciation, hobbies, and employment are crucial components contributing to an individual's overall health. To conclude, the organisation's journey underscores the multifaceted nature of addressing homelessness and health, advocating for an integrated and sustained approach.

9.4 Project housing and employment for homeless people in Greece

This project aims to support individuals who are homeless or at risk of homelessness by providing stable housing and employment opportunities. The initiative began its pilot implementation in 2014, with subsequent cycles following the initial phase. It is carried out by municipalities across Greece, under the supervision of administrators who may be NGOs, Municipal Public Benefit Corporations, or Development/Public Benefit Corporations of the municipalities.

9.4.1 Programme overview

The Housing and Employment for the Homeless programme[32] targets individuals and families experiencing homelessness, working in tandem with public policies to combat this issue. The primary goal is to eliminate homelessness through the following specific objectives:

- *Immediate transition to self-sufficient living*: Providing housing and social assistance to enable homeless individuals to achieve self-sufficiency.
- *Resource mobilisation for employment*: Facilitating employment and counselling services to help homeless individuals reintegrate into society.
- *Employment requirement*: ensuring that at least 20% of adult beneficiaries capable of working are employed in programme-subsidised jobs per approved project, to qualify for funding.
- *Strengthening agency collaboration*: Enhancing cooperation between various agencies to address homelessness effectively.

[32] For more information, https://opeka.gr/stegasi/programma-stegasi-kai-ergasia/

9.4.2 Program guarantees

The programme ensures the following services are provided:

- *Employment counselling:* Employment advisers at Employment Promotion Centres offer counselling and utilise training and work integration programmes.
- *Health and nutrition services:* Collaborating with community centres and relevant municipal or public health agencies to deliver health and nutrition education.
- *Social obligations fulfilment:* Ensuring beneficiaries receive social support, including social solidarity income, benefits for children or the disabled, social tariffs, and free healthcare for the uninsured. It also includes enrolling minors in compulsory education and conducting cultural and educational initiatives.

9.4.3 Specific projects and results (2024)

- 'Housing and Work for the Homeless in the Municipalities of Vari - Voula - Vouliagmeni and Saronicos' (Code SE-10): Managed by PRAKSIS, this project aims to support 18 homeless households (25 beneficiaries).
- 'Shaping the Future - Part 3' in Thessaloniki (Code SE-5): Managed by PRAKSIS for the Social Welfare Centre of the Region of Central Macedonia, targeting 20 homeless households (47 beneficiaries).
- 'Joint Action for Housing and Work for the Homeless in the Municipality of Thessaloniki' (Code SE-1): Managed by PRAKSIS and ARSIS for the Municipality of Thessaloniki, targeting 40 homeless households (70 beneficiaries).

Achievements as of May 2024

- **SE-5**: 23 approved households (43 beneficiaries), with housing found for 20 households (40 beneficiaries). Two beneficiaries integrated into the labour market with full subsidies, and eight received educational training.
- **SE-1**: 29 approved households (49 beneficiaries), with housing found for 22 households (37 beneficiaries). Two beneficiaries integrated into the labour market with full subsidies, one with a non-wage cost subsidy, and four received educational training.

9.4.4 Additional programmes and support

- **Housing allowance for pensioners:**[33] A means-tested scheme providing income support to pensioners living in rented accommodation.
- **Housing allowance for low-income households:**[34] Aimed at low-income households residing in rented accommodation.
- **Project 'KALIPSI' (ΚΑΛΥΨΗ):**[35] Offers free housing for 3 years to vulnerable young people aged 25 to 39 who are beneficiaries of the Guaranteed Minimum Income. Objectives include:
  - supporting young people with rental costs for their first home;
  - addressing housing insecurity for those at risk of losing their homes.

[33] For more information, https://opeka.gr/stegasi-proti-katoikia/epidoma-stegastikis-syndromis-gia-tous-anasfalistous-yperilikes/

[34] For more information, https://opeka.gr/stegasi-proti-katoikia/epidoma-stegasis/

[35] For more information, https://opeka.gr/diacheiristiki-archi-opeka/programma-stegasi-kai-ergasia-gia-astegous/

9.5 Project partners' insights and recommendations

During our visits to various projects and services (see Appendix 3 for an overview), the majority have not demonstrated the ability to provide comprehensive support across all four dimensions - social assistance, health (both mental and physical), housing, and rehabilitation - under a single roof. The reasons for this limitation are varied and stem from several obstacles:

- *Insufficient resources*: Multidisciplinary teams, comprising psychologists, social workers, housing managers, nurses, psychiatrists, work coaches, and more, continue to be perceived as an unattainable 'luxury'.
- *Lack of vision*: In many services there is a deeply rooted view among workers that deficient personal motivation, often intertwined with addiction, stands as the primary barrier preventing individuals from overcoming homelessness.
- *Structural obstacles*: Services encounter challenges in facilitating the transition of homeless individuals into social housing, primarily due to a scarcity of available accommodation, prevalent poverty, and/or unaffordable rent prices, all compounded by restricted government budgets.

9.5.1 Three different cases based on the level of integration of various services

Case 1: One-dimensional services

The men's shelter in Riga exemplifies a typical 'basic facility', offering primarily material and social support such as showers, beds, breakfast, and basic administrative assistance, along with physical healthcare. Within the night shelter, a person-centred approach seems to be lacking, and users are merely categorised based on addiction and employment status. This lack of integration risks to rivet the challenges faced by homeless men, resulting in a somewhat hollow existence determined by the shelter's rules and schedule, with limited success in moderating through activities in the day centre.

Case 2: Partial integration

Some providers offer limited 'service packages' targeting specific target groups, such as young people with psychological issues or homeless individuals struggling with addiction.

