

European Observatory on Homelessness

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Journal Philosophy

The European Journal of Homelessness provides a critical analysis of policy and practice on homelessness in Europe for policy makers, practitioners, researchers and academics. The aim is to stimulate debate on homelessness and housing exclusion at the European level and to facilitate the development of a stronger evidential base for policy development and innovation. The journal seeks to give international exposure to significant national, regional and local developments and to provide a forum for comparative analysis of policy and practice in preventing and tackling homelessness in Europe. The journal will also assess the lessons for Europe, which can be derived from policy, practice and research from elsewhere.

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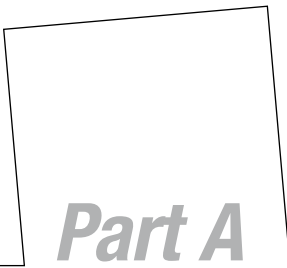
In this edition of the European Journal of Homelessness(EJH), we not only describe, analyse and critique homelessness policies and practices across the European Union, from Spain to Poland, Ireland to Belgium, but also in our new international section, Fiorella Ciapessoni provides a detailed overview of homelessness in Uruguay. While striving to develop new sections in the EJH, we have also maintained core sections that our readers have found of value. In the very first edition of the EJH in 2007, Isobel Andersen reviewed the Scottish Homeless Strategy, and since then the Journal has reviewed homeless strategies in nine other member states, including the review of the Spanish Homeless Strategy by Isabel Baptista in this edition. These detailed county case studies not only provide valuable information on the policy approaches deployed to achieve decreases in homelessness and the degree of ambition in the strategies, but also document the diffusion of coherent, usually national, approaches to ending homelessness in member states.

Ireland, an early adopter of a strategic approach to ending homelessness, is reviewed in a contribution by Eoin O'Sullivan, where he analyses the failure to end long-term homelessness and the need to sleep rough in Ireland by the end of 2016 – a policy objective set out in 2013. The failure to end homelessness is not unique to Ireland. Many Member States, and indeed cities in Canada and the United States with various ten-year plans, have sought to reduce and ultimately end homelessness, but with the exception of Finland, have largely not succeeded. A common feature of the various analyses that attempt to account for the failure of such plans to achieve their objective is the failure of housing markets to deliver housing in sufficient supply and affordability.

The issue of measuring homelessness is a perennial topic in the EJH and Marjorie Lelubre and Maëlle Dewaele provide an informative overview of recent developments in Wallonia. Other regular topics include Housing First, the intersection of mental health, addiction and homeless services, and access to social housing. In this edition Julia Wygnańska provides a concise overview of the demand for Housing First in Warsaw, Ruth Ceannt and colleagues get the perspective of front-line workers in Dublin on the intersection of homeless services and mental health and addiction services, while Guillem Fernandez Evangelista explores access to social housing in Germany, Spain and the UK. This edition of the EJH also has a number of book reviews that we hope our readers find of interest.



Articles



Part A

Ending Homelessness in Ireland: Ambition, Adversity, Adaptation?

Eoin O'Sullivan

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› **Abstract** *In 2013, the Irish Government launched a plan to end long term homelessness and the need to sleep rough in Ireland by the end of 2016. This ambitious target will not be achieved, and indeed, the extent of homelessness, particularly family homelessness, is at unprecedented levels. This paper attempts to explain why homelessness, particularly long-term homelessness, has increased rather than decreased in Ireland over the period 2013 and 2016. The paper provides an overview of the evolution of homelessness policy in Ireland, with a focus on the period from 2013 to 2016. The various initiatives and recalibrations of policy over the period are examined in detail, as are trends in the extent and dynamics of homelessness. The paper concludes that despite the many successful initiatives preventing homelessness and ensuring sustainable exists from homelessness, the unremitting flow into homelessness, driven primarily by a dysfunctional private rented sector and a lack of social housing, has resulted in unprecedented numbers of homeless households in shelters, hostels and commercial hotels at the end of 2016.*

› **Keywords** *Ending homelessness, Ireland, trends in homelessness, housing markets*

Introduction: Ambition

In February 2013, the then Minister for Housing and Planning, Jan O'Sullivan, launched a **Homelessness Policy Statement**.¹ A relatively brief document, it promised to end long-term homelessness, which was later defined as living in emergency accommodation for longer than six months, and the need to sleep rough in Ireland by the end of 2016.² It proposed to end homelessness by adopting a 'housing-led' approach, which was defined as "the rapid provision of secure housing, with support as needed to ensure sustainable tenancies" (Department of the Environment, Community and Local Government, 2013, p.2).³ Thus, Ireland, like many other jurisdictions, set out to end particular forms of homelessness and to put in place measures to prevent homelessness from occurring in the first instance, or from reoccurring. It was a particularly ambitious objective given the contraction of the Irish economy from 2008, and in late 2010, the Irish Government was forced to secure a loan – formally known as a 'Programme of Financial Support' – from the European Union and the International Monetary Fund. As part of the loan agreement and underpinned by earlier and later treaties, the amount of public spending on capital projects such as social housing was restricted.

To assist the Minister in monitoring and measuring progress towards ending homelessness in 2016, a three-person Homelessness Oversight Group was established, comprising a senior social policy academic, a retired former senior civil servant and a senior financial services professional from the private sector. Some 10 months later, in December 2013, the oversight group produced its first and, ultimately, its only report (Homelessness Oversight Group, 2013) as it was effectively made redundant by a change in the Minister with responsibility for homelessness, with Alan Kelly replacing Jan O'Sullivan in July 2014. The report noted that it was difficult,

¹ The report drew in turn on an overview of homelessness policy in Ireland and internationally by the current author, entitled *Ending Homelessness: A Housing Led Approach* (O'Sullivan, 2012).

² This was not the first strategy that sought to end homelessness in Ireland: in 2008, a national homeless strategy entitled *The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008-2013* was published and committed to eliminating long-term homelessness by 2010. The Way Home was published following a detailed review of two earlier strategies – *Homelessness: An Integrated Strategy* (2000) and a *Homeless Preventative Strategy* (2002). These strategies were independently reviewed in 2006 and the recommendations from this review informed The Way Home Strategy (see O'Sullivan, 2008 for a detailed overview). The date chosen for ending homelessness, 2016, was symbolically significant in Ireland as it marks the 100th anniversary of what is commonly known as the Easter Rising, an armed insurrection against British colonial power, which led to further conflict between 1919 and 1921, ending in British withdrawal from the southern part of Ireland.

³ In addition to the national Homelessness Policy Statement, Local Authorities are required under the Housing Act, 2009 to draw up Homeless Action Plans; the first set of plans drawn up covered the years 2009-2013 and the second set of plans cover the period 2014-2017.

in the absence of robust data, to determine if progress was being made in reducing long-term homelessness, but from the limited data available to them, the rate of reduction was “too little and at too slow a pace” (2013, p.10) to achieve the policy objective of ending long-term homelessness by 2016. Despite this caveat, it was noted in the report that, given the relatively limited scale of long-term homelessness in Ireland, which they estimated at between 1,500 and 2,000, the target of ending long-term homelessness and the need to sleep rough by 2016 was realistic.⁴

The idea of ending homelessness has, in the words of Baker and Evans (2016, p.25) “gone from politically unthinkable to politically mainstream.” In a review of over 60 plans and strategies in North America, Europe and Australia that aim to end homelessness, it was noted that there was little consistency in how ending homelessness was operationalized, but that the majority had a broadly ‘functional zero’ definition (Turner *et al.*, 2016). That is a definition that does not seek to completely eliminate homelessness, an ‘absolute zero approach’, but rather aims to ensure “there are enough services, housing and shelter beds for those who need it. In this approach, emergency shelters are meant to be temporary and the goal is permanent housing” (2016, p.5). The definition set out in Ireland in 2013 was broadly a ‘functional zero’ approach, in that ‘ending homelessness’ is ending long-term shelter use and the need to sleep rough. However, it is now clear that the ambitious target of ending long-term homelessness and the need to sleep rough in Ireland by the end of 2016 will not be achieved. Indeed, the extent of homelessness, particularly family homelessness, is at unprecedented levels.

This paper aims to provide an overview how the initial optimism that long-term homelessness could be ended was eroded to the point that the most recent iteration of homelessness policy no longer contains a specific time-frame to end homelessness. Instead, it contains a commitment to ending the use of commercial hotels for homeless families by mid-2017, to minimise the need to sleep rough by providing

⁴ Shortly after publication of the Homeless Policy Statement, an assessment of the need for social housing – a periodic count of the demand for social housing – took place, with 89,872 households assessed as qualifying for social housing support (Housing Agency, 2013). Of these, 2,808 households were residing in an institution, emergency accommodation or a hostel, with 1,937 of these households located in Dublin (Housing Agency, 2013). Detailed analysis of the Dublin figure of 1,937 demonstrated that when rough sleepers and those who were accessing emergency accommodation but had not completed an assessment of housing were included, the estimate for the extent of homelessness in Dublin in early 2013 was 2,867 (Feely and Maphosa, 2015). This was a 48% increase on the assessment figure and if this is applied nationally, a figure of 4,156 is arrived at. Thus, at the time of the publication of the Homeless Policy Statement, a reasonably accurate estimate of the extent of homelessness in Ireland was in the region of 4,150 homeless adult households. If the profile for Dublin was applied nationally, just over 70% of the homeless were male, the average age was 37, and three-quarters were of Irish origin.

sufficient emergency shelter beds and to aid households exiting emergency accommodation by enhancing financial support to access housing. Thus, the ambition to end homelessness was replaced with more modest proposals to reduce the use of inappropriate emergency accommodation, particularly for families, and to strengthen mechanisms that would enhance supply and facilitate exits from homelessness.

Implementing the Homeless Policy Statement: Plans, reports, strategies

In May 2014, a detailed **Implementation Plan on the State's Response to Homelessness** (2014) was published. The response contained 80 specific actions that were required to end homelessness by the end of 2016. On 4 December 2014, a special summit on homelessness was held in the Department of the Environment, Community and Local Government (the lead Government Department with responsibility for homelessness policy) following the death of a homeless man in the vicinity of the Irish Parliament. The outcome of the summit was an **Action Plan to Address Homelessness**, which identified a further 20 actions aimed at ending homelessness, giving a total of 100 actions. These 100 action points ranged from identifying vacant housing units, including NAMA⁵ units, and making them available for homeless and other vulnerable households; prioritizing homeless households for social housing allocations; putting in place protocols in relation to discharge from institutions; and securing rent supplements for homeless households.⁶

In November 2014, a **Social Housing Strategy** was launched by the Government. This provided for funding to allow Local Authorities and Approved Housing Bodies to build, acquire or lease 35,000 units of social housing over a six-year period, and to provide new social housing supports for eligible households utilising the private rented sector. In April 2016, **Laying the Foundations: Housing Actions Report** was launched by the Department of the Environment, Community and Local Government (2016). It outlined the 31 actions that were underway to address the housing and homelessness crisis in Ireland. Five of the actions related to homelessness. They were: the provision of rapid-build (prefabricated) housing for 153 homeless families by the end of 2016; to maintain the 'Housing First' approach to ending rough sleeping; directing Local Authorities to provide up to 50% of social housing allocations to homeless families; to enhance the levels of rent support for homeless households;

⁵ The National Asset Management Agency (NAMA) was established by the Irish Government in 2009 as a 'Bad Bank'. At the end of March 2016, NAMA had identified 6,637 units on its books as suitable for social housing and had delivered just over 2,000 for social housing (some 2,450 units were deemed unsuitable or were in locations where there was no demand).

⁶ Reviews of progress in achieving the 100 actions points are published each quarter. The review for Quarter 2 2016 shows that less than half the actions were outstanding.

and to provide substantially increased levels of central government funding to local government to ensure adequate services. It also noted that from November 2015, legislation governing the private rented housing sector had been changed to permit rent increases every two years instead of one, and that the period of time that a landlord must give to a tenant to vacate their dwelling after a valid notice of termination was served was substantially increased.⁷

New government: more reports

While awaiting the formation of new Government following the general election in February 2016, where a Christian Democrat and others minority government was eventually formed in early May 2016, an indication of the degree to which housing and homelessness were firmly the priority for all political parties was the rapid establishment of an **All-Party Committee on Housing and Homelessness** in mid-April. Having taken submissions from a raft of interest groups, they produced a 157-page report on 17 June (Houses of the Oireachtas, 2016). On homelessness, it recommended that the Government increase the social housing stock by an average of 10,000 units per year for five years; increase security of tenure and protection from evictions for tenants in the private rented sector; reinstate the policy of ring-fencing 50% of local authority allocations to the priority list in Dublin and other areas where homelessness is acute, which was introduced in January 2015, but had lapsed in April 2016; ensure that no homeless shelters are closed until alternative accommodation is available elsewhere; that Housing First should be significantly expanded; and that there should be enhanced cooperation between homeless services and mental health services.

In May 2016, a new Programme for Partnership Government was announced, which stated that “[i]t is not acceptable in 2016 to have families living in unsuitable emergency accommodation or to have people sleeping rough on our streets” (Government of Ireland, 2016, p.19). The Programme committed to publish, within 100 days, a new Action Plan for Housing, to increase the rent limits on the rent supplement scheme and to increase the social housing output substantially. The document also promised that the Action Plan on Housing would contain specific

⁷ In addition, the National Economic and Social Council (NESC), which advises the Taoiseach (Prime Minister) on strategic policy issues relating to sustainable economic, social and environmental development in Ireland, published four detailed reports on aspects of housing policy in Ireland: Social Housing at the Crossroads: Possibilities for Investment, Provision and Cost Rental (2014a), Homeownership and Rental: What Road is Ireland On? (2014b), Ireland's Private Rental Sector: Pathways to Secure Occupancy and Affordable Supply (2015a) and Housing Supply and Land: Driving Public Action for the Common Good (2015b), and the Housing Agency, which supports Local Authorities, Approved Housing Bodies and central Government in their housing functions published a National Statement of Housing Supply and Demand 2014 and Outlook for 2015-2017 (2015).

measures to prevent homelessness and to end the use of hostels and bed and breakfast type accommodation as long-term emergency accommodation, primarily through the provision of rapid-build housing (2016).

On 19 July, and within 100 days of the formation of the Government, an **Action Plan for Housing and Homelessness**, entitled '**Rebuilding Ireland**' (Department of Housing, Planning, Community and Local Government, 2016a), was launched. The Plan stated that the "long-term solution to the current homelessness issue is to increase the supply of homes" (2016, p.33). The Plan promised to limit the use of hotels for accommodating homeless families by mid-2017, to increase Housing First tenancies in Dublin from 100 to 300 by 2017; to extend Tenancy Sustainment services across the country; and to increase the amount of rent subsidy available to homeless households. On 22 September 2016, an elaboration of the homelessness actions was published, which, in addition to the earlier actions, promised to accelerate the rapid-build programme to ensure the provision of 1,500 units by the end of 2018, and the addition of 200 emergency beds for rough sleepers by the end of 2016. It is of note that the **Rebuilding Ireland** action plan does not contain a commitment to ending homelessness, in contrast to the 2008 and 2013 strategies. Table 1 provides a chronology of these various reports.

Table 1. Homeless Strategies, Action Plans and Reports, 2013-2016

	Date		Minister Responsible
Homelessness Policy Statement	February	2013	Jan O'Sullivan
Homelessness Oversight Group Report	December	2013	Jan O'Sullivan
Implementation Plan on the State's Response to Homelessness	May	2014	Jan O'Sullivan
Progress Reports on the Implementation Plan on the State's Response to Homelessness	Q3 onwards	2014	Jan O'Sullivan
Social Housing Strategy 2020	November	2014	Alan Kelly
Action Plan to Address Homelessness	December	2014	Alan Kelly
Stabilising Rents, Boosting Supply	November	2015	Alan Kelly
Independent Review of Homeless Services (Mazars)	December	2015	Alan Kelly
Laying the Foundations: Housing Actions Report	April	2016	Alan Kelly
All-Party Committee on Housing and Homelessness Report	June	2016	
Rebuilding Ireland: Action Plan for Housing and Homelessness	July	2016	Simon Coveney
Rebuilding Ireland: Homelessness Pillar	September	2016	Simon Coveney

What is evident from these multiple reports is the significant degree of overlap, with the provision of social housing and measures to address rent inflation in the private rented sector central in all reports. While many of the reports contain 'something

new' – for example, rapid-build housing or an extension of the Housing First project – ultimately, the reports conclude that increasing the supply of housing, both public and private, is fundamental to reducing homelessness. The sundry plans provide slightly different timelines and output figures, and revisions of earlier objectives, but from the enormous pile of reports, the core recommendation of increasing supply is the common denominator.

Trends in Homelessness: Adversity

To measure progress in ending homelessness, from January 2014, at the end of each quarter, local or municipal authorities, who have primary statutory responsibility for the provision of homeless services, were required to produce **Performance Reports** providing data on a range of indicators, including the numbers in emergency accommodation for more than six months and the numbers exiting homeless services to independent accommodation. These authorities were also required to produce detailed quarterly **Financial Reports** outlining the distribution of funding to preventative, emergency, long-term supported and other services.

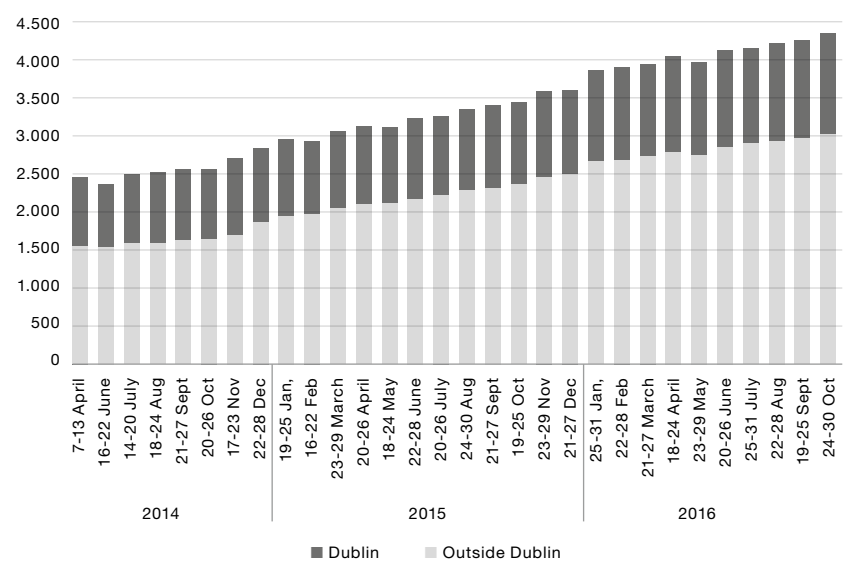
In addition, to address the data deficit highlighted in the first report of the Homelessness Oversight Group, the PASS (Pathway Accommodation & Support System), established in Dublin as a bed management system, was rolled out nationally and allowed for a **Monthly Report** on the number of households in designated homeless accommodation, starting in April 2014 and broken down by gender, age and nature of accommodation to be produced. While not a comprehensive figure of the extent of homelessness in Ireland, in that it only captures those households in designated homeless accommodation, it nonetheless provides timely, detailed, reliable and consistent data.⁸ These three sources of data have allowed, for the first time ever in Ireland, the monitoring of trends in homelessness and of the extent and nature of the now considerable expenditure.

⁸ This data provides information on households in homelessness accommodation funded under Section 10 of the Housing Act, 1988. It does not, therefore, include homelessness services not funded under Section 10, but it is estimated that only a very small number of services with approximately 110 beds do not, for various reasons, receive such funding. In addition, from 1 January 2015, accommodation for those escaping from domestic violence (ETHOS category 4) that was funded via Section 10 – a total of 21 residential services with a bed capacity of approximately 250 – the annual funding of just over €2.1m was transferred to the statutory Child and Family Agency, and such services have not been enumerated in the monthly data since that date (see Mayock *et al.*, 2013 for further information on services and funding of such services in Dublin). Neither does the data include the 3,200 adult individuals and over 1,000 children in temporary accommodation centres for those seeking asylum, which are managed by the Reception and Integration Agency (ETHOS category 5) at a cost of €53.2m in 2014.

Entering homelessness

The data (see Figure 1) show that nationally, number of adult homeless persons in designated homelessness accommodation increased by over 80% from June 2014 to October 2016 – an increase of nearly 100% in Dublin and 60% outside of Dublin. This rapid increase in entries to homelessness exacerbated a situation where the capacity of designated homelessness accommodation had already reached saturation point, and by October 2016, nearly 50% of all homeless adults nationally were being accommodated in commercial hotels, with a figure of 55% in Dublin.⁹

Figure 1. Number of Homeless Adults (in Emergency Services), April 2014-June 2016



Source: Department of Housing, Planning, Community and Local Government (2016) Monthly Homelessness Reports.

⁹ Twice a year, a rough sleeper count takes place in Dublin, and since 2010 the minimum number of rough sleepers enumerated at these counts has averaged 100. On average, nearly 80% of rough sleepers are male and a significant minority are non-Irish nationals. As part of Census 2016, rough sleeper counts were undertaken in urban centres on Census Night, 24 April: the majority of areas recorded no rough sleepers; 25 rough sleepers were recorded outside of Dublin and 102 in Dublin (Dublin Region Homeless Executive, 2016).

A significant contributor to the increase in homelessness is the number of families entering homeless services for the first time. Their number increased in Dublin from 264 in June 2014 to 1,026 in October 2016 – the majority accommodated in commercial hotels; the number outside Dublin increased from 81 to 152.¹⁰ The number of families entering homelessness for the first time ever increased in Dublin each month from an average of 15 a month in 2013 to an average of 32 in 2014 and of 62 in 2015. By the third quarter of 2016, the average per month had increased to 78 new families.

In addition to the 4,377 homeless adults at the end of October 2016, there were a further 2,470 child dependants of these adults. As a result of the increase in the number of families that are homeless, particularly in Dublin, 46% of homeless adults in Dublin, and 34% outside of Dublin, are female. If current trends continue to the end of the 2016, some half of the homeless adults will be female. Given that the aforementioned assessment of the extent of homelessness in 2013 found that 29% of the known homeless population were female, this feminization of homelessness has occurred in a remarkably short period.

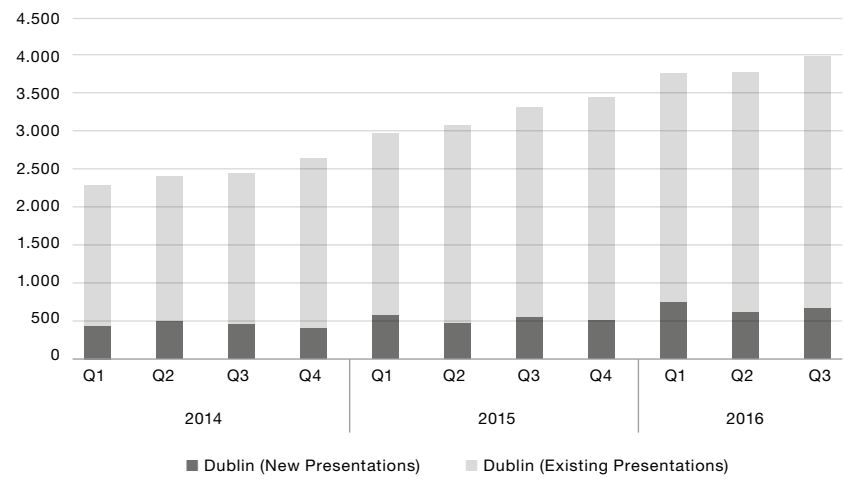
Exiting homelessness

While the numbers of homeless households increased each month between June 2014 and October 2016, a significant number also exited homelessness. For example, in Dublin 1,236 households exited homelessness to a tenancy in the private rented sector, social housing or long-term supported accommodation in the first nine months of 2016.¹¹ However, in the same period 2,039 households presented to services as newly homeless. In addition to the 2,039 new households presenting as homeless to services in the first nine months of 2016 in Dublin, there were a further 3,338 repeat presentations in Quarter 3 2016 (see Figure 3), in that they had presented in earlier quarters but were still in homelessness services in Q3 2016. Consequently, the number of households who, on the last day of the quarter, had been in emergency accommodation for more than six months – the long-term homeless – increased from 48% at the end of Q1 2014 to 65% at the end of Q3 2016 in Dublin.

¹⁰ The placement of homeless families in Bed and Breakfast type accommodation in Dublin started in 1990 when, during that year, five families were placed in such accommodation (Moore, 1994). By 1999, just over 1,200 families were placed over the year (Houghton and Hickey, 2000). No accurate numbers are available since that year until recently, but it would appear that the number of families presenting as homeless declined until the recent upsurge over the past two years. The negative consequences for children living in such accommodation have been documented in a number of research reports (Halpenny *et al.*, 2001; 2002).

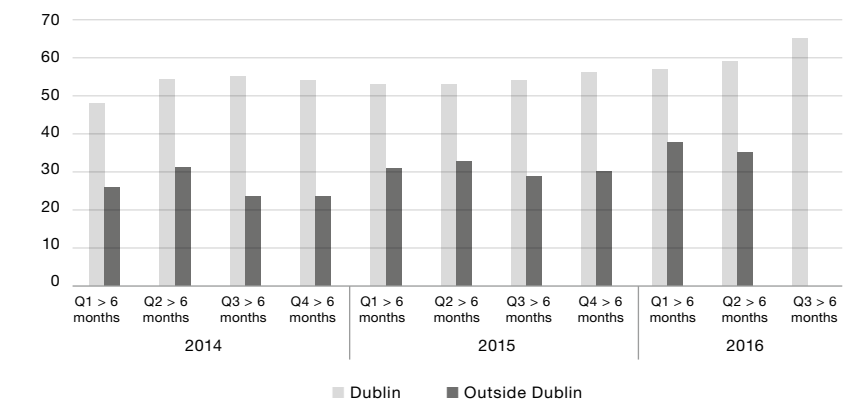
¹¹ A further 619 households exited homelessness in Dublin in the same period – primarily to insecure accommodation with friends or family or for various medical treatments or imprisonment, and these are likely to be episodically homeless. See Mayock *et al.* (2015) for a detailed qualitative analysis of the experiences of single homeless women repeatedly entering and exiting homeless services from prison and psychiatric hospitals.

