

**SMES-Europa**

In collaboration with **Fondazione Istituto Andrea Devoto**

**EUROPEAN EXCHANGE  
AND INTER-VISION PROJECT  
ON HOMELESS PATHWAYS  
AND INTERVENTIONS  
WITH HOMELESS  
AND MENTALLY ILL PEOPLE**

**PERSONS EXIST WHEN THEIR VOICE IS LISTENED TO**

Written by **Fabio Bracci**



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## PREFACE

Luigi Leonori

### **“A person exists when their voice is listened to ...”**

Sometimes we hear a saying that is very simple and yet so insightful that it leaves an almost indelible mark on us. This sentence, that I read years ago in a doctor’s waiting room, expresses singly the philosophy behind the SMES-Europa “Dignity & Well-being” initiative, and how it can be possible – in today’s world – to pick out, to recognise that voice that is drowned out by the cacophony of daily life. This is an exercise that is not easy and, above all, is not something we are used to.

Every year – sadly – a few people who live permanently on the street die because of the harsh weather conditions and situations of extreme exclusion: their lives come to an end when even the most basic conditions for existence have run out.

When faced with tragedies like these it is almost a knee-jerk reaction for policy-makers and public servants to hasten to publish self-justifications in the press, when silence would in fact be the most appropriate reaction. An example of this is the following statement from one mayor who was prepared to justify himself, because *“only last night, the homeless person who died today was the subject of an intervention by the city’s mobile outreach team, the police and the fire service that took the call from a citizen who reported a homeless person with health problems. They tried to help but couldn’t: F. I., which is his name, refused medical assistance, clothes and fresh blankets (...) This is the most tragic part of a difficult job that does not always allow us to help homeless people as we would like to, above all because we are often faced with a refusal of the help offered”*.

It is exactly in this ‘as we would like to’ that we find – at least in part – the reasons for the *refusal of help*.

Are we really sure that we are truly listening to those people’s requests?

Are we really sure that the fact that they refuse the help offered does not actually mean that these people need to be listened to in a way that goes beyond meeting their basic needs?

Is listening to their voice not in fact key to trying to understand their calls for help, expressed verbally, or silently through the very fact that they have stopped looking after their bodies?

The street is the only place where these people can express, through their silences or their cries, through a wounded and forsaken body, a sorrow that no longer has a voice. They clearly cannot do so in the conferences where we discuss this or that method, or modestly list the results of our study that we keep coming up with to try and use as a solution to their problems.

Here I would like to thank those people, who allow us – through their lives and their words – to meet each other, to reflect and to act and spur ourselves on in an undertaking that is attentive and sensitive to their words.

I would like to end with another one of those short sayings that are nonetheless brimming with meaning and above all instructive for us in how we should act (I am quoting from memory):

*“A decent society, or a civilized society, is one whose institutions do not humiliate, but respect the dignity of people who use services, and whose citizens do not humiliate but respect one another...”* (The Decent Society - Avishai Margalit)

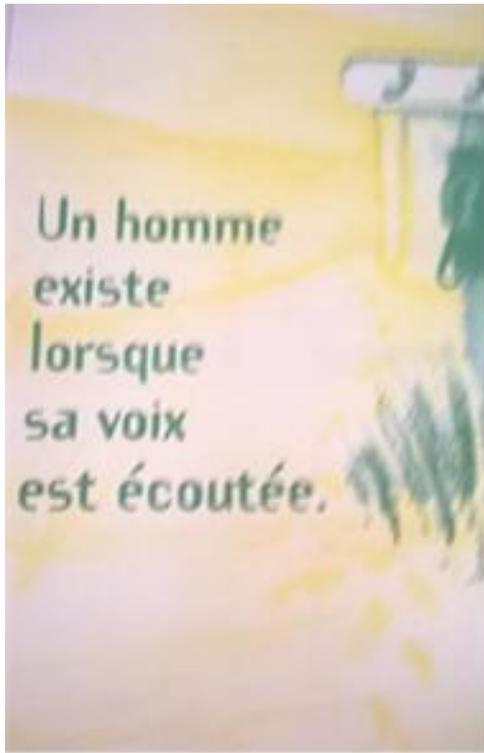
### **Homelessness is not just an individual problem but first and foremost a social issue:**

My point of view is that the main reason for homelessness always is to be found in community conditions. But additionally is to say that it is the socially weakest, the poorest, those with weak social networks, those who abuse alcohol or drugs and those with mental health problems that are really in risk to be affected by homelessness

Preben Brandt, Projekt Udenfor

We will never wait so long anymore before we manage to change people’s condition and give them real access to medical care. You never know the risk you are taking, for people’s life, by waiting.

Pierre Ryckmans, Infirmiers de rue asbl



It is very difficult and exceptional that these people, living permanently in the street, can participate in the seminars and thus be able to express themselves.

We then proposed this alternative, but insufficient: to recall their voice, heard during our interventions in the street, where their abandoned bodies tell us about their sufferings, their total loss.

The presentation of the profiles and the result of this report, with these flashes of street life have only this goal: allow us to listen more closely to their voices.

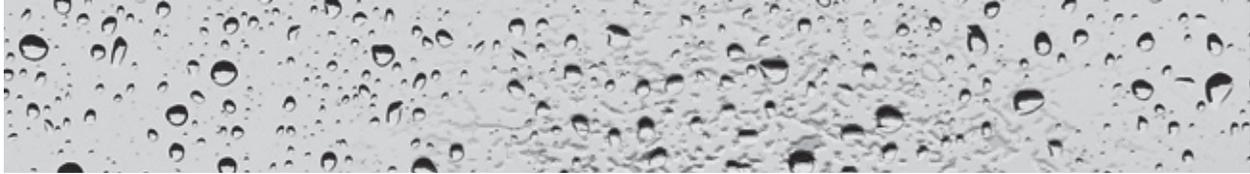


*Overcoming poverty is not a gesture of charity. It is an act of justice !*

*It is the protection of a fundamental human right, the **Right to Dignity** and a **Decent Life**.*

*While poverty persists, there is no true freedom. (Nelson Mandela - London 3/2/2005)*





## 1. THE PROJECT

### 1.1. The Dignity & Well-Being Project and the SMES Network

The key question underpinning the *Dignity & Well-Being* (D&WB) project can be summarised as follows: how does each Mental Health and Social Exclusion network (SMES-Europa) partner active in the project try to listen to, understand and find solutions to the complex needs of homeless people (living mainly on the street, or in squats and shelters) with mental ill health? This frequently extreme condition is characterised by overlapping factors of deprivation. Each of them interacts with and exacerbates the others. The mutual reinforcement of social exclusion and mental health problems and illnesses, often resulting in situations of complete isolation from society and a lack of treatment, is one of the most challenging issues not only for volunteers, social service providers and health/social care professionals, but also for our societies as a whole. Due to their multifaceted needs, frequently unnoticed unless their conditions trigger social alarm or fear, homeless people with mental illness are always the most complex cases for the various people involved at different levels in the attempt to better understand and possibly improve their social and health conditions. Even if these conditions may differ – in terms of personal factors, contextual frameworks or socio-cultural backgrounds – the life stories of these people invariably share similar factors: a significant and intolerable distance between their basic human rights and needs on one side and the concrete possibilities to escape from deprivation and the lack of dignity offered to them by social and health services on the other. The challenge consists in trying to deal with the ethical and practical issues brought about by this distance. It also consists in offering human solidarity, effective support and real protection. We must always remember that homeless people may be more or less aware of their personal condition, their needs can be explicit or implicit, but respect for them and for their dignity must remain the driving principle of any kind of intervention. With this reasoning in mind, beside the key question mentioned above, a series of additional questions immediately arises: how do health services, support services, housing services and reintegration services contribute to promoting the dignity and well-being of homeless people with mental illness? Which factors it is worth examining in order to understand the different outcomes in social and health care? Can we discover any different strategies and tools used to tackle the problem of the frequent refusal of any kind of institutionalised treatment and planned care (including in precisely those situations where care and treatment appear extremely urgent)? Are we able to detect some common features or typologies in this kind of stories? Which pathways promote possible solutions that can be put in place by networks and teams in order to keep adjusting to changing scenarios and at the same time to safeguard the goal of effectively promoting the dignity and well-being of homeless people with mental illness? Which kinds of proposals and priorities can be suggested that are effective and feasible?

D&WB has tried to explore these issues by carrying out a series of exchanges and *inter-visions* within the SMES-Europa network, in line with a specific recommendation that came out of the last SMES-Europa Conference<sup>1</sup>. Through knowledge exchange and analysing different experiences, the project has aimed to highlight effective alternative ways to reach out to, support and guide these suffering people in order to facilitate – with due respect for their personal dignity – their access to physical, mental and social well-being. To outline the main goals, it is useful to restate D&WB's main priorities:

- meeting, listening to and understanding the voice of people who have become “voice-less because they are identity-less, home-less, health-less, hope-less and excluded”<sup>2</sup>;
- evaluating and reflecting on the factors in this deprivation and the reasons why these people often tend to prefer life on the streets or in emergency shelters, even when more adequate forms of assistance are offered;
- identifying some innovative practices and full projects;
- recommending some priorities for social and health policy.

D&WB has aimed to strengthen training and mutual learning, to reinforce multidisciplinary cooperation and networking, and to present and analyse alternative and effective practices for prevention (primary and sec-

ondary), treatment and support, after-care and signposting. On this basis, the project has chosen the workshop method as a central pillar for carrying out exchanges and *inter-visions*. Three main types of workshop were held throughout the project: each workshop centred around the presentation and analysis of life stories (from now on: profiles) providing, at a glance, a contextual reading of these cases (for more details on the workshops and the protocol for collecting profiles see section 1.2). Discussions after each presentation assured mutual learning through the exchange of experiences and knowledge; they provided a common language to participants, which also allowed them to pay serious attention to differences in organisational cultures, institutional practices and the social and economic means available to work with homeless people in each country. As one of the participants in the first workshop put it, “while I was listening to the profiles it became clear to me that we face the same difficulties and challenges. So, perhaps we can also learn from each other, listening to the solutions found to solve the complex problems that homeless people face”<sup>3</sup>. SMES-Europa is an international non-profit organisation<sup>4</sup>. It has been a non-profit association (AISBL Belgian law 1919) since 1992, and was created following the first seminar on “*Mentally ill people at risk of homelessness*” held in Rome. It operates “at the interface and intersection between mental health and social exclusion to improve the mental, physical and social well-being of people living in extreme conditions of social and health deprivation and to promote their human rights and their access to social and health services, citizenship and participation, inclusion and solidarity in European countries”. The core principles of its activity are the following: “there is no dignity without respect for fundamental rights; there are no rights without access to services everyone has a right to; there is no health without mental health; there is no mental health without well-being”. Specific SMES-Europa objectives are raising awareness in civic society, networking (promoting synergies between public and private health and social sector workers and opportunities for them to work together), education and training, lobbying and advocacy. Below is a list of the thirteen seminars organised by SMES-Europa since its foundation.

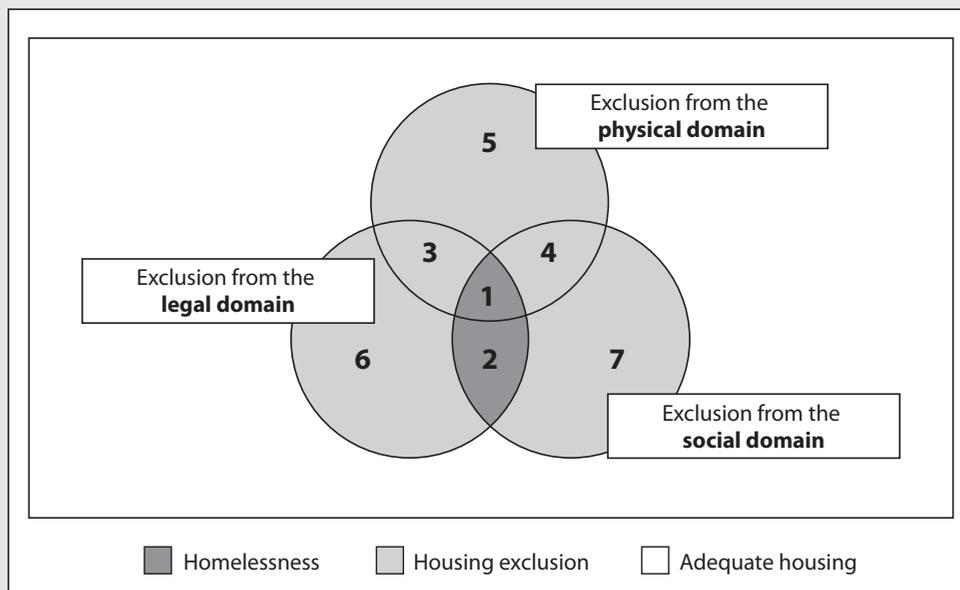
Conferences	Date	Country
1 <sup>st</sup> Seminar: Mental Illness and Homelessness	10-13 December 1992	Rome
2 <sup>nd</sup> Seminar: Mental Health & Social Exclusion ...	2-4 December 1993	Brussels
3 <sup>rd</sup> Seminar: From Exclusion to Participation: An Impossible Challenge?	18-20 May 1995	Paris
4 <sup>th</sup> Seminar: Citizens First. Exclusion: A Burning Issue	16-18 April 1997	Madrid
5 <sup>th</sup> Seminar: Dialogue & Exclusion	6-8 May 1999	Copenhagen
6 <sup>th</sup> Seminar: Living in Health & Dignity	28-30 September 2000	Athens
7 <sup>th</sup> Seminar: Change through Exchange	10-12 October 2002	Lisbon
8 <sup>th</sup> Seminar: Dignity & Health	17-19 June 2004	Prague
9 <sup>th</sup> Seminar: Dignity & Health	06-08 October 2005	Berlin
10 <sup>th</sup> Seminar: Access to Rights: Health - Housing – Employment	23-25 January 2008	Rome
11 <sup>th</sup> Seminar: Invisible Wounds	24-26 February 2010	Athens
12 <sup>th</sup> Seminar: Sharing and Participating	14-15 March 2011	Bucharest
13 <sup>th</sup> Seminar: Home-less & Home-First	6-8 March 2013	Rome

## Homelessness: Definitions and (Some) Data

The definition of homelessness is based on the ETHOS approach (European Typology of Homelessness and Housing Exclusion) developed by FEANTSA (European Federation of National Organisations Working with the Homeless) and the European Observatory on Homelessness. This approach focuses on three domains (physical, social and legal) considered as constituting a home: “living situations that are deficient in one or more of these domains are taken to represent homelessness and housing exclusion,” (Amore, Baker, Howden-Chapman 2011: 24).

The three domains are defined as follows: “having a decent dwelling (or space) adequate to meet the needs of the person and his/her family (physical domain); being able to maintain privacy and enjoy social relations (social domain); and having exclusive possession, security of occupation and legal title (legal domain)” (Edgar 2009: 15). The definition yields the conceptualisation of three different categories: a) homeless population (population located in area 1 and 2 in figure 1; b) the adequately housed population (not experiencing homelessness or housing exclusion: population located outside the circles), c) population experiencing housing exclusion (shaded in light grey).

**Figure 1. ETHOS model for defining living situations as homelessness, housing exclusion, or adequate housing according to the physical, legal, and social domains**



Source: Amore, Baker, Howden-Chapman 2011: 24, adapting Edgar 2009.

As Amore, Baker and Howden-Chapman recall (2011: 24), “the seven theoretical categories of homelessness and housing exclusion shown in Figure 1 translate into the ETHOS typology, which consists of thirteen categories containing twenty-four discrete living situations. These categories are grouped under four headings: roofless, houseless, insecure, and inadequate accommodation. The roofless and houseless categories together define homelessness; insecure and inadequate are categories of housing exclusion [...] This typology is not intended as a definitive classification of living situations into homelessness and housing exclusion categories, as this will vary according to national (and possibly

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regional) housing standards, norms, and tenancy law. However, the typology is presented as a guide to classifying living situations according to the conceptual model”.

Researchers attempting to reach an adequate level of understanding of the phenomenon have often complained of the lack of reliable and/or comparable data (Rees 2009; European Commission 2014). It should be noted that this situation seems to have improved in recent years: according to the review conducted by the European Observatory on Homelessness<sup>5</sup>, several European countries now have sufficiently reliable data to identify the main characteristics and dynamics of the phenomenon (Busch-Geertsema *et al.* 2014). In Italy, the second national homelessness survey carried out in 2014 showed that the number of homeless people was estimated to be around 50,700 (0.24% of the total population: Istat 2015), while a less recent source indicated the presence of 5,290 homeless people in Denmark (0.10%) and 42,768 homeless people in Poland (Rees 2009). Supposing that 0.1% of the total population of European countries were homeless, this last source proposed an estimate of more than 500,000 homeless people on EU soil (*Idem*). It is important to note that other sources show that, following the economic downturn after 2008, these figures became significantly higher: according to a St Mungo’s report, the number of people sleeping rough in England more than doubled between 2010 and 2015. The same report states that, “a review of the best available data recorded by street outreach professionals working with people sleeping rough showed that four in ten people who sleep rough need mental health support”. According to the same source, in the last few years “people sleeping rough with a mental health problem [have tended] to live on the streets for longer” (St Mungo’s 2016). This phenomenon of the increase in the amount of time spent living on the streets was also observed in the aforementioned Istat report on the situation in Italy (with an increase in the percentage of people living on the street for more than two or four years in comparison with the first survey of 2011).

## 1.2. Workshops and Profile-Writing Protocol

As already underlined in the previous section, the D&WB project has centred on exchanges and *inter-visions* of case studies/profiles presented and discussed within the SMES-Europa network. Three workshops have been organised to bring helpers together and to promote the sharing of reflections and ideas about the pathways of care and treatment of homeless people with mental illness. The workshops were held in:

Warsaw, from 1<sup>st</sup> to 3<sup>rd</sup> October 2015;

Athens, from 14<sup>th</sup> to 16<sup>th</sup> April 2016;

Copenhagen, from 27<sup>th</sup> to 29<sup>th</sup> October 2016.

These three-day meetings generally followed a common pattern. On the first day, the participants (coming from different backgrounds and organisational contexts) went on shared study-visits of centres assisting homeless and mentally ill people; on the second day workshops were used for the open discussion of case studies/profiles; on the third day each workshop concluded its work with a focus group on specific issues. In Warsaw, the focus group studied *Homeless Poles in Europe*; in Athens: *Austerity and Extreme Poverty, What are the possible answers?*; in Copenhagen: *Health & Mental Health, Reception & Fundamental Rights of Migrants, Refugees and Asylum-Seekers*. The workshops have to be considered as distinct milestones on the route towards the final Conference in Lisbon: and this final Conference is exactly the event for which this analysis of the collected profiles is intended.