These packages typically include 2 or 3 dimensions, such as social, mental health, and/or housing services. However, for other dimensions and specialised support, like psychiatry, providers rely on collaboration with external ('extra muros') services. While this networking offers flexibility and a broader range of services tailored to subgroups, drawbacks include limited access to specialised in-house staff during emergencies and constrained tasks for in-house staff, potentially impacting service quality.

We observed positive examples of partially integrated services in Nova Gorica, including the housing group for young people (see Section 7.3) and a day centre linked to a mobile team for addicted individuals (Section 6.9.1-6.9.2). Similarly, in Helsinki, the Blue Ribbon initiative offers Housing First for addicted people, integrating housing with social services and healthcare. However, it is striking that none of the providers in these cases had specialised psychologists or psychiatrists in their teams.

Case 3: Comprehensive networks

We encountered exceptional examples of comprehensive networks, such as ŠENT in Slovenia, NPISA in Portugal, and the Y-Foundation in Finland. These networks represent a solution to the challenges of fully integrated in-house provision of services.

A distinction can be drawn between public-private networks and NGO networks:

- In Lisbon, Leuven, and Helsinki, the City Government takes the lead in the network. Local governments are deeply invested in combating homelessness as they are responsible for social cohesion in the municipality/region and contribute to financing services. The Housing Department of the City of Helsinki, in particular, serves as a gatekeeper and regulator, investing significantly in Housing First and other services. While this dominant role enhances transparency in organising services, it may lead to centralised and rigid decision-making, potentially compromising individually tailored solutions. Policy shifts following changes in government coalition introduce uncertainty to subsidised services, making those that rely exclusively on local government funding vulnerable.
- NGOs like ŠENT in Slovenia and, on a smaller scale, No Fixed Abode in Finland, cluster various services under the same financial/administrative umbrella, not necessarily at the local level. Their strength lies in creativity, offering a diverse array of services to multiple groups, leveraging their network to provide various types of support to homeless people, including housing, legal advice, day centres, health care, community action, sports, and advocacy. These NGOs, while relatively independent, face daily fundraising challenges.
- The Y-Foundation in Finland represents an intermediate case, operating as a large autonomous non-profit agency at a regional level (Southern Finland). Predominantly funded by public sources, it combines the benefits of public-private partnerships with substantial autonomy. The Y-Foundation functions as a public housing company with key objectives focusing on the economic and social well-being of tenants, the fight against homelessness, and the green transition. Their activities include Housing First, housing counselling, employment opportunities for tenants facing payment difficulties, and tenant participation. Despite the extensive range of services, it is worth noting that the social assistance and health pillars of the Person First model were not explicitly mentioned in their strategy.

9.5.2 What makes a good network?

While their strategies may vary, effective networks share characteristics such as a clear vision, multidimensional cooperation, creative core teams, horizontal relationships, adequate funding, and strong public support.

The elements below collectively contribute to the effectiveness and resilience of a network addressing homelessness:

- *Clear and shared vision*: A well-defined and shared vision, akin to a 'charter', provides a foundational framework for the network's objectives and goals.
- *Multidimensionality*: Inter-agency cooperation that spans all relevant dimensions of the rehabilitation process for homeless individuals, encompassing the '4 pillars'.
- *Creative and ambitious core team*: The presence of a creative and ambitious core team, as exemplified by organisations like ŠENT, contributes to the innovative development and implementation of services within the network.
- *Horizontal relationships*: Avoidance of excessive hierarchy in favour of horizontal relationships fosters a more collaborative and inclusive network, as seen in the case of NPISA.
- *Adequate funding*: Public investment is needed to facilitate the coordination of networks, in addition to dedicated public services. Additional funding sources may be explored to ensure financial stability.

- *Strong public support*: Beyond financial support, strong public support is essential. This support should manifest itself not only through funding but also through integrated approaches at higher levels of government. For instance, ARA, the Finnish state agency that finances social housing, demonstrates investment not just in 'bricks' (infrastructure) but also in 'people', with housing advisors playing a pivotal role in fostering the smooth integration of Housing First tenants in their neighbourhoods and preventing evictions.

10 | An agenda for policy and practice

This chapter recapitulates the key lessons from the Person First project and their implications for policy and practice, spanning from the European to the local level. Specific attention is also devoted to the role of vocational education and training. It is our profound conviction that achieving the goal of ending homelessness by 2030 will not be feasible solely through measures in the realm of housing and financial support. Ending homelessness also necessitates investments in targeted high-quality social services, physical and mental healthcare, rehabilitation efforts, and the active participation of persons with a lived experience of poverty and homelessness.

10.1 At the European level

a) Further elaboration of the EPOCH strategy

Significant progress has been achieved at EU level over the past decade, and particularly since the adoption of the European Pillar of Social Rights (EPSR) in 2017. Principle 19 of the EPSR stresses the right to social housing or housing assistance of good quality for those in need, the right to appropriate assistance and protection against forced eviction for vulnerable people and adequate shelter and services for people experiencing homelessness. The European Platform on Combating Homelessness (EPOCH) was created by the European Commission in the context of its Action Plan for the implementation of the EPSR. EPOCH operates as an open, multi-level and multi-stakeholder platform with the collaboration of member states, regions, and local authorities as well as non-state actors. EPOCH defines 'ending homelessness in the EU by 2030' as its key ambition, outlined through five objectives:

> *'(1) No one sleeps rough for lack of accessible, safe and appropriate emergency accommodation; (2) no one lives in emergency or transitional accommodation longer than is required for successful move-on to a permanent housing solution; (3) no one is discharged from any institution (e.g. prison, hospital, care facility) without an offer of appropriate housing; (4) evictions should be prevented whenever possible and no one is evicted without assistance for an appropriate housing solution, when needed and (5) no one is discriminated due to their homelessness status.'* (Leterme & Develtere 2023).