Figure 2. Adults Using Emergency Homeless Services in Dublin, Q1 2014 – Q3 2016



Source: Department of Housing, Planning, Community and Local Government (2016) Local Authority Regional Performance Reports.

Figure 3. Adult Individuals in Emergency Accommodation for more than Six Months

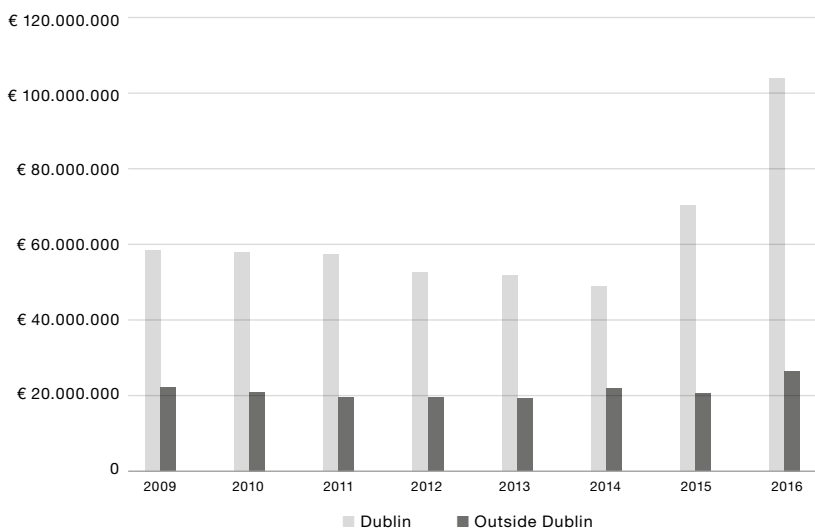


Source: Department of Housing, Planning, Community and Local Government (2016) Local Authority Regional Performance Reports.

Expenditure on Homeless Services

Due to the growth in households entering homelessness, there has been a steady increase in the proportion of funding for homeless services being expended on privately-owned emergency accommodation. In Dublin in 2015, 65% of funding went on emergency accommodation; outside of Dublin it was 50%. In Dublin, by the final quarter of 2015, 54.5% of expenditure on emergency accommodation was on private emergency accommodation; it was 31.4% outside of Dublin. This reflected the fact that accommodation provided by designated homeless service providers had reached capacity, particularly for homeless families, and that authorities were increasingly dependent on securing accommodation in hostels, B&Bs and other private accommodation. In Dublin alone, it is estimated the four Local Authorities and the Department of Housing, Planning, Community and Local Government will spend in excess of €100m on homeless services in 2016 – an increase of €30m on expenditure in 2015. Outside of Dublin, expenditure of over €26m is estimated – an increase of €3m over the previous year (see Figure 4) (Department of Housing, Planning, Community and Local Government, 2016b).

Figure 4: Expenditure on Homelessness Services (Section 10 and Local Government), 2009-2016



Source: Department of Housing, Planning, Community and Local Government (2016) Local Authority Regional Financial Reports.

In addition to Section 10 funding, various service providers receive funding under Section 39 of the Health Act, 2004, which for 2016 will be in the region of €25m.¹² It is difficult to give an overall figure for the income generated by NGOs working in the homelessness sector from fundraising. However, it is not inconsiderable. For example, the Dublin Simon Community, established in 1969, received statutory funding in the amount of just over €7m in 2015; donations and other income amounted to €5.5m. Thus, for every euro received from statutory grants, they generated a further €0.79 from fundraising and other events (Dublin Simon Community, 2016).

Structure of homeless services

The rapid rise in expenditure on homelessness services reflects the demand-led nature of homelessness, and the nature and structure of homelessness services largely reflects the mission of individual non-governmental agencies and the availability of beds in commercial hotels and B&Bs. No local or municipal authority in Ireland operates homelessness accommodation services directly. Historically, most Local Authorities made provision for homeless men in the casual wards of county homes (former workhouses), but they began to be phased out from the mid-1960s (Doherty, 1982). Dublin City Council was unique in that it provided hostel accommodation for homeless men and women, but this service was contracted out to an NGO in 2014. Thus, the nature and type of homelessness service in Ireland is determined in part by the origins and ethos of various NGOs and, more recently, by their funding arrangements with Local Authorities. Being dependent on a disparate range of providers, often with little in common with one another, and seeking to develop services via funding protocols limits the ability of policy-makers to develop coherent strategies. It has also led to a relatively small number of agencies providing most services – for example, 4 NGOs received nearly 50% of all section 10 funding nationally – which poses considerable risk for these agencies if the funding model were to change, and risk for the State as it becomes increasingly dependent on these bodies.

¹² This allows the statutory Health Service Executive (HSE) to provide funding to agencies providing 'similar or ancillary services' to the HSE. It is estimated that 57 agencies providing housing and homelessness services receive Section 39 funding (McInerney and Finn, 2015).

Adaptation

As noted in Table 1, a plethora of action plans and strategies have been formulated and summits convened to respond to the increase in homelessness. Expenditure has also increased. The objective of ending long-term homelessness by the end of 2016 was quietly removed from policy documents and statements and replaced with an adaptive strategy to manage the extent of homelessness through more vigorous gatekeeping and enhancing exit options. The following section looks in more detail at several specific initiatives that aim to prevent homelessness and to provide exit options for those in emergency accommodation.

Social housing supports and exiting homelessness

As noted in the introduction, one of the consequences of the economic downturn was the virtual cessation of the building of social housing units by Local Authorities. By 2015, only 75 units were built nationally – the lowest number in the history of the State, down from nearly 5,000 in 2008. Similarly, due largely to changes in the funding regime, the output from Approved Housing Bodies declined from nearly 2,000 units in 2008 to 401 in 2015. Local Authorities did acquire a further 1,099 units from the private market to make available as social housing and operated a social housing leasing scheme that provided a further 1,500 units in 2015. In addition, at the end of 2015, social housing support was provided via an increasingly bewildering array of schemes: the Rental Accommodation Scheme (circa 20,000 households), the Housing Assistance Payment (circa 6,000) and the Rent Allowance system (circa 62,000). Aside from the 476 units built by Local Authorities and Approved Housing Bodies, all remaining units are being sourced from the private housing market, with little or no additionality relative to demand. The Social Housing Strategy (2014) and the Rebuilding Ireland Action Plan (2016) respectively committed to providing 35,600 and 47,000 social housing units. These units will comprise new builds and the purchasing and leasing of existing units of housing. The Rebuilding Ireland plan envisages that less than half of the target will be met by new builds; thus, the remaining units will have to come from the already stretched existing stock of housing. Many of these are likely to come from the private rented sector – in some cases households that qualify for social housing may simply find that their landlord has changed to an Approved Housing Body or Local Authority; in other cases, this may result in the displacement of one household to facilitate another.

As noted at the beginning of the article, when the Homelessness Policy Statement was published in early 2013, nearly 90,000 households qualified for social housing supports and were waiting for a dwelling to become available. By early 2016, the number of qualifying households had increased to nearly 140,000 and, in response

to high levels of refusals of housing in some authorities for various reasons, it was announced in July 2016 that Choice Based Lettings¹³ would be introduced in every Local Authority to cut down on the rates of refusal.

For homeless families in particular, social housing provided by Local Authorities or Approved Housing Bodies is the preferred option, given their experience of instability in the private rented sector. The Rebuilding Ireland plan envisages that by 2021, some 5,000 units of social housing will be constructed, but between 2016 and 2019 fewer than 10,000 units will be constructed; the remaining units will be purchased or leased from the private market. Thus, in the short to medium term, the construction of new social housing will have only a limited impact on homelessness; in the absence of Directives compelling Local Authorities to provide a specific percentage of allocations to homeless households (see below), and given the number of households assessed as qualifying for social housing, it is difficult to see social housing having a significant impact on reducing homelessness.

Social housing allocations

Following the publication of the Implementation Plan on the State's Response to Homelessness (2014), the Department of the Environment, Community and Local Government noted in a Circular¹⁴ to all Local Authorities that only 4.1% of all social housing allocations by Local Authorities were made to homeless households. The Circular reminded Local Authorities that the Minister had the power to issue directions to Local Authorities as to how an allocation scheme should operate¹⁵ and that he had decided not to exercise this power but would review the position at the end of the year. In January 2015, the Minister for the Environment, Community and Local Government decided to utilize his power, and issued a Directive to the four Dublin Local Authorities to the effect that 50% of dwellings available for allocation for the period 27 January to 26 July 2015 should be allocated to homeless and other vulnerable households, and that 30% should be allocated in the other urban centres

¹³ Choice Based Lettings (CBL) originated in Delft in the Netherlands in the late 1980s and sought to allocate social housing on the basis of qualifying tenants bidding for a desired unit, thus displacing the more common model of bureaucratically matching properties with those households on the waiting list. It was subsequently adopted in Britain and Australia (see Pawson and Hulse, 2011 for further details).

¹⁴ Circular Housing 45/2014, Housing Allocation Schemes: Homeless and other Vulnerable Groups, 23 October 2014.

¹⁵ Section 22(17)(a) of the Housing (Miscellaneous Provisions) Act 2009.

of Galway, Cork, Waterford and Limerick.¹⁶ The Directive was reissued in August 2015,¹⁷ extending the 50% allocation for homeless and other vulnerable households from 7 August 2015 to 31 January 2016, and again on 1 February to the end of April 2016, but it was not renewed thereafter.

On 22 April 2016, the Chief Executives of the four Dublin Councils wrote to the Minister to request that the Directive not be extended. They argued that “[i]t is our view that this requirement is now having the effect of encouraging some households who are in housing need and who are awaiting social housing to enter the ‘homeless’ system in the mistaken belief that this will hasten the allocation to them of a social housing unit” (Keegan, 2016). In February, the Housing Agency, at the request of the Department of the Environment, Community and Local Government, conducted a review of the impact of the Directive, and based on the Housing Agency’s analysis, a decision was taken not to extend it again. The Minister stated that the report “concluded that the prioritised allocation of social housing to homeless and other vulnerable households came at a cost to other households on the social housing waiting lists.”¹⁸ As noted earlier, the Report of the Committee on Housing and Homelessness, which reported in June 2016, recommended reintroducing the Directive. However, the Action Plan for Housing and Homelessness did not specifically address or debate this recommendation; rather, it claimed that the expanded supply of social housing that the plan aimed to deliver would address the issue (2016, p.107).

At the time of writing, the review of the Directive conducted by the Housing Agency has not been published, and therefore it is not possible to assess in full the rationale for the non-renewal of the Directive. However, based on evidence from other jurisdictions, we know that it is difficult to substantiate claims that policies that aim to move households out of homelessness have the perverse effect of drawing households into homelessness in an effort to acquire the scarce resource of permanent social housing. For example, we have some comparative material to reflect on from

¹⁶ Eligible households are those: i) in an institution, emergency accommodation or a hostel (i.e., a homeless household within the meaning of Section 2 of the Housing Act 1988); ii) with an accommodation requirement arising from an enduring physical, sensory, mental health or intellectual impairment (i.e., households where one of its members has a disability and, as such, is deemed to be a vulnerable household); and iii) that were in accommodation unsuitable for the household on exceptional medical or compassionate grounds (i.e., including households that were subject to domestic violence and young people leaving state care and as such deemed to be a vulnerable household). In the first Circular, households had to be eligible on or before 1 December 2014. Between February 2015 and October 2015, 612 Local Authority houses were allocated to homeless families (Housing Agency/Department of the Environment, Community and Local Government, 2016).

¹⁷ Circular Housing 31/2015, Housing Allocation Scheme: Ministerial Direction, 12 August 2015.

¹⁸ Dail Eireann, Debates, 26 May 2016, 141.

the case of what became known as the 'Dinkins deluge', where in the late 1980s, the City of New York substantially increased the rate at which they moved families out of homeless accommodation and into subsidized housing. As the rate of exits to subsidised accommodation in New York increased, the numbers of families in emergency accommodation and hotels doubled and the conventional wisdom was that "families found the prospect of getting a subsidised apartment so enticing that they entered homeless shelters *en masse*" (Cragg and O'Flaherty, 1999, p.378). Following the conventional wisdom, the number of exits to subsidized housing was reduced, but family homelessness increased.

Cragg and O'Flaherty (1999), in their detailed analysis of the policy change, found that the prospect of subsidized accommodation did draw some families into homeless accommodation but that what caused the real increase in the number of homeless families was the reduction in the number of exits to subsidized accommodation; if the City of New York had maintained the increased rate of subsidised exits, the number of homeless families would have been almost eliminated by 2004. They concluded that "it takes placing at least seven families into subsidized housing to draw one family into the shelter system" (1999, p.379). They also observe that in conditions where subsidized housing is rationed and where the demand is significantly higher than the availability, some queue jumping will occur, but reducing the number of families in homelessness may be an overriding consideration.¹⁹

Preventing homelessness: tenancy protection

The substantial increase in homelessness, noted earlier in the paper, has occurred despite the introduction of a Tenancy Protection Service in June 2014. This service allowed for an enhanced rent supplement if the household was at risk of homelessness. Between June 2014 and September 2016, just over 9,000 contacts were made with the service, with just over half the contacts identified as being at risk of homelessness. Just over 2,100 households were provided with a rent enhancement or uplift and only 39 households that contacted the service entered homeless services. The service allows applicants to access an enhanced rent supplement (RS) payment if they are at risk of homelessness, which means that they "face a rent increase that is above the current RS limit and they can't find alternative accommodation that will accept RS as per this limit and thus face the prospect of eviction or have received

¹⁹ One of the proponents of the perversity thesis on family homelessness at the time, Thomas J. Main, recently argued that, although scholarship has debunked the myth of perverse incentives, for the city administrators in New York, it remains a concern (Main, 2016). In the case of England, Pawson's study of homelessness prevention noted that there was a perception that a perverse incentive existed to become homeless in order to jump the queue for social housing allocations and thereby undermine the allocations process, but that "empirical evidence for such arguments has never been produced" (2007, p.874).

a notice (invalid or valid) of termination” (Threshold, 2015, p.8). Thus, the service can only assist tenants where the landlord has sought a rent increase, and not where the property is being sold, reposessed or required for the landlord’s own use.²⁰ In the first year of operation in Dublin, 744 households received enhanced rent supplement payments at a cost of €0.76m, which allowed them to stay in their homes. By May 2016 the service had assisted nearly 6,000 households who were at risk of homelessness. On the basis that in the first three months of 2016, €6.2m was expended in Dublin to keep, on average, just under 600 homeless families in hotels, the Tenancy Protection Service has demonstrated its worth. Despite the undoubted success of the service, in the first nine months of 2016 in Dublin alone, just over 700 families nonetheless entered homelessness for the first time ever.

The limits of Rent Supplement

Analyses of the trajectories of a significant number of homeless families suggested that upward rent reviews in the private rented sector contributed to their initial homelessness, and the subsequent inability to access alternative private rented housing was because the rate of rent allowance was not keeping pace with market rents, or that landlords were refusing to accept tenants on rent allowance. (O’Donoghue-Hynes, 2015; see also Walsh and Harvey, 2015; Focus Ireland, 2015; 2016). The termination of the tenancies resulted from unsustainable rent increases at a time when rent allowances were static, as well as from the sale of dwellings by landlords or banks.

Reviewing the rent limits set by the Department of Social Protection, a review of the private rented sector noted that “it appears that the market for Rent Supplement tenants has become increasingly restricted in recent times and that tenants may be increasingly challenged in sourcing accommodation within these limits in Dublin.” (DKM Economic Consultants *et al*, 2014, p.42). In a review of rent limits in February 2015, where the limits aim to make between 35% and 40% of the private rented sector affordable for qualifying households, the Department of Social Protection (2015, p.24) argued that with such tight rental markets, increasing the allowance “would generate homelessness for low income / single earner families who could no longer compete with the higher rents available under Rent Supplement.” Instead, as noted above, the policy was to allow for an increase in

²⁰ Section 34 of the Residential Tenancies Act, 2004 allows for the valid termination of a private rented tenancy if the landlord wishes to sell the dwelling, or requires the dwelling for his or her own occupation or that of a member of his or her family. Responding to allegations that landlords were terminating tenancies on this basis but subsequently re-letting the dwelling, the Residential Tenancies (Amendment) Act, 2015 amended Section 34 by requiring a statutory declaration (a written statement of fact signed by an authorized person such as a solicitor) as additional proof if the landlord intends to sell the property or if the landlord or a family member of the landlord intend to occupy the dwelling.

the rent payment on a discretionary basis when rent increases were sought by landlords and where tenancies were at risk. This policy was abruptly changed in July 2016 when significant increases in the level of rent allowance were announced. In most areas of Dublin for example, the rent allowance limit for a single person increased by 20% and for a couple or one person with one child by just over 30%.²¹

In late December 2014, a new Housing Assistance Payment pilot scheme was introduced for households who were accepted as homeless in one of the four Dublin authorities.²² Known as Homeless HAP (Housing Assistance Payment), it allows for rent supports of up to an additional 50% of the rent allowance from July 2016. While the rent allowance increases announced in June 2016 will assist households, particularly homeless households, to compete in the private market, a key constraint is the availability of properties to rent. At the beginning of May 2016, the commercial property website, daft.ie, noted that only 3,082 private properties were available to rent nationally (with just over 1,000 available in Dublin) – the lowest on record since the commencement of the collection of this data at the beginning of 2006, and down from a peak of nearly 24,000 properties to rent at the end of 2009 (Lyons, 2016). With further declines in the availability of properties to rent predicted, particularly in Dublin, increasing the rent allowances will have only a marginal effect on assisting households to exit homelessness. Furthermore, it would appear that, in 2016, a key reason for the ending of a tenancy in the private rented sector leading to homelessness was not rent increases, but the repossession of dwellings by banks or landlords. In Quarter 2 2016, 305 buy-to-let (BTL) residential properties were repossessed on foot of an Order or voluntarily surrendered, up from an average of just over 200 per quarter in 2015. With nearly 15,000 BTL properties in arrears for over 720 days in Quarter 2 2016 (Central Bank of Ireland, various years) it is likely that the number of repossessions will continue to grow.

Increasing security in the private rented housing market

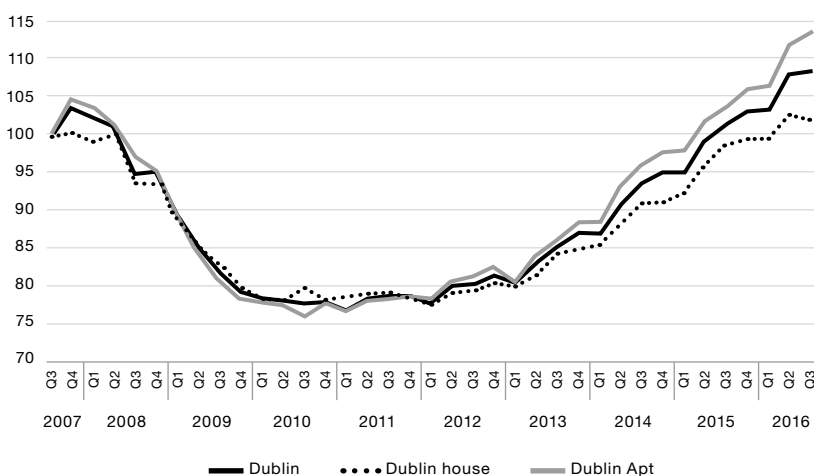
With rapid rent inflation from 2013 in Dublin (see Figure 5), after a period of decline and stability, measures to regulate rent increases were announced by the Minister for the Environment, Community and Local Government in February 2015. Following protracted negotiations between the Minister for Finance and the Minister for the

²¹ Despite these increases, a survey by the Simon Community showed that at the end of August 2016, only 20% of rental properties across a number of urban and rural locations were within the Rent Supplement / Housing Assistance Payment limits (Simon Communities of Ireland, 2016).

²² The scheme was restricted to those who were residing in designated homelessness accommodation on 1 December 2014 or had resided in designated homelessness accommodation in the preceding six months. A couple or one person with one child who qualified could obtain rent support of up to nearly €1,900 in most parts of Dublin. Statutory Instrument No. 575 of 2014, Housing Assistance Payment (Section 50) (No.3) Regulations 2014.

Environment on increasing rent stability and security of tenure in the private rented housing market, legislation amending the Residential Tenancies Act, 2004 was signed into law in December 2015. These amendments came into effect on 9 May 2016, including the following provisions: that rent cannot be reviewed more than once in any 24-month period – it had been once every 12 months;²³ an extension of the notice period of rent review from 28 days to 90 days; an extension of notice periods for both landlords and tenants in respect of termination of longer term tenancies – up to 224 days for landlords and 112 days for tenants; and verification procedures where the landlord intends to sell or refurbish a property and therefore terminate the tenancy. However, as Figure 5 shows, this measure has not resulted in a stability in rent levels in Dublin.

Figure 5. Private Rented Sector Rent Index: Dublin, Q3 2007-Q3 2016 (Q3 2007=100)



Source: Economic and Social Research Institute / Residential Tenancies Board (2016) The RTB Rent Index.

At a Forum on Housing and Homelessness held by the Minister for the Environment, Community and Local Government on 31 March 2016, the Minister claimed that he was restricted in what could be achieved to protect tenants due to Constitutional

²³ This applies only until December 2019; after that date, rents can again be reviewed once in every 12 months. In addition, the Equality (Miscellaneous Provisions) Act 2015, effective from 1 January 2016, prohibits discrimination in the letting of residential property against people who are in receipt of a rent supplement or any other social welfare payment, including a Housing Assistance Payment (HAP).

provisions on private property.²⁴ A strategy on the private rented sector is due to be published by the end of 2016, so an opportunity may present itself to revisit the purpose of the sector and the balance between the common good and the right to private property.

Housing First

In April 2011, a Housing First Demonstration Project was established in Dublin, managed through Dublin City Council with staff drawn from a number of agencies (Greenwood, 2015). This Demonstration Project operated until September 2014, when the service was put out to contract by Dublin City Council; the contract was won by two non-governmental bodies: Focus Ireland and the Peter McVerry Trust. Targeted exclusively at entrenched rough sleepers, with a target to house 100 households by June 2016, 54 individuals were accommodated in 47 housing units in Dublin. Under the aforementioned Action Plan for Housing and Homelessness (2016), it is proposed to increase the target to achieve 300 Housing First tenancies in 2017. According to Quinn and Sheridan (2016) a key constraint is the inability to secure properties in the private rented sector, and as a consequence, a significant number of the units are coming from the Local Authority and Approved Housing Body stock. In addition, many of the prospective tenants express a preference for social rather than private rented housing. Despite the relatively small number of tenancies, the programme has contributed to ensuring that the number of rough sleepers in Dublin has remained relatively low and stable over the last year, with a minimum number of rough sleepers of 91 counted in November 2015 and 142 in November 2016 (Dublin Regional Homeless Executive, 2016).

Rapid-build housing

In response to the growing number of families in temporary accommodation, in October 2015, it was announced by the Department of the Environment, Community and Local Government that Government had approved the delivery of 500 units of modular housing (later retitled rapid-build housing). Twenty-two of these units were to be provided in December 2015 with the remainder coming on stream in 2016.

²⁴ Article 43 of the Constitution states that: "The State acknowledges that man, in virtue of his rational being, has the natural right, antecedent to positive law, to the private ownership of external goods. The State accordingly guarantees to pass no law attempting to abolish the right of private ownership or the general right to transfer, bequeath, and inherit property." However, it does go on to outline that: "The State recognises, however, that the exercise of the rights mentioned in the foregoing provisions of this Article ought, in civil society, to be regulated by the principles of social justice. The State, accordingly, may as occasion requires delimit by law the exercise of the said rights with a view to reconciling their exercise with the exigencies of the common good." Thus, it would appear to be a matter of interpretation whether it is deemed to be in the common good to delimit the absolute right to private property to prevent homelessness.

Due to a combination of inclement weather and protests against the location of the 22 units, it was not until April 2016 that the first families moved into these units. The Rebuilding Ireland plan proposes to increase the provision of rapid-build housing to 1,500 by the end of 2018, with 200 units becoming available in 2016, 800 in 2017 and the remaining 500 in 2018.

Gatekeeping

On presenting to statutory homeless services, two small-scale pieces of research with families that entered homeless services described the majority of front-line staff as helpful and courteous (Walsh and Harvey, 2015; Focus Ireland, 2015). However, their initial contact resulted in few services being provided, and in many cases families were told to try to source their accommodation in the private rented sector, commercial hotels or B&Bs, or to stay with friends or family. Families also commented on the intense pressure that frontline staff were under and the long queues to get advice and accommodation. Frontline staff must balance their statutory obligation under the Housing Act, 1988 to provide social housing supports to those deemed eligible for such supports, with preventing households from entering homelessness and providing supports with existing accommodation. For example, in Dublin City Council, under their Housing Allocations Scheme, homeless persons get priority status for the allocation of social housing supports. Their definition of homelessness is determined by Section 2 of the Housing Act, 1988, which sets out that:

A person shall be regarded as homeless if, in the opinion of the City Council, the person is unable to provide accommodation from his/her own resources and (i) there is no accommodation available which, in the opinion of the City Council, the person together with any other person who normally resides with him/her or who might reasonably be expected to reside with him/her, can reasonably occupy or remain in occupation of, or (ii) the person is living in a hospital, night shelter or other such institution, and is so living because he/she has no accommodation of the kind referred to in paragraph (i).

In addition, the Scheme states that: “The City Council will determine whether applicants who are claiming to be homeless because they have no fixed abode are genuinely homeless or not” (Dublin City Council, 2013). This clearly raises the spectre of intentionality, suggesting that not all those claiming to be homeless are genuinely so, and that some people may be making themselves intentionally homeless to secure social housing by getting priority status for social housing supports.

