Chronically Homeless People in Poland: Target Group of the 'Housing First – Evidence based Advocacy' Project

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Abstract_ *This article presents the methodology and results of three studies conducted under the 'Housing First – Evidence based Advocacy' project implemented between 2014 and 2016 in Poland (EEA Grant). The aim of the studies was to assess the presence, scale and basic characteristics of the predefined target group of people experiencing long-term homelessness (over three years), having at least one 'disabling condition' (mental disorders and/or substance dependency), and additionally sharing some features of Housing First Programme clients, such as difficulties in relations with traditional institutions and frequent changes of facilities, hospitalisation, periodic living 'on the street' and debts. The studies were collected by the Ministry of Family Labour and Social Policy and local non-governmental service providers in Warsaw. The results confirm the presence of the target group, provide quantitative data on its scale at national and municipal level, and reveal patterns in the quality and quantity of interactions with, and the array of, institutions including medical, judicial, employment and welfare agencies. In conclusion, the research demonstrates that the existing support system is ineffective in ending homelessness for target group members and that an intervention such as Housing First would be useful.*

Keywords_ *Chronic homelessness, dual diagnosis, interactions with institutions, statistical analysis, Housing First, Poland*

ISSN 2030-2762 / ISSN 2030-3106 online

Introduction

Poland has a system of 'moving out of homelessness', which is based on facilities 'for the homeless'. There are almost six hundred such facilities, mainly night shelters and other shelters; these shelters have rooms of various sizes and anything from a few to several hundred persons live in them under the watchful eye of social workers and in the company of fellow shelter inhabitants – sharing bunk beds, a wardrobe, a table and a wash basin – for many months. The maintenance of sobriety is a universally applied condition under which this 'roof over one's head' is provided. Forty-three percent of persons recorded during the 2013 homeless count as still homeless (Ministerstwo Rodziny, Pracy i Polityki Społecznej MRPiPS [Ministry of Family, Labour and Social Policy], 2013) have been 'moving out of' homelessness in this way for at least five years. In the same research, only 1,330 people were counted as inhabitants of so-called training or supported apartments for homeless people but, as the Ministry declared in its report, they should not be considered homeless as they do not meet the definition of a homeless person in the Act on Social Welfare (2014) and, in fact, live in a habitable place. Two years later, during the next homeless count they were not even counted for the same reason.

Meanwhile, employees of traditional facilities report meeting people whom they are unable to help among their service users: those who fail to abide by the rules and regulations, leave shelters or are expelled from them, or demonstrate problematic behaviours. The harmful and unfair assertion that people are homeless 'by choice' is very often applied to this group as they permanently live on the streets, in abandoned dwellings and in other 'uninhabitable' places, refuse to be transferred to night shelters and are rejected from shelters as they actively abuse psychoactive substances, which is automatically attributed to personal choice. This group became a focus of the 'Housing First – Evidence based Advocacy' project (NMROD: Najpierw mieszkanie – rzecznictwo oparte na dowodach) conducted by the Ius Medicinae Foundation between 2014 and 2016 and co-financed by EEA Grants.

We expected that such labels might be attached to people who are chronically homeless and share a profile with clients of the internationally known Housing First Programme (Tsemberis, 2010). These characteristics were used as a starting point for planning research in the NMROD project – creating an operational definition of the target group that could be used for data on homelessness available in the country and attempting to prove its existence among people experiencing homelessness and, if possible, assess their quantity and quality of life. Two quantitative studies were designed to help determine occurrence of the target group at country and municipality (Warsaw) level and one qualitative exploratory study to look at the profiles of interactions with institutions of people who met the definition.

Studies in the NMROD project:

- **Quantitative analysis of raw data** (with regard to target group) collected during a national questionnaire-based socio-demographic study carried out in 2013 alongside the homeless count on 7-8 February 2013 by the Ministry of Family Labour and Social Policy (MRPIPS).
- Aggregative study determining the **minimum scale of the target group (dual diagnosis and long-term homelessness)** among persons using services 'for the homeless' in Warsaw. Aggregation of client data collected by providers of the services.
- Exploratory study of the **history of interaction** of members of the target group (chronically homeless persons with suspected dual diagnosis) **with institutions**. The study included 17 case studies of people's interaction with institutions in the period of their homelessness as well as an (attempted) evaluation of the cost of the individual interactions.

This article summarises the methodology and results of the three studies. In the conclusion, it is claimed that the existing support system is ineffective in ending homelessness for the researched group and that an intervention such as Housing First would be justified.