The Person First consortium can fully adhere to these objectives. Our project can contribute to the knowledge base necessary for designing effective strategies to end homelessness. Through the mutual learning within the consortium - building on a series of earlier projects, seminars, and publications – the 'four-pillar' model was developed, reflecting the multifaceted nature of homelessness and underscores the need for integrated approaches. The implications for policy and practice will be provided in the following pages. Stated briefly, the successful implementation of EPOCH's objectives will crucially depend on a comprehensive social investment strategy that combines measures in at least four areas: social support, housing, health/mental healthcare, and rehabilitation into work and social participation. This means that Principle 19 of the EPSR is intimately linked with (at least) Principles 4 (employment support), 10 (adapted work), 14 (adequate minimum income), 16 (healthcare) and 20 (essential services).[36] Moreover, the common thread across all areas is a person-centred, participatory approach.

[36] See e03c60e7-4139-430b-9216-3340f7c73c20_en (europa.eu).

- **Engaging other European instruments**: The European Union disposes of several powerful leverages to boost the efforts of other stakeholders in this endeavour:
  a. The *open method of coordination* (OMC) enables policy learning between member states as well as soft pressure on member states that underperform in the fight against homelessness. EPOCH itself has the ambition of monitoring progress in this field: it can feed into the OMC by preparing targeted country-specific recommendations.
  b. *Financial instruments* (ESF+ and others, up to and including the Multiannual Financial Framework and the Next Generation EU Recovery Instrument) that can be mobilised to boost social investment (in housing, healthcare, social services, etc.) by other levels of government and private actors. The social investment perspective is regaining ground at the European level: it reflects the idea that, in addition to implementing basic social rights, the short-term costs of social policies are outweighed by long-term benefits. Cost-benefit analyses of Housing First have already yielded convincing results in this regard. The EPOCH can promote this perspective in mobilising European (as well as national) resources.
  c. A *common knowledge base*. The European Commission launched a pilot project to measure homelessness in cities across the EU. This can be the start of a continuous monitoring process, which should enable intertemporal and cross-national comparisons. Such monitoring instruments are important in assessing societal trends and the impact of policies. EPOCH partners can also benefit from their own mutual learning activities as well as transnational vocational education and training (VET) projects in the context of Erasmus+, which foster the professional development of workers in homeless services. Scientific research on homelessness in Europe can be bolstered through the Horizon programme.

b) Giving a voice to homeless people at EU level

Giving a voice to homeless people could become an additional leverage at the European level. Due to their state of destitution, isolation and forced mobility, it is extremely difficult for homeless people to create associations and develop a 'lobby' with a common agenda at local and national – let alone, European level. Yet, independent and representative self-organisations of homeless people do exist in several countries: from the Person First project, the Common Front of Homeless People (Belgium) and SOMOS (Lisbon) can be mentioned. Other examples have been signalled in Hungary, Germany, The Netherlands, France and Ireland. More and more NGOs also have their own 'experts-by-experience': employees with a personal experience of homelessness who have received additional training to act as 'bridges' or spokespeople for the users of services. With support from EPOCH, these organisations and representatives could create a European advocacy group to amplify the voices and represent the interests of homeless people, along with federations of service providers.

c) A right to shelter for undocumented immigrants

In some countries, a large proportion of the homeless population consists of undocumented immigrants, including intra-EU migrants whose identity documents or residence permits have expired. There is a tendency among public authorities to use the lack of accommodation for homeless people as an argument to discriminate against these categories of homeless people, denying them access to shelters, whereas 'lack of accommodation' is obviously a matter of political priorities. This challenges Europe's human rights agenda and basic values of solidarity, and the meaning of European citizenship in particular. Legal solutions should be sought in the framework of the EU's Migration Pact, e.g. by distinguishing between the right to shelter (for all individuals) and the right to housing (for citizens), or by using temporary protection status in times of acute housing shortage (as a particular type of 'crisis'). Intermediate solutions may apply to European citizens as a step towards a more generic solution.

d) At the national or regional Level

- **National strategies to end homelessness**
  The right to decent and affordable housing for all is a basic social right, and its implementation a responsibility for public authorities. National action plans to end homelessness, with SMART (specific, measurable, acceptable, realistic and time-bound) objectives and adequate budgets need to be designed and implemented. These action plans should adopt integrated strategies that encompass all key components of the Person First model: person-centred approaches, social assistance, health/mental healthcare, housing, rehabilitation and active participation of the homeless people. Continuous monitoring with participation of (associations of) homeless people and adaptation to evolving needs should be ensured.

- **Putting an end to institutional violence**
  Since the end of the COVID-19 crisis, there has been a radical shift in policy measures and societal attitudes across European countries. At the time of drafting this report, several severe incidents of institutional maltreatment of homeless people were signalled in the European press. In August 2023, for instance, the area surrounding Brussels South station was 'cleaned' in a concerted action by the police and environmental services, following increasing complaints about petty crime and drug dealing in the neighbourhood. Whereas a police intervention was justified, it indiscriminately affected innocent homeless people whose tents and belongings were collected as garbage, without any decent alternative being offered. Similarly, in January 2024, the British police unlawfully destroyed tents and belongings of rough sleepers outside the University College London Hospital following an order of 'dispersal' of homeless people. A similar incident occurred in April 2024 in Paris, where a large-scale 'cleaning operation' was conducted in preparation for the upcoming Olympic Games. Homeless people were even forcibly deported to neighbouring cities. Such unlawful and aggressive treatment is symptomatic of a growing institutional violence against homeless people. This only exacerbates their social exclusion and amplifies the social burden of homelessness in the longer term. Public authorities have the duty to guarantee a dignifying treatment of all citizens by all public services.