As noted earlier, the construction of social housing decreased significantly during the period of austerity, but it can also be argued that the nature of social housing in Ireland has gradually been transformed over the past 35 years (See Norris and Fahey, 2011 and Norris, 2014 for further details). Until the early 1990s, social housing

was largely understood as local authority constructed and managed dwellings, which provided *de facto* life-time security of tenure and the option to purchase at a discounted rate subject to a minimum set of obligations. Since the early 1990s, Approved Housing Bodies have gradually become key social housing landlords, and from the 2000s onwards, income supports to allow households access private rented housing have been relabelled as social housing supports, particularly the relatively new Housing Assistance Payment (HAP) and the earlier Rental Accommodation Scheme (RAS). Until the introduction of HAP, a household could receive a rent allowance that rendered the private rented sector affordable for an eligible household, and they could remain on the social housing waiting list. In contrast, in the case of the HAP scheme, which like the rent allowance scheme requires tenants to access housing in the private rented sector albeit with more progressive rent payment arrangements, the household's social housing need is deemed to be met. While, as noted above, recent legislative changes via the Residential Tenancies Act, 2015 have enhanced the rights of tenants, landlords in the private rented sector can still terminate a tenancy under certain conditions, even where the tenant is receiving social housing supports. In these circumstances, families who are homeless have expressed a preference for Local Authority or Approved Housing Body accommodation, rather than social housing supports in the private rented sector due to the stability and certainly offered by the former (Walsh and Harvey, 2015).

Research in England has highlighted the fact that there is often a fine line between 'homelessness prevention' work that successfully ensures households do not enter homelessness, and 'gatekeeping', which attempts to restrict access to homeless services because of budget or accommodation constraints (Pawson, 2007). Pawson notes that homelessness prevention grew in significance in England in the early 2000s, due in part to the rising cost of placing homeless households in B&Bs and other temporary accommodation and a perception that homeless households were excluding non-homeless households from social housing lettings. Similarly, Alden (2015) found, again in England, that gatekeeping by Local Authority Housing Option Services frontline staff was widespread, due to a lack of resources, heavy workloads, and pressures to reduce the use of temporary accommodation. In the absence of research on gatekeeping in Ireland, it is not possible to state its existence or not, yet when demand outstrips supply, as in the case of social housing, it would be naïve not to think that some degree of gatekeeping is operating in Local Authority homeless services in Ireland. Indeed, one Local Authority in their financial estimates for 2016 made provision to employ a duty officer whose role is "to gate keep entry into the homeless system" (Mid-West Region, 2016).

Conclusion: Adapting to New Realities

It is clear that the ambitious target of ending long-term homelessness and the need to sleep rough in Ireland by the end of 2016 will not be achieved. The aspiration to reorient homeless service provision towards a housing-led approach is further from being realised than at any point over the past 30 years. Instead, this paper suggests that despite the raft of action plans and strategies, homelessness will continue to rise in the short-term, particularly amongst families; expenditure on hopeless hostels and bleak B&Bs will consume an increasing share of homelessness budgets; and Housing First will remain marginal in the overall scheme of homelessness provision, despite some rhetorical nods in its direction from some NGOs. This is due to a lack of social housing in the short term, the relentless increase in rents in the private rented market and the plummeting availability of such dwellings, particularly in Dublin.

The majority of interventions over the past three years are valuable in their own right, and some like the prevention work extremely successful at a relatively low cost, but others, in the absence of housing supply, may have had distorting effects. For example, the fact that the Minister for the Environment, Community and Local Government gave commitments to restrict rent increases in February 2015 but that legislative effect was not given to this commitment until April 2016 may have provided an impetus to landlords to raise rents substantially, in the knowledge that such changes were pending. Increasing the allocation of social housing to homeless households may have had the effect of marginally increasing entries to homelessness, but in the absence of a such a directive, the number of families languishing in extraordinarily expensive and inappropriate hotel accommodation will grow remorselessly. Families may at least entertain some expectation of social housing at some stage, but for the single homeless person, wasting away in homeless hostels, only if they attain the age of 55 and claim senior citizen's status will such security become available to them. In face of such challenges, perhaps it is not surprising that the ambition to end homelessness in Ireland within a defined timeframe has been replaced with a more general aspiration to reduce the use of private emergency accommodation for families, and to increase the number of hostel beds with the objective of reducing rough sleeping. It can be argued that current policy set out in Rebuilding Ireland is an adaptive response to a range of unprecedented current circumstances: unprecedented numbers entering homelessness; unprecedented rates of rental inflation in the private sector; and unprecedented low levels of social housing output relative to demand. In these circumstances, a policy objective of ending homelessness by a specific date may be politically risky, and a vaguer set of ambitions and timeframes reduces such risk.

Finally, the very rapid increase in homeless households over the past 3 years in Ireland demonstrates the centrality of housing markets in creating homelessness. This may seem self-evident, but historically and contemporaneously, a pervasive view was that homelessness was the consequence of a range of individual failings and ailments. There is nothing to suggest that the rate of personal ailments and afflictions amongst the Irish populace increased over the past three years, thus resulting in greater numbers of homeless people. However, there is ample evidence that in the absence of secure affordable housing, as demonstrated in Ireland over the past 3 years, homelessness will increase. This is not unique to Ireland. In a review of 10-Year Plans to end homelessness in four Canadian cities, Adamo *et al.* (2016) noted that despite the plans, homelessness was increasing in all four cities. This, Adamo *et al.* (2016: 36) concluded was 'not the result of poor plan design and weak implementation; rather it is due largely to the limited supply of new affordable housing that cities can deliver with current levels of funding under the Federal-Provincial IAH program, coupled with the declining availability and affordability of purpose-built rental housing in the private rental market and the impact of stagnating incomes and social assistance rates on the ability of households to secure and retain housing.' Both the Irish and Canadian cases demonstrate the value of devising plans to end homelessness and to put in place clear monitoring and reporting mechanisms. However, neither the four Canadian cities nor the local authorities in Ireland could adequately address the structural issues of housing affordability and supply, particularly in the private rented sector, and until this structural issue is addressed by policy makers, homelessness and housing insecurity will remain an extraordinarily expensive and damaging outcome of the failures of housing policy.

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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*

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 Medicinæ 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 Kamilińska Misja Pomocy Społecznej on the determination of the scale of homelessness in Poland of November 2013¹, and position of Ogólnopolska Federacja na rzecz Rozwiązywania Problemu Bezdomności of 19 December 2014²).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

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

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

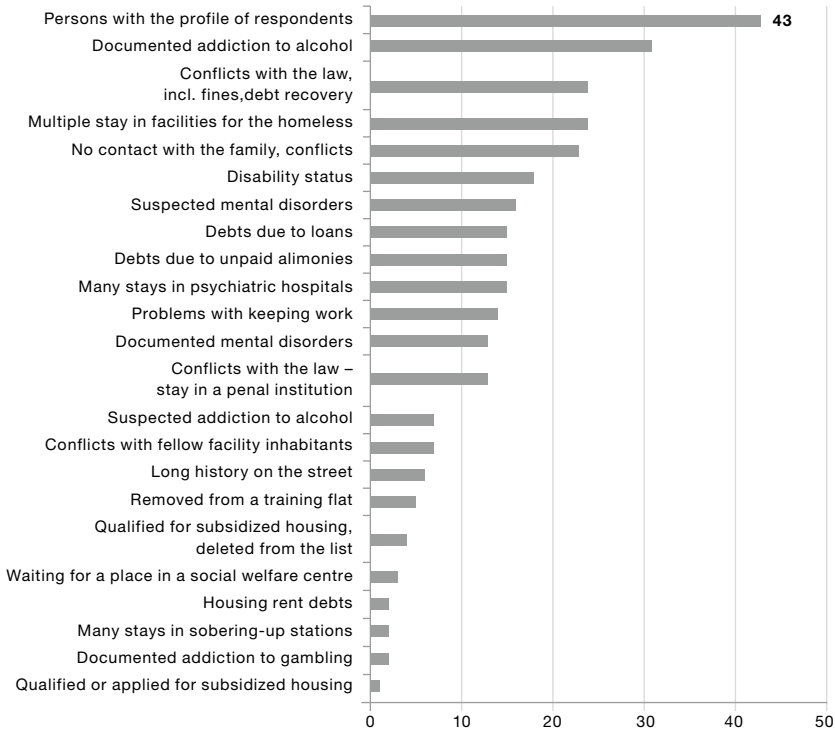
The study was conducted in a very difficult environment, among people living on the street or in a shelter, who were extremely excluded and distrustful. At the same time, the information collected was quite detailed and sensitive, as it concerned contacts with mental health, penal and debt collection 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 not 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' section⁶), 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

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/polina/>

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/>

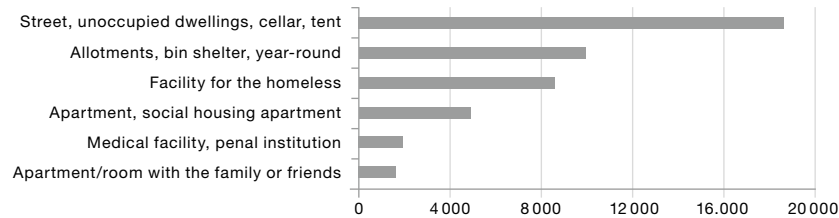
Respondents from the target group rarely stay in facilities for homeless people

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, Błażej 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 Bartłomiej 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; Bartłomiej 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 Bartłomiej 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; Bartłomiej participated in the homeless census in 2001.

Large number of institutions once respondents 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

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 zloty, 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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Circles Within Circles: Dublin's Frontline Homeless Sector Workers Discuss the Intersectional Issues of Homelessness, Mental Illness and Addiction

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► **Abstract** *This article explores the experiences of staff in Dublin's homeless sector of working with clients with mental health issues, the training they receive, and their knowledge of mental health concerns. Semi-structured interviews were conducted with nine participants from a range of Dublin-based homeless organisations. Interviews were audio-recorded, transcribed and thematically analysed. Three main themes emerged: 'mental health and medical service issues', 'dual diagnosis' and 'staff knowledge and training'. The results highlighted difficulties with psychiatric/ medical and addiction services, including access issues, lack of out-of-hours facilities, and poor services for those dually diagnosed with a mental illness and addiction. Inadequate in-service training also emerged as an issue. The most prominent finding was the lack of cohesion, collaboration and communication between homeless, psychiatric/medical and addiction services. Staff working with homeless clients with mental health issues and addictions experience great difficulty in accessing appropriate services for their clients, and lack sufficient knowledge to navigate the mental healthcare and medical systems. The results suggest that there is an urgent need for an overhaul of the services available for homeless people with mental health issues, and of the information available to staff.*

› **Keywords** _ *Homelessness, mental health, mental illness, training, dual diagnosis*

Introduction

The connections between homelessness and mental illness have long been recognized (Frazier, 1985; Timms, 1996). However, homeless people with mental health issues continue to lack access to appropriate care and services (DoHC, 2006). Homelessness is on the increase across the Western world (USICH, 2010; FEANTSA, 2014; Coalition for the Homeless, 2015), and the needs of mentally ill people, who make up a large proportion of the homeless population, are currently not being met (DoHC, 2006).

In the EU, it has been estimated that 4.1 million people per year experience homelessness (EC, 2013), with a recent rise in rates in most EU states (EC, 2013; FEANTSA, 2014). As in much of the rest of Europe, Ireland is experiencing a sharp rise in its levels of homelessness. The number of people accessing emergency homeless accommodation services in Dublin during the last quarter of 2015 was 3,464 – over a thousand more people than three years previously (DRHE, 2016).

Homeless people suffer from more mental health problems than housed populations (Holohan and Holohan, 2000). Mental illness and substance misuse are widely considered to contribute to, perpetuate and result from homelessness (Fazel *et al.*, 2014). Multiple studies have demonstrated higher rates of alcohol and substance misuse disorders, psychosis and personality disorders amongst homeless populations (Feeney, 2000; Holohan and Holohan, 2000; Fazel *et al.*, 2008). The mental health of homeless people directly impacts their morbidity and mortality – e.g., through higher rates of suicide (Fazel *et al.*, 2014). Homelessness in itself can directly affect the ability of people to access appropriate healthcare and can negatively impact adherence to treatment regimens. Non-adherence among this population has been linked to more frequent attendances at emergency departments, which can lead to the inappropriate use of health resources (Hunter *et al.*, 2014).

In many jurisdictions, severe mental illness amongst homeless populations is estimated at 25-50% (DoHC, 2006), with similar rates in Ireland (CPsychI, 2011). When taking mild to moderate levels of mental illness into account, some studies suggest higher rates: Prinsloo *et al.* (2012) found that 81.6% of residents of a Dublin homeless hostel met the criteria for a mental illness. Those who have a dual diagnosis of mental illness and substance abuse have been found to constitute 10-20% of homeless populations (Drake *et al.*, 1991). According to Holohan (1997),

significant numbers of homeless people in Dublin were dually diagnosed. Furthermore, Keogh *et al.* (2015) found that 39% of the Dublin homeless population they studied had an addiction disorder, and 53% met the criteria for having an alcohol problem.

People who are homeless are at a distinct disadvantage in terms of accessing psychiatric services in Ireland. This is largely due to the sectorization of services into a catchment-area based system, meaning that access to local services is based on one's home address, creating obvious access issues for those with no permanent address (DoHC, 2006; CPsychI, 2011). Multiple other barriers to access have been identified including "stigma, financial obstacles, lack of knowledge about state entitlements, healthcare system barriers, the competing priorities of homeless persons themselves and lack of community care" (CPsychI, 2011, p.1). The access issues created by a lack of crisis/out-of-hours psychiatry services have also been highlighted (DoHC, 2006). Stigma is high on the list of barriers (CPsychI, 2011). Stigma towards homeless people is a longstanding phenomenon; being homeless appears to carry equal stigma to that of mental hospitalization and leads to a situation where the trauma of homelessness is worsened by the burden of being stigmatized (Phelan *et al.*, 1997). In the same way as the general public, medical staff sometimes stigmatize homelessness (Wen *et al.*, 2007).

Since the 1990s, experts in the mental health of homeless people have been highlighting the important role that frontline homeless sector staff play in the mental healthcare of their clients. For example, staff in homeless hostels in the UK carry out tasks that would be more usually performed by nurses in a mental health setting, from monitoring behaviour and medications to providing psychological and social support and referral to health services (Timms and Borrell, 2001). However, most staff have little training and can be excluded from some of the information, supervision and support necessary to perform the role of primary carers. Lack of knowledge and training can have adverse effects on clients, increase staff and client vulnerability, and can lead to staff misinterpretation of various behaviours (Vamvakas and Rowe, 2001); for example, misinterpreting the paranoia and amotivation associated with schizophrenia, or attributing it to the client's 'attitude' rather than symptoms, can lead to inappropriate reactions and lack of appropriate care (Burke, 2005). As such, there is a need for mental health training for homeless sector staff (Prinsloo *et al.*, 2012).

In a 2006 report on access to health for homelessness people, Europe's federation of homeless organisations, FEANTSA (2006), emphasized the role that homeless sector workers play in providing healthcare and advice for their clients. Their report highlighted an urgent need to train service providers in mental health issues, including education on clinical features, accessing local psychiatric services, and

techniques for use in crisis situations (FEANTSA, 2006). Homeless sector workers are an underutilized human resource that act as a link with health services and have long been flagged as essential in engaging clients in treatment (Onyett, 1992). As Timms (1998) suggested, training hostel and day centre staff is a valuable option in treating those who are most difficult to reach and treat, such as those who have fallen foul of the main psychiatric system and those with dual diagnoses of substance misuse and psychiatric illness. These staff are far more likely to be successful in engaging clients, and developing trust and a therapeutic alliance, than traditional psychiatric service workers (Onyett, 1992).

There is a need to re-address the models of psychiatric and social care for homeless people with mental health issues, as recent models have failed (Fazel *et al.*, 2008). For many years, researchers have recognized that the situation homeless people find themselves in is “fundamentally at odds with the objectives of equity, quality of service and accountability which are at the core of health care policy in Ireland” (McKeown, 1999, p.3). The literature points to a need for more integrated care, combining housing interventions, addiction services and mental health services (Drake *et al.*, 1997; Fazel *et al.*, 2008). Psychiatric services, addiction services and housing services have long been separate entities with little interaction between them. However, in many cases these three issues are intertwined, and attempting to address them in isolation contributes to a cycle of social exclusion (CPsychI, 2011).

McKeown (1999) suggested that voluntary organisations have a unique and important role to play in treating homeless people with mental health issues and, as such, must invest in training and develop more specialized services, rather than the generic one-approach-fits-all homeless services. In recent years across Europe and North America, the ‘Treatment First’ model for homeless adults with mental illness has been found to be relatively ineffective and costly (O’Sullivan, 2012). This led to its replacement by the more evidence-based ‘Housing First’ model (Greenwood *et al.*, 2013). The Treatment First model dictated that clients progressed through various stages of supported housing before permanent placement once their mental health and addictions had been treated (Stergiopoulos *et al.*, 2014). Unfortunately, this ‘staircase’ model often led to stepping back down the staircase – e.g., with relapses in addiction or mental illness (O’Sullivan, 2012). The Housing First model prioritizes accommodation above all else, and separate from treatment (Tsemberis, 2010). Studies have shown that a Housing First approach results in rates of sustainment of housing of approximately 80%, with additional positive results for cost effectiveness (O’Sullivan, 2012).

It is becoming increasingly clear that more integrated approaches are required (FEANTSA, 2006; Mares and Rosenheck, 2010; Patterson *et al.*, 2012), whereby mental illness, housing and addiction are dealt with together rather than sequentially or in parallel. This may take the form of on-site person-centred holistic approaches (McKeown, 1999) or improved interagency collaboration (Rosenheck *et al.*, 2003). The current Housing First model could be adapted to achieve this by developing mechanisms to identify and address psychiatric and addiction needs early on (Stergiopoulos *et al.*, 2014). Indeed, in Ireland the 'housing-led' approach, a variant of the Housing First approach, is closer to a more integrated model; though housing is the first priority, this approach recognizes the need for supports in tandem with housing provision. This model does not preclude the co-delivery of housing and mental health/addiction services, but rather it prevents mental health and addiction issues from negatively impacting upon tenancies (O'Sullivan, 2012).

The Irish Context

Homeless services

A diverse range of services are provided by various homelessness agencies in Dublin. These services are largely run by voluntary and non-governmental organisations, which have developed independently over the years. In recent years services have become more co-ordinated. Over the past three decades, multiple government policies have been produced, resulting in a more cohesive national plan for homelessness (O'Sullivan, 2008). With the international transition to Housing First, Irish homelessness policy shifted towards the European Housing-led approach, as discussed above. Early moves towards this model emerged around 2008, as hinted at in the Government's policies at the time: *A Key to the Door* (Homeless Agency, 2007) and *The Way Home* (DoEHLG, 2008) – optimistic and ambitious documents aspiring to end homelessness by 2010. A more definitive shift in government policy to a housing-led approach did not occur until 2013 with the *Programme for Government and Homelessness Policy Statement* (DoECLG, 2013).

With specific evidence-based policies now in place on homelessness and housing, Ireland is better positioned to address the issue of homelessness. Nonetheless, there is a homelessness crisis in Dublin currently. The reasons for the difficulties in realizing these policies are complex, but include: the current severe shortage of affordable rental stock in Dublin; recent difficulties in the Irish economy; personnel changes in homeless organisations (O'Sullivan, 2008); and, as suggested by some, a lack of desire to fully realise these changes in some homeless agencies (Brownlee, 2008).

Mental health services

Public adult mental health services in Ireland are primarily community based, coordinated by multidisciplinary community mental health teams (CMHTs), each responsible for patients within a given geographical catchment area. As a rule of thumb, to access catchment-area services, a patient must permanently reside in that area. In Dublin, some homeless psychiatry services are provided with an outreach component. A Vision for Change (DoHC, 2006) recognised the access issues that the catchment-area system poses for homeless people. Recommendations were made, including guidelines on the responsibilities of CMHTs for homeless patients in their area and recommendations for increased resources and longer operating hours for the homeless teams. Many of these recommendations are yet to be realized. Addiction services and psychiatric services are generally regarded as separate. Usually patients must self-refer for drug or alcohol treatment. Psychiatric services often do not accept patients whose active addiction is deemed to be the primary issue.

Study Overview

As the President of Ireland, Michael D. Higgins, a long-time advocate for homeless people, stated: “it will be crucial that the voice of those who are at the coalface in delivering the services...will be heard and will inform the policies that are chosen” (The Irish Times, 2015). There has been little research into the interaction between homelessness and mental health in Ireland, and no study has documented the experiences and training of homeless service staff in relation to mental health.

This research aimed to identify what formal or informal training homeless sector staff receive in relation to mental health and what knowledge staff have of mental health issues; and to examine the experiences of homeless sector staff of working with people with mental health issues. It also aimed to identify whether homeless sector staff believe that training in mental health issues would benefit them and what form they think this training should take.

To achieve these aims, the following research question was applied:

What training, knowledge and experience do frontline homeless sector staff in Dublin have of working with clients with mental health issues?

Methods

Ethical approval was granted by the Health Policy and Management and Centre for Global Health Research Ethics Committee at Trinity College Dublin. Permission was granted by managers at each service to recruit participants from staff working within the service. This study was conducted within an interpretivist phenomenological framework (Crotty, 1998). A qualitative approach was used to explore the sensitive topics and complex relationships at system, individual and interactional levels, which would be impossible to examine using quantitative methods (Barriball and While, 1994).

Using purposive sampling techniques (Marshall, 1996), key informants were recruited via emails sent to a number of Dublin-based homeless service organisations. Participation was voluntary, and key informants were free to withdraw at any time. The final sample consisted of five female and four male participants. Eight were frontline/project workers, one was a manager, and all were salaried employees with daily contact with homeless clients. The sample included staff from a wide selection of services provided by four different homeless organizations, including supported temporary accommodation, drop-in food and drug services, one-night-only accommodation and long-term accommodation services. Face-to-face interviews were conducted by the principal researcher (RC) in April and May 2015, and were audio-recorded with the prior written informed consent of each participant. The interview process continued until saturation was reached. The average interview time was 35 minutes.

An interview guide was developed following a review of the literature to identify major themes to be discussed, and using the principal researcher's experience of working in the field of psychiatry. The guide consisted of open-ended questions asking interviewees to relate their experiences with clients with mental health issues; their knowledge about mental health issues; their experiences of training relating to mental health and homelessness; their knowledge and understanding of the mental health services and referral processes; difficult situations experienced with clients with mental health issues and how these situations were handled; important aspects to include in a mental health training programme for homeless service staff; and suggestions on how mental health, medical and homeless services could be improved to better serve the needs of homeless clients with mental health issues.

The interview data was thematically analysed using NVivo version 10 (QSR International, Victoria, Australia). Data was interpreted using inductive coding, axial coding (Coleman and Unrau, 2011), and selective coding processes (Strauss and Corbin, 1990). Selective coding identified the most pertinent themes, based on the importance given to them by participants, the literature and their relationships to

each other. The 'core category' (Strauss and Corbin, 1990) identified during this phase was 'mental health and medical service issues', around which a high proportion of the other issues revolved, particularly the themes of 'dual diagnosis' and 'staff knowledge and training'.

Results and Discussion

Mental health and medical service issues

Issues with access to, and interactions with, various mental health/medical services emerged as the main theme among participants' responses, and there was an evident lack of connection between mental health/medical and homeless services. When discussing the difficulties of working with clients with mental health issues, the role of the mental health services in these dominated the discourse, with interpersonal difficulties with clients being secondary to interactional issues with components of the health system.

Access issues

Difficulty in accessing mental health services was a major concern for participants, who admitted to being unaware of how to access certain services, being confused about referral pathways, and finding it difficult to link a client in with psychiatric services:

It's just the main issue is referring people, trying to get people connected... it's just a huge struggle. (Participant 8)

Unclear referral pathways and confusion around where to seek care are major barriers to homeless clients receiving appropriate mental healthcare. Not knowing how to access services has been cited in the literature as the most common barrier, closely followed by financial issues, long waiting times, "confusion" and "hassle" (Rosenheck and Lam, 1997, p.388).

The configuration of psychiatric services into catchment areas poses a particular difficulty for homeless people, who, as they have no permanent address, do not have a local catchment area *per se*:

Well I know that they say you have to go back to your local area, which makes sense, but for our clients, being homeless, a lot of times they don't have a local area. (Participant 9)

Participants referred to the difficulties of linking clients in with services, and the problems this caused for those clients, which included issues with their housing:



... one of them is just free-falling, kind of, and I just can't get her in anywhere, no-one wants her, so keeping track of that and building a case for someone to take her on so that she can get, because she could live independently really well probably but she needs some support around her mental health to be able to successfully probably maintain a tenancy. (Participant 5)

Several participants referred to a 'merry-go-round' type of situation, whereby clients or referrals were passed from team to team, often ending in refusal. It seemed that, after exhausting all avenues, A&E (Accident and Emergency Department) was the only option, in both emergency and non-emergency situations:

I've also realised that it's very, very, difficult to get linked in with services, your main option is to go to A&E, which isn't ideal for everyone, a lot of people with mental health [issues] would not want to go near A&E in order to be seen. (Participant 8)

The lack of services other than A&E was particularly evident in crisis presentations, with many participants discussing how unsuitable it is for mentally unwell clients, who, in an Irish A&E, may have to spend hours waiting to be seen by a doctor:

Because there isn't really another option other than go to A&E... I hate A&E and I'm feeling in the best of my health but when you're not feeling well... it's unrealistic that they're going to stay there. (Participant 1)

Mental health issues do not confine themselves to a 9-5 working week schedule, and crises often occur late at night and at weekends, when most services are closed. This was a major concern for participants, who described having nowhere to turn to. In spite of the Irish mental health commission's best practice guidelines for care plans to include crisis planning (MHC, 2009), preferably not involving A&E, and the recommendation that that each catchment area team should provide 24-hour crisis facilities and beds in 'crisis houses' (DoHC, 2006), many mental health services do not provide a 24-hour crisis service. Even within working hours, often the only option in an emergency is to attend A&E, an environment wholly unsuitable for the treatment of mental illness.