The need to promote exchanges and mutual learning by collecting and discussing individual life stories and care/treatment pathways has required the definition of a specific tool: the protocol for defining the guide-

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lines to be followed in collecting each profile. As such, the protocol became the means for translating the questions listed in section 1.1 into common dimensions and issues: an attempt to reduce the high level of complexity inherent in both the issue at hand and in the wide range of skills, specialisms, sectors and professional backgrounds of each participant and profile writer. The first version of the protocol (used for collecting profiles 1 to 37, see table 1 in section 2.2) was divided into five sections, which were as follows (this description is the one that was provided to each profile writer):

**1. Background and environment/context of the personal profile as regards:** the conditions of 'dignity' and 'health' in which these people live. How are these dimensions interrelated as regards: *time*, meaning how chronic the situation is; *abandonment*, meaning the breakdown of any relationships and connections and *refusal*, meaning refusal of any institutional offer of care and assistance services?

**2. Health: physical and mental health conditions.** All additional information on the person's health situation and diagnoses (confirmed or hypothetical) is very useful for discussion, evaluation and proposals.

**3. Description of interventions:** presentation and evaluation of the difficulties, successes and failures in interventions. What kinds of interventions were carried out in the health and social field; what success/failure depends on; highlighting the correlations between the objectives to be pursued, the planned interventions and the outcomes; innovative practices.

**4. Workers & Network:** What kind of collaboration exists between the public and private sectors? What kind of multidisciplinary synergies exist between social, health services and others? What kind of joint working and co-responsibility exists between institutions, associations and administrations?

**5. Proposals:** What possible and innovative interventions can we put forward when solving complex situations seems impossible? What pathways, what specific priorities could be chosen as recommendations?

N.B. The profile - *not more than 2 pages* - will be like an X-ray that will facilitate understanding of the interaction and the causes of homelessness. Please note: we ask you to protect the privacy of service users.

*OPTIONAL: Additional information*

A. Additional information on the gradual decline in both physical and mental health;

B. Risk of mortality: more information on the risk of the homeless person dying on the streets;

C. Brief reference to the national welfare context.

Shortly after the second workshop, held in Athens, the network discussed the possibility of revising the protocol in order to refine and adjust it. This choice was made to improve the overall effectiveness of the tool as a means of collecting data and information. This also incorporated some indications and suggestions from the first two workshops. One of the partners (*Fondazione Devoto*) organised a conference on marginality and health and social care services at the end of May 2016: on that occasion - *Fondazione Devoto* having invited a group of D&WB partners - this same group discussed and approved an updated version of the protocol.

The document produced on how to revise of the protocol represents a sort of intermediate evaluation of the *pros* and *cons* of the 'first version'<sup>6</sup>. It firstly highlighted the abundance of information resulting from the profiles collected, recognising at the same the qualitative nature of the tool: "one senses in the collection of stories the echo of the relationship between the operator writing the protocol and the person whose profile speaks. In some profiles this feature is felt in greater measure, in some less, but in each the personal dimension is still present". The narrative format of the profiles definitively removed from the discussion all ideas that suggested a quantitative use of the data collected. The group discussing this issue in Florence shared

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the idea that analysing the information and data given in the profiles through a quantitative lens would have been methodologically senseless and practically impossible.

It is well known that every survey on personal life experiences can be carried out using different tools that fit onto a spectrum between two extremes. At one end of this *continuum* we find a pool of standardised tools (like questionnaires). These allow researchers to reach a high level of uniformity in their data collection but, at the same time, they risk forcing complex topics to fit into pre-defined and too-rigid frameworks. At the other end of the spectrum we find all the non-standardised methods. These kinds of tools allow a lot of useful information to be gathered but require more effort towards recoding and analysing the data collected (which are only rarely uniform and homogeneous; this also happened with the profiles analysed here). Choosing between these two opposite poles, or achieving a balance between these two opposing needs, typically depends on several factors: the context of analysis, the greater or lesser familiarity with these two approaches and the kinds of people involved in the collection and interpretation of data.

In light of this information and given the direction the protocol has been going in from the beginning, D&WB profiles must be associated with life stories, which is a 'subject' that has an important position – given its specificity – in social research methodology. Only through reading these profiles as narrative tools is it possible to preserve their intrinsically open and discursive structure. Quantitative analysis – based on transforming individual topics into more or less dichotomous variables (for example: absence/presence of a support network, absence/presence of other diseases) – would be a very poor contribution to the needs of D&WB and the SMES-Europa partners. This standardisation would be very difficult even for the apparently easiest variables, since – as we will observe in the next section – biographical information (basic data for each profile) is not always available and can come from indirect sources (being often second- or third-hand, or collected thanks to the voices of acquaintances and contacts of various kinds).

The protocol and its revision have been the answer given to the need to gather as much information as possible and at the same time to make it possible to carry out a meaningful comparative and comprehensive reading of the data. This general choice gave rise to two concrete changes: a) extending the descriptive part of each section of the protocol, in order to suggest all the subdimensions relevant to the section title; b) adding two new final sections: point 6 (representations and self-representations influencing relationships between homeless people on one side and teams, services and organisations on the other) and point 7 (overall assessment of the case). This addition made sense because it was recognised that both the issue of representations and the personal evaluation of each case were already present in some profiles but often not in an explicit way. Therefore, the addition has simply given autonomy to these two issues, allowing them to be consistently present in the profiles.

The final version of the protocol (used for collecting profiles from 38 to 50) thus became the following (in italics are the parts added in May 2016):

**1. Background and environment/context of the personal profile as regards:** the conditions of 'dignity' and 'health' in which these people live. How are these dimensions interrelated as regards: *time*, meaning how chronic the situation is; *abandonment*, meaning the breakdown of any relationships and connections and *refusal*, meaning refusal of any institutional offer of care and assistance services?

**2. Health: physical and mental health conditions.** All additional information on the health situation and diagnoses (confirmed or hypothetical) including:

- *interaction between mental and physical conditions;*
- *influence of health conditions on the lifestyle of a person;*
- *history of interruptions and resumptions of medical care provided to the person,*
- *approaches and opinions of medical professionals working with the person;*
- *interdependence of psychosocial distress in cases where two people from the same family circle are involved.*

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**3. Description of interventions:** presentation and evaluation of the history of interventions with their difficulties, successes and failures, including the circumstances of the person's *first contact with organised assistance; clarification of the objectives of the intervention in its various stages; description, if needed, of specific operational solutions; stating the reasons for compulsory health treatment.*

- What kinds of interventions were carried out – in the health and social field; what success/failure depends on;
- Highlighting the correlations between the objectives to be pursued, the planned interventions and the outcomes;
- Innovative practices.

**4. Workers & Network:**

- *One or many actors?*
- *Is there networking and cooperation between actors or not?*
- *What kind of collaboration exists between the public and private sectors?*
- *What kind of multidisciplinary synergies exist between social, health services and others?*
- *What kind of joint working and co-responsibility exists between institutions, associations and administrations?*
- *What are the institutional and legal barriers to and limitations on providing adequate assistance (cumbersome, poorly defined procedures, "vicious cycles"; resources and funding);*
- *What obstacles could be overcome through "creativity" on the part of the operators in the face of unhelpful or confusing legislation?*

**5. Proposals:** What possible and innovative interventions can we put forward when solving complex situations seems impossible? What pathways, what specific priorities could be chosen as recommendations?

**6. PERSONAL FACTORS** *influencing the initiation and continuation of the support process:*

- *possible stigmatisation of the worker or the person asking for support;*
- *sources of stress and burn-out for support workers;*
- *staff changes during the support process;*
- *cultural clashes.*

**7. OVERALL ASSESSMENT OF THE CASE:** *strengths and weaknesses of the support network and/or interventions provided;*

- *Summary judgment: has the person's condition improved, worsened or remained unchanged? (in relation to the objectives set down)*
- *relevant ethical issues related to the work;*
- *final thoughts, free text.*

*OPTIONAL:* Additional elements on the gradual decline in both physical and mental health [...]

At the close of the project we counted 50 profiles: an impressive range of stories and pathways, and also an inventory of different models of interaction between services and homeless and mentally ill people in different contexts. These data provide a unique opportunity to analyse, on the one hand, recurring factors and common trends and, on the other hand, singularities and critical/creative solutions. This analysis is what we will present in the following pages, starting from a brief sketch of the methodology used to extract and rework the most relevant information from the profiles.

**Table 1. List of profile writers and organisations**

<b>N.</b>	<b>Profile writer</b>	<b>Organisation</b>
1	Preben Brandt	Projekt Udenfor - Copenhagen
2	Preben Brandt	Projekt Udenfor - Copenhagen
3	Preben Brandt	Projekt Udenfor - Copenhagen
4	Preben Brandt	Projekt Udenfor - Copenhagen
5	Andrew Czarnocki	Caritas Archidiecezji Warszawskiej
6	Andrew Czarnocki	Caritas Archidiecezji Warszawskiej
7	Andrew Czarnocki	Caritas Archidiecezji Warszawskiej
8	Antonio Bento	Centro Hospitalar Psiquiátrico de Lisboa
9	Antonio Bento	Centro Hospitalar Psiquiátrico de Lisboa
10	Daniela Pallotti	Cooperativa San Saturnino
11	Daniela Pallotti	Cooperativa San Saturnino
12	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles
13	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles
14	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles
15	Monica Bovi, Giuseppe Riefolo	ASL Roma 1
16.1	Ioanna Pertsinidou	Praksis - Athens
16.2	Ioanna Pertsinidou	Praksis - Athens
17	Jonathan Britmann	Community care in Psychiatric Hospital
18	Robin Schoonjans, Habib Torbey	Samu Social Bruxelles
19	Silvia Raimondi	ASL Roma E
20	Elias Barreto	Serviço de Psiquiatria - Lisboa
21	Pierre Ryckmans	Infirmiers de Rue - Bruxelles
22	S. Artero, Angelina Di Prinzio	Coop Il Cigno - Sala Operativa Sociale Comune di Roma
23	Victor Soto	Parc Sanitari Sant Joan de Deu - Barcelona
24	Victor Soto	Parc Sanitari Sant Joan de Deu - Barcelona
25	Jacopo Lascialfari	Fondazione Istituto Andrea Devoto
26	Hector Cardoso	Caritas France - Marseille
27	Katarzyna Perzanowska	Monar Shelter
28	Ewa Jasik-Wardalinska	Caritas Shelter
29	Stanislaw Slowik	Caritas Kielce
30	Ioanna Pertsinidou	Praksis - Athens
31	Giuseppe Bernetti, Angelina Di Prinzio	Sala Operativa Sociale Comune di Roma
32	Preben Brandt	Projekt Udenfor - Copenhagen

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33	Giuseppe Riefolo, Silvia Raimondi	ASL Roma E
34	Victor Soto	Parc Sanitari Sant Joan de Deu - Barcelona
35	Tony O’Riordan	Midlands Simon Community & Sophia
36	Ioanna Pertsinidou	Praksis - Athens
37	Zhasmina Petrova	Caritas Burgas
38.1	Mieke Portegies	Recovery Group Holland
38.2	Mieke Portegies	Recovery Group Holland
38.3	Mieke Portegies	Recovery Group Holland
39	Giuseppe Bernetti	Sala Operativa Sociale Comune di Roma
40	Celeste Brissos	Diretora Unidade de Emergência SCML
41	Celeste Brissos	Diretora Unidade de Emergência SCML
42	Victor Soto	St Joan de Dios – Barcelona
43	Riefolo-Raimondi	ASL Roma 1
44	Catherine Glow	St Mungo’s – London
45	Chantal Magdeleinat	SMES Centre Hospitalier Sainte Anne
46	Antonio Bento	Centro Hospitalar Psiquiátrico de Lisboa
47	Elias Barreto	Centro Hospitalar Psiquiátrico de Lisboa
48	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles
49	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles
50	Celestine Gallez, Pierre Ryckmans	Infirmiers de Rue - Bruxelles

**1** See point 10 of the priorities recommended by the XIII European SMES-Europa Conference: “to promote exchange for mutual learning and to create synergies in lobbying and advocacy: sharing knowledge of the outcomes, hurdles and solutions which are derived from daily experience; assessing innovative projects”. See [http://www.smes-europa.org/MESSAGES\\_13CONF\\_SMES-2013.htm](http://www.smes-europa.org/MESSAGES_13CONF_SMES-2013.htm).

**2** [http://www.smes-europa.org/Copenhagen-Workshop\\_Invitation.htm](http://www.smes-europa.org/Copenhagen-Workshop_Invitation.htm).

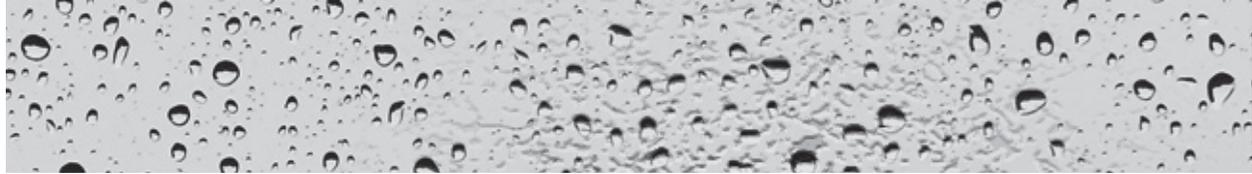
**3** Elias Barreto, report on the first exchange and *inter-vision* programme (Warsaw, 1st-3rd October 2015), [http://www.smes-europa.org/D-WB\\_REPORT-Warsaw.htm](http://www.smes-europa.org/D-WB_REPORT-Warsaw.htm).

**4** All the following information is taken from the SMES-Europa website <http://www.smes-europa.org>.

**5** The European Observatory on Homelessness carries out transnational research on homelessness and housing exclusion. FEANTSA’s statutory bodies decide on the research strategy, the annual research programmes and the research themes. The research is carried out by researchers from research institutes and universities across Europe and beyond. Once a year, the EOH organises a European Research Conference. The EOH produces two issues of the European Journal of Homelessness and one Comparative Study per year. See <http://feantsaresearch.org/spip.php?rubrique10&lang=en>.

**6** [http://www.smes-europa.org/D-&WB\\_PROTOCOL%20of%20profiles.htm](http://www.smes-europa.org/D-&WB_PROTOCOL%20of%20profiles.htm).

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## 2. PROFILES ANALYSIS

### 2.1. Profiles collection: methodology and notes

In the following pages we will analyze the contents of 50 profiles that have been collected. These profiles can be divided into three groups, each of which corresponds to the workshop during which the presentation and discussion took place: 16 of them were presented and discussed during the first workshop (in Warsaw), 21 during the workshop in Athens and 13 during the workshop in Copenhagen.

We have already observed how the protocol has tried to standardize the collecting and descriptive criteria of each story. However, before dealing with the content and collected data, we should treat some methodological aspects. It should be recalled that, first of all, the wide variety of contextual conditions that form the background to each of the paths- described: in the work of teams, mobile units and service operators, as well as in the operation of the welfare system and socio-economic dynamics of realities in which profile stories are placed.

Legislative frameworks, models of organization and availability of resources (not just monetary: think of the various housing solutions in various contexts) are just some of the factors which represent opportunities or constraints, from time to time, with respect to the intervention of the entities which care for homeless people with mental health problems. These differences concern not only national, regional or municipal systems, but also the individual service, in which - for example - a change in the operating team members can introduce significant discontinuity with respect to the previous operating mode (both for the better and for the worse; see Mental Health Europe, 2013).

Secondly, once we said the peculiarities of individual histories and reference socio-cultural and institutional contexts - an inevitable feature when you share and exchange different points of view of profiles on countries and different models - we must report three other differentiating factors of the collected material. The contents of the profile is in fact significantly different, also according to the following aspects:

- writing style. The profiles have a different stylistic connotation, which have a significant implication in terms of information content. Without prejudice to the articulation of sections described in the previous paragraph, some profiles have been written in a narrative / discursive style, others prefer an historical / chronological description, others just give an analytical presentation (in the latter profiles, for example, there are less critical / evaluative reflections about the described path). With the exception of a profile (which is an interview, even if it respects the thematic sequence of the protocol; profile 44B), in all other cases, the story of the person are told by an observer (social worker, health worker);
- position / role of the profile writer. Precisely because cases are not told firsthand, the 'narrator's' position affects its point of view, both in factual terms (for the information available to him and which he can thus provide), and in terms of axiological thoughts (case assessment, the pros and cons);
- availability of information. The amount and quality of information contained in the profiles is very variable. Some profiles are short, concise and bare; others are articulated, complex and extended (in some cases exceeding the limit of the two pages' suggested by the protocol).

Sometimes one or more sections have been preferred at the expense of others; in other cases the distribution of information appears more balanced and homogeneous. Essential information, such as age and nationality, were not always reported, regardless of whether data were actually known or knowable by the writers of the profile - as will immediately be evident, is not to be taken for granted. Profiles, finally, covering different intervals of time, because in some cases refer to people recently met and visited, while others are known cases or followed by many years.

To analyze the content of the profiles we have coded the individual portions of text within a specially formed database. The database, allowing the multiple coding of a single item (ie the attribution to a portion of text of thematic tag), has made possible the analysis of the connections and the articulation of the content; resulting from this activity are the general structure of the report (the index), and the final draft. The activity is

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basically divided into three phases: a) reassessment of the profiles, with an adjacent recoding of individual portions of text; b) the reorganization of the information collected through the enucleation of common aspects, the specificities and recurrence; c) drawing up the thematic sequence of presentation topics (index) and write the report. As you can see, drafting the text, it was decided to interpolate the reconstruction with the inclusion of direct quotations from the profiles, in order to maintain a constant connection between the presentation of the topics and the liveliest parts - expressed in the natural language of the compiler - the collected stories.

It is also chosen to simplify the reference to each profile through the adoption of an alphanumeric code. The choice allows you to associate the citation or reference to a profile and at the same time to maintain the anonymity of the person spoken of from time to time. The code is composed of the sequence number of the profile followed by a capital letter, which generally indicates the name, nickname or alias of the person described in the profile (in some cases when drafting the profile names have been changed by the authors). A few special cases have to be reported: if the number is not followed by a letter it means that the person described was not given a name or that the name was not known (the cases in question are three: the profiles 14, 15 and 30);

if the number is followed by a lowercase letter it means that the profile was presented as unique, but that the stories presented in it were more than one: in these cases there were number as many lower case letters as the people delivered in the profile (these are the cases 16a, 16b, 38a, 38b and 38c); if, finally, after the number there are two letters interspersed with the symbol '/', it means that in the profile stories of two people are described, however, stories that are interdependent so they cannot be presented separately (profiles 17R/M and 31F/C). Since three profiles contain information about two people and a profile contains information about three people, it follows that although collected profiles are 50, people to whom we refer are actually 55 (for the overall picture of the profiles see table 1 of paragraph 2.2).