- **Preventing homelessness**
  While prevention was not the primary focus of the Person First project, it is worth underscoring that homelessness can be effectively mitigated through various preventive measures. Ensuring decent minimum income standards, providing more affordable and adequate housing, offering guidance for people transitioning from institutions, implementing legal protection for tenants and debtors, and initiatives aimed at preventing addiction are crucial components of effective homelessness prevention strategies.

- **Upgrading and diversification of emergency services**
  Services such as shelters will remain indispensable also in the future, and the policy shift to Housing First cannot serve as an alibi to neglect them. The COVID-19 crisis has raised awareness about *minimum standards* for dignifying and healthy shelters. These standards should be maintained, which may involve scaling down shelters and converting dormitories into smaller rooms. Additionally, services or service networks should be available 24/7, with sufficient staffing to ensure a welcoming, person-centred, dignifying, and integrated approach to care. *Small-scale, community-based housing solutions* also facilitate flexible approaches tailored to the specific needs of various groups such as young people, women, persons with psychiatric disorders, asylum seekers, persons grappling with substance abuse, etc.

- **Accessible, affordable and sustainable housing**
  Implement targeted measures to alleviate the shortage of affordable housing through social housing and housing allowance schemes, particularly focusing on solutions that assist homeless individuals in overcoming financial barriers such as advance payments and bail. Secure, long-term housing provision is a fundamental component for addressing other challenges.
  Based on the positive outcomes of the Housing First approach in several countries, secure continued funding and expand the approach. The personal support of housing counsellors is essential to stabilise users' situation and to integrate them into the local community. Conduct regular evaluations to assess its effectiveness and identify areas for improvement. The Person First team fully endorses the Housing First concept, while advocating for a more holistic approach.

- **Adequate social protection**
  It is unacceptable that people have to live in shelters for many years because they are too poor to afford their own housing. Raise minimum income benefits to 60% of the median income (or equivalent reference budgets). Continuously monitor the impact of the progress made on vulnerable populations and consider further adjustments if needed. Remove legal and administrative barriers in access to social benefits, in particular, for homeless people. Introduce digital identification as an alternative for the legal or reference address as a condition for access to social protection; reduce undercoverage and non-take up. Ensure that information about social rights is transparent and accessible to those in need. Organise campaigns to inform eligible individuals about the available support, including housing benefits, social assistance, and healthcare services.

- **Tailored physical and mental healthcare**
  Organise outreaching healthcare services to provide regular medical support to homeless people and harm reduction assistance for drug users. Create safe consumption rooms in major cities and provide free methadone programmes to support individuals with substance abuse problems. Organise networks of community-based mental health services, integrating them with specialised psychiatric services for comprehensive support.

- **Partnership with all relevant stakeholders**
  Foster collaboration with NGOs and advocacy groups to address collective issues related to homelessness. Ensure inclusivity in decision-making processes related to social welfare policies, incorporating the perspectives of individuals with lived experiences of homelessness. This will not only enhance the effectiveness and relevance of interventions. Their active participation is essential in the fight against prejudice, stigmatisation, and criminalisation of homelessness. Promote awareness-raising initiatives, advocate for policy changes, and implement community-oriented actions. Ensure effective collaboration and joint commitment among ministries responsible for social affairs, housing, employment, and health, as well as between levels of government, to facilitate integrated services at the local level.

10.2 At the Local Level

The municipality is typically the level with the closest proximity between public government, practitioners, and service users (homeless people); it is also the playing field where services should be integrated and delivered. Small and rural municipalities can join forces if needed.

- **Think global, act local**
  First of all, it is essential that municipalities are not disconnected from higher levels of government. If the full burden of homeless services is shifted to municipalities, they are forced into a 'race to the bottom'. Indeed, homeless people tend to move to the place where they are treated better; as a consequence, municipalities offering above-average quality of services will see their caseload increase while those offering poor quality will escape the dance. In several countries, homeless people who are not registered in the population files need to pay more or do not even get access

to the public shelter. Hence, higher-level governments should 'level the playing field' by sharing the financial and administrative burden of service provision.

- **Local governments should take the lead**
  In Lisbon and Helsinki, a dedicated department of the city government screens the profile, needs of homeless persons, and dispatches them towards the most suited service, acting as a gatekeeper. A second role of local governments is to try and fill gaps where existing services fall short. The comprehensiveness of service provision obviously depends on the size of the local community, sometimes requiring inter-municipal arrangements for specialised services. Local governments can also coordinate networks of all relevant service providers (as in Lisbon and Leuven), thus facilitating the integration of services. The degree of integration may vary a lot between municipalities, depending on the commitment and cohesion among partners. The mere agreement on referral protocols is not sufficient: direct personal contacts between service providers, swift transfer of cases, a shared vision and periodic mutual feedback are features of strong networks. Active support and periodic evaluation of the networks, based on a person-centred view, is therefore important.
- **Fighting prejudice and discrimination**
  Social exclusion, harassment and discrimination are most visible at the local level. This also means that local authorities can play a prominent role in preventing and combating such behaviour. Local citizens and merchants may react negatively to begging or to the mere presence of homeless people in public spaces (the well-known NIMBY mentality – Not In My Back Yard). Local governments tend to respond too easily to complaints by banning begging or forcibly removing rough sleepers by police intervention. In some cities the police have a reputation of brutality against homeless people. Local governments should refrain from illegal actions against these people and, on the contrary, foster a culture of empathy and solidarity among their citizens. Some city governments have taken proactive steps to combating discrimination in the housing market by conducting practice tests to identify and address instances of discrimination.
- **Leaving no one behind**
  Local services have a lot of discretion in delimiting their engagement with homeless people. They have a limited capacity and staff; professionals can also exert power over service users and set rules that become obstacles to access by imposing rules such as- restrictions on couples, pets, alcohol consumption, fixed closing times, or maximum duration of stay. Joint evaluation sessions and feedback from outreach workers or service users should ensure that no homeless person is excluded from receiving the support they need.