Operational Definition of the Target Group

In Poland, a statutory definition of a homeless person is included in the Act on Social Assistance (2004). It states that a homeless person is a person who is not living in a dwelling as defined in the regulations on the rights of tenants and local housing stock, and is either not registered for permanent stay (per the Act on People's Registers) at all or is registered in a dwelling in which she/he cannot live. In addition, as this definition is rather administrative and difficult to verify in a crisis situation, non-profit service providers often refer to specific housing situations as defined in ETHOS to establish the homelessness of a client. This approach is also used by researchers and recommended by a network of service providers under the project of Local Standards for Exiting Homelessness (Browarczyk *et al.*, 2014).

None of the above definitions and, in consequence, no benefits and services discriminate between chronic homelessness and short-term or intermittent homelessness. It is quite otherwise in the US, where chronically homeless people are entitled to specialist benefits and programmes, and where the US federal Department of Housing and Urban Development (HUD), which is responsible for the financing of local coalitions for the elimination of homelessness, defines a chronically homeless person as any individual remaining homeless for longer than

a year and having a disabling condition, or experiencing at least four episodes of homelessness within the last three years and also having a disabling condition. The disabling conditions include: disorders caused by substance abuse, other mental disorders, developmental disorders, chronic conditions or a disability (also, several of these simultaneously). A person who is simply homeless is understood as an individual spending their nights in a place that is not fit for human habitation (e.g., on the street) or living in a homeless facility, without determining the duration of such a situation (US Department of Housing and Urban Development, 2015).

The profile of the client of the Housing First programme, as described by Tsemberis (2010), uses HUD's definition, which understands chronic homelessness as being/having been homeless for at least a year and suffering from co-occurring mental disorders (dual diagnosis involving addiction to a substance) or having a primary diagnosis of addiction to a substance. We also know that the clients of Tsemberis's programmes possibly stayed in many facilities for homeless people, or hospitals, had dealings with the police, have unsettled matters with the judicial system – such as overdue payment orders, a guardian, treatment ordered by the court – or a history of stays in penal institutions. They are also the group of people least 'liked' by the service providers and are referred to as 'difficult to care for', as they cause most rules-related problems and they are difficult to help using traditional assistance based on the staircase system. The staircase system assumes that making housing assistance dependent on progress in therapy is motivating – e.g., a person unable to remain sober may only get assistance from street workers or night shelters, but if that person signs a contract, obliging himself/herself to start addiction treatment, he/she may get to a permanent shelter. People who manage to demonstrate 'housing readiness' by taking all the necessary stairs finally get to the housing stair.

The operational definition of the target group differed slightly in the different studies, depending on the existing structure of the data under analysis. The adopted operational definition comprised the following elements (two were present in all studies; the third only in the exploratory study of the history of interactions):

- a declared period of homelessness of more than three years – no data allowed determination of the number of episodes of homelessness during the homelessness period; homelessness lasting longer than a year concerned too big a group of people;
- having one or more disabling conditions: addiction to a substance (declared or confirmed in medical documents), mental disorders other than addiction to a substance (declared or confirmed with medical documents);

- additional conditions concerning interactions with institutions, including difficulties in relations with institutions and frequent changes of facilities, hospitalisation in mental health institutions, periodical life 'on the street', debts, difficulties in human relations.

It should be remembered that none of the datasets used for analyses were developed by professional researchers or collected purely for research purposes. Data for the national sociodemographic survey was collected by workers and volunteers from a variety of services, such as the municipal police, social welfare centres and NGOs. Data used in the aggregative study was collected from the registers of service providers (many of which still use paper) as well as most data used for the exploratory study, although in this case important information was also acquired through interviews conducted by social and street workers.

Methodology and Results of the Studies

Results of all three studies confirmed the existence of the target group among people counted as homeless in the country (Poland), using homeless services in the city (Warsaw) and clients of one shelter (St. Lazarus Boarding House CMSA) as well as street work services in one district.

Poland

A national estimate of the scale of the target group was acquired through an analysis of the largest Polish dataset on the homeless population, generated as a result of the sociodemographic study conducted by the Ministry of Family, Labour and Social Policy (Ministerstwo Rodziny, Pracy i Polityki Socjalnej – MRPiPS) during the National Homeless Count on 7/8 February 2013. Researchers obtained the dataset with raw data directly from the Ministry after applying for public information (Ustawa o dostępie do informacji publicznej, 2006).