One more caution, before showing collected data. As we have tried to standardize the thematic sections through the protocol, the theme sequence chosen for writing this report is marked by a subjective mark. Moreover, beyond logic and thematic order which we are presenting, it is worth remembering that the dynamics on the various areas of activity (health, social, housing and reintegration/participation services) are interdependent. The concluding paragraph will organize reflections and final recommendations on the basis of this kind of lay out, but only to support the work of the Conference: since - as it will be seen - only a truly integrated work that involves all the elements of taking-over and care, may contribute to an effective improvement of dignity conditions and well-being of people whose suffering comes from living a condition of extreme marginality.

## **2.2. Profiles at a Glance: Age, Gender, Nationality, Physical and Mental Health Conditions**

Table 1 summarizes the main socio-demographic characteristics of the people we are talking about in the profiles. This paragraph describe first of all these features: age, gender and nationality. We should clarify that the dichotomous 'Yes / Not' of the fourth column in the table refers to the legal nationality of the person: in the sense that express his/her belonging or not, in terms of legal status, to the same geographical and legal context in which the person lives and where the support structures operate. In the second part of the paragraph there is a summary of health conditions detected by the writers of the profiles, both in terms of physical health and in terms of mental health. However, it was already mentioned that in several cases the people identity registry was unknown both to the writer of the profile and to the care / treatment system. In some case personal data have emerged over time, thanks to the patient approaching of the person by operators of outreach teams or after a hospitalization (this is the case of the profile 1M); in other cases they remained unknown, despite operators and services' efforts.

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**Table 2. Summary framework of profiles by age, gender and nationality**

<b>Code</b>	<b>Age</b>	<b>Sex</b>	<b>National (Yes/not)</b>
1M	About 45	Female	N
2F	59	Male	Y
3C	56	Male	Y
4V	About 60	Male	N
5E	55	Female	Y
6M	50	Female	Y
7J	50	Female	Y
8J	51	Male	Y
9M	48	Female	Y
10C	35	Male	N
11J	80	Female	Y
12C	Not known	Female	Not known
13J	Not known	Female	Not known
14	62	Male	Y
15	57	Male	N
16a	67	Female	Y
16b	24	Male	N
17R/M	50/30	Female/Male	Y (both)
18F	Not known	Male	N
19T	54	Male	N
20F	40	Male	Y
21C	46	Female	Not known
22L	44	Female	N
23A	62	Female	Y
24T	72	Female	Y
25B	57	Male	N
26S	72	Male	N
27M	58	Female	Y
28E	29	Male	Y
29P	28	Male	Y
30	76	Female	Y
31F/C	77	Female (both)	Y (both)

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32P	48	Male	Y
33V	39	Male	N
34A	64	Male	Y
35X	40	Male	Y
36K	64	Male	Y
37G	61	Male	N
38a	23	Female	Y
38b	28	Female	Y
38c	40	Female	Y
39P	Not known	Male	N
40J	29	Male	Y
41C	88	Female	Y
42D	32	Male	N
43S	55	Male	N
44B	Not known	Male	Y
45B	About 60	Female	Y
46P	59	Male	Y
47R	40	Male	Y
48G	51	Female	N
49L	41	Male	N
50M	45	Male	N

The first important finding, concerning the genre, shows an ‘almost’ balance situation between women (24) and men (31). It is a not trivial matter: in general studies on this subject tend to emphasize the prevailing masculine declination of homelessness (in Italy homeless women, according to the latest survey, are 14.3% of the total; Istat et al. 2015: 11), on the ground that women in distress condition are often exposed to similar but not identical qualified risks as “hidden homelessness”: staying under a roof, subject to physical and sexual violence, because of lack of alternatives (SMES-Europa 2013). Although it is impossible to draw statistical conclusions based on information gathered in the context of this project, data relating to gender distribution suggests a first line of development of potential, future, cognitive reflection: can we speak of women as a specific target group, with specific occurrences and peculiar causal factors, deserves a special focus?

As regards the age, it must be said in the introduction that in five cases this information is not reported in the profile, while in other profiles the allocation is based on an approximate writer’s observation. As shown in Table 2, in 22 cases among the 50 in which the age is known or estimated, people are placed in the central age group (46-60 years); 18 people are between 31 and 45 and 7 are 30 or less. The most important data can be deduced through the crosschecking between age and gender: all five people over 75 are women, while almost half of men (13 of 31) are concentrated in the age group up to 45 years. It must be said that according to the latest available studies (see the reflections contained in the Busch-Geertsema et al. 2014) in several EU countries are emerging as a significant increase in youth homelessness.

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**Table 3. Profiles by age and gender**

Age	Female	Male	Total
< 30	2	5	7
31-45	3	8	11
46-60	9	13	22
61-75	3	2	5
> 75	5	0	5
Not known	2	3	5
Total	24	31	55

With regard to the nationality, except for three persons for whom the data is not shown or evident from the content of the profile, 18 persons of 52 come from a country different from the one in which they live (table 3). These 18 people are mostly citizens from non-EU countries, but there are also three cases of people from EU countries which are in another EU Member State. Even in this case, as a purely statistical / quantitative reading of the data is to be taken with caution, the framework of profiles shows - as will also be seen in more detail later - how the condition of the migrant person is vulnerable.

**Table 4. Profiles by citizenship and gender**

Same citizenship	Female	Male	Total
Yes	18	16	34
Not	3	15	18
Not known	3	0	3
Total	24	31	55

Health condition (point 2 of the Protocol) has been described in profiles in a very articulate way. In some case there is a clinical diagnosis in the strict sense, with an indication of disease codes based on available rating systems (ICD or DSM); in most of profiles it is anyway a behavioral description and / or of symptoms without the indication of an exact diagnosis. In very few profiles it is detected the lack of diagnosis or observations of any other nature on the health conditions: in some cases it is likely that this is due to lacks in the compilation phase of the profile, and in a few more due to the weakness of the take-over network, lack that would not be allowed to make only a rough hypotheses about the person's condition ("her overall state of health has probably never been diagnosed" [6M]; "he does not go regularly to any health institution; for several years his health has not been checked, neither physical nor mental" [40J]). Note that many diagnoses were made in the street during interventions managed by outreach teams or mobile units.

The protocol required information relating to both physical and mental health. In the first case detected pathologies are largely due to the condition of precarious lives of homeless people, the condition that exposes them ipso facto to high risks and obvious dangers<sup>7</sup>. The health risks intrinsically associated with homelessness are numerous: dental problems, food shortages (22L), toe, knees or legs problems or damage(1M; 21C; 33V; 47R), diseases skin (5E; 16a, in which case the link is explained by the writer of the profile, according to whom these diseases are "all very much related with her living conditions"). Of course these critical factors tend to worsen with age, occurring among older people in the form of "deep bedsores" that can lead to immobilization (30 F), "changes of postures" (in the case of two Italian sisters of 74 and 77 years living in the street; 31F/C), or limitations in sight and mobility (41C: in this case we speak of a Portuguese woman of 88 years).

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There are several cases of alcohol / drug related problems (hepatitis, HIV): drug addiction and alcohol dependence are in fact very common behavior in the described life stories. In these profiles other major diseases exist, without a link with the condition of homeless: stroke (48G), heart disease (46P), infectious diseases (50M), rheumatoid arthritis(17R), syphilis and neurosyphilis (23A ), glaucoma (29P), various types of neurological diseases (29P, 39P). It should be noted, however, that in ten profiles, there were no significant problems of a physical nature, as can be seen from some of the following notations: "bad teeth, otherwise healthy" (2F 59); physical health "more or less acceptable" (5E 55); "No particular health problems, except those which are common to women of her age" (11J); "Despite all these years on streets her physical conditions are not badly worsened" (22L); "Good physical conditions" (25B).

With regard to the mental health, even in this case it should first be detected the cases in which there is not a diagnosis (11J; 49L) or symptoms or behaviors devoid of a precise clinical / diagnostic reference are described. In profiles that use descriptive reconstructions there are recurring expressions such as "many cognitive deficits" (9M), "mental handicap; mental disturbances" (7J), "deterioration of his mental health, putting his life in danger" (12C), "disorientation" (50M). In some case the description is a bit broader and contains personal considerations, as shown by the profile 5E, about a Polish woman aged 55: "[her mental health condition] seems to be determined mainly by anguish and fear. Because of some prevalent fear she is acutely disconnected with her past which finds its obvious expression in refusing to have anything to do with her town of origin. Real or imagined threat of being moved there prompted her to abandon institutions that took care of her. E. is fearsome and depressive".

In many cases people who hear voices or have hallucinations are described ("he often complains about voices in his head" [16b]; "visual and auditory hallucinations, he talks to inanimate objects, but not to people" [39P]). In the only profile we have as the result of an interview, the interviewee described as follows the experience of hearer of voices, started in childhood: "I could hear all kinds of thoughts being put into my head that were not mine. I was paranoid all the time... Anger, a, sort of, angriness and getting upset and angry all the time... was not in control of myself". In another case voices are more paranoid: "he says to be controlled by 'people' using drones and other technological instruments. He says they can control him using electric impulses that hit him in the brain and leave him in a confused condition. Sometime, when he is sleeping, these 'people' put poisoned gas under his nose and when he wakes up he is confused and he can't do anything. He says they hinder every job he tries to organize and for these reason he left his work like street artist" (25B).

Among the cases for which it is possible to have a more precise diagnostic reference, schizophrenias appear as the prevailing pathology (8J; 34A; 14 M; 17R / M, 20F, 21C, 24T, 32P, 35X, 37G, 42D, 43S) . In many of these cases, clinical pictures are shown very clearly: "for many years, he presented a serious framework paranoid schizophrenia with themes of influence and grandeur. At the same time, syndrome of Cotard ideas, or refusal of body parts and each somatic physiology. The conversation with him was totally fragmented. There was no possibility to link the parameters of space and time" (15M); "complete 'self' disintegration: echolalic and imitative mode and psychic regression [...] inability to sphincter's control [...] defensive/retiring" symptomatology, with a positive prognosis" (19T); "when she speaks, it's obvious for everyone that she has a psychiatric illness [...] She has schizophrenia and was hospitalized many times in the past, more then ten years ago. We got her medical file from the previous hospital" (45B).

Seven other profiles generically speak about psychosis or paranoid psychosis (1M; 2F; 4V; 10C; 13J; 48G); among these we have to mention the case of a woman who considers "man and woman, does not want to take sexual identity (does not want his identity card, it says either 'man' or 'woman') [...] considers herself a 'God' and believes that we are his soldiers; can range from 'reality' phase to 'unreality' very quickly" (13J). Instead, four profiles are concerned with people with bipolar disorder (16a; 18F; 30F; 3C), while in one case the text refers to a diagnosis of unspecified psychosis ("a formal thought disorder, with loosening of association, and a delusional content, in relation to the secret services, and as if she was doing some work for them. She was diagnosed as Unspecified Psychotic disorder" [23A]). Another profile is about a person with a history of repeated hospitalization because of "acute maniac psychotic episodes induced by substances" (47R). Less

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severe mental disorders can be identified in four cases (27M; 36K; 38a; 38b), relating fundamentally different forms of depressive neurosis (“first symptoms of neurotic disorder probably occurred during patient’s adolescence: somatic symptoms, emotional disorders, cognitive disorders” [27M]). On one of these cases, originated from an economic downturn and the fall in a state of poverty that led the person to a suicide attempt, we will return later, because anti-depression therapy “had many fluctuations which ended to a second suicidal attempt” (36K).

Not a few profiles reveal the connection between mental health problems and other health issues, in particular under the profile of the interaction between mental disorders and addictions (alcohol and / or drugs). With reference to the case of a homeless Rwandan origin person in Belgium, the profile recalls that “alcohol consumption problem was observed by our team during his stay in our center: this tended to aggravate his symptoms, his mental and behavioral instability, and disturbed the psychiatric treatment that was put in place; it exacerbated his behavioral aggressiveness. when his social income was obtained, he tended to drink up all his money. Severe measures had to be taken (one night exclusion and close searching of his personal belongings for alcohol, administering and safeguarding his income)” (18F).

Before concluding this section, it is essential to underline two passages contained in as many profiles: both of which highlight the inextricable link between health (physical and mental) and social conditions. In the first case, involving a Romanian man taken over by an Italian team, we read that the person has “not any severe mental disease, but only a serious problem of alcoholism, probably emerged after his immigration and after many emotional and working failures” (33V). In the second, even more significant, having assumed a ‘dual diagnosis’ (for mental disorders and alcohol dependence) the profile author textually says: “during the short periods of hospitalization - three times in seven years, one week each time - it was not diagnosed any specific psychic disease nor physical pathology. Her only ‘diagnosis’ made until now was ‘social disease’: she is homeless and nothing more” (22L).

### **2.3. General questions: where do they live? How much time have they been homeless for? Which possible interpretations of their personal stories of life?**

#### WHICH WAY AND WHERE DO THEY LIVE?

One of the most vivid aspects of the descriptions contained in the profiles is that concerning the social perception of people in serious state of distress. It will come back later on the reactions triggered by the ‘social visibility’ of homelessness, from fear and from intervention requests made to police and to outreach teams, but also without forgetting spontaneous forms of support and solidarity from neighbors and shopkeepers. In the initial part of this section we limit ourselves to present a series of statements concerning the way in which people living on the streets look or looked to the gaze of the profilers (and hence also – we suppose – to pedestrians).

The types observed may be divided roughly into two groups. On one side we can put all those descriptions that refer to the most conventional representations of homelessness: here is therefore the woman with “too many clothes on (clothes very eye-catching), who dragged always around some very large bags; her whereabouts in the streets has attracted considerable interest” (1M); the man with “Long hair, dirty, with a mode of rasta, tattered clothes, colorless, almost glued to the body and sneakers with socks, lace perfectly ... but without funds soles or socks to wear two to continuous running around the city” (10C); another woman “Long hair, dirty, with a mode of rasta, tattered clothes, colorless, almost glued to the body and sneakers with socks, lace perfectly ... but without funds soles or socks to wear two to continuous running around the city” (10C); another woman “dressed in long skirt and woolen hats; always busy looking” running after her “carts full of clothes and all she needs to live in the street” (11J) or another woman of 62 years “always localised around the same area, sitting on the floor, with sunglasses, and various layers of clothing independently of the temperature, with multiple bracelets on both her arms and a hand fan. With a very eccentric look, due to the

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colourfulness of her cloths" (23A) Within this macro-type being "filthy", with "no shoes" and "feet in rags" (45B), "with evidence of self-neglect" (34A) and probably with Diogenes syndrome (48G), it is usually the profile of a person living in solitude and that always brings their approximate luggage (shopping carts, plastic bags). On the other side are not lacking, however, traits that contradict the more conventional image just described. So different profiles emerge: that one of a person "well satisfied with life as a homeless person who gave him a sense of freedom. Usually in a good mood and worry free" (4V) or those of two different women; the first "quite social and extroverted" (16a), the second one "collaborative" e "with a warm affect" (34A). Not necessarily people on the street ask for money (45B) or appear dirty ("Careful hygiene and appearance" [41C]); or missing elements that allude to a white-collar business- background (an octogenarian woman who used to work in a bank looks "of a certain cultural level, very polite and courteous relationship and Maintains a large personal dignity" [11J) and a current, active, interest in reading, as evidenced by the short of a 72 year old woman contour description: "Her hair was clean, and her clothing was fine even though being in a homeless situation. Polite and talkative, with a good rapport, and would tell us she enjoyed reading, and learning about things [...] When she was seen having either a walk or reading magazines or newspapers. She was very up to date with certain topics and news" (24T).

At first contact with the outreach teams or mobile units people we are talking about lived and slept mostly in superficial shelters (like the woman "lying under a blue tarp" [13J]) or self-built bed (as a "den of plastic sheeting" [2F] or to "hollow" [4V]). In other cases, the shelter is or was represented by housing without electricity and water ("he had lived in his apartment without electricity and water since sometime in early 2011, stuff packed into the trailer" [3C]) or by a room "at the basement of a block of flats". Even in the latter case one can speak of homeless according to the definition provided above, because the extensor profile pointed out that "the condition of His room was bad since he was lacking the basics, such as electric supply and heating" (36K).

The most frequented urban areas seem to be the downtown ones, and in particular next to the market, for the greater chance they offer to homeless people to find some means of support, as in the case of a man "rough sleeping in nearby hotels in a central area of Lisbon; restlessly walking around, making gestures and whispering to himself" (47R). A significant quantity of profiles refers to railway stations areas (as the woman who lived around the "central railway station in Warsaw, spending much of her time just sitting in some unused corridor" [5E]) and airports (the case of the above mentioned 80 – year – old woman that underlines how the "daily routine" of old, before receiving hospitality in a guesthouse, consisted in remaining in the center of Lisbon all day and then take "the last subway to the airport", where she had arranged his bed). A profile describes the history of fifty year old woman who "lives in the sewage system", and not coincidentally the final comment of the writer emphasizes that it is "one of the most derelict individuals among the homeless, in deplorable state" (6M). Another profile concerning a woman, who is known to the team of which the writer of the profile is a member, since 2006, but systematically oriented to reject any form of contact and assistance, highlights that "nobody knows where she sleeps" (21C)

It must be said that most of the people that have been observed - but not all – are alone (it was already mentioned as a mother and a child are included in the same profile, 17R/M); quite a few women have children (one of them was eight months pregnant at the time of preparation of the profile). Some mothers entertain complicated relationships with their children for addiction problems and / or prison (woman or child). Some of them have contact with family members who occasionally visit them or assist them (in one case, a brother, an uncle in another). Among migrated people some still have occasional telephone contact with members of the families (mainly the mother).

#### HOW MUCH TIME THEY HAVE BEEN HOMELESS FOR?

Since it is not easy, as we have repeatedly observed, reconstruct the past of homeless people, in particular it has not been easy for the profiler to indicate or estimate the time spent by these persons in the condition

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of homeless. The data is known only for less than half of the collected profiles; in other cases there are two possibilities: the contact that originated the drafting of the profile is recent, or they have not yet been able to fully reconstruct the history of the person, or it is the person that has not been able or didn't want to talk about him/herself.

The passages in which there is the unavailability to talk about personal matters are very frequent in the profiles. Speaking of the story of a Catalan woman, in her profile we read that "she would never talk about personal things: 'my things, are private... It's enough for you to know that my name is T...'; she would not give any personal information, and would get annoyed when asked" (24T); in another we read that "she never gives her name or answers a personal question" (45B), and the same 88 years old woman "does not want to expose herself to strangers and not because of any lack of memory" (41C). It's very explicit the refusal of a man who "did not like to talk about his past" (4V). In all these cases it seems to be able to generalize the statement in the profile regarding a fifty-seven Hungarian who is in Italy: "The most part of his personal inner experience remains hidden, we have not many information about His personal history and what we have is not certain" (25B).