10.3 Recommendations concerning vocational training and continuous professional development

- **Initial training of social workers**
  The quality of services to homeless people hinges largely on the qualification of their staff and volunteers. Basic quality principles of *social work* with homeless people, covering aspects such as outreach, 'social presence', trauma-informed care, multidisciplinary teams, crisis management, tackling substance or alcohol addiction, community-based approaches should be taught in all initial training programmes of social work. An integrated set of services obviously does not only engage social workers.
- **Training elements in other related disciplines**
  Other disciplines are involved such as housing counsellors, educators, nurses and doctors, psychologists and psychiatrists, work therapists, job coaches and vocational trainers, social pedagogues, lawyers, intercultural mediators and interpreters. All these professionals need additional training enabling them to work effectively with homeless people. This training includes basic insights into the causes of homelessness, in addition to most items mentioned above for social workers.

- **Training for peer workers and volunteers**
  Specific (in-service) training programmes for *peer workers* and *volunteers* could be relatively short, while more extensive training is needed for *experts-by-experience*. Existing programmes (e.g. in Belgium) include reflection on one's own biography, basic sociological and psychological insights, socio-emotional skills, communication and mediation skills, teamwork, empowerment, and work placements in various contexts.
- **Continuous training and intervision**
  Continuous in-service training, intervision and opportunities for professional development are indispensable to support workers in reflecting on their practice and attitudes, to prevent fatigue and burnout, and to foster learning and growth. This also applies to volunteers and peer workers who do not necessarily have any relevant occupational experience. Mixed (and mutual) training sessions between professionals, peer workers and volunteers promote mutual learning and collaboration across different roles and perspectives.

- APPENDICES -

appendix 1 Glossary: Some key concepts

a1.1 Empowerment

In the context of homelessness research, empowerment refers to the process by which individuals experiencing homelessness are encouraged and supported to take control of their own lives and circumstances. It involves strengthening homeless individuals by providing them with the necessary resources, skills, and knowledge to make decisions and actively participate in improving their living conditions. In this context, empowerment entails encouraging and enabling homeless individuals to discover and harness their own strengths and resilience, ultimately enabling them to break the cycle of homelessness.

a1.2 Holistic

In the context of homelessness, a holistic approach refers to addressing the multifaceted needs of individuals experiencing homelessness in a comprehensive and integrated manner. It considers a complex interplay of factors that contribute to homelessness and seeks to address these underlying issues to promote long-term stability and well-being rather than focusing solely on providing temporary shelter or addressing immediate basic needs. Furthermore, and more specifically it encompasses various dimensions, including access to safe, stable, and affordable housing, offering a range of supportive services tailored to the diverse needs of individuals experiencing homelessness, focusing on mental health, substance abuse treatment, healthcare, case management, employment assistance, and education. The holistic approach also rounds on implementing preventive measures that address the root causes of homelessness, such as poverty, lack of affordable housing, unemployment, domestic violence, and mental health issues. People who have and are experiencing homelessness require empowerment and involvement in their lives. A holistic approach also underlines collaboration and coordination among government agencies, non-profit organisations, service providers, businesses, community groups, and individuals to maximise resources, share expertise, and develop integrated solutions. Overall, a holistic approach to homelessness acknowledges that addressing homelessness requires more than just providing shelter or temporary assistance - it requires addressing the underlying factors that contribute to homelessness and supporting individuals in achieving long-term stability, self-sufficiency, and well-being.

a1.3 Home and Homeless

FEANTSA has outlined a conceptual approach identifying three domains that collectively constitute a home, the absence of which can be considered indicative of homelessness. These domains include possessing a decent dwelling or space to meet individual and family needs (physical domain), the ability to maintain privacy and enjoy social relations (social domain), and having exclusive possession, security of occupation, and legal title (legal domain).

The term 'homeless' is widely used instead of 'houseless', recognising that homelessness extends beyond a mere lack of housing. It is often associated with the disruption of critical relationships that contribute to shaping one's identity, including family, friendship, neighbourhood, and work connections. Homelessness is also perceived as a descent in social hierarchy, evoking feelings of unworthiness and rejection.

Feeling 'at home' involves being in a familiar, comfortable, and secure space, accompanied by emotional connections with trustworthy and supportive individuals (Barreto & Cockersell, 2024). Conversely, being homeless means lacking a sense of familiarity, security, and belonging. It entails occupying an uncomfortable and disconnected position, feeling like a stranger or outsider, and experiencing disregard or denigration by society.

a1.4 Housing First

Housing First, established by Sam Tsemberis, is grounded in two foundational principles: providing personalised housing within the community and delivering specialised, continuous support tailored to individual needs.

Housing First is an intervention that advocates providing individuals experiencing homelessness with swift access to their own homes, without the prerequisite of sobriety or compliance with treatment. This approach represents a paradigm shift, diverging from the traditional linear model that progresses from the street to a shelter, then to transitional housing, and eventually to independent living. Housing First prioritises supporting individuals into their own homes as soon as possible. In essence, those benefiting from a Housing First service are not required to prove their 'housing readiness'; instead, their need for housing precedes the offer of a home (Erasmus project D&WB).