An analysis of the dataset and its structure enabled application of the first and second criteria of the operational definition used in the NMROD studies: homelessness lasting for more than three years, and addiction as a disabling condition as one of the reasons behind homelessness. An absence of information on the current support needs and health condition of respondents – like chronic diseases, disability, mental disorders including addictions, and other health-related problems – was a barrier in the analysis, which certainly excluded a considerable group of people. In the analysis, two benchmark groups were established against which the target group was compared in regard to the occurrence of features in the third criterion of the operational definition of NMROD studies. The benchmark groups

were the following: chronically homeless persons without a disabling condition (addiction declared as a cause of homelessness); and short-term homeless persons (less than three years).

According to the adopted definition, the target group constitutes 19% of the adults in the sociodemographic study (5,338 persons: 4,926 adult men and 412 adult women). The age distribution for men from the target group is the same as for the benchmark groups. For women, elderly women are much more dominant in the target group than among women homeless for a shorter time. Both men and women from the target group have a lower education level than persons from the benchmark groups, although this is more pronounced for women. Men and women from the target groups declared family conflict as a reason for homelessness slightly more often than persons from the benchmark groups (at the same time, they declared poor health status/disability as the cause of their housing situation more rarely).

Both men and women from the target group differ from homeless persons in the benchmark groups in terms of many features marking the third element of the operational definition used in the NMROD studies. These differences are not very considerable, but they are clear. In comparison with persons from the benchmark group, people from the target group:

- have a housing situation which is more frequently non-institutionalised (non-inhabitable places, abandoned dwellings, allotments);
- generate income mostly from non-formal sources (collecting things, begging, black market work) and social welfare benefits, while at the same time declare a total absence of any income less frequently;
- more often use low-threshold and short-term forms of assistance (clothes, meals);
- have more limited access to health services financed by the State;
- have a disability status more often.

An analysis of their territorial distribution showed that persons from the target group are present all over Poland – wherever the people counting the homeless managed to get to during the sociodemographic study.

Summing up, the approximation of the size of the target group in Poland is too general on the one hand, as it covers only one of many possible disabling conditions and, on the other hand, it is an underestimation due to the fact that the methodology used by MRPiPS for the sociodemographic study only includes those with the desired profile due to their prevailing non-institutional housing situation. The study was carried out for only one day in facilities and places previously identified

as being in the public space. The numbers obtained for people in the latter housing situation were questioned many times and deemed to be underestimated due to the varying adequacy of the identification of places occupied by the people the study was measuring (position of the Kamiliańska Misja Pomocy Społecznej on the determination of the scale of homelessness in Poland of November 2013[1], and position of Ogólnopolska Federacja na rzecz Rozwiązywania Problemu Bezdomności of 19 December 2014[2]).[3]

Warsaw

The existence and scale of the target group in Warsaw was assessed based on the aggregative study of client data collected by service providers 'for the homeless': shelters, specialist shelters, advice and information centres, and medical facilities. Employees were asked to fill in a table on persons meeting the two criteria of the operational definition of the target group of NMROD studies, if such information was available in the internal recording system: homelessness lasting for more than three years and addiction to a substance (marking if it was suspected by the staff or confirmed in medical documents) and/or mental disorders other than addiction to a substance (marking if suspected or confirmed). Only in a few services were employees able to generate data from electronic registers – for the majority, the task involved the revision of individual paper records. Other than in the analysis of MRPiPS data, we were able to produce the prevalence indicator for the target group. Double counting was excluded through the coding procedure of personal identification data. Turnout from services for women was not adequate to conduct an analysis.

In 2013 and 2014, Warsaw-based facilities for the homeless recorded a total of 333 men who met the definition of the target group used in the NMROD studies: they had been homeless for more than three years, and displayed mental disorders other than addiction (formal or suspected by social workers), and at the same time had a formal or suspected addiction to a substance. In the case of 180 of the men, the facilities had a confirmation of both disorders in the form of medical documents with a diagnosis entered by a doctor (formal dual diagnosis). Their average age was 46, and 58% of them had experienced homelessness for more than five years (12 years on average – figure for three-quarters of the group). They were recorded in, on average, the biggest number of facilities: 1.6 (maximum of 5). In the case of the other 153 men, the formal diagnosis applied to one of the disorders from both

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1 http://www.misja.com.pl/wp-content/uploads/2013/11/Stanowisko-KMPS-liczenie-ludzi-bezdomnych.pdf

2 http://www.bezdomnosc.pl/images/dokumenty/stanowiska/2014.12.19_Stanowisko_badanie_MPiPS.pdf

3 A full report of the study, including methodology, results, charts and recommendations, is available for Polish language readers (Herbst and Wygnańska, 2016).

groups with a simultaneous suspicion of the second or with suspected disorders from both groups (suspected dual diagnosis). Their average age was also 46 years, and 45% of them had experienced homelessness for more than five years (one third of them for more than 13 years).