This led to many participants strongly endorsing the need for crisis services; some mentioned a need for crisis beds, and others discussed drop-in services specific to mental health:

Back in the day, Saint... [psychiatric hospital] used to have an assessment unit, so when I worked here in the old [name of service]... if you were unwell you could just go over and you'd be seen to in about two hours, so you'd see a psychiatrist and that might be all you needed to do was to meet someone and talk... and say "you'll be alright" or maybe "you won't be alright for a little while but this will help". (Participant 1)

Medical staff treatment of clients

Another issue which seemed to affect access to care for homeless clients with mental health issues was an element of stigma from healthcare staff in relation to homelessness:

Again, you're homeless – you're not seen... And I can understand doctors and the medical carers, and I can see their side of it: it's difficult to engage with people who, I suppose the way doctors look at it, they don't really care about themselves, they're not going to take their prescribed medication, they're not going to be able to look after themselves properly in that way and in many ways that's true. (Participant 2)

Homeless people can feel stigmatized, disrespected and invisible to healthcare workers (Martins, 2008). Participants who had heard accounts from clients, and who had attended hospital with clients, felt that at times there was reduced speed and quality of care for homeless people in mainstream hospitals:

There is definitely a stigma towards homeless people coming in and... I don't know if they get the same service, I'm sure they do once they get through but there's certainly gaps and there's difficulties I think. (Participant 6)

I've heard of... not so much discrimination but... being treated differently, being asked to wait longer, I suppose it would be a type of discrimination against homeless [people] accessing A&E. (Participant 8)

Given the increasing demands on A&E departments, participants displayed understanding of the stressful job carried out by A&E staff; nonetheless, they felt that disrespectful treatment of clients was unacceptable. Homelessness stigma seemed to be prevalent in the health services, with clients being regarded as somehow at fault for their situation, not wanting to take responsibility for their own health and being subjected to longer waiting times and subpar treatment. Indeed, in studies amongst homeless people themselves, feeling unwelcome and 'dehumanized' was a barrier to accessing healthcare (Wen *et al.*, 2007) – an assertion supported by the experiences of participants in this study.

Continuity of care and communication issues

Another hurdle appeared to be a lack of communication and continuity of care once a person was discharged from hospital. Poor continuity of care following discharge from hospital was a cause for concern among interviewees. This was also highlighted in FEANTSA's 2006 report, which commented on "unacceptable discharge practices", such as "the fact that hospitals and other institutions systematically discharge people who are homeless and recovering following hospitalisation into the care of homeless services that are simply not equipped to meet their needs" (FEANTSA, 2006, p.31).

Several interviewees referred to hospitals using hostels as a “dumping ground”, with clients discharged from hospital to the hostel with no communication between the two services, leading to issues with provision of care:

This particular situation is hard because he presented self-harming, he cut himself really really badly, and we’ve never seen that before, but then he was released right away the same night... and I know beds are hard to come by but at the same time I don’t know what happened with that, like I don’t know if that consulting psychiatrist called his actual psychiatrist... so then I’m trying to race around and figure out who communicated what and so I think it would just be helpful if that was communicated back to us... (Participant 5)

Issues with follow-up on discharge were also apparent, including psychiatric services operating a ‘one-strike-and-you’re out’ system, whereby missing one appointment might lead to discharge from the service:

... basically there’s just no kind of follow-up, if you’re on a psychiatric ward and you’re released, if you miss your outpatient appointment you’re just... put back to square one so in order for her to link in with a psychiatrist then she needs to go through A&E again even though she’s already done that, she just missed one appointment. (Participant 8)

Alongside substandard discharge practices were inadequacies in communication from medical and psychiatric services, with staff in homeless services being left uninformed of a client’s diagnosis or medications. Though this is often unavoidable due to confidentiality issues, staff noted that they had experienced difficulty in contacting health professionals.

Causal link between lack of services and critical incidents

Participants drew a causal link between the aforementioned problems and the occurrence of avoidable critical incidents. Critical incidents led to loss of a bed, discharge from services, imprisonment or admission to forensic units. These outcomes often followed aggression, self-harm and criminal acts, such as arson, which participants felt would have been avoided had the client had access to services sooner. Participants felt that these incidents could have been averted if the services had been in place to assist clients, and spoke of the need to highlight this to the mental health services.

One participant detailed an incident where issues of access and continuity led to a poor outcome for a client, and highlighted the issues with access, the frustration of staff and the system failing that individual:

We... dealt with a very severe case a couple of years ago, we got this guy to the hospital, the ambulance services came in, they brought him up to hospital, we spoke to the consultant on duty that day, we described the guy... "yeah, yeah, yeah, yeah... brilliant, we'll look after him". Within an hour or so we got a phone call saying that "we were releasing this chap from care because he wasn't in our catchment area". That night the guy went and he burned down [name of public building], that drove us mad... but like I said for us the fact that we'd asked for help, he'd asked for help, that just annoyed me, regardless of whether it was in his catchment area or not, the guy was unwell and needed help, and the state or the hospital or the services or whatever you want to call it, failed us and definitely failed him, he's now in [forensic psychiatric hospital]. (Participant 2)

Frustration and powerlessness

The difficulties discussed above led to a palpable sense of frustration amongst participants, with the system in general, and with individual professionals:

What do you do or what do you advise people to do? (Interviewer)

[Laughing] Bang my head off the wall! (Participant 2)

If there was a clearer referral system or if we knew that there was a respite service that they could access or there was something they could get but we just know, no matter what we do, it's going to be a futile exercise, really. (Participant 9)

Frustration appeared to be due to several issues relating to the mental health and medical professions, including a feeling that medical services had landed issues on them:

Sometimes we have situations that are really, really, desperate and you're left with no avenue to go to, because if they rob a phone they're going to be put out, they could still go and hang themselves... and you just feel like what's the point? And I'm not saying mental health services are there to be punch-bags, but nor are we. (Participant 9)

Frustration among participants also arose from a feeling of powerlessness in the face of the system's inflexibility, and from having their opinions undervalued:

Well, most of the mental health services, apart from the [homeless psychiatry team] who actually their brief is in relation to homelessness... I find the mental health professions tend to be quite cagey, exclusive, very procedural and they don't... tend to take anyone apart from a medical professional seriously, so they would... well... the opinion of a staff member in a voluntary or non-profit organi-

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sation, they wouldn't take that into account to any great extent I would find, they would say "no... the referral has to come from a doctor, really I'd need to speak to a doctor about this." (Participant 7)

Interviewees were evidently frustrated with the medical and psychiatric services as a result of the reported difficulties. There was also a marked sense of powerlessness when the opinions of homeless sector staff were disregarded. Staff had pushed for their concerns to be heard with such infrequent success that they had begun to feel that there was no point in trying.

Potential solutions

Participants proposed a number of solutions, including suggestions for crisis mental health teams and crisis beds (as discussed above). Better communication between services was also suggested, as well as placements for health professionals and students in homeless services. Many participants also recommended putting in place on-site mental health professionals:

I think there's a huge, huge opportunity if they put professional services on site, I think it's good to have... community mental health teams but if you really wanted to really resource people in homeless services you need to put professional people on-site. (Participant 6)

I think also it would be useful to have... some sort of dedicated staff member or members in these organisations with a brief around mental illness... this is such a big issue. (Participant 7)

The current trend in homeless services is a move towards a Housing First model, as opposed to the other major model of Treatment First (Padgett *et al.*, 2010). However, as apparent from this study, a more holistic, person-centred and integrated model may be more appropriate, whereby, as Participant 6 suggested, the services are "wrapped around" the individual, and housing, mental illness and addiction are addressed concurrently, coordinated by a single agency. Putting mental health professionals on-site may be the most manageable of the proposed solutions, and is in line with a more integrated model of having a single agency taking responsibility for housing, mental health and addiction (McHugo *et al.*, 2004).

Addiction and dual diagnosis

Multiple gaps in services were identified; however, the gap that most dominated the interviews was the lack of services for those with a 'dual diagnosis' (i.e., having both a mental illness and a drug or alcohol addiction). Neither the psychiatric nor medical services currently take ownership of addiction services, a longstanding issue due to the historic divisions between psychiatric and addiction services.

The theme of vicious circles arose repeatedly, with participants referring to people being trapped in homelessness – the vicious circles of homelessness and mental illness, and mental illness and addiction, combining to create circles within circles, rendering escape and recovery almost impossible.

Dual diagnosis is a major issue for homeless people (Drake and Mueser, 2000) and, as participants pointed out, it is a significant element in their daily work:

Put into the mix... drug use and alcohol, so if you have a mixture of mental illness and drug use, poly-drug use and alcohol addiction plus *highly* stressful conditions in terms of your living conditions, you're sleeping rough, you're subject to violence, all of that, so you have clients who are very, very, troubled... you would deal with these people on a daily basis. (Participant 7)

Participants frequently referred to difficulties distinguishing between mental illness and the effects of drugs and alcohol.

... definitely 50 percent plus would present with mental health issues. It is quite difficult to kind of distinguish whether it would be substance or alcohol related as well. It could be a combination of the two, or it could be brought on by substance use, or substance use could be kind of a symptom of the mental health as well. (Participant 8)

As discussed by participants, for clients with a dual diagnosis, addiction issues and mental illness are intertwined and cannot be easily isolated from one another, being referred to as a "chicken and egg situation" by two participants.

Dual diagnosis services lacking

In recent years there has been an increase in the prevalence of drug use amongst Dublin's homeless population (O'Carroll and O'Reilly, 2008). Despite the high prevalence of dual diagnosis, there is a lack of services for dually diagnosed people and these people continue to fall through the cracks (NACD, 2004). This is not a new issue; when Dublin's homeless population was surveyed in 1997, one of the main issues homeless clients themselves identified was the lack of services for individuals with co-occurring drug problems (Holohan, 1997).

Interviewees described inflexible practices in the psychiatric services, and the requirement to be “squeaky clean” (Participant 1). Every participant had experienced clients being rejected from psychiatric services due to their addiction issues:

... nobody will go there, once there is any type of drug addiction or alcohol addiction doctors are loath to get engaged with it... (Participant 2)

When asked about recommendations for mental health and homeless services, many participants responded similarly:

... joining up addiction and mental health services, I think, because a lot of it's like chicken and the egg... they can't get their addiction treated until their mental health is sorted but the mental health organisations won't... they say “oh we can't help you with this because it's been caused by your addiction”, so there's very few that I know of that actually join up the two and can treat both at the same time... it's like a carousel... (Participant 3)

Some homeless accommodation services themselves were portrayed as prescriptive in their requirements, despite evidence that stable accommodation helps with recovering from mental illness and addiction, as per the Housing First model (Tsemberis and Eisenberg, 2000):

That's another thing, like people who do mental health housing, it's like, well you want to remember to fit into a very small niche to get into one of their houses. (Participant 1)

Addiction, mental health and housing services generally do not take responsibility for issues considered outside their remit. This contrasted with an ideal holistic and person-centred model described by one participant, with mental health, addiction and housing services interconnected on site, and services tailored around the individual:

The big problem is you need housing. The best way for people to improve, and for... mental health services to work and the homeless services is housing... you can't state that enough. I mean, the ‘Housing First’ model would work in Dublin if it was funded appropriately and if all the supports are put in place, and that's what I'm... thinking when I'm saying put people on site, if you put someone into accommodation and support them there eventually they won't need you, so it's putting the supports around the service user. (Participant 6)

Traditionally, mental health and addiction services in Western contexts have been very separate (Minkoff and Cline, 2004). Concern regarding the effect of this fragmentation of services has been growing over the past few decades (Rosenheck *et al.*, 2003), as clinicians have begun to realize just how intersectional these two issues can be (Harrison *et al.*, 2008). It became clear during the interviews that this

was a group of clients who were triply vulnerable, due to homelessness, addiction and mental illness; yet, they had the fewest services. Minkoff and Drake (1992) even referred to homelessness as a 'third diagnosis'. It is evident that those unfortunate enough to meet these three 'diagnoses' are chronically underserved.

Accessibility of drugs in services

The high prevalence of dual diagnosis was likely compounded by the availability of drugs within the services themselves. Participants referenced cases in which clients with mental health issues developed drug problems on entering hostels due to the easy accessibility of drugs, and spoke about the contribution of drug dealing at addiction treatment centres to the continued use of illicit substances by clients.

There's a rake of drugs... you can get anything and everything here. (Participant 1)

Some participants discussed how clients without a drug problem to begin with could develop one whilst in homeless services due to a lack of appropriate housing for people with mental health issues:

Some people here will never live by themselves but they have to stay in here, pick up a few... drug habits, come out, sometimes improve their mental health, but develop massive big debts and massive big... drug habits where they didn't have before... so I think there needs to be smaller services and also there needs to be more beds for people regardless... (Participant 1)

Participants were acutely aware of the major service gap for people with dual diagnoses and many of their recommendations related to "joining up addiction and mental health services" (Participant 3), as does the extant literature (Drake *et al.*, 2001). Others suggested more collaboration between services, which is also recommended in the literature (Rosenheck *et al.*, 2003). Between the easy accessibility of drugs, the lack of services for those with a dual diagnosis and a lack of appropriate housing, participants felt that recovery for clients in these situations remained an unlikely prospect unless structural change could occur.

Staff knowledge and training

Staff knowledge, training, and training needs were extensively discussed during the interviews. A quantitative measure of staff's knowledge was not applied; however, interviewees discussed what they thought their own knowledge levels and deficits were. During the literature search, a gap around mental health training for homeless staff was noted, leading to a focus in this study on issues around training and training needs. Participants revealed a lack of any formal standardized mental health training for staff, which ties in with the paucity of literature on the subject.

Experiences of training

Participants were asked about their experiences of training since taking up employment in the homeless sector. In most services it was mandatory to attend 'TCI' (Therapeutic Crisis Intervention), a short course focusing on de-escalation techniques, not specifically directed at mental health issues but with relevance to dealing with clients with mental illness, though participants were unsure how often they were supposed to receive refresher courses.

Otherwise, training was un-standardized, with some agencies providing no training, some providing non-mandatory basic workshops, and others permitting leave to attend external workshops. Several participants had attended ASIST (Applied Suicide Intervention Skills Training), a two-day suicide first aid workshop run by the Health Service Executive, which they found useful. Some participants had experience or training relating to mental health from courses or jobs prior to entering employment in the homeless services. Otherwise, most training took place in an informal manner from colleagues.

Where training was facilitated by the organisation, participants considered it basic or unsatisfactory:

The organisation that I work for does provide optional mental health training: one-day mental health trainings for staff... very basic training, providing you with the sort of medical model of... a neurosis versus psychosis type, diagnosis of mental health... illness. (Participant 7)

Mental health training for homeless sector staff has long been suggested by experts in homeless psychiatry as a route to treating the most vulnerable and difficult to reach clients (Timms, 1998). Maslin *et al.* (2001) identified that frontline staff working with people with mental illness or dual diagnosis have high training and support needs, and homeless sector staff most certainly fit this description. Despite the clear need, and the benefits that mental health training would confer on these frontline workers, a deficit of formal or standardized mental health training was evident.

Learning on the job and from experience

Most learning took place on the job, from colleagues and from experience, resulting in fragmented knowledge and lack of staff confidence in their own abilities. Participants cobbled together their own approaches from various sources – most often experienced colleagues and peers.

To be honest with you, when I first started here I shadowed a number of experienced staff... So, I think I took a little bit from everyone, and then made my own method... (Participant 4)

Some also learned from mental health professionals, and one of the homeless psychiatry teams was singled out as being particularly helpful in providing informal training and advice.

Well I would have had a certain amount of, I would have picked up here and there, knowledge, partly through experience... and linking in with mental health services in relation to mental health and mental illness but it would have been fairly... bits and pieces picked up along the way as opposed to being systematically trained or learned. (Participant 7)

Perhaps because of this, participants reported occasional uncertainty as to whether they were taking the right approach:

I think there's a lot of stress around it, not knowing... if you're handling it properly. (Participant 5)

As a result of this unsystematic knowledge accrual, participants expressed a need for training to consolidate and reinforce their knowledge:

Like I say... it just makes you aware that you're doing quite a lot of things correctly... it's nice to hear that... you're getting affirmation about the way you're operating is maybe not a hundred percent correct but it's, it's nearly there. (Participant 4)

Knowledge, knowledge gaps and training needs

A lack of training and knowledge on mental health can lead to misinterpretation of behaviours linked to a person's mental illness and potentially inappropriate or overly strict treatment of these individuals due to a lack of understanding of their illness (Vamvakas and Rowe, 2001; Burke, 2005). This was confirmed by participants who spoke of the fear and lack of understanding of some staff. Within homeless services there appeared to be some stigma surrounding mental illness:

I think people are just really scared to make it worse and so people kind of just don't really want to be around it at all. (Participant 5)

I think there is probably stigma... whether people want to know it or not, tacit stigma amongst staff around people with mental health issues... there's definitely fear there. (Participant 6)

There was also a suggestion that lack of training and knowledge could lead to fear, stigma and avoidance of dealing with mental health issues by management and staff. For example, Participant 1 highlighted the lack of ability to connect symptoms with mental illness:



I think... we can't name it sometimes, like... someone isn't [saying] "you're lazy or unmotivated"... I'm not saying staff would call people that, but the idea of... "they're not doing anything for themselves". It's like, well there's something, obviously if you're using heroin, it's a depressant. If you're drinking every night of the week, you're going to feel depressed. So I think, linking it together. (Participant 1)

This lack of understanding sometimes also extended to management level:

The problem with some homeless services is... they don't want to take any of the risk on. I think personally because they don't understand it, and they want outside services to take on everything else. (Participant 6)

Participants commented on several areas in which they could benefit from more training, including diagnosis, recognizing signs and symptoms and medication. However, unexpectedly, referral processes surfaced as the major knowledge gap and training need:

I think what we really lack is a training on referral process, and how to actually access services. I would love to do training on it but I don't know of any that actually exists. (Participant 8)

Participant 7 also discussed basic in-service training:

I think they didn't cover... what I would have found useful would have been more coverage of how to link people into existing mental health services, the procedures for actually getting people into mental health services, legislation, all that sort of stuff – the actual practicalities I would have found quite useful as well. There wasn't so much of that. (Participant 7)

Despite poor in-service training, many participants felt that they had a reasonable knowledge of certain aspects of mental health issues acquired from ASIST training, training prior to entering homeless services, learned on their own time and from experience. However, staff expressed a desire to have more training in several domains, including medication, signs and symptoms, diagnosis and management. The sparse literature in this area points to a need for training on dual diagnosis, assessment, when to seek help, treatment and accessing resources (Maslin *et al.*, 2001). The configuration of the mental health system remained a mystery to most participants, who described a lack of clarity around the referral process, and building their own knowledge in a haphazard manner from sources such as websites, colleagues and friends, and from calling different services. This led to stress, frustration and disenchantment amongst staff.

These knowledge gaps generate inefficiency, which could be addressed via a number of approaches – for example, through inter-professional learning, an emergent tool in the social and healthcare sectors (Barr, 2005; Maddock, 2014).

Participants discussed the benefits of informal learning from services such as homeless psychiatry teams. Some interviewees suggested that doctors and students spend some time on placement or visiting homeless services to foster understanding and communication. Some such interdisciplinary learning endeavours exist, such as a mental health training module run for homeless staff by nursing students in Philadelphia (August-Brady and Adamshick, 2013). Though few other examples surfaced in the literature, this type of collaboration heralds a potential opportunity for training of both medical and homeless sector staff. As recommended by FEANTSA (2006), inter-sectoral working is paramount to realising the right to health for homeless people.

Conclusion

This study sought to identify: *What training, knowledge and experience do frontline homeless sector staff in Dublin have of working with clients with mental health issues?* Interviews with front-line homeless service workers highlighted gaps both covered in, and absent from, the literature. The main concerns highlighted were at system rather than individual level. Most apparent from responses was the lack of accessible and cohesive services for those affected by the triple vulnerabilities of homelessness, addiction and mental illness.

These findings suggest a need for a restructuring of the way mental health and homeless services operate in relation to clients with mental health issues, as these are being failed by the current system. Participants made several recommendations for how services could be improved to better meet the needs of homeless people who are mentally ill, including crisis services, on-site mental health professionals and a better outreach component to mental health teams. There is evidently a need for new approaches, which should be more person-centred.

As suggested in the literature, to tackle current service gaps, housing, mental health and addiction services ought to be integrated and co-located (FEANTSA, 2006; Mares and Rosenheck, 2010; Patterson *et al.*, 2012). Instead of narrow views of homelessness services as exclusively housing-based, a focus could be placed on developing more holistic models, with investment in mental health training for staff and hiring of mental health professionals. Similarly, mental health and addiction services should stop viewing their specialities in isolation and adopt collaborative approaches. Restructuring and aligning addiction and psychiatric services is required and is long overdue. Furthermore, the mental health services must reconsider the provision of adequate out-of-hours cover in order to move away from the current situation where the Emergency Department is the only port of call in a crisis. Both sectors need to work to improve communication between them and avail of

inter-professional learning opportunities. Links between services should be made and strengthened in order to work towards integrated services. As suggested by Frazier, “in the long term, patient-oriented, system-wide solutions will be more humane than quick fixes.” (Frazier, 1985, p.462). Evidence-based policies exist; however, they remain under-actioned and under-funded. For their goals to be realized there must be governmental and non-governmental will; as one participant starkly stated:

“If [the Government] wanted to resolve homelessness, they could.” (Participant 6)

Study Limitations

This study focused on the experiences of a small group of homeless service staff in Dublin, Ireland. As such, it may help sensitise other professionals to key issues when working in this region. Although the diversity of configurations of homelessness services across different countries means that this study’s findings cannot be generalised across the European context, it is likely that the results are transferable, and can help inform policy relating to service integration, as they provide a perspective from the ‘bottom-up’, directly identifying needs as perceived by staff on the front-line of implementation.

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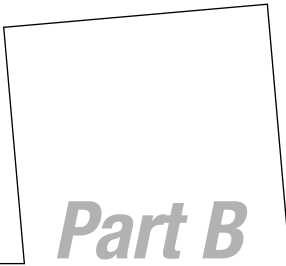
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Strategy Review



Part B

Strategically Moving Forward in Combatting Homelessness in Spain

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› **Abstract_** *The first National Comprehensive Homelessness Strategy 2015-2020, adopted by the Spanish government in November 2015, is an innovative policy reform developed with wide political consensus at the national level. With an overall aim of overcoming the lack of integrated policies in tackling homelessness, the Strategy envisions the eradication of homelessness as its ‘final horizon’ under the leadership of the public sector. This paper discusses relevant EU dynamics leading to the growing adoption of holistic approaches to homelessness, focussing on the development of Spanish policy and providing comparative snapshots with the path followed by the first southern European homelessness strategy. It explores key drivers behind the adoption of the Spanish National Comprehensive Strategy on Homelessness as well as its contents and underlying principles, and it discusses the Strategy’s potential to deliver on its promises.*

› **Keywords_** *Homelessness strategy, policy change, policy innovation, Spain.*

Introduction

Over the last decade, a growing number of EU countries have adopted or announced the development of comprehensive and integrated national strategies to prevent and address homelessness. Spain is the second southern EU country¹ to embrace a political commitment towards “a global and territorially coordinated approach of homelessness policies” (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2015, p.8).

The National Comprehensive Homelessness Strategy 2015-2020 (ENI-PSH – Estrategia Nacional Integral para Personas Sin Hogar 2015-2020) was adopted by the Spanish Council of Ministers on 6 November 2015. The ENI-PSH represents an important strategic step forward in the commitment of the Spanish State to homelessness policies and is, at the same time, a positive response at the planning level to EU demands, to evidence of the increased risks of marginalization in recent years and to growing pressure by NGOs advocating structured and long-term solutions to address homelessness.

This paper provides an outsider’s perspective on the Spanish homelessness strategy, building on available information and on the wider EU context that led to its approval. It discusses the relevant EU dynamics that are impacting in different ways on the decisions of Member States to adopt integrated strategic approaches to homelessness and that are impacting on the increased public and political visibility of the realities of homelessness.

Policy development leading to the adoption of the Spanish homelessness strategy – the latter being a necessary response to the structural limitations of the intervention system (Cabrera and Rubio, 2008) – is briefly described as an innovative policy change within the southern European context.

Comparative snapshots of developments in Spain and Portugal leading to the adoption of both countries’ first national homelessness strategies reveal interesting similarities and divergences that may be useful for informing future debates on the Spanish strategy’s progress.

The discussion around key drivers of the adoption of the ENI-PSH illustrates some convergent and divergent patterns that highlight common EU legacies, shared features within past political and policy frameworks, and relevant legislative and political developments. The strategic role of social organisations and their capacity to foster change is especially important within this debate.

¹ Portugal approved its first national homelessness strategy in March 2009.

Finally, the contents and the underlying principles of the Spanish National Comprehensive Strategy on Homelessness are explored and then discussed within the framework of the Strategy's potential to deliver on its promises.

Strategically Addressing Homelessness in the EU: Dynamics in Progress

For almost a decade, the European Observatory on Homelessness has fostered the production of a growing number of policy reviews on existing homelessness strategies across Member States (e.g. Benjaminsen and Dyb, 2008; Baptista, 2009; Wygnańska, 2009; Hansen, 2010; Houard, 2011; Hermans, 2012; Lux, 2014; Sahlin, 2015).

In 2010, the EU Network of Independent Experts on Social Inclusion recognised a growing trend among Member States “moving in the direction of developing strategies or at least more comprehensive and integrated approaches” (Frazer and Marlier, 2009, p.4), in a context where a number of countries had already developed overall national strategies. It is now possible to identify overall strategic approaches to homelessness across more than 10 Member States (Fondation Abbé Pierre and FEANTSA, 2015).

Over almost two decades, a number of EU-level initiatives have helped in establishing homelessness as a relevant topic on the EU agenda. In 2010, the adoption of the Europe 2020 Strategy would enhance a new governance context, which would provide a unique opportunity to boost EU progress on homelessness. For the first time, the EU set a headline target on poverty reduction – to lift 20 million people out of poverty – and Member States committed themselves to adopting complementary national targets within this framework.

In 2010, the Joint Report on Social Protection and Social Inclusion – one of the key instruments of the Social OMC (Open Method of Coordination for social protection and social inclusion) that is published annually by the European Commission – called on Member States to develop comprehensive homelessness strategies, and provided guidance on how to do this, putting a strong emphasis on effective governance, monitoring and evaluation, and on the setting of specific targets. The European Consensus Conference on Homelessness held in Brussels in December 2010 resulted in a set of policy recommendations, which aimed to provide a sound basis for strengthened ‘ambition and action’ in the area of homelessness. Its conclusions clearly highlighted the need for an integrated strategic approach towards homelessness, both at EU and national levels.