Not for everyone, in addition, the condition of homeless is or has been continuous: in several cases mobility between cities or countries became relatively frequent passages between shelters, occupied apartments and street life. Emblematic, in this sense, the path of a 29-year-old Portuguese: "he goes out of Portugal, moves to Spain, trying to live from his performance as a street artist and occasional jobs; he starts consuming illegal drugs and committing small crimes, that leads him to being arrested for one year in this country. Returning to Portugal he goes to live in a squat house in Lisbon, together with other youngsters. He starts a relationship with a girlfriend, also living in the streets and they both start to consume harder drugs, he creates a heroin dependency and commits small crimes that lead him to one year prison sentence on parole. Switching between living in squat houses and roughly on the streets" (40J) In another case stays at hostels and hospitalization that have interrupted from time to time sleeping rough were so short that - as significantly and bitter statement says the author of the profile "no one has the time to care for him" (32P).

In two cases, both regarding people living in Rome, it is being ascertained a condition of life in the street that has lasted for over thirty years: they are the life stories of the two Italian sisters of 74 and 77 years (31F/C) and that of another 80 year old woman (the latter sleeping in the streets of the downtown [11J]). In many other respects the references to the time duration of homelessness are more general, but they make no reference to any short period case: "for years" is in fact the expression used in at least four other cases (19T; 20F; 45B; 7J). In other cases for which the street life period is to be indicated, eight profiles refer to periods greater than 10 years (5E; 6M; 34A; 37G; 41C; 39P; 48G; 30F), nine to periods between at least three years and less than ten (16a; 18F; 21C; 22L; 25B; 33V; 35X; 42D; 43S).

#### WHICH POSSIBLE INTERPRETATIONS OF THEIR PERSONAL STORIES OF LIFE?

The stories described do not allow to identify the 'causes' of the condition in which there are the homeless and mentally ill people. In some profiles, as already mentioned, the personal stories are presented in a few key strokes, without considering causalities or venture attempts at explanation. It's significant the descriptive style of this part of the profile of the thirty-nine years old Romanian emigrated to Italy: "he came to Italy roughly five years ago, with his wife that later he left. He worked as a baker at first in Turkey, later in Italy, where he worked also as workman in building, until his retirement, three years ago in the actual situation" (33V).

On the other hand, even if you have a larger set of data about personal history, it is equally difficult to talk about causal factors in the strict sense, especially when such factors are considered individually. As you will see shortly, no linear and deterministic explanation seems to be able to give an account of what causes the loss of the most basic rights and basic guideline references in a person's life; only a multifactorial and procedural perspective seems to be equal to the complexity and multiplicity of implications in these stories. The same literature on the explanatory reasons of homelessness, if at first - until the seventies - was inclined

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to give priority to individual factors, has gradually shifted the focus on structural factors, and then achieve, more recently, a wider consensus on the need to integrate the two interpretative polarity in a complementary way (FEANTSA 2010).

For this reason, each of the topics below (family relations, social status, mental health problems and traumatic events) should be understood not as a 'cause', but as a related factor with respect to the condition we're talking about.

So, in terms of correlation, is the reading of the first profiles refer to critical issues that occurred within the family sphere. These critical aspects are essentially of two types: the disappearance of members of the family and the presence of dysfunctional relationships within it (in some cases the two elements overlap). In the first case it is to be reported as a possible contributory factors or that cause the crisis loss of unspecified relatives (5E; 31F/C), of the partner (16a; 17R; 30F; 37G), one or both parents (9M; 49L). In all cases, these events are defined as "disturbing" as factors that contribute to weaken the social and family networks and to increase the sense of isolation. Under the second profile references are equally numerous, both as regards the description of the elements of generic or unspecified dysfunction (20F; 39P; 40J; 49L), and for the indication of the presence of substance abuse and violence (predominantly by parental figures paternal [42D, 27M]).

A short extract of a personal story seems to be able to take a more general symbolic value: the story about the protagonist of 28E profile "brought up in a dysfunctional, alcoholic family. Father, alcoholic, used psychological, material and physical violence, tormenting his wife and children. Five sibilings (he was the second). Convinced he was hated by his dad, and therefore mostly abused. E. remembers a leather belt with lead balls at the end, which his father used to beat him until the belt down. Sometimes his monster father soaked the belt in the water to make it more elastic and cause more pain. He also remembers the father's counting his kids and picking one at random. The 'lucky one' got the beating. Sometimes when his brother happened to be chosen, his father would say – laughing – that it would be E. anyway" (28E).

In seven profiles is plausible to identify mental health problems the main factor that initiated the progressive detachment from the proximity and labor relations, as in the case of the octogenarian woman on whose behalf it is stated that "probably due to mental health problems such paranoid (thought to be poisoned), he left work and family, who maybe looked for her in the past, but is not currently interested in her" (11J). In the case already mentioned Hungarian man who moved to Italy, the profile recalls that "he left Budapest when the 'people' who control him have begun to harass him and they started to make his life not more normal. He says it became impossible having good family relationships and he was forced to leave his family" (25B). It is interesting to observe that mental disorders seem to take on an autonomous importance in at least three of the stories that tell the personal stories of migrants (15M, 18F, 19T). In the case of the Nigerian woman (22L), however, the disturbing factor seems to lie between a 'classic' psychological / psychiatric symptoms and a culturally founded system of beliefs / values ("Once L. told that she was rejected by her community because of some kind of 'spell' or 'curse', so that she is forced to live alone and in poverty"). Around profiles of migrants, it has to be recalled the role played by specific traumatic events, as in the case of the man escaped to Belgium who "never went back to Rwanda" because he "witnessed the massacre of some of his family members" (18F). Another important component is due to the adverse events affecting the material dimension, and in particular the loss of work and home. Not a few references to discontinued business activities: in the case of old Portuguese woman her profile indicates that "as an adult she worked in a social institution in Coimbra town, where she took care of children. Later she came to Lisbon to work as a nanny at 'wealthy' families' houses, having also traveled a lot over the years. Even after she was 65 years she worked as domestic but caring for an elderly woman. When that elderly woman died, she became houseless and 'took refuge' at the airport" (41C). In this case the loss of home and work are the same; in others it is the eviction (3C) or expulsion from a coexistence with other people (38b; 44B) that open the path to marginalization and social exclusion.

What is clear from these brief hints is the confirmation that in any case no-one of the factors described is able to provide complete and exhaustive explanations of the analyzed life paths. However the multifactorial dynamics are better understood, in their inescapable complexity, if you leave space to the narrative contained

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in the profiles. For this purpose an extract of the story of a young Dutch woman is illustrative: “her mother become ill and she took care of her mother for two years. Her mother died in December 2015. Depression for a long time. Because of her depression and taking care of her mother and her isolation because of her depression, she did not think about what happens after her mother died [...]. In March 2016 she had to leave the house. She becomes homeless and had a big depression. She had no income and decided to ask staying with a former boyfriend. She tries to work, but because of her depression, she could not manage this. She stays with him, without income and because he has one, she did not get welfare money. He has a small studio, one bed, no sleeping room. So she pays with sex and a little physical violence”.

Bereavements, economic crisis and rupture of important emotional bonds also add up in the history of a man of 64 years Athenian: “graduated from high school, married and father of a daughter while he was working in a publishing house. Later on he became involved in a trading business as he was the owner of a small paper company. He was in a good financial condition enjoying the general prosperity of the Greek society during the 80s and the 90s. From 2010 and onwards in accordance with the general socioeconomic crisis his personal story of loss has just began. His second wife and his sister passed away due to a serious form of cancer (also a widower from his first wife). At that moment his business is starting to have serious losses. A little later his small business shuts down permanently and Mr. K is losing all the feedback that maintain his sense of identity. Two serious losses and no income: he refers to the network of social services. The matter of survival is coming forward for the first time and this particular fact leads him to despair. Receiving daily phone calls from several banks concerning his loans, which ended up in a very serious threat for the foreclosure of his house. As a result there were many days that he was staying at home having no place to go. ‘I have never been in this situation before, idon’t know how to live like that’” (36K).

The most obvious example of the coexistence of multiple correlation factors is that offered by the overlap of physical and mental health problems, alcohol and drug addictions, problematic relations with the justice system and lack of a decent work and housing opportunities. In twenty profiles it emerges in fact the presence of addiction problems (in many cases these are problems common to several generations in their family contexts): almost always they feed back negatively on the mental condition, on other aspects of the physical condition and more generally on social relations. Very often, these troubled paths open prison doors (be worth, for example, these two statements: “Numerous convictions, he had spent time in prisons for repeated Offences to public order” [35X]; “he creates a heroin dependency and commits small crimes that lead him to a one year prison sentence on parole” [40J]). And right the alternating between prison, addiction, health disorders (both mental and physical) opens its doors to those forms of extreme marginality, that, as we will see later, seem to be marked by the sign of the non-recoverability (paragraph 2.4.5).

## **2.4. Homeless People with Mental Ill Health and Service Delivery: From refusal to care? When and why? Four typical pathways**

### ***2.4.1. Refusal and non-compliance as a general feature***

In this section (2.4), we are reflecting on the four types of enucleated path based on the reading of the profiles, taking as a benchmark the outcomes assessment or at least the evolutionary trend (positive, interlocutory, pending, negative) in the interaction between the person and the service system. In the next paragraph (2.5) the focus will instead be directed to the characteristics of the interventions and the nature of the activated networks.

It should be stressed that the objective of taking charge and the characteristics of the paths tend to vary with the passage of time, for reasons and events that modify the context or condition of the person. The reflections presented in the following pages must therefore take into account the inherent specificity of each profile (personal characteristics, conditions of the context, resources activated etc.) and the respective path: types and the

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reconstruction of networks and interventions are limited, therefore, to highlight some common factors, providing guidance and ideas which implications will be developed in the concluding paragraph.

Before going into the details of the four types detected we need to reflect on an issue that is upstream of the interaction between the person and the system of services: the issue of the refusal of the health or social support.

A more or less pronounced and lasting hostility in relation to the proposed aid is notoriously one of the characteristics of homeless people with mental health problems. The literature about the subject shows that they generally express “a sense that they can solve problems their own”, give “a low priority” to health topics and have “low levels of awareness of illness and / or motivation to change” (Rees 2009: 11). Reading confirms these observations profiles: 39 profiles of 50 contain notes recording hostile reactions, waste or other forms of opposition to the proposed care, social support and housing support.

In 14 profiles rejection appears systematic, as some extracts try: “always refused any treatment” (13J); “she refuses care, such as referral to a hospital, a place to sleep, a place to receive personal care; no room for dialogue” (12C); “many times she had been simply asked whether she could apply for a shelter but she had been systematically refused” (16a); “never agreed to come with us for a shower or a dorm” (10C); “always refusing any help, and making it impossible to work with her in that setting” (23A); “Different mobile units have tried to communicate with her: social teams, medical teams, volunteers... She never accepts shelter, even in winter and sleeps every night outside” (45B).

Not always the refusal to operators is aggressive (“if you go for a visit, it seems like he really wants to talk to you, but he builds a wall of words, which is impenetrable and he doesn’t activate any kind of listening” [43S]) and highly significant, in this regard, is the position of the octogenarian woman who has long lived in the street: “during the years, she never wanted anything from our service, even if some of us have established a meaningful relationship. We are greeted with pleasure, but do not want to be contacted too often. She has never accepted in night shelters or other forms of assistance [...] Every winter with bad weather and frost, we offer hospitality to shelter from the cold, and every year, he replied: I’ am 38 winters step on the road and I’m still here” (11J).

We will see in the next section that in some of these cases the interventions of integrated teams, modeled on the person’s specific needs, they have managed to overcome the barrier initially opposed. In other cases, the resolute rejection of all forms of support is solved just for short periods (4V; 39P), usually related to hospitalization or temporary access in dormitories shelters (especially in periods of intense cold: “in colder periods she tends to move to night shelters where only sleeping place and some food is on offer [7J]). But in cases where it was not possible to overcome the distrust of the person also emergency interventions (shelters, accommodation in winter shelters, etc.) were not followed. The lack of compliance and non-observation of deliveries prelude very often the abandonment of these provisional path and return to the streets (“many times she entered in the emergency room of the hospital, leaving off a few hours or days later, again to the street; entered in a housing first program, but she remained there only for a few days, going back to the streets, drinking every day” [9M]).

But there are not only forms of systematic opposition. If radical rejection attitudes of institutional take charge were detected (“he had no trust in grown-ups and no trust at all in social workers or the municipality social service” [32P]; “she refuses contact with most of the people, especially with people she identify as social or health workers. With them she can be verbally very violent, starting to shout in the street and insult them, puke on them” [21C]), in a not insignificant number of profiles we find forms of selective opposition. Sometimes they are directed towards specific figures or aspects, such as psychiatric treatment (R. refusal to receive institutional assistance is invariable and is directed mainly at psychiatric” [17R/M]) while the material support (food, money, clothes, sometimes the proposal to be a guest of a dormitory) and “some perfunctory assistance from street-workers” (6M) are accepted (see also profile 4V; 5E; 22L; 48G). Notes, in this regard, the story of a young Portuguese homeless; in this case in fact the only form of support not rejected is the treatment against heroin addiction: “he doesn’t look for any help from formal institutions and tries to manage his life

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on his own and with his street friends. Suspicious about any formal institutions he doesn't look for any help. After breaking up with his girlfriend, he recognises his heroin dependency as a problem and seeks help on the Lisbon Support Center for Homeless Persons, looking for drug dependency treatment. He refuses any placement in homeless shelters [...] Proposed to go into a methadone treatment, he refuses saying he does not want to replace his heroin dependency with other dependency". (40j).

Interestingly, finally, the case of a Catalan woman of 72 years, whose opposition to all forms of support appears as the result - as reported by the writer of the profile - that "would never elaborate negative aspects of homelessness": "We tried -we read in the profile - to provoke conversations about her homeless situation and what she thought: 'there are positive things about living in the streets, people show interest, they give me things to eat, to read.... I can see a lot of things happening, distracting myself. If I wanted to live in a house I would, some people have offered it to me.... Everyone chooses the type of life they want to have...'. She would keep insisting that being in the street was due to a personal decision 'it's my decision' [...]. She was always refusing any help we would offer" (24T).

#### **2.4.2. Typology 1. Integrated interventions and user's improvement**

The first type of analyzed paths is characterized by the gradual emergence of an improvement in the interaction between the taking-over system and person, with a positive impact also on the level of the health conditions of the latter. In some of these cases the improvement was even more significant as it occurred with respect to initial conditions marked by an almost systematic refusal of any proposed aid (15; 18F; 19T; 42D; 44B; 46P).

Sometimes the factor that seems to have triggered this is represented by the tenacity of a single operator. Reading the profile of a French woman who lived in the street in Denmark shows that it was the long work of a street worker to convince the woman - after many attempts - to undertake a care and recovery path (in this case the team contacted a shelter in Paris - a riverboat - for mentally ill homeless and followed the woman returned to France [1M]). Often considerably more, however, the decisive factor seems to lie in the activation and modus operandi of a support network able to work in an integrated and complementary way.

In some cases a small sequence of organizational changes seems to be able to make positive elements. It's emblematic in this sense, the case of a 56 years old Danish man, who had lost his apartment because of some manic-depressive episodes and nevertheless had always rejected help proposals of housing counselor who had taken over (3C). Visited in the street by a psychiatrist, C. initiated a treatment which has improved the overall condition; while remaining in the street, the path started seems to be promising, and from this point of view changes that have occurred in the take-over system seem to have been very important. The street units began to stop where the person is stable for most of the time; the homeless unit and a municipal street worker were involved; finally, to treat wounds to the arms of C. a nurse was included in the team (C. had always refused to be examined, for those injuries, by a doctor).

In cases where it is detectable a real improvement of the person's condition is still critical the full and effective cooperation between social services, health services and voluntary organizations / third sector. In this respect one of the most significant profiles is on the development story of a man who emigrated to Italy in the late eighties to study and later found himself living in a park and near a busy road junction (15M) . Followed by volunteers for several years, in a condition of "real risk of death", the man had received a diagnosis of paranoid schizophrenia, accompanied by Cotard syndrome. "The conversation with him - we can read in the profile - was totally fragmented. There was no possibility to link the parameters of space and time. Physical health severely compromised particularly in personal care, food and living conditions (living in a pile of plastic bags and newspapers). Lately, was visibly emaciated".

In these dramatic conditions it was put in place a TSO (on the specific issue of mandatory treatment is discussed further below). Hospitalized, initiated to drug treatment and then placed in a psychiatric clinic for two months, "in recent months - as we read in profile - he began to heal in terms of hygiene". The positive evalu-

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ation of the journey and the indication of the reasons of this evaluation are very clear from the final thought of the profile: "Significantly improved the recovery of psychopathological ability to organize thoughts and to have a dialogue with others. What worked and restarted the recovery process is that the collaboration between social services, health and volunteering. He agreed to seek establishment run by Deaf S.Teresa of Calcutta, where he agreed to move and where it is still a client. Mental condition of J. are much less affected than may appear at first as it is this great healthy parts of his personality and it is possible to envisage a complete mental recovery in even shorter time"<sup>8</sup>.

The presence of a plurality of well-concerted media is also recover in the evolution of the story of a forty year old Portuguese man, who was also schizophrenic (20F). Followed by an association linked to a local church who had decided to call an outreach team, the latter in turn had requested the intervention of the psychiatric service. Taken over through the accompaniment at a nursing home, from which he had never expressed an intention to escape, the man had a "rageful outburst" that brought him back under psychiatric observation. After F. "was discharged back to the shelter", the psychiatric service was involved again, also because "the staff of the shelter was quite scared of F". At that point, as we can read in the profile, "with the cooperation of several partners (family, local community, outreach team, social services, psychiatric hospital, nursing home) that were able to put together their efforts and expertises, a synergy of actions converged for a final outcome that was much better than previously was thought to be possible. F. stayed as an inpatient in our service for three weeks, exhibiting a very discreet, peaceful behaviour that caused no problems whatsoever at the unit. [...] the social services found a nursing home specialized in serious mental health problems. So, when the time came to get out of the hospital, a nice solution had been found". It was possible to manage, with good results a "very difficult situation, that seemed impossible to change for many years"<sup>9</sup>.

The cooperation between services seems to have been the key even in the case of another homeless diagnosed as schizophrenic (37G). Starting again from the initial unwillingness of the person to cooperate ("every day he was coming to our minivan and was only consuming his food. He did not want other contact with us"), thanks to assiduous presence of support team "after few weeks he took from us clean clothes and that was the first step. The second step was to come to our center and to took a shower. We succeeded to persuade him to being checked by a psychiatrist. So he was accepted in a center for a mental health and cured for one month. He had not been drinking alcohol at the time of his stay". The conclusion of the profiler, a worker of Caritas of Burgas (Bulgaria), is clear: thanks to the "cooperation by the municipal social services and the psychiatric hospital, G. was accepted in a shelter, where he began social and psychological assistance".