During the two-year period under study, 1,246 men who were registered in the facilities declared homelessness lasting for more than three years, had a formal or suspected diagnosis of mental disorders, and/or had a formally determined or suspected addiction to a substance – mainly alcohol. It is important to note that this number does not reflect either the full scale of chronic homelessness, or the prevalence of mental disorders or addiction (which is possibly much larger) among the entire group of service users in the period covered by the study – it reflects only the intersection of these sets.

Due to the methodology of the data collection on users of homeless services in Warsaw (determination of the group's size only at a given point in time, without being able to determine its size over a longer period – e.g., that covered by the NMROD research – so as to exclude multiple counting of the same person using the services of many facilities), it is impossible to determine the share of the 1,246 men from the target group in the total number of male service users. Assuming that the conditions of the users were recorded correctly in the registers kept by the services, we may, however, note that during the two years in question, they dealt with 333 persons whose health and homelessness history pose a challenge that cannot be solved within the traditional staircase system of assistance in Warsaw.[4]

History of Interactions with Institutions

The goal of the exploratory study on interactions with institutions was to look for people who meet the full operational definition of the target group in the NMROD studies, including all three criteria (profile of respondent) and then reconstruct the history of their interactions with any institutions in the last three years of their homeless life.[5] The profile of the respondent was: homeless for longer than three years; suspected or formally diagnosed mental disorders and/or substance dependency or substance dependency as primary diagnosis; established in an

4 A full report of the study including methodology, results, charts and recommendations is available for Polish language readers (Wygnańska, 2016).

5 Initially, the plan was not only to reconstruct the history of contact with institutions but also to evaluate the costs of their interventions for individual respondents. After initial trials, this goal was given up due to very limited information on the costs of individual interventions and rejections from institutions to assess them.

interview having had difficulties in relations with institutions and frequent changes of facilities, hospitalisation in mental health institutions, periodical life 'on the street', debt, difficulties in human relations.

The study was conducted in cooperation with the Camilian Mission for Social Assistance (CMSA), which was responsible for the selection of respondents according to the profile and data collection process. In order to select respondents, CMSA employees used interviews while performing their regular duties as workers of CMSA Boarding House for the Homeless (for one hundred men) and street work in three districts of Warsaw over a four-month period. The scenario obliged them to establish the length of homelessness, history of housing situations according to ETHOS, causes of homelessness (subjective and evaluated by data collectors), family and household structure, sex, age, place of birth and, last but not least, the list of institutions that were present in their life during the last three years of their homelessness. In this stage, CMSA identified 43 people who met the profile and provided necessary data.

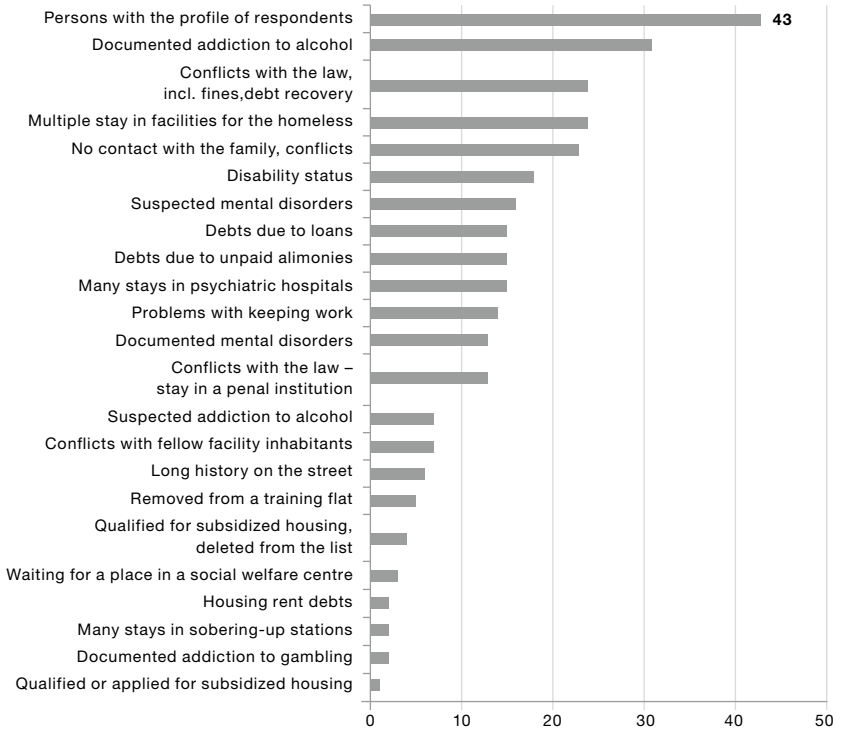
The study was conducted in a very difficult environment, among people living on the street or in a shelter, who were extremely excluded and distrustful. At the same time, the information collected was quite detailed and sensitive, as it concerned contacts with mental health, penal and debt collection institutions, as well as reasons behind the homelessness – i.e., conflicts in the family and life failures. It was necessary to obtain respondents' consent to apply to institutions for information on their behalf. This is why the final selection of the respondents whose life stories were included in the study was based not so much on their compliance with the profile, as on the ability to obtain detailed information. Twenty-six persons who qualified for the study on the basis of their profile refused to participate, withdrew their consent to participate or broke off contact with the data-collecting facility (e.g., left it or changed their whereabouts in the public space). In the end, we were able to conduct the full study of interactions with institutions for 17 respondents.