The European Parliament's Resolutions adopted in September 2011 and January 2014 urged the Commission to develop an EU homelessness strategy that could support Member States in taking up the fight against homelessness, recognising that "an increasing number of Member States have a holistic homelessness strategy and could benefit from European cooperation to further develop their policies."²

Within the framework of the EU Social Investment Package (SIP)³ launched in 2013, the Commission called on Member States to develop integrated national strategies on homelessness and at the same time committed itself to monitoring progress within the framework of the European Semester exercise. Moreover, the SIP included a staff working document entitled 'Confronting Homelessness in the European Union', which explored, among other issues, core elements of integrated homelessness strategies. At the Ministries' informal Round Table on Homelessness in the EU and the Social Investment Package, also in 2013, six principles were agreed, which would inform homelessness policy across Europe, including the commitment 'to enhance the development and implementation of national homelessness plans and respective monitoring'.

Additionally, evidence of increased dynamics around strategic approaches to homelessness is growing across Europe. The first Spanish strategy on homelessness takes on this EU 'legacy' and positions itself also as a response to "EU demands on Member States to better develop integrated policies on homelessness" (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2015, p.7).

However, those EU-driven dynamics seem to be developing in different ways and with various complexities. Benjaminsen and Dyb (2010) note that holistic approaches to homelessness seem to follow a geographic pattern across Europe. According to these authors, such approaches appear primarily in northern and western European countries rather than in southern and eastern countries – a trend that may be explained by the relevant histories of welfare policy formation (older versus younger) and the role of the state within specific national contexts. In some Member States, these strategic policy approaches to homelessness are barely emerging, whereas in others the national strategy process has gone through various stages of evaluation and revision (Owen, 2015). In central and eastern European countries, homelessness policies remain largely anchored in specific social assistance programmes (Šoštarić, 2013).

² European Parliament Resolution on an EU Homelessness Strategy, 16 January 2014, available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=MOTION&reference=P7-RC-2014-0008&language=EN>

³ Communication from the Commission Towards Social Investment for Growth and Cohesion, available at: <http://ec.europa.eu/social/BlobServlet?docId=9761&langId=en>

Yet, there is also evidence of extensive variation as regards the structure, focus and scope, as well as the sustainability and effectiveness of existing homelessness strategies. Benjaminsen *et al.* (2009) found that strategies developed in social democratic welfare regimes (e.g., Norway, Sweden, Denmark and Finland) tend to have fewer but more focused targets and objectives. Some countries, given the complexity of their administrative and territorial competencies, have engaged in strategically responding to homelessness at the regional level (e.g., Belgium and Germany). In other countries (e.g., Portugal), national strategic approaches to homelessness have initiated innovative developments (Baptista, 2009) that would not be properly implemented. Finally, in some 'modern, inclusive' welfare states (Sahlin, 2015) like Sweden, national strategies appear to have followed 'inverted time trajectories'.⁴

Overall, strategic planning and the implementation of policies to address homelessness have become more common across Europe. However, the varying systems and structures and the connections between them are determining how such programmes and plans evolve in specific national contexts.

Responding to EU Challenges: From Strategic Planning to Actual Delivery

Spain's commitment to the EU2020 target of reducing poverty and social exclusion is translated into a national goal of reducing the number of people at risk of poverty and social exclusion by between 1.4 and 1.5 million by 2019. In recent years, poverty, social exclusion and inequality have worsened in Spain and remain among the highest in the European Union (e.g., the poverty rate⁵ reached 22.2% in 2014 against an average of 17.2% in the EU-28).

Over the last fifteen years, a series of social inclusion plans and strategies have been put in place in response to the regular reporting and assessment exercise set up by the European Commission through the social Open Method of Coordination (OMC). The first National Action Plan for Social Inclusion of the Spanish Kingdom (*Plan Nacional de Acción para la Inclusión Social del Reino de España*), established in 2001, has been succeeded by six more national plans, the most recent one for the period 2013–2016.

⁴ The Swedish National Strategy that ran from 2007–2009 did not have any continuity until the present day.

⁵ The EUROSTAT figure for the at-risk-of-poverty rate after social transfers.

Measures specifically addressing the homeless population may be found in all the Spanish National Action Plans. In general, those measures have aimed at improving access to accommodation support, social care and health care, and at increasing homeless people's social and labour integration. Since the 2001-2003 National Action Plan for Social Inclusion, homelessness has been identified as a paradigmatic example of extreme social exclusion.

However, and in spite of an increasing number of measures being implemented over the years, homelessness policies in Spain have been lacking an overall integrated approach to provide the necessary framework for changing "the structural limitations of the intervention system in all its aspects, social as well as economic (labour market, health, education, social networks) and political, thus allowing the actual acknowledgement of the right to housing and to dignified accommodation" (Cabrera and Rubio, 2008, p.75).

The National Action Plan for Social Inclusion 2013-2016 (PNAIN) explicitly includes a set of measures directly addressing homelessness, and – for the first time – announced the "design and implementation of a National Comprehensive Strategy on Homelessness, in accordance with European recommendations, in cooperation with the Autonomous Communities, the cities of Ceuta and Melilla and Third Sector organisations" (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2013, p.99).

The National Comprehensive Homelessness Strategy 2015-2020 recognises the need both to respond to national commitments to EU policy and to address the lack of an "overall policy coordinated approach towards homelessness across the national territory" (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2015, p.8), and it proposes a comprehensive reform of the homelessness support system in Spain, where society needs to change to allow the social integration of homeless people (Ministerio de Sanidad, Servicios Sociales e Igualdad, 2015).

Spain, like Portugal, belongs to the relatively less advanced welfare states of southern Europe, where the adoption of national homelessness strategies came later than in the Nordic social democratic welfare states and the Anglo-Saxon liberal welfare states (Benjaminsen and Dyb, 2010). However, in both countries, the course of homeless policies seems to be in line with the paradigm shift that informed the development of the first generation of homelessness strategies in EU Member States – i.e., viewing homelessness as a consequence of a wide range of individual, organisational and structural hindrances, rather than simply a housing or a social problem (Benjaminsen *et al.*, 2009).

Both the recent approval of the Spanish ENI-PSH 2015-2020 and approval of the 2009-2015 Portuguese National Strategy for the Integration of Homeless People represent important landmarks in the holistic approach to homelessness strategic

planning in southern Europe. Both strategies announce the potential for policy change in addressing the fragmented nature of traditional approaches to homelessness.

Yet, the Portuguese National Strategy failed to ensure coherence in the delivery of services in a context where the State has increasing ownership of homelessness policy (Baptista and O'Sullivan, 2008). The gap between the expectations that this first southern European national strategy on homelessness engendered and what had been achieved through its implementation by the end of 2015 (Baptista, 2013) may provide useful lessons for the implementation and evaluation of the Spanish national strategy. All the more so, as it is possible to identify disquieting similarities between both countries in the design and implementation of strategic approaches to social inclusion.

The Interim Report on the Implementation of the National Action Plan for Social Inclusion 2013-2016 confirms a focus on vulnerable groups and highlights the approval of the National Homelessness Strategy in November 2015 (Dirección General de Servicios para la Familia y la Infancia, 2015). However, the report fails to provide any actual assessment of the implementation of the remaining five measures in the sub-section on homelessness. The only information given is the amount of public finances allocated to measures supporting homeless people, which increased from €19,998,037 in 2014 to €20,346,988 in 2015 – an increase of less than 2%. It is therefore not surprising that the European Commission's 2016 Country Report on Spain underlines the weakness of the impact assessment exercise in the mid-term review of the PNAIN.⁶

The 2016 Country Report, which accompanies the 2016 Country Specific Recommendations for Spain, highlights the deterioration of living conditions and the increase in inequality and regional disparities since 2009/2010. The social consequences of evictions and mortgage foreclosures are mentioned as some of the most serious impacts of the crisis. Moreover, the document identifies specific barriers to the delivery of social services, including the lack of integration between programmes, weak coordination (horizontal and vertical) between services, the need to improve monitoring and evaluation mechanisms, and uncertainty about financial resources for existing plans.

The need to overcome some of these barriers that continue to affect the planning and delivery of services in the Spanish context has been recognised in both the National Action Plan for Social Inclusion 2013-2016 (PNAIN) and the National Comprehensive Homelessness Strategy 2015-2020.

⁶ Available at: http://ec.europa.eu/europe2020/pdf/csr2016/cr2016_spain_en.pdf

In Portugal, similar obstacles to the implementation of the first national homelessness strategy have been identified (Baptista, 2013): resource allocation that is not clear or transparent, weak horizontal coordination at state level, and a failure to implement monitoring and evaluation mechanisms. Yet, the potential for change created by the operationalization of the strategy's principles and methodology led to positive changes in the development of local responses to homelessness in major cities.

In both countries, while there seems to be a genuine desire to respond positively to EU challenges at the level of strategic planning in the social sphere – embodied by the existence of several national strategies (e.g., the Spanish State Housing Plan; the Portuguese National Housing Strategy; national plans on childhood and adolescence; national strategies for the social inclusion of Roma) – there is a systematic failure to provide evidence-based evaluations of the impact of policy measures.

The report on Homelessness and Housing Exclusion across EU Member States (Frazer and Marlier, 2009)⁷ already identified the need for the European Commission (and Member States) to enhance monitoring and reporting mechanisms on homelessness and housing exclusion by agreeing on a “common framework and common guidelines” (Frazer and Marlier, 2009, p.8) as well as the need to support transnational exchange and learning in this domain.

It is clearly too early to assess whether the ENI-PSH will deliver on its promises and take a step to overcome this ‘southern paradox’. However, critically assessing the opportunities and obstacles encountered in implementing it – as measured against policy experiences in other national contexts – may make a valuable contribution to avoiding some of the mistakes that all European countries have made in trying to stop, reduce and prevent homelessness (Pleace, 2015).

⁷ This report summarises the main findings from the national analysis undertaken by the EU Network of Independent Experts on Social Inclusion, available at: <http://ec.europa.eu/social/BlobServlet?docId=9046&langId=en>

Key Drivers of the Adoption of the First Spanish Homelessness Strategy

The National Comprehensive Homelessness Strategy 2015-2020 identifies three major drivers for its adoption:

- the need to respond to European commitments for an integrated policy approach to homelessness;
- the Spanish context of homelessness support policies and the need to adopt an overall approach;
- the situation of homeless people in Spain, aggravated by the economic crisis.

Cabrero and Gallego (2016) add two more factors that, in their opinion, also contributed to the approval of this first strategic approach to homelessness in late November 2015: (i) national legislative developments in 2013 and 2014; and (ii) increasing pressure from social platforms and organisations working in the fields of homelessness and housing exclusion.

From a Portuguese perspective, these key drivers appear both familiar and unfamiliar. The EU influence on the adoption of a strategic approach to homelessness in both countries is a similarity that we have addressed in earlier sections. The main difference here between the two (first) homelessness strategies is the extent of the 'EU legacy' – i.e., in 2009 there were significantly fewer EU initiatives (e.g., resolutions, reports, conferences) driving Member States to adopt holistic approaches to homelessness than in 2015. Nevertheless, in both countries the role of the social OMC was particularly relevant as regards commitments in the national action plans for inclusion.

The need for an overall policy framework in the Spanish context also shares some similarities with the Portuguese context. Portugal and Spain share similarities as regards the late emergence of their welfare states following long periods of dictatorship, a relative inefficiency in their social protection systems, and the centrality of family as a safety net. Despite major transformations in social policies since the late 1970s, neither country has been able to provide a comprehensive and adequate response to homelessness (Torres, 2006; Baptista and O'Sullivan, 2008; Cabrera and Rubio, 2008; Baptista, 2009). In both countries, homelessness has been approached from a social services point of view rather than a housing perspective (Baptista, 2009; Aldanas, 2013), which has directly influenced policies and measures to tackle homelessness. The adoption of an overall integrated approach to homelessness came at a crucial stage in solving – rather than managing – the problem in both national contexts.

One major difference appears when comparing key drivers in both countries: the role played by national legislative developments in Spain – i.e., the explicit announcement of a measure for the design and implementation of a homelessness strategy in the National Action Plan for Social Inclusion 2013-2016 and the legislative proposal for a national homelessness strategy that was approved by the Spanish Parliament in April 2014. The former was mentioned earlier and represents the achievement of EU commitments at national level. The latter represents an important political consensus around the homelessness issue. Both legislative developments represent important steps in the policy process, as homelessness achieved recognition as a political issue, creating ‘an opportunity for action’ (Kingdon, 1984) that could be embodied in the formal adoption of the ENI-PSH in 2015.

This pattern is in clear contrast with the development of the other ‘southern strategy’, where this kind of political legitimisation occurred only at a later stage. In Portugal, there was no political consensus (or explicit endorsement by the Government) on the need for a national approach to homelessness before its approval of the national homelessness strategy, which was never translated into a legal act.

Another difference between the two strategies is the pressure created by social platforms and organisations working on homelessness and housing exclusion in Spain, which helped lead to the political initiative for a strategic and integrated policy approach at national level. In both Spain and Portugal, charities and NGOs have played a central role in the delivery of social services, including within the homelessness sector. However, the role and the organisational and political capacity of the third sector in both countries are hardly comparable.

The high degree of centralisation of the Portuguese State in the design and implementation of social policies has prevented third sector organisations from pushing social rights issues onto the national political agenda (Ferreira, 2004), something that is aggravated by a strong financial dependency on the State. Within such a framework, the capacity of the sector to intervene politically depends greatly on the degree of intra-sectoral organisation (Santos, 1999). The homelessness sector in Portugal is not an example of a strongly-organised sector capable of exploiting existing political opportunities and putting pressure on the political decision centres: the Government and the Parliament.

Spain is a highly decentralised state, in which social protection competences have been devolved to the Communities. The Public System of Social Services is responsible for implementing homelessness policies at the regional and local level. The Ministry for Health, Social Services and Equality coordinates and co-finances homelessness services through the Public Social Services Network. Social organisations play a major role in implementing projects and services to address home-

lessness. However, from an outsider perspective, there are aspects of the organisational capacity of the third sector in Spain that contribute to their greater ability and power to influence policy than is the case in Portugal.

The Spanish NGO Platform of Social Action is a private, nationwide non-profit organisation involving NGOs, federations and other relevant social entities, and one of its main goals is to strengthen the social sector. It has launched two Strategic Plans for the Third Sector of Social Action, the last one covering 2103-2016 (II Plan Estratégico del Tercer Sector de Acción Social). This Plan recognises the diversity within the sector but aims at promoting cooperation and unity around common projects and a commitment to social change. Moreover, the Platform is supported by the State Council of Social NGOs established by law in 2005, which, under the auspices of the Ministry for Health, Social Services and Equality, promotes NGOs and acts as an advisory body in the development of public policy.⁸ Last but not least, it is important to mention the role of the Federation to Support Homeless People (Federación de Entidades de Apoyo a las Personas Sin Hogar – fePsh), formally established in 2010, which assembles over 40 organisations across Spain and aims, among other things, to generate opinions and push homelessness onto the political agenda.⁹

The first National Comprehensive Strategy on Homelessness explicitly recognises the increasing demand from third sector organisations in Spain for a holistic and integrated approach to homelessness – advocacy work that also pushed the initiative forward. The first Portuguese national homelessness strategy can only claim to have been supported by relevant NGO federations – none of which are linked to homelessness, as such federations do not exist in Portugal – once the drafting process had begun (Baptista, 2009).

Overall, if the Spanish homelessness strategy shares some foundational elements with its Portuguese counterpart, the former strategy seems more robust in terms both of political endorsement from the central state and the strategic role and capacity of the NGO sector. These differences may prove crucial in the implementation stage, even if the lingering political uncertainty and unrest in Spain seem to be hindering implementation of specific measures and policies in the initial stages.

⁸ More information on the operation of the Council is available at: <http://www.msssi.gob.es/ssi/familiasInfancia/ongVoluntariado/consejos.htm>

⁹ More information on the fePsh is available at: <http://www.fepsh.org/es/presentacion.html>

The Spanish National Comprehensive Strategy on Homelessness: From Managing to Ending Homelessness?

The Spanish homelessness strategy aims at overcoming a lack of integration in policies that tackle homelessness, and it envisions the eradication of homelessness as its 'final horizon' under the leadership of the public sector.

Similar to other plans and strategies adopted in different EU Member States, the ENI-PSH adopts the ETHOS typology (Edgar, 2012) as its conceptual model, and this provides the basis for identifying the homelessness situations on which the strategy will focus – i.e., the roofless and houseless categories.

The adoption of a narrower approach than the one proposed by ETHOS is not new among Member States (Busch-Geertsema, 2010) and like the official definition in the Portuguese strategy – although broader – it may have been the result of a pragmatic need to reach consensus (Baptista, 2009) among a wide range of stakeholders (e.g., central administration, autonomous communities, local authorities, third sector organisations and homeless people themselves).

Thus, the ENI-PSH proposes to provide “concrete efficient solutions” for those two homeless categories, and extends its mandate to the need to establish “preventative actions addressed to all those who are at risk of social exclusion”.

A thorough overview of homelessness in Spain is given in a lengthy and detailed section within the strategy document. However, a complete understanding of the situation is hampered by a lack of existing information and by the restricted focus of the 2012 and 2015 Statistics Spain (INE) surveys on which this section draws, which only covered homeless people using support centres that offered accommodation and/or meals in municipalities with more than 20,000 inhabitants, thus including only a fraction of the entire homeless population.

The Strategy underlines the growing nature of homelessness (from 21,900 people in 2005 to 22,938 people in 2012); the increase in women's homelessness, particularly among young women (18-29 years old); the increase in homelessness among non-Europeans living in Spain for more than five years (from 19% of the total foreign homeless group in 2005 to 58% in 2012); and the increasing number of people remaining homeless for longer periods of time. Night counts in different Spanish cities provide data on the number of people sleeping rough and on those resorting to homeless accommodation. Based on these figures and on the 2005 and 2012 surveys, the Strategy extrapolates an interval of 30,250 to 36,300 homeless people in Spain in 2015.

A toolkit for developing an integrated strategy to tackle homelessness, which was developed by the European Federation of National Organisations Working with the Homeless (FEANTSA), outlines ten approaches that have been proven to promote the effectiveness of homelessness policies. The ENI-PSH incorporates several of these approaches, some of which are clearly identified in the Strategy's underlying principles.

First, a rights-based approach to tackling homelessness is announced as fundamental to the Strategy and to ensuring public commitment to homeless people's rights (to housing, security, health and protection, and social support). Such public commitment should lead, *inter alia*, to the effective realisation of such rights, which, although proclaimed by the Spanish Constitution, have not yet been fully realised (Cabrera *et al.*, 2008).

The development of the ENI-PSH also reveals the concern to adopt a participatory approach, fostering the involvement of and cooperation between relevant stakeholders: different levels of government, different sectoral agencies, the third sector and people experiencing homelessness. Such an approach will continue during the implementation stage through the establishment of regional and local cooperation structures.

The Strategy's principle of centring on the needs of the individual and on a case-management approach aims to bring (or disseminate) innovation into working methodologies. Once again, it responds to one of FEANTSA's ten approaches: the needs-based approach. Developing policies according to the existing needs of individuals rather than the structural needs of the organisations will certainly present a challenge in a country where "the existence of entrenched operational modes among those in charge of the design, planning, and implementation of the different homeless policies is another non-negligible difficulty" (Aldanas, 2013).

The Strategy recognises ongoing progress in recent years in the production of reliable information on homelessness in Spain and proposes to deepen such efforts by adopting evidence-based policies, investing in sustained research, and ensuring methodological innovation and training.

The approach taken by the ENI-PSH to preventing homelessness – together with emergency and resettlement/integration measures – addresses the need for a comprehensive approach to combatting homelessness directly. A particular emphasis is put on preventing the loss of housing (eviction and foreclosure procedures), which has become a key social and political issue in Spain in the context of the serious housing situation emerging – along with other structural legacies – from the economic crisis (Denche *et al.*, 2015).

Based on this set of main principles, the Strategy aims to reduce homelessness from around 23,000 people in 2015¹⁰ to 18,000 people in 2020. It sets out five main goals or objectives to achieve this:

1. Preventing homelessness
2. Raising social awareness about and fighting against discrimination and hate crimes against homeless people
3. Ensuring physical and mental integrity for homeless people
4. Supporting homeless people to achieve their potential
5. Strengthening the public service system for homeless people, and improving information and evaluation mechanisms

These five goals are translated into strategic aims, which in turn correspond to specific activities and indicators.

The Strategy advocates preventive actions (Objective 1) through the establishment of counselling services to prevent housing eviction and of protocols to address potential homelessness as a result of institutional discharge from detention facilities, youth institutions and immigrant and/or refugee accommodation centres.

It also envisages the development of a communication and awareness-raising strategy (Objective 2), which will foster the right to a “truthful and respectful image of homeless people” and the elimination of intolerance and indifference towards violence against homeless people.

Objective 3 is to provide a wide range of accommodation solutions based on a housing-led approach, together with an improved network of support services (e.g., mixed outreach teams involving social and health professionals; day centres). Implementing the Housing First model is a specific focus. It prioritises chronic homelessness situations, explicitly adopting some of the principles of the Housing First approach: immediate access to independent and permanent housing; continued support for clients as long as needed and at the required level of intensity; consumer choice and self-determination. The implementation of the Housing First model also aims to increase the involvement of housing entities in ensuring access to public housing.

Supporting homeless people to achieve their potential is the focus of Objective 4. The Strategy aims to introduce a case-management approach based on a collaborative and person-centred strategy in order to ensure that a person who experiences homelessness gets the support they need from the very first moment. There

¹⁰ Estimate based on INE 2012 figures.

is a specific focus on improving the employability of homeless persons by facilitating hiring by social employment companies, and strengthening mixed programmes for training and employment.

The final objective is the strengthening of the public system of social services targeting the homeless population in cooperation with third sector organisations, in order to address the issue of fragmentation and unequal support in Spain. Several actions are foreseen, including: developing a comprehensive public intervention in each territory, ensuring the necessary resources; developing comprehensive homelessness support plans; and ensuring that support services are in line with public regulations. Improving existing information systems on homelessness and enhancing knowledge and research is included in this last objective as key to developing more effective policies.

A one-page section is devoted to evaluation and financing. For the former, the document merely refers to the need to monitor the proposed indicators, the preparation of two monitoring reports (one in 2019 and one in 2021) and the participation of different national and regional stakeholders and even of other Member States and FEANTSA. Funding and the allocation of resources are dealt with very briefly and vaguely, leaving such decisions and responsibility to the different levels of public administration in the different territories.

The final section of the national strategy outlines eight quantified targets for reducing the number of homeless people in Spain to 18,000 by 2020, taking into account different variables: sex, age, health conditions and living situations (i.e., rough sleeping). A summary table provides indicators and data sources for the different actions under each objective.

Discussion

The first Spanish homelessness strategy demonstrates a clear wish to promote policy change and to drive the increased leadership of the public sector in preventing and tackling homelessness, namely through local administrations. Both the strong political consensus around the adoption of the Strategy and the recognition from important players within the homelessness arena¹¹ of the value of such an instrument in the Spanish context are key to success in the implementation stage.

¹¹ See, for example, the press release by the fePsh published on 11 November 2015, available at: http://www.caritas.es/noticias_tags_noticialInfo.aspx?Id=8603

However, the Strategy's potential to foster a more coherent and integrated delivery of policies and measures addressing homelessness may face some barriers due to the gap between the intentions announced and the lack of a pragmatic approach clarifying how to attain them; the quantitative targets set; and the 'proposals for action' under the five objectives.

Several inconsistencies could, in our opinion, benefit from further reflection in order to build on the work already done and improve the feasibility of the proposals, which will necessarily have to be implemented at regional and local levels.

One important barrier to the Strategy's potential effectiveness is the overall lack of information on resources and funding. Moreover, at this stage there are no clear indications as to timelines or the allocation of responsibilities (leading and contributing roles) for implementing the large number of actions proposed, which would positively contribute to the State's 'enabling approach' (Cabrera, 2006)

Moreover, there is room for improvement in the final tables listing the 'actions' identified under each objective; given the lack of clarity and consistency in their selection, they can hardly be defined as measures, activities or targets (e.g., counselling services and support to prevent the risk of eviction, social awareness, disability, Housing First, case management, resource manual on homelessness).

The indicators provided for each 'action' in these tables are mainly output indicators – i.e., they merely identify numbers of protocols, programmes, people, places, localities, etc. There is an overall lack of outcome indicators that could help demonstrate the impact of many of the Strategy's measures and activities, including those that, for example, aim to prevent the risk of homelessness among people in detention or youth institutions, improve access to public or private housing, or implement a case management approach.

From the information provided, it is not clear how the Strategy's effectiveness will be monitored and evaluated. It is also not clear how evaluation of the Strategy will respond to at least one key question on the impact the ENI-PSH aims to have in the Spanish context – i.e., whether the outcomes prevented and/or reduced homelessness?

One of the key drivers of the ENI-PSH was the need to respond to the aggravated social needs of homeless persons and, specifically, to the serious consequences for housing of the financial and economic crisis. Although it clearly identifies a sharp increase in the numbers of people becoming homeless following the loss of housing or the financial inability to sustain their home, the Strategy falls short of addressing the issue of housing affordability or access to housing. The Strategy prioritises housing-led approaches and recognizes the effectiveness of Housing First programmes for homeless people with severe support needs. However, rapid access to housing, which has proven to be one of the elements leading to the

success of Housing First (Busch-Geertsema, 2014), depends on the availability of affordable housing (e.g., social, private rented). It would be important to address the mismatch between the scope of the problem, the ‘wished-for’ solutions and the feasibility of implementation.

A similar mismatch applies to the ENI-PSH’s acknowledgement of the investment needed in research and “extending, improving and systematising information on homelessness” and the actual means of and concrete measures for achieving such a goal. Two indicators are included for measuring this goal: number of places undertaking night counts on homelessness; and number of seminars aimed at improving knowledge on homelessness. Further improvement in this domain will certainly be needed in the implementation stage of the ENI-PSH.