In another case involving a migrant, a thirty-two of Equatorial Guinea moved to Barcelona, in the profile text is observed how the main feature in the appreciable evolution of the taking-over ("The persons condition has improved") is that "many actors" were involved and that these actors were coordinated by a case manager ("to provide a more individual approach"). The starting conditions very similar to the previous (diagnosis of schizophrenia, rejection of aid proposals) have been addressed before with two "involuntary admissions" and then with the activation of all possible synergies: from the public sector (social services and mental health) and [...] from the private, like the hostels (Social services pay for the room in the hostel: due to the lack of income, the pensions had to be paid with a budget that the social provider has for these cases)". Interesting notations about the operation of the network "synergies between social services and mental health services occurred in the way of formal meetings every 1-2 months where cases were discussed, and action plans shared. Other contacts were in the way of informal telephone contacts, and joint visits with mental health professional and social worker. Between the service providers, each institution which is private, acts as a service provider for the administration, and therefore one institution contracted by social affairs, acts as a service provider for social affairs and is responsible of all the social action plans, pensions, housing, hostels, food [...] he could benefit from free lunches, laundry etc.: benefit allowances were applied for; [...] offered a hostel by social services, and still keeping the room, and well adapted". The case manager, in particular, "can individualize the interventions and is a source of detecting the needs that D. expresses".

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A situation not too different, in terms of the effective impact of an intervention network set up by an institutional service and as a voluntary organization, is the one of B., an adult man diagnosed as schizophrenic and from his adolescent forced to live with the experience of a hearer of voices. Housed in a structure and run by mental health services, B. was followed by a "care coordinator". After spending "time in inpatient psychiatric care and in prison" and "slept rough again for 2-3 weeks after leaving prison", he "received well - organized care and treatment and progress made With His recovery". According to the profiler, B. has appreciated consistent and coordinated support from his mental health team and care coordinator, an example of joint work between the public and the voluntary sector. "They've been here 24 hours, 7 days a week where I can contact them... They've worked through thick and thin on my behalf. They connected with my key workers, connected with my substance abuse worker".

It must be said that for cases with less severe mental health is often the social service to become the decisive factor, thanks to the ability to activate external resources aimed at re-employment of the person. Exactly, what seems to happened in the case of a Polish fifty-eight years old woman, suffering from depression for a long time ("in the initial period our patient revealed often the anxiety states of increased tension, irritability, depression; also somatic complaints"). Inserted in a center where he received professional care (psychological and psychiatric) and social care, through this last service she received a certificate of disability degree (moderate) and fixed income. Later she completed a computer course and "she took a course for the property security staff at the Labour Office of Warsaw. For several months now, the patient Has Been working property as a security guard in one of the residential areas of the city".

Given the initial conditions, as we have repeatedly stressed, they can be considered as positive paths also those described in two other profiles that share the gradual withdrawal from drug addiction. See for example the troubled case of P. (29P), a young Polish man suffering from a neurological disorder and "walking and speech disorders" (but not mental retardation): despite the rehabilitation path has been marked by some stop-and-go, "after passing cycles of therapy for people addicted to psychoactive substances, P. maintained abstinence". In the text of his profile you can clearly understand the dynamic and procedural character of the objectives, from time to time, relevant to the support network: "P. is an example of complementary activities: at the beginning adopted because of homelessness, after a few days received the help of a psychologist and therapist, then classes rehabilitation".

This reference allows us to remember once again that the submitted reflection is based on the situation found at the time of preparation of the profiles. In this section, we are limited in fact to report all of those cases in which it was observed an overall improvement of the conditions of the person and of its relationship with the network of support compared to the situation detected during the first contact. This means that the evolution of the personal stories can not at all be taken for granted, and that the improvements observed are not to be considered as acquired nor as definitive. These improvements in fact need to be constantly monitored; in particular, they require constant attention from operators and service so that acquired positive elements do not deteriorate and will not occur a new relapse into marginality.

The final considerations contained in the profile relating to the case a Rwandan man migrated in Belgium, are a clear proof that the caution may also accompany positive feedback of the path. In the case of F, who suffers from bipolar disorder, with psychotic symptomatology, and strong alcohol consumption, which tends to exacerbate their symptoms and aggression, after a series of hospitalization to psychiatric hospitals between 2003 and 2009 it was started psychiatric treatment aimed at stabilizing the symptoms; when the first positive effects of the treatment appeared - "such as an improvement in socializing with others, more stable emotional states, better accountability for his social procedures and a more down-to-earth personal expectations" the man was followed by a clinical / constant psychiatric care and was placed in facility and has been supported by a "property manager", in order to reobtain all of his social rights, put his administrative situation in order and obtaining him a social apartment at a social housing institution". However, despite the profiler states that "his objectives were finally met: thanks to close teamwork between our different services (social, medical and psychological), as well as close collaboration with different social collaborators (social assistant

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from CPAS, the team from the social housing institution, the property manager, etc)”, the result is that “his stability today is still dependent of the network collaboration”.

### **2.4.3. Typology 2. In contact, but with no long term plan**

The second type emerging from the reading of the profiles is the one that collects all the cases that show an evolution of the interlocutory paths. It is those cases in which at the time of drawing the profile of the person is still living in the street but remains in some way attached to a supporting network, in case of the institutional care system one or the volunteer organizations one. The element of greater weakness, with respect to the first type (in which - let us remember - also of cases have been included in which the condition of homeless has not yet been exceeded) it is identifiable in the fragility of the support system. Which means that to meet the needs of these people, who also do not seem to recede in a condition of complete invisibility as in the cases which will be discussed in section 2.4.5, there isn't the main element that characterized the first subset of profiles: an integrated support network and capable of deploying a plurality of medium / long-term interventions.

It is obviously important that the person, while remaining in the street, can be regarded as 'treatment' as yet monitored and observable by some entity (usually outreach teams or voluntary organizations) capable of activating the emergency response that eventually may become necessary. In the case of a man in his sixties suffering from Asperger Syndrome and paranoid psychosis, in 2013 it was the Homeless Health Team, who regularly visited the man at the local library, where he spent most of the time, that suggests surgery and persuade him to accept “a vacant hostel room where Mr. V. agreed to stay until the surgery” (4V). But when these interactions are not followed by the activation of other subjects also the positive potentialities of the first contact, run out. In the case of a patient diagnosed as psychotic (one that “considers herself a ‘God’ and believes that we are his soldiers”), with alcohol abuse problems (13J), the multiple hospitalizations reported by the team that has followed the case over time have not started any post-hospital path either on the basis of social benefits or from that of housing conditions. “No long term ‘visions’ implemented”, is the synthetic evaluation of the profile related to this case: the visits of street units continue to “ensure her physical and mental state”, but no significant action appears to be on the agenda.

What is most striking, in reading the profiles we have placed in this second type is the discontinuity of operations. It's emblematic what happened to a 46 year old woman (21C), which - as stated in the profile “has been put several time in forced observation in psychiatric hospital, at least in 2006, 2009 and 2013. In 2006, the result was very good, and she accepted to continue to take injection treatment regularly. She was speaking about getting an apartment. But the treatment was discontinued because of the absence of the psychiatrist. Since then the contact is very bad. The following forced observations were not long enough (only 40 days) to allow sufficient improvement, and she was released on the street (even knowing she would not accept any treatment)... Now she is met regularly by two teams of street workers, but the contact is very short [...]. A third service, for mental health, doesn't see the patient but meet regularly with the other services for support and propose interventions”. A mentor was assigned to the woman, hoping to “obtain some benefits for her”, but at the time of drafting the profile she lives on the street.

Continuous hospitalizations often recur in the stories of this type, especially in cases in which the mental health problems overlap those related to alcohol or other drugs. A 62-year old man (14), diagnosed with schizophrenia, dependent for years both by alcohol than by drugs comes and goes to the psychiatric hospital: his career now extends to a psychiatric hospital, where he stayed a few weeks to two months, and the street where he spent the rest of the time, until someone believes it is no longer able to stay in the street and it was made under duress at the psychiatric hospital where Mr. is known”. It is no coincidence that, when proposing the profiler indicate how to reach the goal of “develop the network” and “monitor a long-term treatment and an appropriate structure” (all absent aspects at the time of the profiling).

In many of these circumstances the only considered reachable operating horizon is that of damage con-

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trol, horizon that almost always takes the form of reducing the number of hospitalizations. In view of the fact that sometimes hospitalization may represent in itself an important goal (especially when the person continues to refuse any support and so jeopardizes their safety, but the questions opened by the dilemmas involved in this context will return in paragraph 2.5), in cases in which the picture is static because chronic cycles (such as the mother and son - diagnosed for both of paranoid schizophrenia "interdependent in their mental health problems" [17R/M]), the "success of the intervention is mainly found in decreasing number of hospitalizations". The author of the 17R/M profile points out that it would be preferable to separate the two components, offering different paths according to their conditions, but this is not possible due to lack of collaboration between public and private sector (institutional lack of collaboration and even communication, leading to both systems providing separate and uncoordinated services").

The interim nature of these paths remains, in general, marked by precariousness and vulnerability, and consequently the constant danger of returning to the starting point or a further setback. In the case of R., 40, drug addict since he was 21 (47R), the sequence of hospitalizations arising from psychotic episodes, induced by the use of substances, has not been followed by other intervention until November 2015 (therapies were always interrupted and further aid have always been rejected). At that stage, the outreach team was called by the hotel near where R. was.; in turn, the team asked the psychiatric equipe of the hospital to go out into the street to assess the condition of R. As a result of this assessment, the man was hospitalized to the psychiatric ward, and after the resignation was supported from social service, which has made available a room.

"At the present moment, R. is attending his psychiatric consultations and adheres to medication", as we can read in the profile that concerns him. "He might not be sleeping in the streets, since he presents himself clean and good looking, his behavior is more adequate". However, "during daytime he is doing the same activities he did before: parking cars for money. Recently he was seen at the same place where he was rough sleeping before, casting doubt if he is back on the streets or if he goes there to earn some money by helping park the cars (a common way to earn informally some money)". Essentially, whilst there has been "some progress with his life", the danger is that "long history of drug abuse and no giving up his habits of consumption make him vulnerable to loose what he has built and eventually go back to the street".

In the case of R. concatenation of interventions follow a scheme common to that in many other respects: the first contact in the street by an outreach team, reporting to the psychiatric service, hospitalization, therapy, surgery of the social service. What seems absent is the connection between these interventions, each of which it seems to be perceived as the responsible for a fragment of the path of taking-over of R. instead of an integrated sequence. In such cases the outcome is often the prefigured one only hypothetically for R., namely the return in the streets. At that point, as we shall see in section 2.5, the ability to stay in touch with the person and monitor the conditions are only two: the action of the mobile units (with the visit by the physician road) and activation of a proximity network, able to act as 'antenna' and to detect and report any worsening in the condition of the person.

#### ***2.4.4. Typology 3. Suspended pathways, between organisational and legal barriers***

The third type includes the paths characterized by a shutdown of the take-over process: a suspension that at the time of writing of the profile appears to prevent the network of services to develop additional activities. The reading of profiles show that the occurrence of a block of this type depends on two reasons: organizational factors, related to the operational functioning of the network or services; factors relating to legal, administrative and / or bureaucratic, which often manifest themselves in the form of 'vicious circles'.

The first order of motives links all the profiles in which, although there is a present and active composite actors network, it stops at a certain point of the path for reasons referred to the settlement of one or more components of that network. The most typical case, in this respect, is the lack of communication or collaboration between services. In the case of a Polish woman aged 55, repeatedly hospitalized and in contact with an association of street workers (5E), not just the hospital ward seems to have paid attention "to the underlying

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causes of her misery”, but little it seems to have served the transit in “various shelters run by various organizations”: the problem detected by the writer of the profile is that it has not occurred any “exchange on her condition between the agents and apparently not much effort in organizing untypical assistance”.

The problem of insufficient cooperation between services is also detectable by reading the profile T., 72 year-old Catalan woman (24T). Long known to an NGO, marked by a long history of intermittent contacts with the hospital and with the formal and informal support network, T. was the subject of constant attention by the police, who repeatedly reported that “she could not be occupying a bench all the time and would remove some of the bags she had” (the only result of these occasional interventions – “depending on neighborhood pressure” - seems to have been to push T. to move to the opposite side of the road). T. is followed by a volunteer of the NGO operator (the operator continues to visit her regularly), an operator of social work (also this operator visit her regularly) and the mental health team (“seen by psychiatrist and a nurse, Provide mental health follow-up”). The critical aspect is - as indicated by the author of the profile - in the “lack of collaboration” (and the consequent “lack of possibilities of claiming any benefit”) between these three components. These three figures meet “once every two months to discuss and organize a care plan”, but the network - which does exist - appears inflexible “in the service provision”. It is no coincidence that in the final section of the profile the writer indicates as specific proposals to improve the situation forecasting “case meetings of all key figures to organize interventions (including police, and neighborhood associations)” and “more visits, more empathic approach”.

Even in the case of two elderly sisters living on the streets for many years (31F/C) the intervention capacity of the network of services seems to be limited by the difficulties that the same network meets trying to put in place integrated and shared actions. As mentioned in the previous pages, it is indeed a very complex case, since the two sisters, even if constantly monitored over the years, have always shown towards numerous attempts to persuade them to accept recovery and assistance also through help of volunteers, an attitude of “total closure and isolation”, symptomatic of a “strong adaptation to life on streets” (attitude that according to the profile of the author has made “impractical” every strategy for risk reduction). Over the years there have been various interventions, both social and health, but without significant results, because at the end of each attempt the two sisters “hope to go back on streets and to regain their freedom”. The result of the profile is also in this case very clear “the main difficulties were found in the development of a shared action participated by all services involved – social work agencies, local health authorities, voluntary work, police, health centers”.

In other cases the organizational deficiency, which results in a factor of interruption or slowdown of activity, is detected in the absence of a decision-making center or coordination of existing interventions. The profile of A., a 64 – years-old Galician man, shows the story of a person affected by “a certain degree of pre frontal cognitive deterioration associated with psychosis”, subject to alcohol and drug abuse, stubbornly opposed to any submitted service or aid (even if “in the past he had contact with social services and Had Been in hostels”); two forced hospitalization were not used to start a path of stable care, and the NGO who knows him for years has only occasional contact with him, “due to the lack of engagement in any plans offered to him”. The problem, in addition to infrequent visits in the street, is that “coordination between NGO in private, social services from the council and our mental health team needs of a case manager to figure that brings together all the different agencies, and is in charge the action plans are carried out” (34A).

While remaining within the framework of the factors relating to the organizational dimension, it should be reported cases in which the interruption occurs for reasons related to the malfunction, or the inappropriateness of a specific service. It happens sometimes that the structure in which is located the person is not able to offer the corresponding services to his/her needs, as in the case of E., a 29 year old man, whose profile is shown by a welfare organization operator which manages the temporary accommodation facilities that host E. The operator explicitly declares that the Centre is not able to offer “such care and interest as he needs (group therapy, therapeutic community, working on problems by the method of psychodrama, controlled medication application)”; the consequence is that E. “does not receive proper care and he does not rework

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his problems, stops taking drugs, his disease becomes active again and he ends up in a psychiatric hospital. There he is taken care of, stabilized and comes back to us"<sup>10</sup>. Basically, given the structural difficulties of the accommodation facilities to take charge of E. needs, we are faced with a vicious circle (a subject on which we will return in Section 2.5).

In other circumstances, the problem seems related to response times, more than to the inappropriateness of the offer. In the case of the young Portuguese of which has already been discussed several times (40J) the enabled network is extensive: overcoming the initial hostility of any proposed aid, an outreach team managed to convince J. to contact the local center for homeless people; the latter has awarded J. a "case manager", who addressed the same J. towards treatment of addiction ("one week detoxification followed by a one year treatment in a therapeutic community"). The assignment of the case manager as a figure of coordination between outreach teams, health services and services for addiction treatment seemed to work, a recovery plan is being defined and accepted by J. (which has also helped to obtain new identity documents). However, as how we can read in the profile, "addiction treatment on a rehab center follows standard procedures that take some time between first consultation and the referral to a detox treatment (need for several consultations, medical exams that have to be done outside of the public services with need for further scheduling and finally waiting list for treatment: at least 3 months pass, on wish motivation for treatment can fluctuate). Admission should be a less bureaucratic process and more agile, since the recovery process can be compromised by the process sluggishness".

The delay in the answers can easily determine a relapse, such as the one that occurred in the case of X, a forty year old man addicted to heroin and diagnosed as schizophrenic. Admitted after the release from prison at an emergency service units for rough sleepers, the man was placed in a treatment program in a center for 18 months, with initially satisfying results he progressed well and attained a considerable degree of stability"). However, partly because of resistance to get in touch with him in the spread social context, it occurred "a very long delay on his release from prison to get admission into addiction treatment and support services". The service that has followed him offered him an apartment to implement a solution like 'Housing First', but X. spent there only four months, after which there was a relapse in his addiction. He committed a minor offence and because of his previous convictions he was returned to prison". The final evaluation of the profiler is that because of detected resistances and of a "lack of consistency in community services responses and interventions [...] the response was not fast enough to prevent him from a full scale relapse into his addiction".

The second set of factors includes the limitations resulting from obstacles of a legal or administrative nature. Not coincidentally, these three profiles included in this subset relate the stories of people who find themselves living in a country different than the one they are from. Hungarian human case of 57 years residing in Italy has already been discussed above, with reference to the problem of 'voices' and delusions of persecution; in this context it is worth noting that the man is in a day center and collaborative exhibition center and with the other guests to the staff ("he is always helpful every time someone asks him something"), in addition to participating with good results to play and manuals activities organized by the center. The problem is that despite having accepted the advice of professionals to consult a doctor to speak to him of his mental condition, had neither health insurance nor personal documents, has not been able to benefit from mental health services. The man was then referred to the medical service run by a voluntary association, which nevertheless could not formally take charge for lack of resources. It follows that currently there is no effective cooperation between day center and mental health services, and that informal resources made available by the voluntary association are not enough: because of the "impossibility to insert Mr B. inside a formal network of mental health services", egli "can have only a occasional therapy and he is not in the condition to leave the homeless' life".