Having determined the list of institutions, data collectors applied to the institutions for information on the respondents from internal registers. In addition, for the respondents chosen from among the inhabitants of the shelter, documents available in personal records were also used. Finally, information on over 1,300 interactions was collected and analysed. In addition, information on the housing (according to ETHOS), administrative (registration for permanent stays and personal IDs) and health situations was added. The results are described below.

During the four winter months, the CMSA hostel and street work services supported to 36 persons with the profile of the respondent, while the independent researcher discovered the presence of seven such persons in places unfit for human habitation in one of the districts of Warsaw. This group comprised 41 men and two women

with an average age of 51 (maximum age 67, minimum age 33). The majority – 84% were single, divorced or widowed. Only four persons (9%) were married. One third of the respondents had no children, and 60% had between one and three children who did not stay with them. During the research period, most had a single-person household – only two persons who lived outside the facilities, in the public space, shared a household with a partner. They had a suspected (verified by a psychologist) or formal (confirmed by medical documents) diagnosis of mental disorders and/or a suspected or formal diagnosis of addiction to a substance (alcohol in the vast majority). The average period of homelessness was more than 11 years (the maximum period was 41 years, and the minimum period was two years). During their homelessness history, 30% of the persons in question were registered for temporary or permanent residence at three, four or eight addresses, which very clearly testifies to their unstable housing situation. At the time of the research, one fourth of the group members (26%) were not registered for either a permanent or temporary stay under any address. The history of their homelessness included many additional conditions from the third criteria of the operational definition of the target group, as illustrated in Figure 1.

Figure 1. Additional Conditions of the 43 Respondents



The full history of interactions with institutions was reconstructed for 17 respondents (16 men and one woman) from the initial group of respondents who met the profile. They had experienced homelessness for 11 years on average (min. 3 years, max. 25 years). As at the research date, two persons lived with a partner and 11 persons stayed in a shelter. Five persons had lived in non-conventional places in the public space for a long time, and one lived in communal housing but was threatened with homelessness. Each of them suffered from a diagnosed or suspected mental disorder and/or a diagnosed or suspected addiction to alcohol: eight persons with a suspected dual diagnosis and five with a formal dual diagnosis. Nine of them were born in or very near Warsaw.

Since the study was small-scale and qualitative, we do noty claim that it is representative. However, since the study was exploratory and it refers to a previously non-studied phenomenon, at least in Poland. It may concern only the studied group, but it may just as well apply to many persons meeting the profile of the target group identified in other NMROD studies.

Considering the above, the authors of the study decided to put an emphasis on graphic presentation of the individual cases in order to facilitate independent analysis by any interested person. Two tools were used: interactive visualisation of individual cases on the website www.czynajpierwmieszkanie.pl in the 'Chronic homelessness' section[6]), and diagrams of the connections of each person with identified institutions. For both methods of presentation, respondents were given names starting with the letter "B" (just like *bezdomność* – homelessness in Polish).