One final consideration should be made in respect of the quantitative targets proposed by the Strategy, which have been presented above. Quantifying targets are an important element of a strategic approach to homelessness. The Jury Recommendations at the Consensus Conference on Homelessness underpin the need for Member States to focus on clear targets when developing homelessness strategies; “[w]ithin the proposed EU strategic framework, the Jury calls on Member States to fix dates by which they will end rough sleeping and long term homelessness”(Vandenbroucke *et al.*, 2010, p.3). The Spanish Strategy’s objective for 2020 is to reduce the total number of homeless people in Spain by only around 20%. The aim to end homelessness as the Strategy’s ‘final horizon’ announced in the document’s very first page will certainly remain a very, very distant goal if targets remain at their current level of ambition.

Conclusion

The first National Comprehensive Homelessness Strategy 2015-2020 adopted by the Spanish Government in November 2015 is an innovative policy reform developed with wide political consensus at the national level. Its implementation may represent a decisive step in the paradigm shift necessary to move from a traditional policy response – largely based on reactive solutions – to structured, long-term solutions for ending homelessness.

The ENI-PSH is a positive response to the EU challenge to Member States to strengthen ‘ambition and action’ in addressing homelessness. Learning from the dynamics and complexities of national developments in implementing holistic approaches to homelessness across the EU may prove useful in preparing future stages of the Spanish strategy. The potential of the Strategy to foster a more

coherent and integrated framework for the development of policies addressing homelessness will also depend on the direction of such multi-level dynamics in the national context.

The opportunity to review the Spanish national homelessness strategy has enabled a comparative look at the development of its Portuguese equivalent and the identification of some disquieting similarities but also of some promising divergences at the initial stages of its development. Examples of similarities include insufficient attention to monitoring and reporting mechanisms, problematic horizontal and vertical coordination within public administration systems, and a reluctance to provide clear funding and resourcing information. On the other hand, the recognition of homelessness as a political issue – which already translates into important legal milestones; the commitment and experience of some regional administrations in developing strategic approaches to homelessness; and the organisational and political capacity of the homelessness third sector in Spain may provide a sound base from which to ensure consistent progress in delivering on the ambition and the promises of this first national comprehensive approach to homelessness.

While the ambition to eradicate homelessness under the leadership of the public sector is clear in the Strategy, more transparency and coherence about how to achieve this goal is crucial for successful delivery of policies. The ENI-PSH is based on seven principles, many of which are aligned with approaches that have been found effective¹² in combating homelessness. However, it will be crucial to ensure that implementation of the Strategy will be able to bridge the gap between the idealistic nature of many of those approaches and the practicalities of implementing such changes over the next four years (e.g., ensuring the right to housing, actively preventing homelessness and housing exclusion risks, enhancing innovation in working methods, developing existing information and data on homelessness, and investing in sustained and continued research).

The opening of a second ‘policy window’ (Baptista, 2009) in another southern European country six years after the first will hopefully be able to overcome the apparent paradox between ambitious strategic policy planning in the social arena and meagre outcomes in bringing about actual change in homelessness policies and the delivery of homelessness services.

¹² FEANTSA Toolkit for developing an integrated strategy to tackle homelessness available at: http://feantsa.org/spip.php?action=accéder_document&arg=1534&cle=0de165c774c66302f92e3c3c912b64e8ec85abfa&file=pdf%2Fenfr_2006toolkit_5b1_5d-2.pdf&lang=en

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International Review



Part C

Homelessness in Uruguay: A Trajectories Approach

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› **Abstract_** *In Uruguay, particularly in Montevideo in recent years, the problem of homelessness has become very publicly visible. This has led to greater academic analysis, state-funded surveys on the populations living on the street and in shelters, and the development of a new 'Homelessness Attention Programme'. This paper seeks to explore homeless pathways in Uruguay through analysis of the residential trajectories of homeless people using night shelters in Montevideo, and to contrast these findings with European evidence.*

› **Keywords_** *Homelessness, displacements, housing pathways*

Introduction

There is widespread consensus in European and American literature on the importance of studying the trajectories of homeless people. The analysis of homeless pathways is often seen as a useful method for deepening understanding of the risk factors and triggers that lead to homelessness. The study of homeless pathways is also seen as a way of understanding different trajectories through homelessness, ranging from a single experience of homelessness through to multiple experiences of homelessness over time (Fitzpatrick, 1997, 2000; Anderson, 2001; Clapham, 2002, 2003, among others).

The last two decades have been characterized by the development of longitudinal and retrospective analyses that aim to understand the nature and dynamics of homelessness in a new way. These new methods emerged as a result of criticism

of limited cross-sectional studies that offered a static view of homelessness. Much of the literature maintains that homelessness is better understood as a process with different entry and exit (and re-entry) routes. Thus, life before, during and after homelessness needs to be understood in order to comprehend pathways through homelessness (Sosin *et al.*, 1990; Piliavin *et al.*, 1993, 1996; Pleace, 1998; 2000; Anderson, 2003; Busch-Geertsema *et al.*, 2010).

Some scholars argue that a proper understanding of homelessness means looking beyond the known trigger factors or focusing on the characteristics of homeless people; homelessness, it is argued, is actually the result of a complex set of adverse circumstances, which usually begin at an early age and cause changes in the residential situation of people (Ravenhill, 2008). Thus, advances in homelessness studies using longitudinal analysis are seen by some as a way of understanding at what stages of life the risks of homelessness increase, what type of events produce these risks, and which interventions can prevent and reduce homelessness (Fitzpatrick, 1997; FEANTSA, 2010; Quilgars *et al.*, 2011).

Therefore, the most recent research aims to work out how individual and structural factors interact in a way that leads to homelessness (Pinkney & Ewing, 2006; Busch-Geertsema *et al.*, 2010; Fitzpatrick and Stephens, 2013). Specifically, certain individual characteristics are identified, such as problematic consumption of psychoactive substances or alcohol, mental health problems, learning difficulties or brain injury alongside structural factors, such as failures of the housing or labour market and changes in family structure (Fitzpatrick, 1997; Anderson, 2001; Edgar *et al.*, 2007).

Over the years, these explanatory models acting in isolation have been subject to criticism due to their inability to account for why certain individual characteristics on one hand, and structural tendencies on the other, create a problem for some individuals but not for others. That is to say, they have been unable to explain why some people do not go through periods of homelessness while others who have similar personal characteristics (severe psychiatric disorders, substance abuse) or who share the same position in the social structure, do (Ravenhill, 2008; FEANTSA, 2010).

In this context, the study of the careers, trajectories or paths of people who go through periods or stages of sleeping on the street or in homeless shelters has become increasingly important. These approaches aim, from different theoretical perspectives and survey techniques, to understand homelessness and the experiences of homeless people.

This current understanding of the causation and nature of homelessness in Europe is heavily influenced by North American, and particularly US, analysis. However, the extent to which this work provides a satisfactory explanation of homelessness in Uruguay is debatable.

In Uruguay since mid-2000s there have been isolated attempts by social scientists to understand homelessness. Although some research has been done (Chouhy, 2010), knowledge about the processes that result in people entering homeless shelters or sleeping rough remains limited. This paper aims to deepen the study of homeless pathways in Uruguay using an analysis of the residential trajectories of homeless people inhabiting night shelters in Montevideo. In doing so, it critically assesses the utility of European and North American ideas about the nature of homelessness causation in explaining the experience of homelessness in the Uruguayan context.

First, the paper reviews the current European and North American literature, followed by an analysis of information on homelessness in Uruguay based on data taken from two censuses in 2006 and 2011. Third, a typology of the pathways of men and women who inhabit shelters for single people in Montevideo is presented. Finally, the paper reflects on the findings and the implications of state practices for addressing homelessness in Montevideo.

Homelessness as a Process

The literature contains three sets of analytical models, which present pathways-based explanations of homelessness. An initial approach, called 'downward spiral', draws on theory from the interactionist approach to deviance (Becker, 2009) – i.e., changes of identity cause people to enter homelessness and to remain homeless. With slight variations, research from this perspective maintains that most people who start out on a homeless trajectory inevitably finish in a chronic state – that is, they accept and adapt to homelessness as a 'way of life' (Chamberlain and McKenzie, 2003; Johnson and Chamberlain, 2008).

A second approach centres on residential instability, which is associated with shelter use and living rough (Sosin *et al.*, 1990; Piliavin *et al.*, 1996; Kuhn and Culhane, 1998). These studies tend to use multivariate analysis on large datasets (Mayock *et al.*, 2008). Residential instability research suggests that homelessness is not a lifelong experience, but also that exits from homelessness may not be sustained. Some work suggests a pattern of increasing duration and periodicity of homeless episodes over time (Piliavin *et al.*, 1996), with homelessness becoming a semi-permanent state (Culhane *et al.*, 2013).

Finally, arising from criticism of the widespread conception of downward spiral and of quantitative research limited only to recording residential variability, the third perspective emphasizes that the study of homelessness must be explained considering the personal and residential history of individuals over time. This approach predominantly involves the use of qualitative survey techniques, such as in-depth interviews, life stories or biographical approaches (Pinkney and Ewing, 1996).

Contributions from the 'life course' perspective

The analysis of homelessness across the life course requires the study of residential trajectories over time and in a comprehensive manner. Longitudinal analysis is necessary in order to contemplate the events and transitions that increase the risks of experiencing homelessness through the life course. At the same time, it allows us to observe movements within and outside of homelessness together with the factors that lead to it, individual decision-making when faced with trigger events, and the different perceptions associated with those experiences (Fitzpatrick, 1997; Fitzpatrick *et al.*, 2011).

The above-mentioned advances allow us to state that the problem stems from changes that operate at the macro level, which have a more severe impact on those with personal vulnerabilities of several types, and this would explain the concentration of people with support needs within the homeless population (Pleace, 2000; FEANTSA, 2010).

So, homelessness has been seen as a result of a complex combination of risk factors where the homeless situation is triggered when one or more traumatic events occur in the lives of the individuals (Clapham, 2003). Researchers distinguish between: i) 'risks', considered to be those characteristics related to the social context, individual relations and attributes that would increase vulnerability as a result of that experience and, ii) 'triggers', which impact differently according to gender and age and which are liable either to cause homelessness immediately or be "one more step in the 'career' that may result in that situation" (Fitzpatrick, 2000).

The life course approach (Elder, 1994) provides an analytical framework through which homelessness can be understood within a global understanding of the life stories of individuals, by reconstructing the trajectories of those who have experienced homelessness. The main theoretical contribution of this approach is that it shows the relational and independent nature of the different elements involved in the homeless trajectory (education, work, family, residential), which accounts for how certain events or transitions in one element impact on the other elements (Feijten, 2005).

'Transitions' are understood as changes in one's state, position or situation (e.g., leaving one's home, or entering or leaving the education system or labour market), which are closely linked to a normative system of (often) age-related expectations (Blanco, 2011). 'Events' are important occurrences involving a relatively abrupt change that may have severe and long-lasting effects (Settersten, 2003 cited in Hutchison, 2011). Hand in hand with this, the principle of 'interconnected lives' by which "social regulation support occurs through social relationships across the life span" (Elder, 1994, p.6) is one of the central aspects, alongside individual agency and capacity.

Homelessness in Uruguay: The 'Homelessness Attention Programme'

Homelessness has become a more visible social problem in Uruguay in recent years, particularly in Montevideo. Two state surveys on the population living on the street and in shelters have been conducted, and a 'Homelessness Attention Programme' (PAST – Programa de Atención a los Sin Techo) was developed in 2005 under the auspices of Ministry of Social Development (MIDES). The statutory definition of a homeless person is anyone over 18 years of age (families and single people) who sleeps rough or in night shelters; it excludes people living in slums, hostels, guesthouses or in shanty towns (MIDES, 2012).

The *Homelessness Attention Programme* focuses on the provision of night shelters (PASC, 2013). Shelters are open from 7pm to 8am, 365 days a year, and are run by a multidisciplinary team of community workers, psychologists and social workers, among others. The programme also has a street outreach team designed to connect homeless people who are sleeping rough to the shelter system, and there is an additional night shelter operating under the auspices of MIDES and the Ministry of Security for people sleeping rough and breaking the 2013 Law 'Offence, Conservation and Care of Public Spaces'.

There are three types of shelters, all of which are managed by NGOs. Night shelters at level 1 are the point of entry to the system, and are designed for people who are entering homelessness for the first time as well as for those who have unsuccessfully used the shelter system before. In shelters at level 2, staff members facilitate a 'housing ready' training process for each participant, which aims to create stability in their living conditions, enabling autonomy for sustainable housing in the future (PASC, 2012). Shelters at level 3 are pre-discharge services. Homeless people are expected to consolidate the 'housing-ready' process they have been developing at previous levels, with the goal of being ready to live independently when they leave (PASC, 2012).

In summary, homeless people are expected to 'progress' in the shelter system until they reach the level of regular housing – i.e., Montevideo's homelessness system follows the staircase model familiar from Europe and North America (Sahlin, 2005).

Nevertheless, one of the main goals for 2016 is implementing an interinstitutional agreement between MIDES and the Housing, Land Planning and Environment Ministry (MVOTMA) to develop a supported housing service with 13 places available for people who inhabit night shelters but can live independently with a welfare benefit.¹ The form that the supported housing plan will take is still being decided.

Descriptive analysis of the official census of people living in shelters in Montevideo

In 2006, the first count and census of people living on the street and in shelters in Montevideo was carried out by MIDES and the INE.² Preliminary data showed a total of 320 people sleeping rough and 419 individuals in night shelters. Five years later, the second count and census of homeless people 2011 was carried out – for the first time within the framework of the National Census of Population and Housing.³ In this count, 1,274 people were found to be homeless across the country: 837 in shelters and 437 sleeping rough (MIDES, 2011).

In both cases, the point-in-time (PIT) technique was applied, taking a census of the population making use of night shelters and counting the population sleeping in the streets on the night of the survey in Montevideo (2006 and 2011) and outside of Montevideo (2011). Both surveys are essential to developing knowledge about the characteristics of homelessness in Uruguay. However, some limitations and information gaps are evident in the censuses. First, the fundamental limitation of the PIT methodology relates to the intermittency and mobility of different living arrangements that characterise actual experiences of homelessness (O'Connell, 2003 cited in Busch Geertsema *et al.*, 2010). That is, the total number of people sleeping in shelters or public spaces on one day in the year is only one part of the population that could be in this situation in a given period (e.g., over the course of a year).⁴

Secondly, it is important to highlight the absence of information on the prevalence of certain psychiatric disorders and problematic consumption of illegal drugs among homeless people. Gathering these data would have constituted a fundamental quantitative and qualitative leap forward. Finally, no data were collected in

¹ www.presidencia.gub.uy

² National Institute of Statistics of Uruguay

³ According to the last census, the population of Uruguay is 3,286,314, with 1,319,108 people residing in Montevideo. See www.ine.gub.uy.

⁴ For a discussion of current techniques of enumerating homelessness in Europe, see Baptista *et al.* (2012) and Busch-Geertsema *et al.* (2014).

the 2011 census on the employability of homeless people. Having this information would have allowed comparison with the 2006 survey and increased understanding of the relationships between homelessness and the labour market.

A descriptive analysis of the quantitative information from both censuses is provided below to give a general overview of the more structural characteristics of the phenomenon at the local level, while also allowing observation of its evolution in the time between one census and the other.⁵ The descriptive analysis refers to comparable variables between both censuses: age, sex, time on the streets, educational level; and for comparable populations: people over 18 who live in night shelters in Montevideo.

Composition of the population in shelters by sex and age

As previously mentioned, in 2006 the total number of people using shelters according to the census was 419 people (all over 18 and in Montevideo). In 2011, of the 837 people using shelters, 167 were in shelters outside Montevideo and 83 were under 18 (in Montevideo). Therefore, 587 people over 18 were sleeping in shelters in Montevideo on the night of the census. Regarding the gender distribution in Montevideo indicated by both censuses, Table 1 shows an increase in the male population, which exceeds the variation in the overall population. The number of women in shelters actually decreased slightly in absolute terms in 2011, but as the report indicates, the census showed a worrying quantitative increase in girls under 15 (1 in 4) (MIDES, 2011).

Table 1. People over 18 in Shelters in Montevideo by Gender, 2006 – 2011

Gender	Year		Variation Factor
	2006	2011	
Male	267	457	1.7
Female	152	130	0.9
Total	419	587	1.4

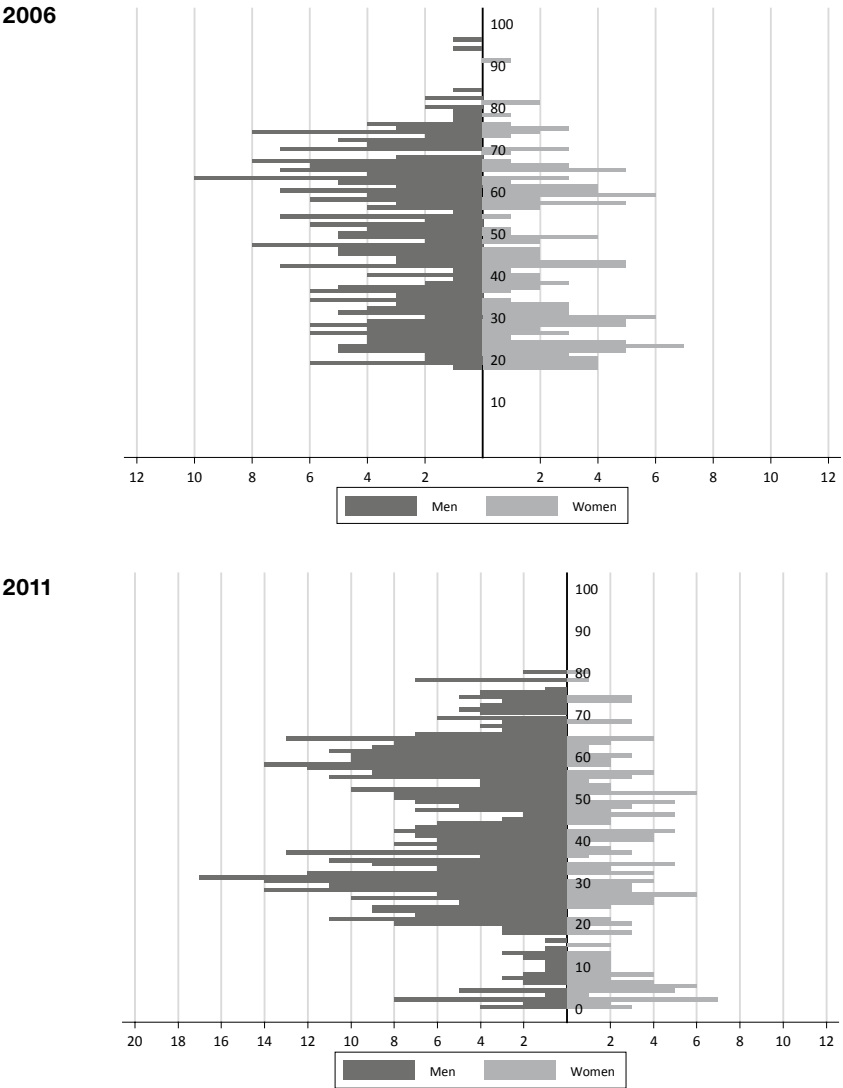
Sources: Data from First Shelter Census (MIDES and INE, 2006) and Census of Homeless People (MIDES, 2011)

As can be seen in the pyramid graphs presented in Figure 1 below, the increase applies to all ages for both sexes, but mainly to men aged between 20 and 40 and middle-aged women (34 to 53). Similarly, a concentration is seen in one of the most extreme age categories (over 68 years old). However, the comparison between the two population pyramids shows an age shift that tends to include increasingly younger people, mainly males of reproductive age (and a significant number of women under 18).

⁵ This is the first time that work has been done using both official empirical sources on people using night shelters.

As FEANTSA (2012) highlights, there has been an increase in youth homelessness in many European countries. The data also tell us that this trend should be considered when interpreting the different pathways through homelessness of young people to address not only the differential outcomes and trajectories, but also the multi-level factors that lead to homelessness in young women and men.

Figure 1. Population in Shelters by Number of People



Time spent homeless by sex and age

Table 2 shows data on time spent homeless disaggregated by gender. The table shows slight variations for the different groups with the exception of males with less than a year spent in that situation. The factor of variation indicates that the male population homeless for less than one year increased more than threefold between 2006 and 2011, which implies that the inter-census increase was highly concentrated in this group.⁶

Table 2. Time Spent Homeless by Sex and Year: People over 18 in Shelters in Montevideo

	2006			2011			Factor of variation (2011/2006)		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
Less than 1 year	70	50	120	218	60	278	3.1	1.2	2.3
1-3 years	85	65	150	121	39	160	1.4	0.6	1.1
4-8 years	55	24	79	63	21	84	1.1	0.9	1.1
Over 8 years	47	10	57	55	10	65	1.2	1.0	1.1
Total	257	149	406	457	130	587	1.8	0.9	1.4

Source: Data from First Shelter Census (MIDES and INE, 2006) and Census of Homeless People (MIDES, 2011)

In summary, the brief comparative analysis highlights some changes in the problem that deserve to be considered. It is worth noting that the trends indicated by both censuses are for large numbers of people spending relatively little time homeless (less than one year). Furthermore, we see that those who indicate having spent less than one year homeless are mostly young men – the group that accounts for almost the entire variation between 2006 and 2011.

⁶ There is no information for this variable in 13 cases in 2006. As such, the total number of men and women surveyed according to time spent homeless presented in Table 3 drops to 406 cases.

Pathways Through Homelessness

This section aims to present a typology of pathways leading to homelessness. Seventeen qualitative interviews (11 men and six women) were conducted with individuals who inhabited night shelters for single homeless people in Montevideo. The eligibility criteria for being interviewed were: time being homeless (two years or less) and being aged 18 years or over.

Three pathways to homelessness are distinguished according to: i) the intensity of housing displacement, considering events and transitions in such areas as health, relationships and work; ii) how the impact of serious events was dealt with; and iii) individual strategies to deal with critical scenarios.

This approach uses 'accommodation biographies' (May, 2000) – mapping the length of time for which individuals use different forms of accommodation in their homeless trajectories, as well as time spent sleeping rough. The personal history of the individual is also explored, looking at work, health and relationships in order to contextualize changes in accommodation and relate those changes to the experiences of the individual.⁷ The testimonies of the respondents and the reconstruction of their biographies reveal the events and experiences that gradually led to their becoming homeless. This approach can also show the sequence in which these events occurred and how the interplay of different factors resulted in far-reaching and lasting changes in their lives. Displacements are defined as either voluntary or forced movements.

For each move, data were collected on when each living arrangement ended, the reasons they left, the next living arrangement they moved to, data on anyone who accompanied them, the type of employment (if any) held and any health problems. For the biographical reconstruction, the causes of homelessness that were perceived as important by respondents were defined as trigger events, with these being examined in the context of other information on their pathways through homelessness.⁸

Commonalities and differences

While the pathways of the people interviewed were different, reflecting the heterogeneity of life situations, certain patterns of needs, characteristics and experiences appeared regularly in the biographical reconstructions.

⁷ The interviews were carried out under the CSIC project: *Advances in the Typology of Homeless People in Montevideo* (Ciapessoni, 2009).

⁸ In some cases, information could not be included because respondents could not remember what had happened, usually as a result of psychiatric hospitalizations.

The first element to highlight is related to the markedly critical way the majority of the respondents spoke about the household in which they were raised (Chouhy, 2010). The testimonies of men and women of different ages reveal environments often characterized by bad relationships with their parents, partners or siblings, and with frequent references to acts of intra-family violence. Acute psychiatric disorders or severe problems with alcoholism in one parent were also widely reported. The second and third elements that became apparent when reconstructing the biographies were early school leaving and unskilled, low-wage labour. Formal schooling had often finished at around 11 years of age, and respondents had often only completed primary school and not resumed studies at a later time. In parallel, these individuals generally only entered the labour market with precarious, low-skilled, low-wage jobs with no social security protection or health insurance coverage.

Domestic violence, scant educational levels and early entry into the informal labour market are the main components which, for the majority of the respondents, lead to a process of residential instability from an early age and which gradually lead to homelessness.

Pathway One

The first pathway can be described as the route into homelessness for men who share five characteristics: 1) the highest levels of residential instability in their trajectories; 2) high levels of work instability; 3) problematic substance use; 4) sleeping rough for a sustained period of time; and 5) deploying 'typical' street strategies such as begging, rummaging or cooking outdoors.

For this group of respondents, the first indications of residential instability occurred between 15 and 18 years of age. However, there were risk factors from an earlier age in the household: dysfunctional family environments, rapidly changing circumstances during childhood, severe alcoholism, acute psychiatric disorders, abandonment, etc. The testimonies reveal that family relationships – following the 'interconnected lives' principle of the life-course perspective (Elder, 1994) – were a long way from providing support in the early development of the respondents. In fact, this type of relationship planted the first seeds of ontological insecurity (Giddens, 2006), which gradually led to a marked instability that manifested itself in almost all areas of their lives.

In this context of precarious relationships, the first indications of residential instability were, for the majority, between the ages of 15 and 18. Two respondents in this group were displaced from their original home and onto the streets where they

remained for approximately a year, with the following year spent in a pension or shelter. In one of the cases, the move to the streets was the result of a relationship formed with “someone who worked and lived on the street”.⁹

The remaining respondents left home in the context of one of the transitions to adulthood: marital relationship. In these cases, the residential transition is characterized by precarious, insecure or inadequate housing: squatting, or living with the family of a partner, in the home of close relatives or in a pension. Then, events such as a relationship breakdown, possibly leading in turn to progressive use of psychoactive substances, led to the progressive deterioration of physical and mental health:

And this is not new: I escape, I relapse, I escape, I relapse. Because something happens to me, I have emotional issues, I look bad (...) I cut back but it's not easy, every now and again I stumble, I fall, I had cut it out for a long time, I had a good job and I relapsed due to a similar emotional situation [speaking of his separation], and I stumbled and I screwed up again, and that's how it goes, time passes and I am the same, I can't get out of this, but I am trying and I know I'm going to get out.¹⁰

Those who return to the family home could face situations of conflict or bad relationships, and recurrent, violent episodes that drive them out of that living arrangement. Following this, homeless people could spend time period of time in mental health hospitals.