An illustrative story of the dramatic implications that you can hide behind the issues concerning the legal status is the one described in the profile of S., a Serb origin man of 72 years (26S). He arrived in France in the sixties, twice married, in the early eighties S. was wounded during a shootout, causing serious injuries. In

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1997, a widower, had declined to renew his passport for lack of money; however, a few years later, when the time to retire had requested a birth certificate to the City of origin he was told that he had been declared dead. As stated in the profile that tells his story, "when he learned that he had been declared 'dead', it was a tremendous shock for him". Reduced to living in the street, S. has received counseling at the hospital in Marseille and is followed by a "public-private network" and rated as "very efficient" (currently he lives in "a social care institution [foyer] that he has known for many years. He has a private room"). However, it remains the unresolved legal identity problem, since "three hospitals in Marseille, two private hospitals, city town social service (CCAS), a doctor from the DDASS (Direction of the Bouche-du-Rhone District for Social and Health Security), a legal expert, translation services, the embassy and consulate of Serbia in France, the city town of N-S in Serbia, the regional court and the public prosecutor, all have tried one after the other for more than 10 years to solve this legal and administrative question: none of these parties has managed to deal with them. The paradox of the situation is best summed up in this sentence that describes the administrative vicious circle in which S. still seems today to be a prisoner: he has succeeded in proving that he is still alive; today's challenge is to prove that he is Mr. S. and he is entitled to retirement pension in France, but it is impossible to receive the retirement pension without a residence permit. To get a residence permit, he needs a passport, and to get a passport, he needs to prove his identity".

The last profile on which it is worth dwelling in this paragraph is the one of a Swedish citizen intercepted in the street by the social emergency service of the city of Rome (39P). The case is very complex, because P. suffers from several organic and neurological problems, as well as auditory and visual hallucinations. Known and monitored for about 10 years, after a hospitalization P. was placed in a accommodation facilities; from that time he began to be followed by professionals operating in an institute specialized in the treatment of diseases linked to poverty and migration. The network created around P. contributed to the improvement in his condition; however, at the time of reactivating relations with family members still living in Sweden - strategy considered appropriate by the Working Group on the grounds that P. in Italy has no relations with any other person -, the staff has had to struggle with the delays of the embassy: as reported in the profile, despite P. signed the authorization for the tracing of relatives, we are still waiting for news from the Embassy. Significantly, the writer of the profile states that the wait depends on the fears of the diplomatic mission "to deal with cases of people suffering from psychiatric disorders". With the result that "the slowness of interventions by the Embassy risks causing further adaptation of P. to where he is now - shelter".

#### ***2.4.5. Typology 4. Stalling and lack of engagement: no solution in view***

From the point of view of the criteria defining the types, the fourth and last of these is undoubtedly the easiest to identify. In fact, it is common to all the cases in which the paths and measures appear to be least affected the condition of the person and the difficulties that each situation, taken as a whole, presents. In essence, it is the type which collects the cases in which the drafters of the profiles explicitly say they do not know what to do and / or do not show not much possible solutions, as even alternatives of approach compared to those practiced without significant outcomes until the time of the drawing profile.

The sense of helplessness of the operators and the perception of the 'illegibility' of the situation ("I do not really understand what is happening", we read for example in profile 38c) are the most common reactions to situations that appear chronic, and against which established services, are not present or are inadequate. We have already mentioned that when the different interveners services in complex cases like these move individually, without coordination, the services provided are largely insufficient: how two psychiatrists active in the SMES-Europe and the D & WB project network mention in a recent essay on services targeting people who live on the streets with mental health problems, "in a mental health center drugs for emergencies are not available and prescription drug therapy it makes little sense if the patient does not have the minimum conditions to maintain the necessary continuity and adherence to care, nor to prepare themselves to come back for further checks".

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This condition obviously amplifies the problems of “difficulties of dialogue and cooperation between different agencies and operators. Also very elementary analysis shows that each of the organizations involved do not know the skills and specificities of each other and projected on other institutions or on other operators the urgency weight and especially the frustration of his helplessness in the face of complexity of cases that arise” (Riefolo, Raimondi 2016: 66-6).

This is the typical situation seen in cases of ‘dual diagnosis’, which require interventions both in the field of mental health and on the dependency. As based on the reading of the profiles are not lacking, as has been seen, the ‘virtuous’ cases of integrated collaboration, in other complicated cases the inherent difficulty of the situation is unmanageable if approached in a fragmented and piecemeal way. The comment placed at the end of the description of the profile of the Nigerian woman (22L) demonstrates that (please note that L. does not have specific health problems, and is still adamant in rejecting any form of material aid) “usually psychiatric agencies have difficulties to define the border between psychic pathology and alcoholic effects. On the other side agencies competent for the cure of addiction symptoms work in a vision of self-determination: people must choose to be cured. In the absence of a multidisciplinary analysis of the problem these situations remain crystallized for years and people like L. live in an inexorable worsening of their conditions”. In other profiles the impasse of the service system is entirely explained by the conditions of the person with whom the same services have to deal with. In the case of M., Polish woman of 50 years, the writer of the profile, after having reconstructed the personal stories, marked by a very heavy condition with dependence on alcohol, declares that M is “out of reach of any sustained assistance as it is offered mainly in shelters where sobriety is a condition for admittance”. The author of the profile says that “there are no agents able to pursue this difficult case [...] Destructive patterns seem to be deeply ingrained, the barrier erected against reality and other people very effectively stifles any contact”. Similarly, in the case of another Polish woman (7J), the no lasting results of attempts to structure a gripper path of taking – over by the at temporary accommodation centers are explained in profile with the simple observation that J. “did not engage in the recovery process offered at the shelter, probably for the reason of her weak mental capacity”. The same interpretation is to be found in the profile of another woman (12C), with respect to which the support network fails to go beyond short temporary observation because – according to what we read in the profile about her - for its major psychiatric disorders it is impossible to get in touch with C.”

Interestingly, in three other cases, the non-positive assessment of the tempted path is simply described, without being accompanied by any comments or assumptions aimed at interpret the incident. About Croatian man diagnosed as psychotic, substances addicted and hospitalized for this reason by a TSO, in the profile that he is concerned (10C) we read that “discharged and escorted to the center for the homeless, he moved immediately (since then, he began to walk barefoot through the city and this day is still running); after admission, the boy goes all around the city, state clothing and degradation are the same as then: tattered clothes and parasites in the hair”. In the case of J., a woman of about 80 years to which the opportunity to be hosted at a nursing home had originally proposed (11J), the writer of the profile would simply point out that after the visit, “there was a clear rejection of inclusion in the place” (the reason given by the woman was that “she could not leave her cart” and that she feared being poisoned by other guests). About the young migrant in Greece with the problem of ‘voices’ (16b), we learn that an emergency hospitalization ended with the dismissal and that at the time of the writing of the profile the young is “still sleeping roughly and he is not complying with his treatment or sessions”. No further detail is used to speculate on the reasons for the deadlock. The uncertainty about what to do characterize cases collected within this type is well represented by the question that concludes the profile relative to a case already mentioned (12C). In the text, written by one of the street workers who followed the woman, we read that from the beginning, given the “deterioration of her mental health, putting her life in danger”, the street workers, having detected the condition of “isolation, mistrust and stall”, were “challenged”. Having reached the end of the description, the operator, significantly, asks himself: “what will we do when she leave the hospital?”

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## 2.5. Interventions and networks

Before providing the summary statement of the types of intervention and activated networks, worth repeating - although this may seem obvious - that the difficulties inherent in the assessment of the operation of these interventions are closely linked to the complex and multifaceted nature of the situations experienced by the type catchment of which we are speaking. Only with this necessary caveat in mind we try to sum up what emerges from reading the profiles in terms of the types of action proposed and promoted networks. In this paragraph in fact we do not have, nor can have, any claim to completeness and comprehensiveness compared to the specificities represented by each of the analyzed path; more modestly, it will just present a few thoughts in the hope that these make it possible to more effectively connect the reasoning just ended on four types with concluding remarks.

According to the above it is not surprising that the first element on which we attention must be taken is represented by the significant differences observed between the profiles. The differences relate to many dimensions: the number and frequency of hospitalizations (in some cases very numerous, and in other sporadic); the setting of health interventions and the frequency of visits (in the street, in the hospital, in the assistance centers); the range of accessible services (canteens, shower facilities, dormitories, shelters, rehabilitation centers); the composition of the working groups and networks (nodal theme reflected on key issues such as the availability or not of a multidisciplinary team and of a case manager); the presence (or not) of an informal support network (neighborhood associations, available single people). However we must not forget that these differences are related, and in their turn interact with the specific characteristics of individuals: from health condition, of course (we spoke about in paragraph 2.2), but also the availability or not of relationships with one or more family members. In much of the people described in the profiles they are alone, but there are cases in which any of them is in contact with a brother, a sister, a parent or some other family member. For the purposes of the interventions implemented, these relationships, even if the contacts are sporadic, can represent a relevant resource when the person begins to be supported by a network capable of setting a work not only of emergency type.

From a strictly operational point of view it is evident the fundamental role played by the outreach teams, in particular for the first contact and maintaining the relationship with the person who lives in the street. However they are organized and whatever their location with respect to the institutional system (types vary by teams consist exclusively of volunteers to those who actually constitute a moving projection of structured professional services), we cannot imagine any kind of meaningful action in this area without having street units and support services of this kind. And it is not just to offer hot meals, drinks and blankets - services that in some periods of the year are literally vital for people living on the streets -; it is also about getting in touch so respectful and careful with people in extreme marginality, often unable or unwilling to submit an application for aid. The so-called 'engagement' of the person, as some cases already mentioned, it requires a sensitivity that can become the first network enabled device. And even when it has earned the trust of the person, the supporting role of these teams is crucial, both because paths are not necessarily linear (and back to the street is always a distinct possibility, as already noted several times), and because a model of truly integrated interventions should still be able to count on gradually and on the plurality of nursing actions and taking charge.

Once that has been in contact with the person, the main concern of the staff and of the working groups is to prevent it from activating 'recurrent circles' margins: those paths for which they pass from the street and from the hospital and here again on the street (sometimes via the prison or to attempt some rehabilitation), in a perpetual entrapment of people in 'revolving doors' of the services. In fact, if they are not able to really take charge of the person's needs, tending to "excessively rely on emergency-type" (Mental Health Europe solutions, 2013), this cycle can reproduce with a dramatic continuity. In the case of E., a 29 year old man living in a "forest shack" (28E), the vicious cycle is generally triggered by the police, culminating in hospitalization (profile about him has counted 15 in the period between 2006 and 2015) and begins again, after discharge

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from hospital, with life on the street. On the other hand, in cases in which the mental health conditions are very compromised is the same state of isolation and closure towards the outside to interfere with the possibility of insertion in a structured path. In these cases, health condition and social / material inconvenience are combined, by activating the so-called "circle of deprivation", or "cycle of exclusion": a circle in which conditions of poverty, exclusion from social networks, absence of work opportunities and rough sleeping huddle the person in the 'loop' of extreme marginality.

From the point of view of an organizational profile, beyond the differences of staff and interveners services, worth mentioning the importance of the role of case manager. In fact, it ensures the most complex cases coordination between different actors: the coordination that is not always perceived as necessary by services that operate according to the logic and compartmentalized routine. It should also be recalled that to be able to do its job the case managers should not be burdened with the task of handling too many cases at the same time, as noted in the final review of the writer of the profile of D., thirty-two men from Guinea Equatorial (42D). In assessing the role played by this figure in the management of a very complex case, characterized by the involvement of many actors but satisfactory outcome ("the persons condition has improved, he continues with a case manager that can individualize the interventions and is a source of detecting the needs that Daniel expresses"). The profile states that "the case manager is important in the way that it can help with all the coordination difficulties; he increase the engagement of the person and acts as a referent for the person. This figure has to be empowered by all the network, and work closely with the person, and that is why he should only take max 15 cases".

It is also interesting to dwell on what emerges which relates to social services. It should be recalled that a significant subset of people described in profiles survives "begging for a coin after parking cars" (8J), "collecting and selling bottles" (4V; 6M) and selling the material found in the trash (16a; 37G) , while for the food recurs not infrequently to municipality soup kitchen (as in the profile 30) or to the support of charitable organizations (36K). In parallel to the action of health services, social services move substantially in three directions: the search for a housing facility; verification of the possibility of access to some form of earnings (an income - through job placement, if the conditions of the person allow - or more often social allowance, as retirement); putting in order of administrative and identity documents. It should of course taken into account the fact that in the most complex situations social services are called upon to appoint an administrator of the goods - as happened in the Rwandan man (18F) - "as a safeguard measure".

The interventions of social services are further complicated in cases where the followed person has not the nationality of the country in which it is located. In these circumstances the main job is the reorganization of administrative documentation (as already mentioned in section 2.4.4) and in the search for contacts with embassies and consulates (especially to allow the return to the country of origin [1M; 10C; 33V] and to track down any family members [19T, 22L, 39P]). However, precisely in cases where the support network considers appropriate to promote the return to their country of origin, there is the problem of the difference between the different institutional systems: in the case of M. (an 50 years-old Italian man resident in France, without an accurate diagnosis but hospitalized for 'disorientation' problems [50M]), the hypothesis of return arouses in the operator who has followed him and drafted the outline an explicit question: "will be provided an adequate medical care in your country? This situation really calls into question access to care in Europe".

The question just mentioned is only one of many that occur in the 50 profiles collected. In the texts, it emerges very often the dilemmatic character of paths taken: a character that has a particular importance for two main reasons. The first is revealed by the presence, in some routes, of conflicting representations and alternative visions of taking-over by professionals and involved services. Some operators have shown how in the course of their activities they faced with objectively limiting points of view formulated by other service providers, in particular concerning the alleged 'life choices' made by the person in marginal condition. In the case of L. (22L), the writer of the profile pointed out the following: "sanitary agencies often diagnosed that L. lives this way because she is homeless, while our hypothesis is that she is homeless because she lives this

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way. We think it is not a choice, but a result of different processes. Is L. really able to clearly choose about her life? Or is that her needs petrify her in a state of inability? In other cases the source of interpretative conflicts is the concept of 'danger', as can be seen from the passage on the choices to be made regarding the situation of a woman hospitalized (12C): "fieldworkers were to maintain her at the hospital, since a hosting solution has not been found; but since C. said she was 'ready' to return to the street, the hospital let her go saying she was no longer in danger to herself. In the street, a treatment has not been established, degradation is likely to occur when the psychiatric treatment will have no effect".

The second reason for the presence of so many unanswered questions is the high frequency of situations that require operators to choose between operational alternatives which effects are uncertain and unpredictable. "We have done the right thing?" The writer of a profile asked himself, at the end of the survey carried out on the case below (4V): "should he have had another outcome than that which we have given him?". Particularly significant from this point of view are the ideas in the profile on the 39-year old man of Romanian origin taken over by an Italian team and then repatriated to his country (33V): being released from the hospital in fair condition, and having exhausted the time-limit in order to stay in the clinic, faced with the risk that V. reverting to live on the street, the working group has prompted him to return to Romania at the family home. The particularity of the case lies in the fact that V. was accompanied in Romania by either voluntary ladies who had witnessed while on the road: and since the re-integration in his family was initially very complicated (V, contacted by the lady, continued to be depressed, expressing suicidal thoughts) voluntary felt guilty, and was then shown herself "very angry for her agreement and cooperation to this project" (for the implications arising from this case and for a more general reflection on the role of volunteers within the taking-over networks refers to the final chapter). The problem "what to do?" also arises when the health situation is not serious, but mental illness is chronic, however (as stated in the profile 45B): "What should we do? Leave her on the street or bring her to the hospital against her wishes? It was very difficult to decide: it was not an acute problem but something very chronic and there was clearly no physical problem that required immediate attention. [...] How to decide what's better for homeless people with chronic mentally illness without any acute medical problem?"

In some cases, operators face this uncertainty by making use of the available margin of discretion to them. The choice to go beyond the pre-defined rules and pre-established roles represents an option that can sometimes produce a discontinuity (or failure) of organizational routines. In a particular case the writer of the profile, after describing the choices made to cross a number of administrative barriers, has explicitly stated that "in a vacuum of regulations, our group tries to compensate in a naive way, sometimes at the limits of legality" (43S). In another case, the release element has been identified in the direct involvement of the mayor of the city in which the support team operated: "sometimes – we can read at the end of the profile – it may be necessary to involve the top political system at a local individual problem, and by this to solve the problem, and to produce new workflows in the public authority" (2F).

All operators are obviously aware of the need to obtain the consent of the subject on which one works (consensus "Which in turn can only be Obtained by a worker whom the person would trust" [5E]); the problem arises when a person exercising his right, rejects any form of support, and yet, as a result of that refusal, puts at risk their own life. In these cases the dilemma on the choices to be made essentially concerns the use or not to compulsory admission, an tool of which use was applied in 15 of 50 profiles collected. Generally the compulsory admission appears as a measure of 'extra ratio', as the means which is used when the support team feels it cannot do anything and have no alternative (6M; 30; 33V; 34A; 45B). In many of the profiles the evaluation of the effects of compulsory admission is positive (1M), especially if it is placed in the taking-over planned strategy (19T; 42D). However there are different cases: such as compulsory admission which decision was the subject of dispute among the intervention network (10C) and those devoid of positive outcomes in terms of initiation capability of a path of non-emergency cares (10C; 22L).

Finally, it should take some attention to the background in which the actions are placed, in the knowledge

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that social attitudes and proximity relationships developed around people living on the streets influence significantly the take-over path. This happens, of course, from the time of first contact, which is often generated by reports and complaints of people who live and work in areas where homeless people spend their days. In these cases is the “social pressure” to invoke the intervention of the services so that they “do something” to end reported behavior as aggressive, disturbing or ‘out of place’ (7J; 10C; 12C; 13J, 20F, 22L; 47R)<sup>11</sup>. Sometimes they indicate demonstration interventions and therefore short-sighted of municipal police forces (6M; 16a; 24T)<sup>12</sup>, while on one occasion the social pressure seems to have even attracted the attention of the local political sphere (22L): “politics were interested into the case when citizens protested for L. and her critic conditions – she usually leaves garbage and dirt on the streets – and helped to organize admitting in hospital”. Not even there, unfortunately, references to acts of “bullying” (31F/C).

It should also be noted that the social reactions that occur in front of the extreme discomfort are not always based on feelings of fear or hostility. There are many cases in which Community localized networks or individual play an important supportive function. Sometimes the same institutional services rely on the observation skills of a sort of “parallel regulatory network” (49L), based on neighbors and merchants, “to be attentive to the significant physical and mental deterioration” (12C). In one case (21C) The informal network is based on “snacks and cafés where she used to go. They used to offer them meals or drinks for free, but we arranged that they could send the bills to the administrator, and so now they can be paid for the meals they offer, which is a way to ensure that she eats correctly and regularly [...] This seems to work well until now. We also told these people to alert us if anything changes: when she doesn’t appear any more, or if she is in a bad condition, especially in the winter”.