The interactive visualisation was prepared by Laboratorium EE, a for-profit social enterprise based in Warsaw.[7] It consists of a description of most characteristic elements of the respondent's interactions (e.g., no contact with social welfare centres, 70 stays in sobering-up stations, seven fines for swearing, etc.), reasons behind their homelessness, as well as qualification (by social workers) for the research – i.e., the justification for having the profile of the respondent. Further, the interactive time axis can be entered, showing the housing situations according to ETHOS, administrative history (registrations for permanent stay, personal documents) and health situation (based on medical documents), as well as the history of interactions with institutions ordered into five categories: medical treatment, social welfare, employment, law and housing support.[8]

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6 http://www.czynajpierwmieszkanie.pl/bezdomnosc/wizualizacja/

7 Laboratorium EE provides IT solutions for social issues such as malnutrition, migration and citizenship, elementary education, volunteering and public spending transparency http: //laboratorium.ee/polona/

8 The visualisation is available in Polish; however, time axes are quite universal and some explanation in English is available at http: //www.czynajpierwmieszkanie.pl/en/research/other/

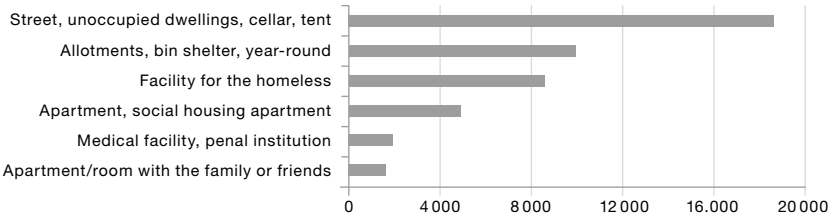
Respondents from the target group rarely stay in facilities for homeless people

Although most of the respondents were identified for the study during their stay in a homeless facility, this was not a situation that dominated their housing history for the period of homelessness. In evaluating housing history, the European Typology of Homelessness and Housing Exclusion ETHOS (FEANTSA, 2010) was used.

Some respondents felt they had been homeless for a much shorter time than their housing situation would suggest; e.g., Baltazar felt homeless since he was admitted to a facility for the homeless, although he had lived for 10 months in a cellar of the block in which his flat was situated, and from which he had had to move out due to a conflict with his wife.

The mean duration of the homelessness or housing exclusion of respondents was 11 years, but they had only spent a total of 10 months in facilities for the homeless on average. They had mainly stayed on the street, in a cellar, tent, or (throughout the year) in allotments and bin shelters (Figure 2).

Figure 2. Total Number of Days in all Housing Situations of all Respondents



The respondents' housing situation changed frequently, as is well-illustrated by the example of Borys, who actually has a legal title to a flat but cannot go back to it due to his family's (his father's and other relatives') decision resulting from his disastrous behaviour in the course of their life together: he failed to pay rent, invited acquaintances, started rows. Borys is mentally ill. He has been diagnosed with two disorders: bipolar disorder and addiction to alcohol.

Initially, Borys lived 'on the street' for six years (he did not feel homeless then) to get to a facility in 2011 (when he actually started to feel homeless); he was rejected from that facility and the subsequent ones. He left to go on the street or to allotments five times in four years.

People living permanently in the public space with practically no assistance from institutions

In comparison with Borys, Błazej and Bogumil have a very stable situation: for years they have been living in the public space (in allotment huts or bin shelters) all year long. What is striking is that, they receive practically no formal assistance from social welfare centres, facilities for homeless people or street workers, but have regular interactions with public order institutions: the city guard, police, courts and debt collection agencies. The only assistance they get from health-related institutions is the provision of detoxification in sobering-up stations, which lasts anything from a few hours to one day. One of the men regularly receives a care package from Caritas through a parish under the PEAD programme – and that is basically it.

Their interactions with institutions were recreated with particular care – the researcher contacted literally every single institution indicated by the respondent in the interview carried out over several meetings, and exacted the history of their interactions with the respondent. In two cases, the respondents were not mentioned in the registers of the local social welfare centre, which means that they did not get any assistance from this source (which, after all, is the facility most obliged to help them and developed especially for the purpose) during the five years covered by the detailed analysis. The researcher summed up the complete absence of assistance in the life of this group of people with the following bitter statement: "there is nothing cheaper for the State than to let human beings live and die in the rubbish bin."

Treatment – when there are injuries, accidents

Bolesław and Bartlomiej have also lived in the public space (for 18 and 14 years subsequently), practically in the same location, which according to ETHOS would be categorised as a non-conventional shelter. At some point they began to have health-related problems. Bolesław broke his arm and had to attend rehabilitation; Bartlomiej fell asleep in a tent that caught fire and he was later badly beaten. He had to seek medical assistance, also in the emergency department, but had no right to public health care, so a bill was issued for it. Debt collection is in progress, but will possibly be discontinued due to the lack of financial means. Before injuries and urgent health problems appeared, assistance from institutions is just as scant in data as in the previous cases: we only have the city guard (transport to the sobering-up station), the police (fines for swearing), a sobering-up station, and social assistance in the form of a care package distributed under the PEAD programme by a non-governmental organisation. It is also true that Bartlomiej was covered by assistance from the local social welfare centre (designated benefits, a gas bottle) and several times registered himself as unemployed in the labour office at the beginning of his homelessness. Both men have no registration for permanent residence; Bartlomiej participated in the homeless census in 2001.