Parallel to residential displacements that begin to increase in intensity, successive entries to and exits from the labour market occur. Intermittency in the labour market is not only associated with ongoing (re-) entries and exits (with repeated episodes of resignations, dismissals or prolonged periods of unemployment), but also with variations in the types of jobs accessed (short-term sheltered employment, seasonal work, low salary and unskilled), including the use of the workplace as an alternative living space:

I lived in a workshop where I worked. I am a car painter and I had a place there and just stayed there (...) Later I came to Montevideo and unfortunately ended up sleeping in the Maciel!¹¹. (*Respondent 2*)

A common pattern in these trajectories is that the successive and rapid ‘changes of state’ caused or aggravated by critical transitions in relationships and health, reduce the ability to make commitments that could create more stable and/or

⁹ Respondent No. 9, 38 years old. Second time in a shelter.

¹⁰ Respondent No. 4, 26 years old. Fourth time in a shelter.

¹¹ Local hospital

lasting states in central aspects of life (Feijten, 2005, p.45). Moreover, in line with European and North American research on lone homeless men (e.g., Kuhn and Culhane, 1998; Fitzpatrick *et al.*, 2000), recurrent entries and exits from psychiatric hospitals, the shelter system and prison means that this group of shelter users experiences homelessness as a revolving door, which is the main reason these individuals do not become long-term shelter residents (Kuhn and Culhane, 1998).

Pathway Two

The second pathway was that of women sharing the following characteristics: 1) high peaks of residential intermittency, although less so than in pathway one; 2) they had generally abandoned their home as a result of domestic violence and abuse by their partners; 3) they sleep rough intermittently or over a sustained period of time, 4) they have very little work experience; and 5) they deploy 'typical' street strategies.

Respondents had generally left home between 15 and 20 years of age, when the transition to life in a couple begins and women start a family. Women on this pathway often lived in situations of hidden or concealed homelessness with their partner's family, or lived in insecure and precarious conditions with a partner and other family members. Literature on homeless women has pointed out that women make greater use of family networks to avoid sleeping rough, which is known as hidden or invisible homelessness (Watson and Austerberry, 1986; May *et al.*, 1999).

Another critical stage is the violence and abuse that directly impacts the physical and mental health of these women while they are living in these situations. Those who suffer sustained abuse can also face, in some cases, sexual or attempted sexual abuse of their children by the partner, leading to abrupt departures with their children from that residential arrangement and to the homes of close relatives:

Ten or twelve years... I was beaten a lot. I couldn't take it anymore and I left. I left, I went with my sister who lived in a pension [and then] to my brother's house... with my children. (*Respondent 17*)

As European studies on homeless gender based perspective highlight (Jones, 1999; May, 1999; Reeve *et al.*, 2007; Mayock *et al.*, 2015, among others), homeless women have been invisible in much homelessness research because homelessness has been perceived as mainly a male problem. However, there is a growing literature pointing out the critical condition of single homeless women in the homeless population. Consistent with European literature, those women's pathways show a pattern of running away from stressful and violent home environments in their youth and later from the households they move into as young adults. In our

case, these women's pathways indicate an intermittently hidden accommodation situation where they stay with friends or relatives before going into a shelter, as well as exits from and re-entries to night shelters.

The abuse and violence causes high levels of emotional stress, exacerbated for those who are mothers by separation from their children when they are placed in the care of child care institutions. The testimonies indicate that a lack of income prevented them from taking care of their children, and that residential transitions have such an impact on their well-being that they operate as highly distorting events in their trajectories. In this context, these episodes cause emotional instability with consequences for the living situation – leading to their return to the homes of family members, alternating with the use of pensions and, in one case, sleeping intermittently in the street.

In terms of working, the limited experience that these women have in the labour market is generally associated with two recurrent issues in the analysis of poverty and gender: 'pre-commercialization', understood to mean that the social wellbeing of women comes from family dependence (Esping-Andersen, 1990), and intermittent participation in the labour market, linked to family responsibilities. In addition, as with some respondents in pathway one, for some women who at some point in their trajectories have nowhere to live, performing tasks in family homes in exchange for accommodation and food allows them to tackle the absence of a roof.

Extreme material poverty, being victims of gender-based violence at home, low self-esteem associated with perceptions of their cognitive disabilities, and other traumatic experiences, as well as pathologies or illnesses suffered, make them one of the most marginalized groups within the homeless population. Their social exclusion is manifested also in the coping strategies they display:

I took stuff from the dump trucks. The things they left hanging. I also checked. Yes the first time. Yes, in the bakery I asked for pastries. I beg now [for coins].
(Respondent 18)

Pathway Three

The last of the pathways relates to men and women with: 1) the lowest peaks of residential intermittency; 2) high levels of job insecurity; 3) no episodes of sleeping rough, or sleeping rough for just a few nights; and 4) not using typical street strategies. Those with this pathway have varied life stories, but share, in addition to the characteristics above, the fact that it was their first time staying in a shelter.

For some, this pathway is characterized by displacement at an early age to childcare institutions, with a stay of approximately 15 years. For others, moving to a shelter is strictly linked to a precarious position in the labour market that leads, at some point in the life course, to the inability to access living arrangements other than a shelter.

For the majority of respondents, displacement to a shelter is the result of family separation and a precarious position in the labour market, both of which impede access to housing. In this sense, the risk factors appear to be on another level, where housing and labour market factors (access to low-skilled and temporary jobs) combine to exacerbate residential vulnerability at a certain stage of the trajectory. As Meert and Bourgeois (2005) stress from their research in Europe, there is a sub-group of the homeless population “structurally caught in a closed circuit” marked by housing insecurity and poor housing conditions. At some point, unemployment, separation or the death of a partner, and possibly having exhausted the option of doubling up with friends or relatives, leads them to a night shelter in Montevideo:

We had built a shed to live in, but it rained; we had to fix the roofs, water used to filter through and we were always sick with the kids. We had to go to my parent’s apartment (...) and then the rent went up, so I stayed in a pension with the kids.¹²

Finally, the respondents do not use typical street strategies over time nor do they use them while inhabiting the shelter. However, two very different behaviour patterns can be identified. One is where those with paid jobs – i.e., working homeless people – do not use the services on offer (meals and clothing) but organize their day around paid work. The other is where those who face homelessness by making use of the services offered by the system of shelters and day centres.

This paper has provided an overview of homelessness biographies or pathways into homelessness in Uruguay, revealing the impact of events and transitions on the lives of homeless people. Homelessness has become an important concern for public authorities and society in Uruguay. However, there is an enormous gap in the national academic research on its underlying causes, and a better understanding of the relationships between macro-level and individual factors in homelessness causation is still necessary.

¹² Respondent No. 16, 40 years old. First time in a shelter.

Conclusion

This article had as its main objective to assess critically the utility of European and North American ideas about the nature of homelessness causation in the Uruguayan context. First of all, in accordance with the current European literature, the complexity of homelessness in Uruguay appears self-evident, even drawing on the limited empirical information currently available. In Montevideo, homelessness is the result of a combination of factors operating on different levels: care, housing, health policies, fragile relationships, early victimization, income poverty, precariousness of the labour market. Additionally, homelessness cannot be reduced to a simple housing problem (Tosi and Torri, 2005), and the residential histories of the people interviewed indicate that their trajectories are marked by vulnerability and precarious living arrangements. As such, homelessness arises as the last stage in a continuum of residential vulnerability. The parallels with Uruguayan experience of homelessness and reports from European research are clear.

Secondly, as European research has shown, young people are particularly vulnerable to homelessness as a consequence of family breakdown and leaving care institutions (FEANTSA, 2012). In the case of Uruguay, the comparison of census data provides evidence of current trends and the fact that homelessness mainly affects young men and women of different ages. Furthermore, the qualitative analysis in this paper supports the European thesis that abuse and family violence are factors that trigger homelessness at an early age, aggravating drug abuse and problems of low self-esteem as a result of victimization (Fitzpatrick, 1997; 2000). The need to look at programmes like the UK's 'Positive Youth Accommodation Pathway' (Fitzpatrick *et al.*, 2011; FEANTSA, 2012) seems clear. This means using a comprehensive approach to developing homelessness prevention strategies for young people leaving care or unable to stay with their families.

Thirdly, the analysis of pathways has shown the profound impact of macro-level factors on homelessness, as well as on the recurrent use of shelters. This is particularly so for long-term homeless women and people with addiction problems, whose ability to access sustained housing solutions is systemically undermined. As some authors highlight, even countries with very extensive welfare systems experience gaps in social interventions that largely affect the most marginalised people and that are associated with lone adult homelessness (Benjaminsen and Andrade, 2015).

People with complex support needs and long-term homeless trajectories, as well as those discharged from institutions such as prisons, childcare and hospitals without support, are the most affected by failures in the welfare safety net. Consequently, shelter users become trapped in the 'revolving door' of homeless-

ness – between the criminal justice system, psychiatric hospitals and the shelter system – and fail to successfully re-enter the community (La Vigne *et al.*, 2003; Metraux *et al.*, 2008; FEANTSA, 2010; Quilgars *et al.*, 2011).

The Homeless Attention Programme has diversified, reflecting the changing profiles of homeless people and an increasing diversity of pathways into homelessness. Montevideo has day-centres, halfway houses, 24-hour shelters and temporary accommodation for women with children and for victims of domestic violence or abuse, and day care centres for mentally ill homeless people. However, the main response to homelessness is still the night shelters – more than 50 centres with over 1,500 places. The European and North American literature have shown the shortcomings of staircase or ‘housing ready’ models for accessing housing (see Busch-Geertsema and Sahlin, 2007; Sahlin, 2005). The European literature has also stressed the deficiencies of an extended shelter system that “does not facilitate independent living, conversely, it might entail opposite results: institutionalisation, secondary adaptation and stigmatisation” (Busch-Geertsema and Sahlin, 2007, p.87). This is particularly important for social policy since this preliminary analysis shows an absence of preventive and integrated strategies for people who are at increased risk of experiences of homelessness in Uruguay, as well as indicating adverse impacts from long-term use of the shelter system.

The Homelessness Attention Programme seems to follow European countries such as Austria, Belgium, Spain, Luxembourg and Italy, with strategies seeking to ‘manage’ homelessness rather than to solve it (FEANTSA, 2012). Most importantly, the shelter system seems to diminish the chances for homeless people to access regular housing.

To conclude, in order to provide a comprehensive and coordinated response to homelessness, the following would be extremely useful: sensitize and train shelter staff; incorporate international theories and methodologies; provide practical support; strengthen coordination among agencies and social services; and achieve a well-designed way to monitor homelessness in Uruguay. The crucial role of housing policy for the most vulnerable people at risk of homelessness seems clear. To prevent homelessness, it is necessary to take measures such as preventing evictions, ensuring housing and income benefits, and planning for discharges from the care system and prisons, taking into account the special needs and attributes of released people (FEANTSA, 2012). In relation to strategies to reduce homelessness, the successful approach of Housing First – providing early permanent housing solutions with social support and community reintegration (as in e.g., Sweden, Denmark, the UK and Finland) – also needs to be considered for use in Uruguayan homelessness policy.¹³

¹³ See FEANTSA (2012); Pleace *et al.* (2015).

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Research Reviews



Part D

Do Statistics Help our Understanding of Homelessness and Housing Exclusion? – Creating a Methodology for Harmonised Data Collection across a Territory

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› **Abstract** *The fight against homelessness and housing exclusion requires a better understanding of the phenomenon, as much from a qualitative as from a quantitative point of view. On the latter, the enumeration of homeless people remains a demanding job in many European countries. In Belgium since 2008, several actors – public authorities, researchers, field operators – have gathered to create a harmonised tool of data collection for Wallonia (the French-speaking part of the country). In this article, we bring to light the challenges that arise from such an approach. The data from this first round of data collection is presented in order to give an overview of housing exclusion in this territory but especially to highlight the biases detected during the undertaking. We consider, in particular, the question of unique identification of people frequenting several services and even several territories, and the question of the inevitable time lapse between the collection, processing and usage of such field data.*

› **Keywords** *_ Belgium, statistics, methodology, census, results.*

From the middle of the 1990s¹ in most countries in Europe, homelessness became a prominent social issue (Damon, 2002). From the start, experts on the phenomenon of homelessness were faced with recurrent questions: who are the homeless people and through what processes does this type of exclusion take shape? But mostly, how many homeless people are there? Is this phenomenon in constant expansion or do current public policies manage to reduce this extreme kind of exclusion? In Belgium, these realities are even more difficult to grasp because the sector that fights against homelessness and housing exclusion is under the authority of different political bodies. The State Secretary for the fight against poverty at the national level, the Ministers of Social Welfare at the regional level and the local authorities – in particular through the CPAS² – are all involved and often seem to have differing views. However, all parties seem to agree on the need to count the number of homeless people efficiently.

In Brussels, a widespread movement for the enumeration of homeless people started in 2008 when mobile teams were sent out across the city on the same night to identify all people who were living in a public space. The visitation statistics of all temporary accommodation facilities located within the city completed the inventory made by the mobile teams. Using this method, 1,944 people were counted in 2010. 611 of those could be included in the first two categories of the ETHOS typology (329 on the street and 282 in emergency accommodations).³

In the Walloon Region, ⁴ the reproduction of such a process seemed complex, even impossible, because of the size of the territory and because of the number of institutions involved on a local level. In addition, even if a count enabled us to obtain a general number with regard to the size of the population in question, it would not provide for the inclusion of other fundamental indicators, such as family composition and health status. In fact, the conditions of this kind of count – done at night

¹ In Belgium, the decriminalisation of vagrancy and begging dates back to 1993 and a programme called *Programme d'urgence pour une société plus solidaire* (emergency programme for a more consolidated society), which led to the gradual closing of workhouses and, hence, the increased presence of homeless people in public spaces. Several citizen movements and an extensive media campaign forced public authorities to finance the opening of several services for emergency accommodation in Brussels and other parts of the country.

² Public centres of social action; institutions regulated by the organic law of 8 July 1976.

³ Source: www.lastrada.brussels/portail/fr/

⁴ Belgium is composed of three regions and three communities. The Walloon Region covers the southern French-speaking part of the country and is the competent authority in the fields of economy, employment, agriculture, water policy, housing, public works, energy, transport, environment, spatial and urban planning, conservation of nature, credit, foreign trade, and tutelary power over 'provinces', 'municipalities' and 'intercommunales'. The area of homelessness was transferred from the communities to the regions in the 1990s. www.belgium.be/fr/la_belgique/pouvoirs_publics/regions/competences#sthash.xzUoECuO.dpuf

and simultaneously in different locations – limit the time that can be devoted to each individual. Thus, such an enumeration can offer a reliable answer to the question ‘how many homeless people are there?’ but it doesn’t answer the question: ‘who are they?’. Yet, this thorough knowledge is fundamental to the creation of public policies and the implementation of suitable solutions in the field.

To meet the challenge of counting the number of homeless people in its territory, the public authority of Wallonia assigned this mission to the IWEPS⁵ and the Walloon ‘Relais Sociaux’⁶ in close collaboration with its administration. The goal of the resulting task force was to implement a statistical tool allowing the harmonisation of data collection and the construction of indicators for the comparison and collection of local data. This work has provided an estimate of the number of people excluded from housing – taking the majority of the categories established by FEANTSA’s ETHOS typology into account – as well as a better understanding of the main features of these people, which can lead to improved direct responses in the field. While the implementation process was started in 2008, this tool was only used for the first time in the field in 2012. Since then, the collection has taken place every year. The results of this first edition will be presented in this article.

Implementation of a Harmonised Tool: What Challenges?

The involvement of the Relais Sociaux in this process can be justified by their local coordination role in policies of social assistance for homeless people and people excluded from housing in the Walloon Region. However, although participation of these groups and their partners enables a full picture to be painted of the reality of homelessness, the multiplication of viewpoints brings many challenges. We have identified two main challenges (see below). One is the definition of a common scope in the data gathered, and the other is the use of a common vocabulary when collecting and interpreting the data.

⁵ Institut wallon d’évaluation, de la prospective et de la statistique (Walloon Institute of Evaluation, Prospective and Statistics)

⁶ The Relais Social (plural: Relais Sociaux) is both a coordinating body and a network of public and active associative institutions in the assistance of populations in ‘very precarious situations’ (homeless and inadequately housed people; rough sleepers; prostitutes; drug users). There are seven ‘Relais Sociaux’ in the Walloon Region, regulated by the legislative decree of 17 July 2003 on social inclusion and set up under Chapter XII of that law.

Determining which Data to Collect

Up until 2008 there was no harmonised data collection initiative in the region. However, Walloon operators had their own mechanisms by which to respond to the increasingly precise instructions of the subsidising authorities when drafting activity reports. During the first meetings in the IWEPS offices after the winter of 2008, rather than having to start from scratch, those involved were faced with a multitude of differing tools built according to local needs. The first step was to single out a common base from the hundreds of categories used in the existing processes.

At this preliminary stage, the task force⁷ was faced with two imperatives. One was to maintain a link to existing tools in order not to upset field operators by introducing a totally new and unknown system. The other was to find the right balance between wanting to obtain precise information, and restrictions on the services responsible for data gathering. So, while consensus was reached on a number of categories, regular feedback from field workers obligated the task force to reconsider certain previously concluded agreements.

Two types of data were gathered: individual data linked to homeless people and collective data linked to the functioning of services. While the form for individual data is used by all field operators, the form linked to services was created taking into account the specificities of the spheres of activity in which these services operate. In fact, the legal base behind the Relais Sociaux organises its actions in four spheres of activity: night shelters, social emergency, day centres and street work. However, the types of services offered within these spheres of activity were never defined and a first pooling of data of the different Relais Sociaux showed the need to define the nature and composition of these spheres. 'Day centres' proved the most difficult to define as they include, a priori, all services operating during the daytime. Here again, establishing a common definition required going back and forth many times with field workers. The result is a very broad definition (*a service that operates during the daytime and that applies an unconditional and low access threshold*), which has led to the creation of a 'catch-all' sphere that includes very diverse services. To tackle this, sub-categories of this sphere have been created: 'day centre – low threshold'; 'day centre – food aid'; 'day centre – health'; 'day centre – social support for housing search'; 'day centre – prostitution'. This solution has proven only partly satisfying because one service could be included in different sub-categories. The decision was thus made to include each service in the sub-category representing the service's primary mission.

⁷ Coordinated by the IWEPS and composed of a member of each Relais Social in charge of statistics, as well as a representative of the Walloon administration and the Walloon cabinet of social action for certain steps of the process.

After defining spheres of activity, identifying the categories (the variables and their modalities) that best reflect the functioning of the services required numerous debates, particularly items within the 'day centres' sphere. So, whilst for 'night shelters' the category 'number of overnight stays' was obviously the main indicator, the category 'number of daytime stays' for 'day centres' has required more sub-categories, in particular to distinguish the simple use by a person of a room from a person who has engaged in a more in-depth interview with a social worker. The interventions practiced by the teams of street workers also raised a number of discussions. The concepts of 'adhesion', 'contact' and 'follow-up' had different meanings depending on the Relais Social involved.

While harmonisation with regard to the spheres of activity was complicated, harmonising individual data from all services – regardless of the spheres of activity – has been even more complex. We present two examples to illustrate this when we talk about sensitive data later. However, we can already mention an item here that was taken out of the data collection after the first collection round. This withdrawal generated a lively debate within the task force as to the question of orientations.

The form for individual data was initially drafted to include the types of referrals that were available to each individual that showed up at a service. Because one service can't respond to all needs, these referrals were meant to show the networking of services in a certain local territory. Following the first year of data collection and data processing at regional level, this item brought up too many questions to be treated validly. A number of services questioned the relevance of this item because referrals are continuous in light of the demands of clients, while data collection takes place at a given time. It was therefore withdrawn at regional level but a number of local Relais Sociaux have maintained it in line with the agreement that they maintain a common base form but can add any additional items they desire.

Finally, setting aside the need to choose the most convincing data, the greatest difficulty relating to the collection of individual data, which has not yet been overcome, is duplication. The same individual is, indeed, likely to visit different services in the same territory, or even move from one territory to another. Yet, every service has its own database, even if they all use the same form. Currently, not many social services are willing to accept the merging of these databases. So although different ideas for the use of a unique identifier for each individual have been put forward, at this point in time it is not yet possible to gather data relating to the same individual that visits different services. In certain cities, initiatives were started for the same sphere of activity but this willingness is far from general, which hinders a valid enumeration.

Although the visual count at a given moment in time was certainly an effective way of answering the question 'how many homeless people are there?', it didn't make it possible to answer the question 'who are they?'. This second method that was developed in the Walloon Region makes it possible to paint a better picture of the homeless population and its main features, but it can only report *tendencies* because of the multiple counts inherent in the method.

Developing a Common Vocabulary

Although certain data categories, particularly at the socio-demographic level, seemed self-evident, they were quickly called into question. The determination of gender, for example, was a problem for some transsexuals who refused to be included in the dual identification 'man/woman'. To avoid 'gender unknown', a new 'transsexual' category was added. Likewise, age caused some difficulties. A first issue was the degree of precision of this category: some called for the collection of the date of birth while others preferred to ask for the age and still others still wanted to use age groups. This last option highlighted a new difficulty – namely, that the statistical tool had to be flexible enough to answer all statistical demands from the subsidising authorities. In effect, even though age is frequently asked for in forms, its presentation in age groups is variable (five-year, ten-year...). Eventually, to tackle this difficulty, the first option was chosen for the data collection – date of birth, while the final form given to the IWEPS presented age in age groups (five-year, after a long debate in the task force). This required internal data processing by the Relais Sociaux. However, other concepts have been even more difficult to define, as shown in the examples below.

Agreeing on the very notion of 'homeless person'

Although the ETHOS typology has made it possible to categorise the population excluded from housing in different, very precise sub-categories, the notion of a 'homeless person' continues to be interpreted in multiple ways, using different residential and time-based criteria. The same difficulty appears at the European level. In Belgium, the concept of homelessness as it appears in different laws is defined in more than one way. The difficulty is even greater due to the different official languages in Belgium. The mission of the Relais Sociaux is to address all people in 'very precarious situations'. Even if all users of homeless services fit the definition of 'homeless' as defined by FEANTSA, day centres and social emergency services deal with populations with a much broader profile. For an analysis of the homeless population, only part of the population should be taken into account or the phenomenon will be overrepresented. On the other hand, the data collection system, as intended, only includes those people that make use of social services;

the existence of a 'dark figure' that includes those who don't use the services (/any longer) is inevitable, although it is probably marginal due to the presence of mobile teams of social workers who also participate in data collection in each territory.

Sensitive data

Two concepts in particular have raised questions: mental health issues and residency status. The very definition of mental health issues is interpreted in multiple ways. If interpreted strictly, it is limited to diagnosed psychiatric disorders, while a broader view would include states of ill-being, whether permanent or temporary. Inevitably, the choice between these two extremes has repercussions for the numbers presented and, ultimately, for the public policies that are implemented. More than an epistemological debate, in defining the notion of mental health issues in the context of this data collection, the portrayal of the population and potential sources of funding were at stake. On a practical level, the field workers felt uneasy when asked to detect a mental health problem because their professional training didn't prepare them for this. Finally, a third difficulty was that the forms were completed on a voluntary basis and a person could obviously choose not to reveal this type of problem, which is still relatively stigmatised in society. However, despite these difficulties, the item remained on the form. A definition was provided in an *ad hoc* glossary and a distinction was made between explicit mental health problems and problems observed, thus removing any onus on the social worker to make a diagnosis and leaving space for the social worker to share observations if desired. The two categories are processed separately.

The question of residency status is also problematic from an ethical perspective. Although most services that stem from the Relais Sociaux offer unconditional access and/or accommodation, the continuous increase in demand has forced certain providers to review their access policy. Due to the structural organisation of Belgium, the question of residency permits has emerged. In effect, funding for the care of homeless people and funding for those without residency rights fall under two different levels of power: regional and federal. In practice in the field, however, these two populations mix and frequent similar services. Although updating on the presence of people with no residency rights in homeless services highlights the need for co-financing, such data may also lead to the tightening of access in a context of growing demand. This category is also very difficult to define and collect data on, as providing the exact residency status implies very precise legislative knowledge.

A tool not fixed in time

A third challenge concerns the temporality of data collection. Whereas homelessness is a dynamic process, data collection is done at a given moment and doesn't allow for follow-up over time, which hinders our understanding of the complexity of the homeless person's experience. While a unique identifier would make it possible to eliminate duplicates, it would also make it possible to carry out long-term follow-up. However, in addition to technical difficulties inherent in such follow-up, ethical concerns arise. Likewise, the processing of such a large amount of data requires a lot of time, which entails an inevitable time lag between data collection and the presentation of the data to field workers and public authorities.

The Data Collection: A Network of Actors

We have highlighted the work conducted by the team in charge of the tool's construction. However, this work has only been possible through close consultation with the social services in the field who, ultimately, are in charge of the data collection for their service users.

Although creating a list of the common and most relevant categories turned out to be a difficult task, it was only the first step. In fact, the forms constructed by the task force were destined for a final encoding; construction of the raw data collection tools was left to the different Relais Sociaux, who were responsible for finding the tools most suitable to their services, taking into account the material realities (available IT tools, for example) and the training and availability of the teams (minimal statistical knowledge, case load per social worker...). In the early stages of data collection, most social services opted for paper forms, which were completed when first meeting the users. These paper forms sometimes differed greatly from one service to another, especially their layout, because the goal was to collect information on all the categories selected at regional level while using forms that remained quite similar to the original data collection forms used in the services. Over time, most sheets have been harmonised, at least at the level of each Relais Social. Furthermore, different services have progressively taken over the encoding of these sheets in their own databases (in Access or SPSS, according to available resources). Here again, these databases differ from one service to another. However, crossovers would be possible if a common identifier could be implemented. The processing of this data is done by the local Relais Social, while processing of the aggregated data is done at the Walloon Regional level by the IWEPS.