In proximity spontaneous, solidarity relationships is the sign of a very intense personal involvement and emotional. The forms of this solidarity vary by the offer of food (“two resident ladies, little by little, started to take care of him bringing him breakfast in the morning and helping him for lunch” (33V) ) to that of money and clothes (“well known character in the neighborhood: people would give him money, and clothes on occasions [34A]). Sometimes the feeling appears to be driven by the qualities of the person, as shown in profile of a 48 years-old Portuguese woman (“she had lost the house, 15 years before, but remained a charming woman and everyone liked to try to help her; strong social pressure to take her off the streets” (9m)); in the case of old woman who lived for years near the airport (41C), the author of this profile recognizes “an air hostess that daily spoke and supported her” the character of “reference figures” in achieving the main goal of intervention (“this older woman left the streets after years that she stayed overnight at the airport”). And it is significant even if the intervention of the municipal police aimed at remove from the street a 55 year old man (43S) has aroused negative reactions in the neighborhood: “people living nearby his couch never complained about his presence and even provided food and clothes, when allowed by him”; in particular, a resident of the area “missed S. and was very much upset for the rude way the intervention was set up.

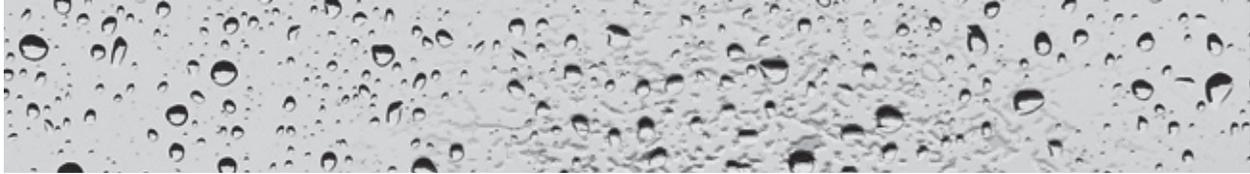
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<sup>7</sup> In many profiles risks and dangers are explicitly underlined. According to St Mungo’s, between 2010 and 2016 in London 129 persons died while living in the streets (St Mungo’s 2016). According to *Les Morts de la Rue*, an association founded in 2001 to detect and identify persons dead while living in the streets, in 2016 in France 501 homeless died (età media 49,5 anni). Vedi <http://www.mortsdelarue.org/spip.php?article14>.

<sup>8</sup> “In recent months, parents who live in Buikina Faso and are willing to accept him at home were contacted. The working group decided to wait for the clinical improvement of the judge are sufficient for a full and adequate return home”.

<sup>9</sup> “The trust that social services would support the patient once he was discharged from hospital, enable the psychiatric team to open the doors and admit him as inpatient (without the fear of having no other solution afterwards). Similarly, the social services were not afraid to find unusual and expensive solutions (nursing home) because they trusted that the mental health team would continue to give all the necessary support and felt that this was an adequate solution from the technical point of view”.

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- 10** “Not taking the prescribed drugs, he took his belongings and walked away from the Centre. One resident called an ambulance, he was once again transferred to the hospital psychiatric ward. Currently waiting for his return. Nobody had time or remembered to check whether Ernest have actually taken his pills. The Center is not prepared for such a far-reaching individual treatment of a resident, not to mention that the Centre workers should have special licence to administer such strong, prescription medications”<sup>5</sup> The European Observatory on Homelessness carries out transnational research on homelessness and housing exclusion. FEANTSA’s statutory bodies decide on the research strategy, the annual research programmes and the research themes. The research is carried out by researchers from research institutes and universities across Europe and beyond. Once a year, the EOH organises a European Research Conference. The EOH produces two issues of the European Journal of Homelessness and one Comparative Study per year. See <http://feantsaresearch.org/spip.php?rubrique10&lang=en>.
- 11** In 47R profile the pressure on the municipality outreach team is explicit, because it is invited “to do something: several hotel customers complained inappropriate behaviour (masturbating openly in front of the hotel)”. In profile 20F we read that F. “was a big concern for all the community of the neighbourhood. He drank heavily and was so careless with himself that was often seen defecating while walking”.
- 12** “The police would continue to come on occasions telling her she could not be occupying a bench all the time and would remove some of the bags she had. She would get very annoyed ‘police should care about me, not take things away from me...’. She had to move from the place she was, due to police pressure, and moved to almost opposite the street. Police remove the bags occasionally, depending on neighbourhood pressure” (24T). Differently, in the case of profile 5E, this person is “tolerated by the station’s security” since she looks “quiet, clean and not aggressive”.



### 3. CONCLUSIONS AND RECOMMENDATIONS

The final Paragraph is divided into three parts. The first focuses attention on basic elements that, regardless from peculiarities of institutional contexts and from specific individual cases, appear indispensable for taking-over people in extreme condition of marginality. The second is dedicated to a specific deepening of the four operational areas in which there is the sequence of described operations (health services, social services, intervention on housing and intervention aimed at social reintegration). Finally, in the third one there are some general reflections on the political and institutional background in which interventions to homeless and mentally ill are placed

#### THREE PRIORITY GUIDELINES.

The reading of the profiles has exposed the enormous complexity and variety of situations in front of what the services are operating. At the end of this work, however, we believe we can indicate to the system of taking-over (Institutional Services, Community, Mobile Unities, support associated networks) three priorities orientation: the networking, location of the person at the center of intervention strategy and attention to training and practical working methods of operators. It's about guidelines strongly interdependent, which can be considered as a first hypothesis of reasoning aimed at identifying a basic strategic / organizational facilities that every service system have to have. In other words, we believed to be able to say that any intervention can be used in this area without the simultaneous presence of these three elements likely to develop in a piecemeal way and - rather - to run out inside an emergency and short perspective.

**a. The networking.** It has been said repeatedly and it is repeated here: if in this field they don't work in an integrated and coordinated way the work of operators ends sooner or later to stop in front of the finding of one's inability to affect. To prevent this we need to face each of the path phases in a coordinated manner: this means preparing hospitalization, accompany the treatment and at the same time think of the discharge from the hospital setting ourselves in the context of the perspective of re-socialization path. Although the classic devices often tend to take-over one dimension of vulnerability at a time, as we can explicitly read in the text of a profile (33V) "each intervention by individual institution is useless". The services that operate in isolation, following predefined routines, do not work: the needs and emerging critical interaction with people living on the street and with mental health problems are manifold shapes and changing with respect to time, and no organization, professional or actor can declare themselves self-sufficient.

The networking has to assume as a fundamental operating horizon person's access to the care / treatment path. The access here is intended "not only as an entry or use of available services, but as a multifaceted set of factors that influences entry or use. Access is therefore the result of fit between the user and the system, based on the characteristics of both [...]. Exclusion is thus seen here as a mismatch between the characteristic of a service and a user" (Mental Health Europe 2013).

Considering that in this perspective "it is services that need to find ways to gain access to people in need" (Idem), the first orientation for facilitating this meeting is precisely the performance of a work coordinated by the whole of the actors called to intervene.

This way of working requires - rather than specific resources - a change of perspective, which does not make necessarily easier its implementation, as organizations move almost always following routines and paths in some predetermined measure. The fact remains that an orientation of this kind not only involves no additional cost, but in most cases leads to not disperse energy and resources (both professional and financial). From the operating point of view this orientation can be declined in a plurality of ways: integrating the work of outreach teams and that of hospital staff; assigning responsibility for coordination to a specific figure (case manager), able to play the role of interface between user and network; discussing in a participatory way and

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non-conflictual cases of 'dual diagnosis' (in order to avoid liability discharges and triangulations); defining continuity of care interventions capable of foreshadowing 'accompanied' paths of exit from hospital; balancing responsibilities between professional teams and volunteer groups<sup>13</sup>.

**b. The person-centered services.** Just to facilitate access, in the sense above clarified, and a path of care/cure sustainable during the time, the vulnerable person must be met and welcomed in the manner and in the most relevant and appropriate times compared to its actual conditions of life and health. So that this does not remain a mere rhetorical statement, we should remember that an approach of this kind, similarly to what was about the first point, requires a change of mentality, since meeting the homeless where he/she is and accept it could take long time to get in contact" (1M). On the other hand, the fact that an approach of this type requires the overcoming of organizational structure rigidity and consolidated structure does not mean that conferring centrality to the needs and criticalities of the person is not a viable and necessary option. Especially since the choice of "working close to the person in need" is not to be considered as the reflection of an ethical or humanitarian choice, but as the precondition of an organizational orientation that requires actions and tools consistent to it.

The operational implications are also evident here. When the refusal of the taking-over and aid proposals persists, for example, the switching network must be alert and ready. As shown in the profile text about an elderly woman unavailable to receive the services proposed (11J), rejection "does not mean do not treat, but continue to expertise services network to monitor the situation". In a more complex case (8J), this attitude of 'sensitive' listening is summed up in a simple but effective final consideration because of its brevity: "we have to work to a good relationship with the homeless patient, respecting his will".

Putting people at the center means exactly respect the will and recognize the dignity, nothing more but also nothing less. And this is even more true in cases where the person is located in the most precarious conditions; in particular, it applies in those cases in which by reason of severely compromised mental health conditions, a 'will', in the strict sense, is not readily detectable or manifests itself in a contradictory manner. In these circumstances compulsory admission can become a tool postponed, as was stated in the previous paragraph; nevertheless remains the need they must be adopted taking into account the entire framework within which the person - in its singularity and instability - is placed. Without prejudice to in all other cases in which an expression of will is identifiable must be recognized to the person - as written by the writer of a profile - a possibility of 'starting from where he is, and not from where I think he is'" (32P).

**c. Operators.** Precisely because complex and centered on the person, actions such as those we are talking about cannot be based solely on a voluntary approach. This expression doesn't mean to assign a negative value to the momentum and the involvement of individual operators, nor diminish the importance of the work of volunteers within the take-over networks; more simply, we want to underline that an organized and effective response, hopefully systemic, cannot be based only on the approach of individual figures (as ethically oriented will be their *modus operandi*).

Operators are aware of the fact that the stories that they have described in profiles require time. Time is required both to arrive at a good level of relationship and understanding of the person, and to process a socket project long term load. The time variable in turn calls three major organizational components involved: flexibility, understood as "a time / space for adaptation (critical time)" (23A); the stability of the staff, especially in cases in which they are working in an integrated manner; the professionalism of the working groups. It is worth mentioning that in several profiles it is noted that the dynamics of taking charge may constitute for traders a source of burn-out and stress. To address these risks, they can work on several fronts: with the supervision and emotional support, first of all, but also with the exchange of experiences (the inter-view), training and in-depth knowledge of the general frameworks ( in sociological, political and economic) within which the phenomenon of homelessness is placed. Exchange and inter-vision are at the base of D & WB, while training is the cornerstone of the Erasmus project recently showed by SMES-Europe<sup>14</sup>.

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## SERVICES

**a. Health services.** Healthcare services are the pivot around which the other interventions rotate. Of course these are services which type depends on the person's condition. It is viewed as the main objective of the taking-over is to build a path that allows to come out of emergency and short perspective; but it must also be said that in cases in which the person tends to shun any contact hypothesis with the services even hospitalization it may represent a significant first goal.

Looking ahead, an interesting perspective for SMES - Europa and its partners would be to reach the definition of guidelines in health care taking-over. Within these guidelines, that should necessarily take into account the diversity of institutional systems and contexts, in addition to the three cross-cutting issues listed above (networking, centrality of the person and attention to the operators), a series of issues specifically concerning healthcare path could be developed: frequency and characteristics of interactions with outreach teams; opportunities and constraints for the involvement of volunteers and the informal network; conditions, characteristics and outcomes of compulsory admission; connections between learning experiences and exchange operators, and work staff.

Two themes are well worth special consideration. The first is that of the continuity of care: what happens after discharge from the hospital in cases where it is still necessary to take care of the person not only from the social point of view, but also from a health care? Think highly disabling situations, that require constant monitoring and concrete supports, even after leaving the hospital: in these cases the continuation of care pathway should be examined by multi-professional team can prepare a personalized care plan (which - as we have seen - can occur, but not occurs however in a generalized way) and to detect any 'critical' steps, those in which the social and health overlap, to prevent and avoid the contrasts or potentially arising slowdowns.

The second point concerns the interactions with foreign people and the consequent need to adapt the conceptual apparatus of the staff. If the extreme marginal condition is already in itself a node which places the services issues of great complexity, difficulties are amplified when the interaction takes place between culturally not isomorphic systems: in these cases, it becomes even more difficult to distinguish a pathological manifestation by a behavior with an incomprehensible meaning for those who do not know the context of expression, especially since what is considered morbidly in context, can be considered cultural expression in another one. In a profile they speak about "clashing cultural aspects" (38), while in the case of the Nigerian woman the operator who wrote the profile pointed out the following: "We Should Also consider the presence of cultural aspects. How are predominant anthropological elements in people perception of disease? Does L. thinks she is 'cursed' to live like that? How 'care' and 'social assistance' are perceived in her culture?" (22L). In concrete terms, if we want to bet "to enforce cross cultural mental health support" (1B) it needs to direct the operator training and enter into staff ad hoc specialists (as anthropologists and linguistic mediators).

**b. Social services.** The abstract representation of the ideal take-over operations places the sequence Health Services> Social Services> housing> reintegration temporally ordered along a continuous axis. However, if it is true that health interventions are priorities, representing a precondition of all other supporting hypotheses, it is also true that social services overlap each other phase accompanying taking charge throughout its development. In some cases the sequence of the fact reversed, for it is the intervention of social services to make the provision of health services possible, as happens when the management is hampered by legal / bureaucratic problems (paragraph 2.4. 4) and it is therefore necessary to reorder the documents or the status of the person to be able to proceed beyond the provision of emergency services.

In most cases social benefits are intended to ensure the person a financial support in the form of allowances or pensions, goal to which it's often possible to reach through the removal of legal obstacles or for the documentary reconstruction of a plurality aspects (health in particular). Consistent with the conditions of the person, the efforts of social workers are also directed to consider and choose the job opportunities, the dual purpose of restoring autonomy to the users and to reduce the stigma attached to the formulation of the aid application.

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The return to work of course is a crucial step, comparable to the phase of social rehabilitation (d). Operators are aware that critical at this stage can feed back all the way done: in the case of R. (47R) the difficulty to “stabilize in an occupation or job” seems to have been one of the main factors of the reactivation of recurrent cycle street / acute psychotic episode / hospitalization / a period of overall improvement / drug abuse / street”. When the health condition seems to improve, in fact, the “basic need” - as stated in the Athenian man’s profile that he ended up living in the street following a series of financial and family losses (36K) – is “to become productive in the social environment, to form again a social identity and [...] to regain autonomy outside of the mental health sector”.

**c. The housing services.** Since the condition of homeless defined by the unavailability of decent housing and sustainable costs, as operators are aware that only providing a home is not sufficient and further services must follow”, at the same time “a secure home is the basis for change” (Mental Health Europe, 2013). It therefore seems obvious that there is no intervention, among those surveyed, who has not raised the issue of how to succeed to steal the person from life on the street and extreme marginal condition. Rather, as we have seen, even we are accepting that the abandonment of rough sleeping perspective is postponed indefinitely, but working at the same time to be able to intervene in case of change of the attitude of the person or upon the occurrence of an acute need / hazard .

The context is particularly complicated. It is known that in Europe the price of housing is growing faster than that of wages and that the share of household expenditure allocated to the maintenance of the house is growing for the entire population and especially for poor families (Abbé Pierre Foundation, FEANTSA) . These trends are problematic not only because upstream contribute to expand the size of the phenomenon of homelessness (through expulsive processes from the housing market), but also because downstream they shrink bid field. On the other hand, if on the one hand, the market appears very little accessible, on the other hand the framework of public policies is strongly influenced by the austerity dynamics, as implicitly noted in the text of a Greek user profile, about which the creator of the profile points out that “at the service level we are limiting our listening very often to what we are able to offer” (30).

It is within this framework that the reasoning on the strategy of the so-called ‘Housing First’ should be put back. From the reading of the profiles it is not possible to draw elements which allow us to formulate an estimate of the degree of effectiveness of this type of strategy. Certainly, beyond the principle of judgment that we can give, if it is assumed that in the word ‘first’ phrase in question indicates accorded priority, in terms of response to the “basic need” noted above, to permanent and not temporary solutions, the constraints and difficulties that limit the feasibility of such a solution in different contexts appear relevant. What one can hope, to stay on the ground of the formulated observations following the reading of the collected material, it is that in each case the application of this strategy can be placed within a sequence of broader interventions, such as the one previously described and characterized by a holistic approach centered on the person.

**d. Social reintegration and participation.** Said about the job opportunities as qualifying tool for social recognition and material autonomy regaining (b), the reintegration path also involves the gradual reacquisition of ‘ability to stay in the community’. This ability represents the counterpart of the obstinate rejection of all forms support; not surprisingly, the first sign of the opportunity to break the deadlock and isolation is made by the opening of a dialogue with the operators or the informal support network (see section 2.5): an opening that brand availability to expose himself to another that you can begin to see (or see again) as an aid and not just as a threat.

The process is naturally long, but what is clear from reading the profiles is that an important contribution in this direction is provided by the operators’ ability to leverage personal interests / passions and the informal networks. The cases described show that in fact both aspects resides considerable therapeutic potential, which has to do with both the size of the reactivation of individual ‘dormant’ or ‘forgotten’ skills (as in the case of the man with a passion for working with wood added to an ad hoc rehab program [8J]), and with growing emotionally supportive relationships.

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## CLOSING THOUGHTS.

As we have repeatedly stressed, the interventions of which we discussed in this paper are closely related to large institutional contexts. However it should be noted that in recent years in this area is an ongoing process of progressive Europeanisation of policies. Examining the soft governance mechanisms in the policy-making of the Union, Gosme (2013) noted that this process is the result of the combination of three different dynamics: the top-down one (characterized by the transfer of information in the policies of the EU national and sub-national levels of government); the bottom-up one (the opposite process to the previous year); those, finally, characterized by “cross-national horizontal developments”. “Generally speaking – we read in the essay of Gosme (ibid: 45) -, Europeanisation is a process whereby national and EU policy-making become interwoven”.

This process represents an opportunity to develop reflections regarding this area of policy on a larger scale, including appropriate actions of advocacy and lobbying, involving both civil society and the political level. Poverty and social exclusion represents one of the objectives of Europe 2020, while the policies on homelessness, although they remain primarily a national responsibility, in recent years have become the subject of increased attention in the framework of the Social Investment Package<sup>15</sup> (including the priorities which the EU suggests to pursue the Member States, there are, among others, the need to carry out extensive research and to collect systematic data on the subject).

The Social Investment Package should “provide guidance on increasing efficiency, effectiveness, and adequacy of social protection systems; improving activating and enabling policies; social inclusion and adequate livelihoods. The Communication guided MS in making best use of EU funds and is directly linked to the directly linked to the European Platform Against Poverty and Social Exclusion (EPAP)” (European Commission 2013). In this context also it places the initiative of the Commission aimed at giving life to the so-called European Pillar of Social Rights, “to reflect on new trends in work patterns and societies, due to the impact of demographic trends, new technologies and other factors of importance for working life and social conditions” (European Commission 2016: 9).