Large number of institutions once respondets become users of services for the homeless

The small scale of the interaction of respondents staying in the public space on a permanent basis with institutions can be seen more clearly when we compare it to the history of respondents who entered the system of aid 'for the homeless' – night shelters and ordinary shelters. Regardless of the respondents' previous experience, when they get to a facility, the social work 'machine' is started.[9] Day treatment for alcohol addiction is arranged quickly outside the facility, and involves group meetings and individual sessions with an addiction counsellor or a doctor. The person's health status is also determined quickly and, if necessary, the process of applying for a determination of the degree of disability or qualification for a place in a social welfare centre is commenced.

Baltazar's and Borys's stories are good illustrations of the sheer number of activities carried out as a part of the machine. Baltazar spent 14 months in a facility. Addicted to alcohol for many years, at some point he was made to leave his flat by his family, who were no longer able to help him. In this way, his formal homelessness started. His life in the facility is very difficult for him: he is over reactive and aggressive, has frequent conflicts with the other people staying in the facility, and he requires patience, long conversations and mediation. The facility's employees suspect that he is mentally disturbed.

The story of Borys, whose five-month stay in the facility conducting the study is the fifth stay of his homelessness period, is an example of the great number of interactions with institutions that homeless people have regardless of where they stay; if it is not social work and benefits in a shelter, it is fines for travelling without a ticket and their enforcement over many months, staying in a sobering-up station during life on the street and in non-permanent structures, or stays in psychiatric hospitals. Borys has been suffering from alcohol addiction and bipolar disorder for years. He went through several inpatient addiction treatment courses, and has a disability certificate. He has problems keeping a job – he has only worked legally for a few years in his life. When under the influence of alcohol, he regularly breaks the law. He is unable to maintain relationships with his partners. Borys's situation possibly most fits the description of the target group profile: a chronically homeless person

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9 We do not know how the 'machine' operates in facilities other than the one in which the study was carried out, since it was not the subject of an equally detailed analysis. We determined the very fact of stay, but details of the assistance were not analysed as carefully as in the facility whose employees were responsible for the selection of respondents and the collection of data for research. We can assume that, at least in Warsaw, the related activities are similar, because all facilities implement the same social work programme, resulting from long-term contracts with the capital city.

with a dual diagnosis. Just like Baltazar, Borys started to live on the street after his family gave him an ultimatum concerning conquering his addiction – possibly as a result of their helplessness.

Housing aid – hardly present

Very few respondents (3), including Bronislaw, were able to use the housing aid scheme, which involves applying for subsidised housing to the city and/or participation in the scattered training flats programme run by the Camillian Mission for Social Assistance. In the programme persons moving out of homelessness live in flats rented from private owners, in the 'normal' local environment, and are simultaneously equipped with a security blanket in the form of support from employees of the homeless facility. The programme resembles the Housing First programme more than shelters do, owing to the scattering of the flats, but at the same time it is very different from it, since the rules and regulations still make assistance dependent on the maintenance of sobriety and progress in treatment as evaluated by social workers. Despite attempts, it does not guarantee the availability of specialist care. However, it is one of the most advanced programmes for homeless people in Poland, as it is housing led.

Unfortunately, the programme proved inefficient in Bronislaw's case and he was unable to keep the flat. Due to progressing illnesses (organic hallucinosis and organic mood (affective) disorders), he lost his job. Bronislaw also had problems with money management – he generated debts of several thousand złoty, although he realised that it would be impossible for him to start work again. After more than a year of participation, he returned to a facility for homeless people, in which the social assistance machine – suspended when he moved to the flat – had to be started again; the social welfare centre in his registered place of residence again started to cover the cost of his stay in the facility, and a multiple-stage procedure (due to refusals and appeals) of applying for a place in the social welfare centre was initiated. Bronislaw feels he has been homeless for 20 years. He thinks that his homelessness is mainly caused by his breakdown following divorce; his wife asked him to leave and, along with the roof over his head, he lost the will to live.

The above are just a few stories showing the interactions of some members of the target group with institutions. These people are still homeless, even though they were served by multiple agencies.