Practitioners implementing this model emphasise that Housing First thrives as an intervention when there is an investment in comprehensive multidisciplinary interventions. This includes professionals such as psychiatrists, mental health nurses, housing officers, support workers, addiction specialists, and peer specialists.

a1.5 Institutionalisation and de-institutionalisation

Institutionalisation entails harmful effects, including apathy and loss of independence, stemming from prolonged exposure to an institution. It is the process through which individuals become overly dependent on an institution, compromising their ability to make decisions independently. De-institutionalisation refers to the transition from large institutional settings, such as psychiatric hospitals or residential care facilities, to community-based care and support systems. This shift aims to offer individuals with mental health issues, disabilities, or other support needs the chance to live more independently and inclusively within their communities.

a1.6 Outreach

The concept of outreach involves actively seeking out potential patients or clients, even in the absence of a formal invitation, as opposed to waiting for them to initiate contact (Erasmus+ Project Dignity & Well-being, 2019).

Various definitions of outreach share common principles:

- to find, meet, and engage with individuals in need of assistance;
- to identify and provide support for basic needs;
- to establish connections with social and health services, facilitating both access to services and ongoing engagement with them.

Outreach work is essential when dealing with individuals who may have avoided or found traditional (health) services inaccessible or unhelpful. Through active engagement and a dedicated commitment to developing meaningful relationships, trust emerges as a central element. This acknowledgment is rooted in an awareness of the inherent scepticism frequently found in individuals who have endured prolonged periods of homelessness.

a1.7 Peer workers and experts-by-experience

Peer workers are individuals who offer support based on their personal experiences, providing empathy and understanding to others facing similar challenges. On the other hand, experts-by-experience contribute broader insights beyond personal encounters, informing and improving services or policies. The value of peer workers lies in their unique ability to connect on a personal level, fostering trust and relatability. Meanwhile, experts-by-experience enhance decision-making and initiatives by offering a comprehensive understanding gained through both personal encounters and additional knowledge. Together, these roles enrich support systems by combining lived experiences with broader expertise, creating a more holistic and effective approach to addressing various challenges.

In No Fixed Abode, Helsinki, a distinct separation is made between peer workers actively engaged in frontline services and experts-by-experience, who serve as advocates by expressing the concerns of homeless individuals in public forums, discussions with other services, and interactions with policy-makers. According to No Fixed abode working with peer workers offers various advantages:

- *Shared language:* Peer workers communicate in a language familiar to the users of the services, promoting a genuine and easily understood dialogue without the need for interpreting hidden agendas in staff communication.
- *Understanding of situations:* Peer workers possess firsthand knowledge of the users' situations and comprehend the effects on behaviour, stress levels, and overall functioning.
- *Conflict resolution:* Peers are adept at handling and preventing conflicts among users, contributing to a more harmonious and supportive environment.

a1.8 Trauma

Trauma is the emotional response to a negative event, and its effects can significantly disrupt an individual's ability to lead a normal life. Those who have experienced trauma may encounter various emotional challenges, including anger, sadness, anxiety, post-traumatic stress disorder (PTSD), survivors' guilt, and more. The impact can extend to ongoing issues such as sleep disturbances, physical and emotional pain, and difficulties in personal relationships. Additionally, individuals who have undergone major traumas are more prone to developing needs for addiction support. Adopting trauma-informed approaches ensures that services are delivered in a supportive, empathetic, and non-judgmental manner that promotes healing and recovery.

appendix 2 Project partners overview

SMES-Europa (Belgium) serves as the leading organisation in this project, collaborating with nine partners. The primary aim is to foster a network that supports professionals in the social, health, and mental health fields, both in private and public services, as well as volunteers. These dedicated individuals confront a daily spectrum of complex needs, emerging issues, and challenges.

Coordinamento Toscano Marginalità (Italy) operates at the level of day and night centres, focusing on the promotion and rehabilitation of individuals. Its mission is to fight poverty and every form of social exclusion. The CTM team actively assists homeless people through by implementing personalised projects to end housing exclusion situations. CTM was one of the founders of SMES-Italia, a national network connected to SMES-Europa, that operates in the field of homelessness and mental health.

EAPN-Latvia (Latvia) concentrates its efforts on addressing poverty & fundamental rights, wealth & inequalities, as well as empowerment and employment. As an integral part of the European Anti-Poverty Network, the association strives towards establishing a secure society, free from poverty and social exclusion. Their vision encompasses ensuring that economic, social, and cultural rights are accessible to all.

In pursuit of its objectives outlined in the Statutes, EAPN-Latvia is committed to upholding gender equality and prohibiting any form of discrimination. The organisation endeavours to:

- enhance and optimise the operational effectiveness of entities dedicated to combating poverty and preventing social exclusion;
- increase public awareness regarding issues related to poverty and social exclusion;
- facilitate opportunities for individuals living in poverty and social exclusion to enhance their well-being;
- advocate the interests of individuals experiencing poverty and social exclusion, as well as the organisations representing them.

PRAKSIS (Greece) is a humanitarian and independent Civil Society Organisation (non-profit association) with a primary focus on planning and implementing projects of development, humanitarian, and medical nature. The organisation is dedicated to eradicating social and economic exclusion experienced by vulnerable social groups and defending their personal and social rights. PRAKSIS operates across three key dimensions:

I. Prevention
II. Intervention/Support
III. Lobbying and Advocacy

ŠENT (Slovenia) is the Slovenian association for mental health. The purpose of the association is to protect the human rights and dignity of individuals facing mental health challenges. Our goal is to enhance their integration into society and bolster employability. We carry out activities in the areas of advocacy, psychosocial and employment rehabilitation, and the creation of new jobs.

Mændenes Hjem (Denmark) in Copenhagen, is an NGO umbrella organisation that offers a variety of services to support vulnerable and homeless men and women. Most of the users of the services are drug addicts. Our services encompass providing food, shelter, supervised drug consumption rooms (DCRs), facilitating contact with the established psychiatric system, and conducting examinations. The mission of Men's Home is to empower homeless and vulnerable individuals by helping them recognise and utilise their own resources to achieve a fulfilling life and contribute meaningfully to a diverse society.