Without prejudice to national specificities, it is the European level that one in which the reflections emerging from D & WB project by SMES-Europa’s activities are placed and discussed. And it is here, above all, that must be paid the attention to the need to address the problems of financial sustainability and the availability of resources repeatedly underlined by the operators in the preparation of the profiles. In the hope that the dignity and well-being of people living in the street with mental health problems return to being a ‘detected’ issue from the debate and confrontation between policy-makers, SMES-Europe offered with this work its cognitive contribution to the public discussion. A discussion which, however, beyond any technical and operational consideration, we hope will always be guided by the principles of social justice and collective responsibility towards any form of discomfort.

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<sup>13</sup> About profile 33V, already cited in paragraph 2.5, it is useful to recall the final part of the protocol: “Volunteers’ participation can be extremely risky, as in this case, due to a overwhelming deep emotional involvement. If unprotected, the volunteers may feel the entire responsibility of the project and may refuse the limits of the intervention, considering themselves guilty about negative outcomes. Actually, we always registered that, with different intensity, an exaggerate involvement of the volunteers in cases’ handling, occurs. At the very beginning, this may be useful in order to keep the case in our mind and in our agenda. However, in the long term, if the team doesn’t support these persons, they may personally incur severe depressive disorders”.

<sup>14</sup> The project aims at creating a strategic partnership for vocational education and training of professionals working with homeless and refugees with a special focus on the most deprived and severely mentally ill.

<sup>15</sup> “The Social Investment Package (SIP) is a series of non-binding documents, adopted by the European Commission (EC) on February 20<sup>th</sup> 2013 as a response to the economic crisis, threatening the achievement of the EU2020 poverty and employment targets and to the demographic changes that are shrinking the size of the working-age population in Europe. The package aimed to incentivise Member States (MS) to maintain investment in social policy areas despite the current negative fiscal situations as this might help saving future costs for social expenditures”. See <http://easpd.eu/en/content/social-investment-package>.

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## Bibliographic references

Amore K., Baker M., Howden-Chapman P. (2011), "The ETHOS Definition and Classification of Homelessness: An Analysis", *European Journal of Homelessness*, Vol. 5, No. 2, pp. 19-37.

Busch-Geertsema V., Benjaminsen, L. Filipovi? Hrast M., Pleace N. (2014), *Extent and Profile of Homelessness in European Member States. A Statistical Update*, European Observatory on Homelessness - Comparative Studies on Homelessness.

European Commission (2013), *Commission Communication. Towards Social Investment for Growth and Cohesion - including implementing the ESF 2014-2020*, COM(2013) 83

European Commission (2014), *Study on Mobility, Migration and Destitution in the European Union. Final report*, European Commission, Brussels.

European Commission (2016), *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions launching a consultation on a European Pillar of Social Rights*, 8.3.2016 COM(2016) 127 final

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

FEANTSA (2010), *Homelessness and Homeless Policies in Europe: Lessons from Research*, European Consensus Conference on Homelessness 9-10 December 2010.

Foundation Abbé Pierre, FEANTSA (2015), *An Overview of Housing Exclusion in Europe 2015*.

Gosme L. (2013), "The Europeanisation of Homelessness Policy: Myth or Reality?", *European Journal of Homelessness*, Vol. 7, n. 2, pp. 43-61.

Istat, Ministry of Labour and Social Policy, FIO.psd., Italian Caritas (2015), *The people homeless. 2014*, December 10, 2015, <http://www.istat.it/it/archivio/175984>.

Mental Health Europe, *Access to services by people with severe mental health problems who are homeless*, position paper - September 2013 [http://www.mhe-sme.org/fileadmin/Position\\_papers/Access\\_to\\_services\\_by\\_people\\_with\\_severe\\_mental\\_health\\_problems\\_who\\_are\\_homeless.pdf](http://www.mhe-sme.org/fileadmin/Position_papers/Access_to_services_by_people_with_severe_mental_health_problems_who_are_homeless.pdf).

S. Raimondi, Riefolo G. (2016), "Home-less, home-first and nursing processes. Complex Interventions for Sfd in the frame of a mental health center", *The seed and the tree. Social science magazine, Applied Psychology and community policies*, 2016, year II, no. 1/2, pp. 65-75. doi: 10.17386 / SA2016-001011

St Mungo's (2016), *Stop the Scandal: the case for action on mental health and rough sleeping*, <http://www.mungos.org/documents/7430/7430.pdf>.



**DIGNITY & WELL-BEING PROJECT**  
**EXCHANGES & INTER-VISIONS PROGRAM**  
concerning interventions and pathways for Homeless in  
extreme poverty situation and with mental health problems

**Home-less - Health-less - Hope-less**

When person have lost everything, there is no more that body for cry and street to get lost Homeless living in severe & chronic social, physical, psychical precariousness are a symptom of the malaise of our society and a permanent injury to democracy and social cohesion. They are almost a provocation and a challenge, both : for those who are working in this sector and for those who should be responsible of the polis and citizens.

SMES-Europa, co-working with other European Organisations involved in this specific field, would like to propose the transnational project '**Dignity and Well-being**', promoting exchanges of experience and knowledge in the field of ***extreme poverty*** and ***mental illness*** / health.

Through thorough analysis of the experience of some of these people in conditions of extreme deprivation and degradation, we would like to listen their voices and understand their help request, in order to improve adequate, effective and coherent answers and ensuring for each person **dignity** and **well-being** promoting and facilitating the access to fundamental right and to basic citizen services.

Main objectives of 'Dignity & Well-being project', to :

- **meet, listen** and **understand** deepest, the **voice of people** who has become **voice-less** because **identity-less, home-less, health-less, hope-less...** and excluded.
- **evaluate** the causes & factors of this deprivation and the reasons explain why **they seems to prefer** life in the street or in the emergency centres, despite more adequate proposals,
- **identify** some innovative practices and coherent projects ;
- **recommend** some priorities in social & health policy.

The workshops will focus attention on relation and interaction between each individual homeless and the interventions made by social & health providers of services as:

- Mental health services in Institutions and in Community;
- Emergency shelters, drop inn centres; dispensaries ...
- Supported housing; community housing; solidarity apartments...
- Outreach team.

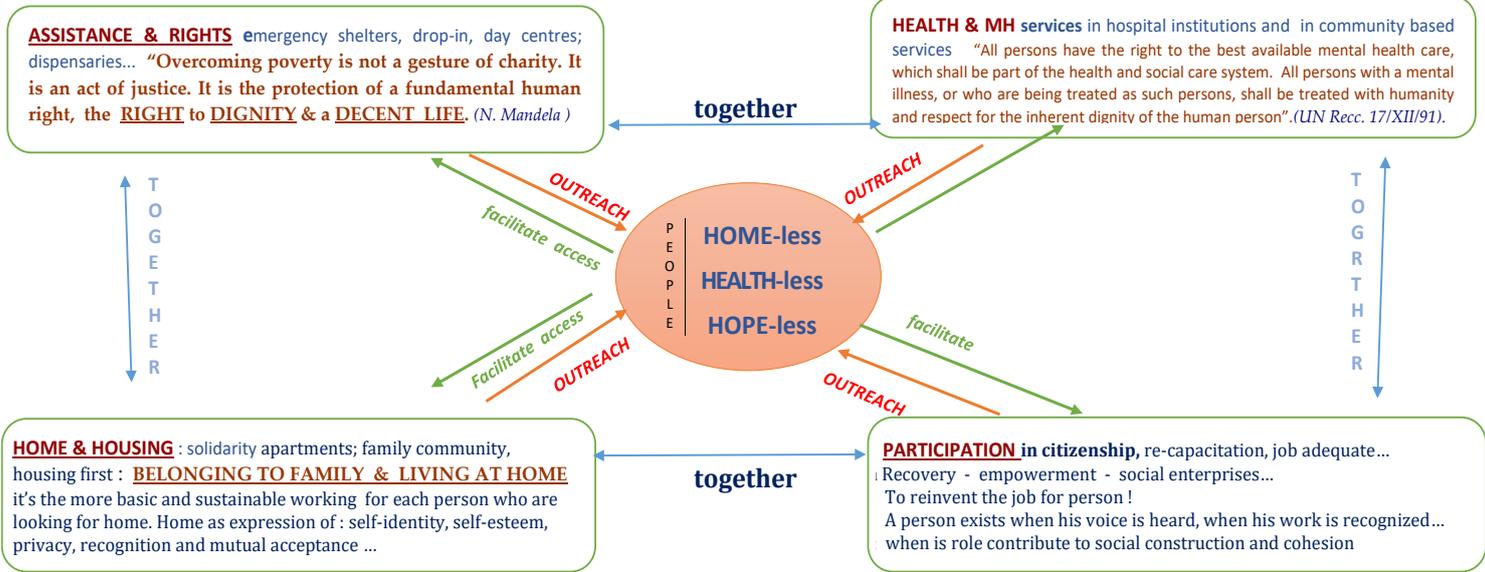
**How the social and health policy and services insure the promotion of Dignity and Well-being ?**

SMES-Europa with the initiative: « **DIGNITY and WELL-BEING** », would contribute to increase awareness about the homeless & psychical suffering people, who are the centre of our project.

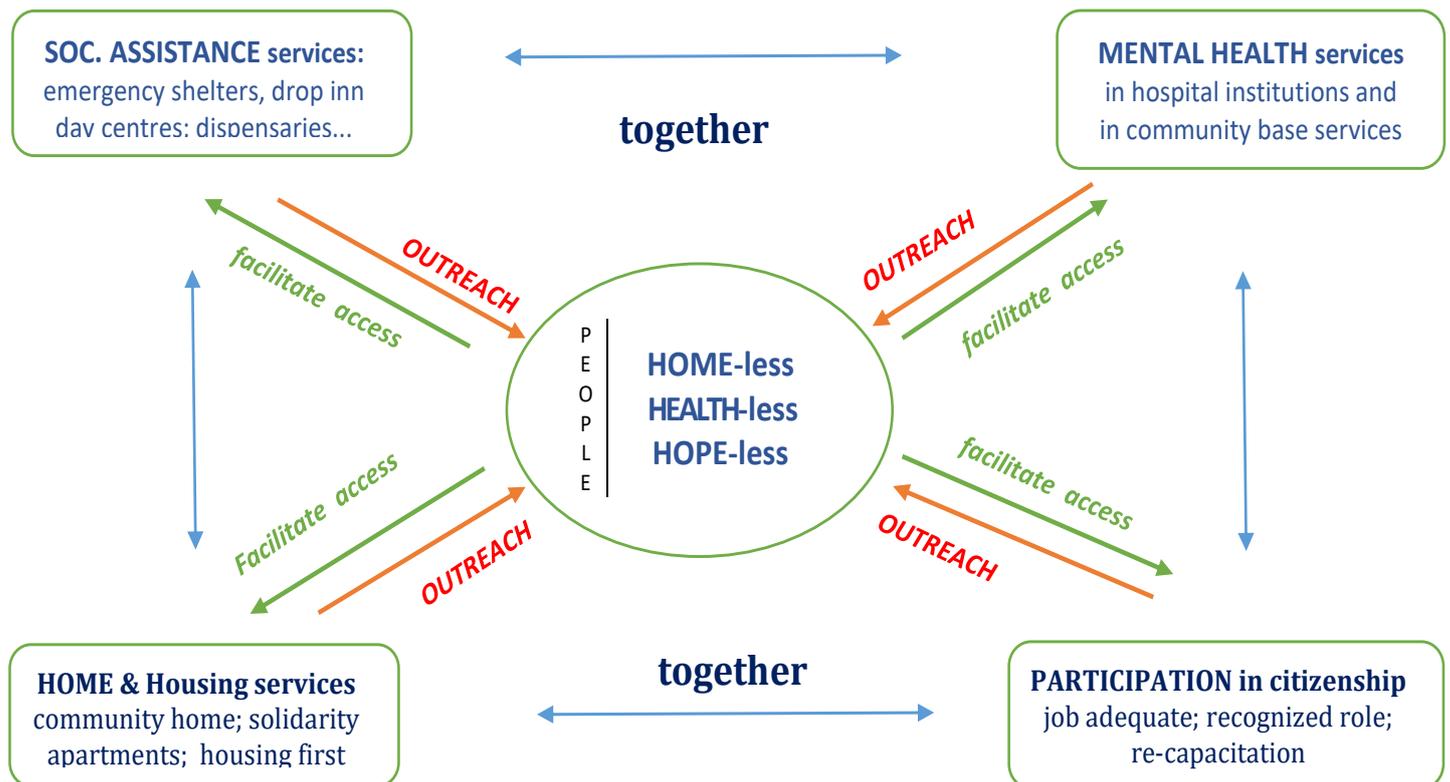
**When the person have lost everything, there is no more that the body for cry and the street to get lost !**

**HOME-less → family-less → HEALTH-less → job-less → HOPE-less → self-esteem-less**

Homeless living in severe & chronic **social - physical - psychical** precariousness are a symptom of the malaise of our society and a permanent injury to democracy, to fundamental rights and social cohesion. They are almost a provocation & challenge, for those who are working in this social and Health/MH field and for responsible of the polis and citizens.



- WHY** some homeless people - with mental health problems - rough sleeping in permanent way or in emergency centres & squats - frequently - giving the impression to refuse any institutional offer of assistance & integration?
- HOW** these services to person – **TOGETHER** - contribute to promote Dignity & Well-being ?



**Instructions and proposals for  
optimal redaction of protocol concerning  
individual homeless people with  
important health/mental health problems**

**1. Target: individual person**

- a. without home: living in permanent way in the streets, or emergency centres, or squats
- b. in extreme deprivation conditions: (hygiene – clothes – personal bag...)
- c. with “evident” health problems (physical – psychical)
- d. who seems to refuse any contact and / or institutional offer of care and cure
- e. other .....

**2. Person: well known by own Association** and also by health – social – care services  
The case will be discussed with own team , before drawing up the protocol.

**3. Working method:** After a rapid presentation of ‘case’, following the first question: the context and the conditions in which the person lives in permanent way, to try to underline and to analyse the specific elements that allow to report causes and effects, factors and consequences.

**4. Study of case:** the study of the case is not a photo of the situation, but rather a radiography that tries to analyse and to underline the interconnections and interrelations - and when it's possible - the causes and effects.

**5. Two pages max.** and be careful to respect of privacy

**6. Presentation of case max. 10 minutes:**

The presentation of the 'case' at time of small workshop, it cannot last more than 10 min max.

To underline above all:

- the elements that presents great difficulty
- what proposed by you, obtains a important and great success
- what is common with similar cases and what so specific and different
- responsibility and co-responsibility of services
- hypothesis of possible alternatives runs

In the case of success and resolution of the case, to what the solution of the case must be attributed..



**PROTOCOL for redaction of PROFILES of study case's  
for D-&-WB workshops inter-vision & evaluation  
about : background - health - intervention - network - proposals**

When the solution of complex situations seems impossible: *how to listen for a deepest understanding ?*  
When the body speaks through his silence and his wounds: *who will listen and hear before intervening*

**N.B. The PROFILE more than a PHOTO is a RADIOGRAPHY which will facilitate the comprehension of the inter - action and the causes. NOT MORE than 2 pages. Attention please **PROTECT PRIVACY OF EACH ONE****

1. **BACKGROUND and environment / context of** profile of the person in relation to : the condition of '*dignity*' and '*health*' in which these people live. What kind of interrelation between these dimensions:

- **time**, in relation to the chronic situation;
- **abandonment**, in relation to the breakdown of any relationship and link;
- **refusal**, in relation to any institutional offer of care and assistance services

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2. **HEALTH: physical and psychic conditions.**

All additional information on the health situation, information on hypothetic or declared diagnoses including:

- interaction between mental and physical condition;
- influence of the health condition on the lifestyle of a person;
- history of interruptions and resumptions of medical services provided to the person,
- orientation and opinions of the medical players in respect to the person;
- interdependence of psychosocial distress in cases where two people of the same family circle are involved

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3. **INTERVENTIONS description** : presentation and evaluation of the history of interventions with their difficulties, successes, failures, including the circumstances of the person's first contact with the organized assistance; clarification of the objectives of the intervention in its various stages; description, if needed, of specific operational solutions; stating the reasons for compulsory sanitary treatment .

- What kind of intervention – in health + social field - success of non-success depends of ...;
- Highlight the correlations between the objectives to be pursued, programmed interventions and outcomes...
- Innovative practices.

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4. **WORKERS & NETWORK:**

- One or many actors? - Does the networking and cooperation between actors exist or not?
- What kind of collaboration between public and private sector?
- What kind of multidisciplinary performing synergies between social, health services and... others?
- What kind of co-working and co-responsibility between Institutions - Associations - Administrations?
- What are the institutional and legal barriers and limitations to providing adequate assistance (cumbersome, poorly defined procedures, "vicious circles"; resources and financing).
- What obstacles could be overcome by "creativity" of the operators in the face of the unhelpful of confusing legislation?

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5. **PROPOSALS:** What proposals of possible and innovative interventions when the solution of complex situations seem impossible?  
- What pathways, what specific priorities could be taken for priority recommendations?  
- Make the proposals as concrete as possible and avoid generalities.

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6. **PERSONAL FACTORS INFLUENCING** the launching and continuation of assistance process:  
- possible stigmatization of person taking charge or applying for assistance;  
- sources of stress and burn-out for assistance workers;  
- changes in staff during assistance process; clashing cultural aspects.

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7. **OVERALL ASSESSMENT OF THE CASE:** strengths and weaknesses of the support net and/or interventions provided;  
- synthetic judgment: the person's condition has improved/worsened or remained unchanged?  
(in relation to the assumed objectives relevant ethical issues related to the work; - final thoughts, free.

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**OPTIONAL:** Complementary elements on the situation of gradual degradation in terms of both physical and mental health

**DIVERS:** ....

When the solution of complex situations seems impossible, how to intervene?

<b>Fictitious name</b>				Codex D&W:
<b>Gender</b>	M	F		
<b>Age</b>	known:		hypothetic:	
<b>Permanence time on the streets (in months)</b>	known:		hypothetic:	
<b>Permanence time on the shelters (in months)</b>	known:			
	hypothetic:			
<b>Hygienic conditions</b>	Acceptable	bad	very bad	
<b>Health conditions</b>	acceptable	bad	very bad	
	diagnosis declared:			
	diagnosis hypothesized:			
<b>Mental Health Conditions</b>	diagnosis declared:			
	diagnosis hypothesized:			
<b>Causes / factors of loss</b>	housing:			
	health:			
<b>In charge of</b>	social services:			
	health services			
	mental health services			
<b>Collaboration of people</b>	with a request:			
	collaborative			
	indifferent:			
	oppositional:			
<b>Interventions</b>	net-working:			
	individualists:			
	complementary:			
	occasional:			
	sustainable:			
<b>Pathways</b>	alternative:			
	possible:			