Summary of Results

Summarising the results of all analyses conducted in the NMROD studies leads to the following observations:

First, the data available at the national level make it possible to identify a group of persons only approximately meeting the definition of the target group. However, comparing this group with the benchmark groups reveals patterns consistent with the third criterion of the operational definition used in NMROD studies: more frequent stays in non-institutional housing situations, more frequent use of low-threshold assistance (meals, clothes) and shelters (throughout the homelessness period), more frequent possession of sources of income in the form of social welfare benefits and work in the grey zone (garbage/food scraps collection, begging, work without a contract), less formalised health status (less frequent coverage by health insurance and less frequent confirmation of disability by a certificate), and, despite the latter, more frequent possession of the status of a disabled person in comparison with persons experiencing short-term homelessness.

Secondly, there is no doubt that within two years, as many as 333 long term homeless men with dual diagnosis of mental disorders and substance dependency (mostly alcohol) were admitted to homeless services in Warsaw: shelters, specialist shelters, medical points and advisory posts.

Thirdly, there are people in the public space and in non-inhabitable places in Warsaw who live without any help from institutions that are obliged to provide such assistance and that have the appropriate qualifications to do so (social welfare, departments of housing stock), even though representatives of other local institutions, such as the municipal police and sobering up centre, know about their situation.

Fourthly, the respondents' housing situation, as classified according to ETHOS, is very changeable – from the street through allotments and facilities and back to the street – and the stay in facilities is not the dominating housing situation. The respondents evaluating their homelessness believe that it begins when they enter the system 'for the homeless', and not at the moment indicated by their housing situation according to ETHOS.

Fifth, both the number and variety of institutions in the history of the interactions of those who in the system of assistance 'for the homeless' is substantial and involves many departments – not only social welfare, which is generally believed to have the sole competence to respond to the needs of people experiencing homelessness. The number of categories and the quantity of institutions within them does not bring about the desired result – moving people out of homelessness into a permanent housing situation.

Sixth, although the adequacy of institutions for the profiled respondents' needs was not the subject of detailed evaluation (the aim was to present the current range of institutions), what is striking is the absence of housing assistance, which would seem to be the most appropriate solution for the respondents studied. Another noticeable shortcoming is an absence of coordinated assistance (e.g., by a street worker, an assistant, or a designated social worker) when respondents with significant mental disorders stay in the public space, and while their situation engages many institutions.

Last but not least, data collection on homelessness at the national level is not adequate to evaluate important features of the homeless population, especially support needs and current health status. Important data on homelessness in Warsaw – with the biggest homeless population in the country – has to be collected on *ad hoc* manner as there is no other way to acquire information on the number of unique clients and their characteristics, such as length of homelessness and health needs as well as migration through services.

Conclusions

We do not know for sure if the people hidden behind the numbers and characteristics of the target group of NMROD studies are the same as those reported by employees of traditional facilities as 'difficult to serve' and 'homeless by choice'. However, the operational definition that was finally applied in the NMROD studies, even considering that all three criteria could not be applied to all studies, is close enough to the profile of the clients of Housing First Programmes developed by Dr Sam Tsemberis from Pathways to Housing in New York at the beginning of the 1990s.

The Housing First programme is based on the conviction that housing – as a place that provides protection against unfavourable weather conditions, privacy, an opportunity to draw satisfaction from social relations and a sense of security – is one of the most fundamental of human rights. The programme is addressed to a group of people in a special life situation – people for whom it is the only way to obtain housing. They are people who despite obtaining assistance from many institutions for many years (including those 'for the homeless'), continue to experience homelessness, failing to meet the challenges posed by life.

Housing First (HF) was popularised in Europe during international meetings of researchers and practitioners, such as the European Consensus Conference on Homelessness in Brussels in 2010 (European Consensus Conference on Homelessness, 2010) and the Final Conference on Housing First Europe in Amsterdam in 2013, as well as taken up in recommendations of European Commission and Parliament in their Social Investment Package (European

Commission, 2013). Clients of the HF programmes implemented outside Poland generated high housing retention rates – not recorded in traditional services – even after the completion of the programme (Pleace, 2013; Busch-Geertsema, 2014).

It is fair to conclude that potentially as many as 5,338 people in Poland, 333 men in Warsaw and 17 clients of one service (of over 20 such services in town) might benefit from an intervention based on Housing First.

Such a high share of chronically homeless persons (19% of adults covered by the national sociodemographic study) among people actually using the support of the existing system of assistance is a very poor testimony to the national system. Until recently, many stakeholders coped with the above, blaming the users of services for their situation. As can be seen, this does not bring about any changes – the people are still homeless. What we need is to solve the problem, not to collect arguments confirming that it is impossible – especially that, as proven in many places all over the world, it is possible to solve the problem through the implementation of Housing First and other specialist programmes for persons with the NMROD target group profile.

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