No Fixed Abode (Vailla Vakinaista Asuntoa Ry) (Finland) is a grassroots organisation founded by individuals who have experienced homelessness, and it operates independently of any political or religious affiliations. The organisation's primary goal is to eliminate temporary solutions and ensure that everyone has the opportunity to live independently while receiving the necessary support. What sets the organisation apart is its commitment to the active participation of homeless individuals and those who have experienced homelessness in its activities and decision-making processes.

CARITAS Warszawskiej (Poland) is dedicated to offering an alternative to street life and isolation. They provide individuals a dedicated space and time to find calmness, feel secure, and initiate the process of regaining control over their lives. Their approach emphasises human connection and relationships, aiming to accompany individuals on their journey towards making informed decisions about themselves. Through a foundation of support, meaningful relationships, and empowerment, they strive to guide individuals towards positive transformations in their lives.

NPISA, The Homeless Planning and Intervention Centre (Portugal) is a collaborative initiative stemming from the Social Network, structured through a tripartite partnership involving the Social Security Institute, Santa Casa da Misericórdia de Lisboa (SCML), and the Lisbon City Council. NPISA was represented in the Person First consortium by the City of Lisbon. NPISA is committed to facilitating integrated intervention among institutions dedicated to addressing homelessness in the city of Lisbon. Its primary objective is to enhance the autonomy and full exercise of citizenship for homeless individuals. Over recent years, NPISA Lisbon has strengthened its operations by implementing an Integrated and Networked Intervention Model. This model fosters collaboration among the founding partners and other entities, allowing for the maturation of effective work practices.

HIVA-KU Leuven (Belgium), the Research Institute for Work and Society is a multidisciplinary research Institute of the University of Leuven. It conducts scientific, policy-oriented research that responds very specifically to all sorts of questions posed by policymakers and practitioners. Within this institute, the research team 'Poverty and Social Inclusion' has a tradition of participatory research in close collaboration with civil society organisations, service providers and grassroots organisations. It plays a supportive role in reporting and facilitating professional development through professional learning communities, teaching and training, and the dissemination in this project.

appendix 3 Organisations visited during the four study visits

I. Riga (Latvia)
1. Association 'Rīgas pilsētas Rūpju bērns' (The Child of Care in Riga City), social enterprise 'RB Cafe'
2. Latvian Red Cross Shelter 'Gaiziņš'
3. Riga Shelter Day Care Centre
4. Riga Shelter Men's Department
5. Riga Shelter Women's Department
6. Shelter 'Blue Cross'
7. Shelter 'V.E.L.G.'
8. St. Luke's Group Day centre

II. Ljubljana (Slovenia)
9. Day centre for people with mental health issues
10. Housing group for young people – Nova Gorica ŠENT
11. Kralji Ulice – Association for help and self-help of homeless people
12. Nova Gorica Mobile team for users of illegal drugs
13. Nova Gorica shelter for homeless people
14. ŠENT day centre
15. Shelter for alcohol and drug users
16. ŠENTPRIMA – Institute for Rehabilitation and Education
17. ŠENT Residential Group Homes for adults with mental health problems

III. Helsinki (Finland)
18. Centre for people experiencing homelessness – No Fixed Abode
19. The house of Fellows. The first Housing First-unit in Finland – No Fixed Abode
20. Alppikatu housing unit – Salvation Army
21. Experts-by-experience and Advocacy, fundraising and communication – No Fixed Abode
22. Homeless centre – Hietaniemi service centre for the homeless
23. Island Vartiosaari – No Fixed Abode
24. Liisankoti, supported housing unit for women – Suur-Helsingin Valkonauha ry
25. Ruusulankatu Housing First-unit – The Blue Ribbon Foundation
26. Super Novat

IV. Athens (Greece)
27. Babel Day Centre
28. Médecins du Monde – Open Polyclinics
29. MSF (Médecins Sans Frontières) Day Care Centre
30. OKANA Supervised Use Space 'STEKI 46' (harm reduction)
31. PRAKSIS Community Centre
32. PRAKSIS Day Centre for homeless in Athens and Piraeus
33. POSITIVE VOICE – REF CHECK POINT & RED UMBRELLA
34. PROLEPSIS
35. Sxedia

appendix 4 Survey questionnaire on services

I. Profile of the organisation
   1. Name
   2. Level (for which level is this questionnaire filled in?)
      - ☐ National
      - ☐ Regional
      - ☐ Local
   3. Category
      - ☐ Public
      - ☐ Private, subsidised
      - ☐ Private, not subsidised
      - ☐ Mixed
   4. Mission/objectives?
   5. Specific field of intervention (social, health, housing, work, other)?

II. Profile of users/guests
   6. Total number of (different) persons/year?
   7. Average number/workday?
   8. Average duration of stay in days?
   9. Maximum duration of stay in days?
   10. What categories of persons use your services? (please check box if relevant and, if possible, give approximate percentages among all users)
      - ☐ Homeless: %?
      - ☐ Persons with mental health problems: %
      - ☐ Poor/destitute: %?
      - ☐ Female users: %?
      - ☐ LGBTQ+: %?
      - ☐ Aged less than 18: %?
      - ☐ Migrants: %?
      - ☐ Other specific characteristics, please specify: %?
   11. What kind of mental health problems? (no percentages needed)
      - ☐ Domestic violence
      - ☐ 'Mental suffering' (loneliness, anxiety…)
      - ☐ Psychiatric disorders
      - ☐ Addiction (alcoholism, substance abuse)
   12. Categories of migrants (no percentages needed)?
      - ☐ Legal residents
      - ☐ Asylum seekers
      - ☐ Undocumented migrants

13. Reason(s) for non-admission of applicants?
    - ☐ Age/family composition (e.g., presence of minors)
    - ☐ Sex (e.g., no men)
    - ☐ Lack of legal residence (undocumented migrants)
    - ☐ Violent/risk behaviour
    - ☐ Psychiatric disorder
    - ☐ Pet animals
    - ☐ Use of drugs or alcohol
    - ☐ Non-compliance with rules of the organisation
    - ☐ Other, please specify

III. Profile of staff

14. Number of paid staff?
15. Number of volunteers?

Among the paid staff:

16. Number of workers with social qualifications?
17. Number of general medical workers?
18. Number of mental health specialists?

IV. Your organisation's experience with regards to poverty and (mental) health

19. Emergency services
    a) Does your organisation offer emergency services?
        - ☐ No
        - ☐ Yes
    b) If so, what kind of services?
20. (mental) Health care
    a) Does your organisation offer specific (mental) health care?
        - ☐ No
        - ☐ Yes
    b) If so, please describe briefly how this is organised in practice (on site or not, free of charge or not, specialised or not, ...)?
21. Requests for help/support
    a) What are the most frequent requests for help/support received by your organisation?
    b) Do your services see other latent needs that users/guests do not express?
        ☐ No
        ☐ Yes
    c) If so, what needs?
    d) What are the main difficulties in responding to these requests?
    e) What do these needs/difficulties imply in terms of staffing/staff training?
    f) Do your services at times experience a mismatch between users'/guests' needs and the services you offer them?
        ☐ No
        ☐ Yes
    g) If so, please describe this
    h) What are the complaints/criticisms that you most frequently receive from users/guests?

22. With whom and how do you collaborate in addressing the needs of your users/guests, please specify?
    - ☐ Outreach services/street work, please specify
    - ☐ Social services, please specify
    - ☐ Health services, please specify
    - ☐ Mental health services, please specify
    - ☐ Housing services, please specify
    - ☐ Job services, please specify
    - ☐ Other, please specify
23. COVID-19 crisis
    a) Did the COVID-19 crisis have any (direct or indirect) consequences for the users/guests of your services?
        - ☐ No
        - ☐ Yes, harmful consequences
        - ☐ Yes, positive consequences
    b) If yes, what kind of harmful and/or positive consequences?
    c) If yes, will some consequences for the users/guests persist after the crisis?
    d) Did the COVID-19 crisis have any (direct or indirect) consequences for the staff of your services?
        - ☐ No
        - ☐ Yes, harmful consequences
        - ☐ Yes, positive consequences
    e) If yes, what kind of harmful and/or positive consequences?
    f) If yes, will some consequences for the staff persist after the crisis?
    g) Did the crisis create opportunities for transformation and innovation in your organisation?
        - ☐ No
        - ☐ Yes
    h) If yes, which opportunities for transformation and innovation?
24. Influencing public authorities and/or public opinion
    a) Does your organisation influence public authorities, the media and/or the public opinion to combat poverty and homelessness more effectively?
        - ☐ No
        - ☐ Yes
    b) If yes, how do you lobby for your recommendations?
25. Giving a voice to users/guests
    b) Does your organisation give a voice to users/guests in the way services are developed?
        - ☐ No
        - ☐ Yes
    c) If yes, how do you organise this (evaluation forms, specific group sessions, exit interviews, complaint procedures, ...)?

References

-, Analyses of 50 Profiles of Homeless People with Mental Illness: REPORT PROFILES D-&-WB_SMES.pdf (smes-europa.org)

Barreto, E. & Cockersell, P. (2024). Attachment, trauma and homelessness. Mental Health and Social Inclusion. Vol. 28 No. 1, pp. 30-41. https://doi.org/10.1108/MHSI-06-2023-0066

Barreto, E., Bento, A., Leonori, L., Raimondi, S., Timms, P., Ryckmans, P., Brandt, P., Glad, P., Aalbæk, G., Fitsiou, P., Darmogianni, N., Tataridis, S., Pournara, R., Lascialfari, J., Czarnocki, A., Boczkowska, A., Soto, V., Martínez, I., Campo, I. & Mcevoy, John. (2019). Dignity and Well-Being - Practical Approaches to Working with Homeless People with Mental Health Problems. Erasmus-English.pdf (caritasaw.pl)

Bonvin, J.-M. & Laruffa, F., Towards a Capability-Oriented Eco-Social Policy: Elements of a Normative Framework, Social Policy and Society , 21(3), July 2022 , pp. 484 - 495

Byrne, G. (2018). The postal paradox: how having no address keeps people homeless. Retrieved from London, UK. https://www.citizensadvice.org.uk/Global/CitizensAdvice/Post%20and%20Telecoms/Homelessness%20report%20-%20Final.pdf

Edgar, B. (2009). European Review of Statistics on Homelessness (Brussels: FEANTSA).

European Parliament, Council of the EU and European Commission (2017), *The European Pillar of Social Rights*, Luxembourg, Publications Office of the European Commission, 22p.

Fondation Abbé Pierre and FEANTSA (2023), Eighth Overview of Housing Exclusion in Europe, Brussels: FEANTSA/Paris: Fondation Abbé Pierre, 129p.

Leng (2007). The impact on health of homelessness. Local Government Association, London.

Leterme, Y. and Develtere, P. (2023), The European Platform on Combating Homelessness (EPOCH): From Policy to Practice and from Practice to Policy, European Journal of Homelessness, Volume 17, No. 2

O'Sullivan, E. (2012). Ending homelessness – A housing-led approach. Dublin. School of Social Work and Social Policy, Trinity College Dublin.

Robben, Laure-Lise & Pierre, Adèle & Hermans, Koen. (2023). 'Without an address, you do not exist': the administrative invisibility of people experiencing homelessness in Belgium. Citizenship Studies. 27. 1-18. 10.1080/13621025.2023.2237418.