These different steps generate a time lapse between the collection of data and their availability for the social workers in charge of collection. This time lapse has sometimes been discouraging for social workers who don't see the fruits of their

work immediately. To counter this discouragement, local feedback has been given by the Relais Sociaux to their services, and at regional level, study days have been organised to present preliminary results, but mainly to enable exchanges between field workers. These have resulted in the improvement of the common data collection tool for future years, notably thanks to the more precise breakdown done within the services, which take local realities and social work more into account. The appropriation of the statistical tools by field workers is essential to the success of such an undertaking. In fact, as they are dealing with multiple difficulties that need to be overcome urgently – the users of these services live in great material and social misery – the professionals can get the impression that this data collection is a waste of time. We therefore have to make sure that the collected data can be useful within their daily jobs, notably by generating a debate around the data (by linking it to its interpretation) but also by showing its importance in arguments presented to the public authorities. In the next section we will present the most important results.

Homelessness in the Walloon Region

Obtaining a precise count of the number of homeless people and people excluded from housing is a difficult task. The method that is currently implemented did not aim to do this and consequently involves a certain bias. However, this method makes it possible to determine certain tendencies and estimates of the number of people frequenting the services of the Relais Sociaux. 2012 was the first year of harmonised data collection at Walloon level. For this first year of data collection, we will mainly present information on the prevalence of homelessness and its characteristics. As will be shown, the profile of homeless Belgian people shares many similarities with other European countries.

Between Quantification and Description

Emergency accommodation

To simplify the presentation of the results of the report drafted by the IWEPS on 2012 data (Deprez and Simon, 2015), we primarily focus on the subject of emergency accommodation, complementing it with data from the other spheres. Indeed, as mentioned previously, the users of emergency accommodation⁸ do not represent the whole phenomenon of homelessness; a significant part of this population opts for alternative solutions like staying with family and friends, in reception centres,⁹ on the streets or in a squat. However, to concentrate on this fringe element of the population gives an overview of the phenomenon in the French-speaking part of Belgium, across the different cities of Wallonia. The more structures a city has, the more likely it is that the issued figure includes a significant number of duplicates, or people included several times in the count, as they frequent several services at the same time.

At the level of Wallonia as a whole, we counted 58,629 overnight stays in 2012; the majority, 47,260 overnight stays were by males, followed by females (9,767) and children (1,602). This result can be linked directly to the available services: in emergency accommodation, there is a higher number of beds available for men than for women/children in the whole territory of Wallonia, although local disparities exist. The difference in the number of overnight stays between localities is also linked to the density of the population and to the socio-economic characteristics of each of these territories.

Beyond the link with services offered, this male overrepresentation can also be explained by one of the dominant socio-demographic characteristics of the homeless population. Although media discourse and the feedback of social workers points to a feminisation of homelessness, the available figures tend to show that the ratio of men to women remains stable in the homeless population of the French-speaking part of Belgium, at 80% male (Lelubre, 2012).

Besides the need to quantify the phenomenon of homelessness, the statistical data collection makes it possible to deconstruct and objectify observations mentioned by field workers in the sector, which are mostly based on perceptions and impressions.

⁸ For more information on the services that are part of the 'emergency accommodation' sphere, please see the IWEPS report and the activity reports of the different Relais Sociaux.

⁹ Not all reception centres are included in the data; only certain cities include this data in their databases.

Figure 1. Number of overnight stays and number of people in 2012 according to the cities depending on the Relais Sociaux. Numbers from the IWEPS report, Working paper, April 2016.

	Number of people and overnight stays of children, men and women							
	Children		Women		Men		Total	
	Overnight stays	N	Overnight stays	N	Overnight stays	N	Overnight stays	N
Charleroi (4 services)	938	122	3,213	207	17,262	1,252	21,413	1,581 ¹⁰
Liège (4 services)	0 ¹¹	0	2,104	182	16,929	1,682	19,033	1,864
Mons (1 service)	1	0	835	76	3,315	220	4,154	296
La Louvière (2 services)	277	12	2,120	74	2,261	175	4,658	261
Verviers (3 services)	386	139	571	117	144	339	1,296	531
Namur (1 service)	0	0	924	61	7,206	329	8,130	393
Total	1,602	/	9,767	/	47,260	/	58,629	/

With regards to the number of people frequenting accommodation services, the big cities of Wallonia (Charleroi and Liège) host the majority of the homeless population. This observation is linked to the services being offered – both accommodation and access to social services, which is greater in the big urban centres.

Street work

A portion of the population does not frequent night shelters or any other social services. Establishing how many people this might be is a complex task that takes a substantial amount of time, also accepting that this number is only an estimate. However, the data collected by street workers gives a first overview, with two caveats. First, not all people encountered in the context of street work are exclusively homeless or can be included in one of the ETHOS categories; in fact, certain street work services have specific missions like working with prostitutes or drug users. In those cases, the people encountered can belong to a broader population than those excluded from housing. Secondly, a significant number of people encountered in the context of street work also frequent night shelters. Consequently, these people are recorded twice.

¹⁰ The number in the chart excludes duplicates thanks to data-sharing among all accommodation services at the local level.

¹¹ In Liège, the number of overnight stays of children is included in the gender distribution but remains marginal (45 overnight stays).

Figure 2. Number of people encountered in the context of street work in the different cities of Wallonia where there are Relais Sociaux. Numbers from the IWEPS report, Working paper, April 2016.

	Number of people			
	Women	Men	Not communicated	Total
Charleroi	137	412	10	559
Liège (partial data)	32	80	0	112
La Louvière	60	202	0	262
Mons	32	130	0	162
Namur (partial data)	11	74	0	85
Tournai	71	111	0	182

Because it is the first data collection based on the harmonised tool, the coverage rate and the quality of the data means that caution is required in the comparison of different territories, particularly in Liège where the figures presented are largely underrepresentative.

Day centres – low threshold

Lastly, to finish the quantification test, it is important to mention some data relating to the day centres. The category ‘day centres’ is multifaceted and consists of a great number of services with different objectives. To concentrate on the homeless population, we only present data here from services classified as ‘low threshold’. These services have users whose residential situation mostly matches the two first categories of the ETHOS typology. By contrast, there are no services listed in this section for Namur or Tournai, which is likely to give an incomplete view of reality.

Figure 3. Number of stays and number of people encountered in low threshold day centres in the Relais Sociaux cities. Numbers from the IWEPS report, Working paper, April 2016.

	Number of stays	Number of people			
	Total	Women	Men	Not communicated	Total
Charleroi (2 services) ¹²	18,673	158	676	425	1,259
Liège (3 services) ¹³	33,599	134	738	/	872
La Louvière	3,681	35	120	/	155
Mons	3,442	40	160	/	200

In total, 59,395 stays were recorded in the four cities of Wallonia. Liège and Charleroi account for 88% of these, which was also the case for night shelters.

¹² People frequenting both services are included in the total.

¹³ People frequenting both services are included in the total.

Description of the Homeless Population

Rather than quantification, the goal of this harmonised collection is to be able to outline the main socio-demographic characteristics of people who are homeless or excluded from housing – who they are, family composition, means of support.

To do this, we draw exclusively on the profiles of people who frequent night shelters in Wallonia – the sphere of activity with the most complete individual data. In terms of age, they are largely aged between 25 and 54 (67%) and predominantly male. The predominance of men in the homeless population is a phenomenon that we can find at European level; women tend to be less visible as they use informal solutions, including family, friends and acquaintances (Busch-Geertsema *et al.*, 2014). The majority are single (at least 65%), while 13% are accompanied by children, in monoparental or biparental families. In terms of nationalities, the majority are of Belgian origin (53%) and 36% are of foreign origin, of which 29% are non-European. Data relating to residency permits are not sufficiently complete to be taken into account for the analysis.

We know that this population is faced with many difficulties on a daily basis, but three problems appear to be the most common. These are: administrative difficulties (19%), addictions (18%) and financial problems (16%).¹⁴ In addition, mental and physical health problems account for 9% and 8% of the difficulties reported, respectively. The item ‘housing’ hasn’t been included as a difficulty because we can assume that this is a problem for all people in a night shelter. However, all respondents are asked for details on residential status and the subsequent period of data collection has introduced the field ‘housing’ in the list of difficulties. In terms of revenue, 35% of people in night shelters don’t have any source of income, 46% have some resources and we have no data on 18.6% of people. Income type is mainly reintegration income (16%), unemployment benefits (9%) and welfare payments (9%).

The above description of the homeless population in Belgium is similar in many respects to other European countries, particularly the proportion of men in emergency accommodation and the data on age groups. In terms of income, the welfare state is relatively strong in Belgium, unlike other European countries, which explains the number of people benefitting from reintegration income.

¹⁴ Several difficulties can be collected for the same individual. The percentages presented include all the listed difficulties.

Conclusion: Recent Debates in Europe on Measuring Homelessness

Although the statistical analysis of homelessness appears to be a difficult task for the field workers in charge of data collection, the institutions responsible for the processing of this data and the users who are more and more regularly asked to complete – sometimes long – questionnaires before obtaining any assistance, it remains an essential component for the comprehension and better handling of the phenomenon. The experiment conducted in the Walloon territory shows that there are many obstacles to such an undertaking but that these can be overcome. Although the tool presented here still contains numerous flaws, it is a first essential step aimed at the development of efficient public policies to fight homelessness and exclusion from housing. Although the Belgian public authorities now seem convinced that a count is indispensable,¹⁵ we are in favour of one that is not a simple enumeration but a real improvement in our knowledge of the inherent characteristics of this changing and not easily accessible population.

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¹⁵ In 2016, several Belgian universities were mandated by the federal State to implement a coherent counting tool for the whole territory.

Shrinking Social Housing Stocks as a Barrier to the Eradication of Homelessness: The Cases of Germany, Finland, the United Kingdom and Spain

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› **Abstract_** *This article is based on research aimed at reassessing the role of social housing in the 21st century. Beyond the debate among researchers, policy-makers and social organisations on the Housing First model of intervention for homeless people, or on measures to prevent evictions, the fundamental debate on the existence and expansion of the social housing stock has largely been abandoned. This research shows that public administrations are losing their capacity to address homelessness as a consequence of both the steady reduction of social housing stocks and their residualisation. In addition, the system of social housing provision still fails to cover certain kinds of homeless situations. Therefore, the article argues for a full rethinking of the social housing system, from planning, regulation, production and funding to the mechanisms of allocation, with the aim of incorporating new accompaniment systems adapted to the needs of tenants, thus ensuring the affordability, continuity, safety and adequacy of housing. A different social housing system is possible.*

› **Keywords_** *Social housing, residualisation, comparative housing policy*

Introduction

From World War II to the present, housing policies in Europe have changed in terms of both goals and instruments. Housing has increasingly been understood as a market asset, and intervention by the public administration has shifted from the direct 'provision' of social housing to a focus on 'facilitating' access to housing market through counselling services or financial assistance. In parallel, there has been a shift from a generalist provision of social housing to broad sections of society to a focus on targeting aid to the needy (Sánchez, 2010). At the same time, in some countries, traditional models of homelessness intervention are being rethought or replaced by new models that understand housing as an essential factor in the pathways out of homelessness. Intervention models are being reoriented in order to relieve, stabilise and rehabilitate homelessness through temporary residential resources. This is a modern model based on preventing homelessness and providing prompt and non-conditional access to permanent housing with support services (Pleace, 2011).

From a social perspective, several factors are leading to an imminent scenario of a rising need for affordable housing: growing unemployment and, especially, long-term unemployment; persistent high levels of youth unemployment; the increasing risk of poverty and social exclusion in the EU (European Commission, 2013); and the recent refugee humanitarian crisis. In addition, at the European level, homelessness is a reality that in recent years has grown considerably in most countries (FEANTSA, 2012; Social Protection Committee, 2013). Consequently, in the current context the problem lies in the fact that, while housing is identified as key to the processes out of homelessness, the housing policies of EU Member States are not promoting social housing. Instead, they are reducing its weight relative to the overall housing stock, which, I argue, ultimately affects the ability of administrations to tackle homelessness with residential resources and generates dependency on the private rental sector. In turn, the private rental sector responds to the economic interests and dynamics of the housing market and is not necessarily oriented towards the fulfilment of the right to housing. This article relies on

previous research¹ on the access of homeless people to social housing in Germany, Finland, the United Kingdom and Spain. Our previous research examined the relationship between levels of homelessness and the size of social housing stock, as well as the impact of homelessness strategies, and barriers to social housing faced by those deprived of a home. Starting from this point, the paper focuses on social housing trends and their impact on social housing access for homeless people.

Social Housing in the European Framework

“Under EU law, the right to accommodation is a fundamental right guaranteed under Article 7 of the Charter that the referring court must take into consideration when implementing Directive 93/13”, which relates to unfair terms in consumer contracts. A judgment by the Court of Justice of the European Union (Third Chamber) from 10 September 2014 puts it thus very clearly and sets a key milestone in the development of housing rights in Europe.² The judgment builds on jurisprudence from the European Court of Human Rights and adopts an approach deriving from the recognition of the right to housing assistance in Article 34 of the Charter of Fundamental Rights of the European Union, in Articles 30 and 31 of the Revised European Social Charter adopted by the Council of Europe, and in Article 25 of the Universal Declaration of Human Rights on the right to housing, as well as in the constitutions of many Member States (Kenna, 2011). In 2008, the Commissioner for Human Rights of the Council of Europe, Mr Thomas Hammarberg, shed light on the legal protection of housing rights and the related obstacles and gaps in implementation, with recommendations on how these rights are to be realised. One of the conclusions was that a national strategy for implementing housing rights in accord-

¹ This paper includes a part of its author's PhD dissertation, 'El acceso de las personas sin hogar a la vivienda social. Estudio de casos: Alemania, Finlandia, Reino Unido y España' [Homeless People's Access to Social Housing. Case Studies in Germany, Finland, UK and Spain] deposited at the Universidad Autónoma de Barcelona. At the methodological level, the dissertation was based on a qualitative and quantitative investigation to develop a comparative analysis, which used a case study methodology to select the four countries compared. This work involved conducting field research in each of the selected countries. We collected extensive information on the object of study, complemented with a total of 23 interviews with people related to the problem of homelessness (whose contribution is warmly acknowledged). Interviewees come from different backgrounds, including some with political and technical profiles in the administration, staff from social agencies and social housing providers, scholars and expert researchers, and homeless people who explained their life experience. All of them responded to structured interviews. This research is not free from important limitations in terms of comparison, definitions, multilevel agency or language problems.

² Judgment. <http://curia.europa.eu/juris/document/document.jsf?docid=157486&doclang=EN>

ance with international human rights instruments and recommendations should include “sufficient, accessible, affordable and appropriate social housing across Europe for those excluded from the housing market”.³

According to the European Commission (EC), housing policies are entrusted to each Member State, so the role of that institution is confined to ensuring fair competition and the enforcement of the rules of the internal market. For the EC, social housing is a service that provides an essential safety net for citizens and helps to promote social cohesion (European Commission, 2011). Access to services of general economic interest is one of the rights recognised by the Charter of Fundamental Rights of the European Union (Art. 36) in order to promote social and territorial cohesion within the EU (Ponce and Fernández, 2010). In Europe, social housing is considered a service of general economic interest. The EU’s Court of Justice ruled, in its judgement of 8 May 2013 on the joint cases C-197/11 and C-203/11, that social housing constitutes a service of general economic interest. These cases addressed preliminary rulings by the Belgian Constitutional Court on fundamental matters related to the articulation and development of social housing policies in the European Union, including the consideration of social housing policies as non-economic services of general interest (Tejedor, 2013). The conclusion is clear and consistent with previous judgements: the Court of Justice rules that the public provision of social housing, either directly or setting up public service obligations in specific cases, are “a fundamental interest of society” and “constitute overriding reasons in the public interest” (ruling on the SHLM case, § 28 and 30, 1 February 2001).

In its resolution of 11 June 2013 on social housing in the European Union, the European Parliament emphasised that social housing policy must be considered an integral part of services of general economic interest, as it helps to meet housing needs. The resolution makes references to, among other things, the written declaration of 22 April 2008 on ending street homelessness and that of 16 December 2010 on an EU homelessness strategy, the final recommendations of the European Consensus Conference on Homelessness of 9 and 10 December 2010, and the resolution of 14 September 2011 on an EU Homelessness Strategy.

Each country defines its own system of social housing, enjoying wide leeway in creating the relevant criteria and conditions for access, the priority target populations, funding systems, regimes of tenancy, and the pertinent property or rental regulations. According to CECODHAS Housing Europe (the European Social Housing Observatory), despite the diversity of social housing systems in Europe, it is possible to identify common elements (Czischke and Pittini, 2007). All social

³ Commissioner for Human Rights (2008) *Housing Rights: The Duty to Ensure Housing for All*, CommDH/IssuePaper (2008)1 (Strasbourg: Council of Europe).

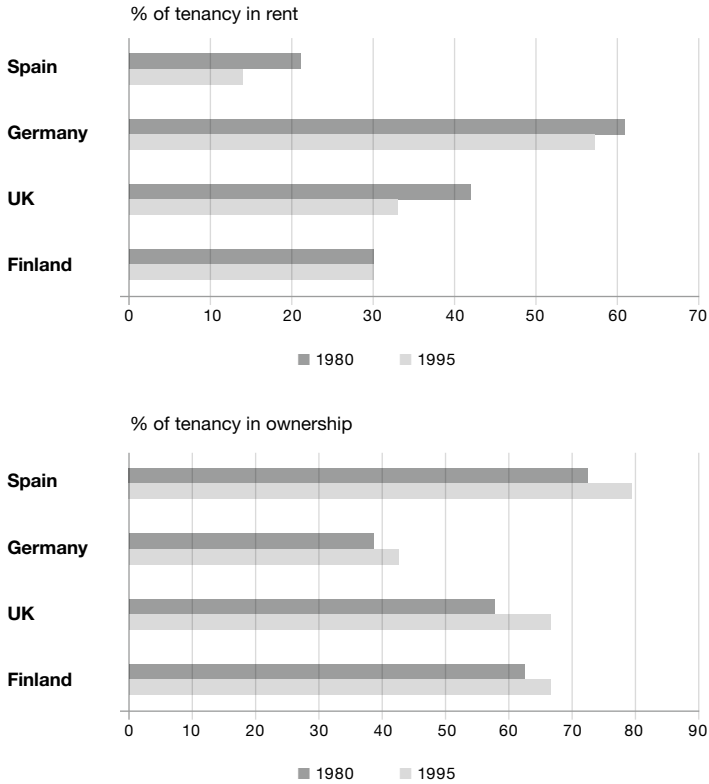
housing systems take into account the general interest in their mission; they are aimed at increasing the supply of affordable housing through the construction, management, acquisition or leasing of social housing; and they are oriented towards certain groups according to some criteria of need. Concerns with security of tenancy and housing quality are also common features of the different social housing systems.

The European Social Housing Observatory developed a classification showing the differences and similarities between social housing allocation systems in different countries. This classification distinguishes between a 'universal model' and a 'targeted model'. In the first model, social housing is seen as public utility housing that belongs to the social welfare system, and it is intended to accommodate the whole population in affordable housing that complies with certain quality standards. In addition, the social housing system must regulate the trends of the market. The 'targeted model' of social housing assumes that the market is the main mechanism of housing allocation and those whose housing needs are not covered by the market will be granted the opportunity to apply for social housing. For the countries that develop a targeted model due to problems accessing the housing market, some focus on the provision of low or medium-wage units, targeted at the working population or middle classes unable to afford market prices. In other countries, the focus is on the most vulnerable or those excluded from the housing market, such as recipients of unemployment benefits and people relying on social welfare. Some countries combine both allocation criteria. Ghekière (2007) labels the first subgroup the 'generalist model' and the second the 'residual model'. Beyond the differences in allocation systems, the size of the housing stock shows the relative importance of social housing systems within the housing policies of each country.

Reducing and Residualising the Social Housing Stock

From the early 1980s to the mid-1990s a change took place in the orientation and the conceptualisation of housing policy and the function of social housing. The construction of the economic and political project of the European Union led to: a) restrictions on the role of the state in strategic sectors such as energy, transportation, infrastructure and telecommunications; b) the promotion of privatisation and processes of deregulation of trade, the labour market and finance; and c) significant budget cutbacks in social spending. In particular, housing policy experienced budget cuts, the privatization of the social housing stock, and a change of political orientation to the promotion of property ownership as the preferred tenancy regime.

Figure 1: Tenancy Regimes: Property Ownership and Rental, 1980–1995



Source: Based on Boverket (2005)

As pointed out by Sánchez (2010), in the 1980s and early 1990s, European countries showed major differences in public spending on housing. For instance, the United Kingdom spent in excess of 3% of its GDP on housing while Spain spent less than 1%, and Germany and Finland spent roughly 1.4% and 1.5%, respectively. However, in the first half of the 2000s there was a convergence in public spending on housing, generated not by *increased* expenditure in less generous countries, but rather by shrinking levels of spending in the most generous ones.

In England, for example, monitoring reports show a significant reduction in economic support for homelessness policies (down 26% in three years), compounded by significant budgetary cuts due to the Welfare Reform Act, 2012 and the Localism Act, 2011; this has increased pressure on homelessness services at the local level (Fitzpatrick *et al.*, 2015). The reform of housing aid schemes such as the Local Housing Allowance and the Shared Accommodation Rate has exac-

erminated the difficulties of relocating homeless or low-income people through the private rental market. These aids related to the housing welfare system have been reduced by 46% over five years. Additionally, monitoring reports underline a consequential change in the Supporting People programmes; as their budget is no longer conditional on spending on specific projects, municipalities can allocate their budget at will.

In Finland, budgetary cuts have not directly affected services to homeless people or the PAAVO I and II national strategies, but in 2015 the new government initiated major cutbacks in social and health spending, which could indirectly affect support services related to the provision of housing to homeless people.

In the United Kingdom, a constant and common feature in all regions has been the reduction of the social housing stock, in particular stock belonging to local administrations. Scotland has, proportionately, a considerably larger social housing sector than England, Northern Ireland or Wales and is the only region where the share of social housing owned by local administrations exceeds 50% (Fitzpatrick *et al.*, 2012). In addition to the reduced construction of social housing, this also caused a significant transfer of social housing stock to housing associations (RSL in Scotland), not to mention the introduction of the so-called 'right to buy', introduced in the 1980s.

In Germany, as explained by Egner (2011), the rise to power of the conservative government and the implementation of neoliberal housing policies were not the only factors in the abandoning of social housing as an instrument of housing policy. In 1980, a political consensus was reached that the existing social housing stock was sufficient in light of the number of applicants, with the exception of some towns or metropolitan areas with higher levels of economic activity and bigger populations. The social housing system was considered flexible enough to cope with internal migratory fluxes between most rural areas and big towns. The number of neighbourhoods with concentrated social housing, where unemployment and immigration levels were high, expanded, and social housing became identified with vandalism and marginality in the collective imagination; these were the so-called 'social hotspots' (Sozialer Brennpunkte). As a consequence of these developments, the 1990s saw an intensification of the privatization of social housing, as most social housing stock owned by municipalities and cooperatives in East Germany was sold. In the former West Germany, hundreds of thousands of social housing units reached the end of the term during which they were subject to social restrictions, and all of them became part of the private rental stock, free from the usual mechanisms of price control applied to the rental of public housing (Busch-Geertsema, 2000).

In Spain, housing policy during the Francoist dictatorship was characterised by the promotion of ownership as an instrument of economic and employment policy, but also as a social control mechanism that eased governance: ownership generated dependency in terms of income needs, a higher level of local self-identification, a lesser degree of mobility, and a more 'integrated' society made up of owners. Consequently, the stock of public rented housing was privatised through programmes granting deferred access to ownership. This policy of selling social housing to its tenants resolved both the issue of complaints about the quality of housing, very common in working class districts, and management problems related to non-payment of rent, which was also very common and entailed no legal consequences (Leal, 2005).

In Finland, in the 1970s and 1980s, insurance companies and industrial enterprises developed rental housing, but they later sold most of their housing stock.

These policies were not developed in the same fashion or with the same intensity in all countries. For instance, in the United Kingdom, the right-to-buy policy led to an individualised privatisation of the social housing stock, whereas in Germany, social housing was mainly acquired by companies and organisations. During the 1980s, in a similar vein to the British right to buy, Finland introduced the possibility of purchasing a rental social housing unit if the owner agreed and the term of protected tenancy had ended. The selling price had to be set by the municipality and any profit margin had to be handed over to the central government. At the same time, housing construction loans shrank in the context of the economic crisis, so alternative residential solutions were sought, such as increasing the supply of private rental housing and introducing new tenancy statuses based on intermediate tenancies (ARA, 2005). During the 1980s and 1990s, housing policy shifted away from a focus on the provision of housing and responding to accommodation needs, towards a drive to facilitate access to housing for social segments unable to afford market prices, as well as excluded social sectors. Both private rental and social rental lost prominence as tenancy regimes, while ownership was promoted.

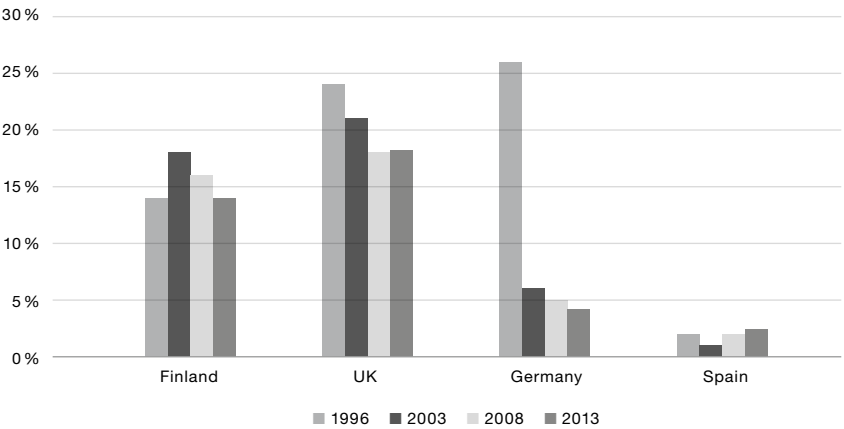
Changing tenures

Some of the structural patterns that have dominated housing provision systems since the beginning of the 21st century are now showing signs of change, mainly due to the impact of the latest financial crisis. The private rental sector is gaining momentum in countries where it used to enjoy less prominence, such as Spain and the United Kingdom, while Germany and Finland show a slight increase in ownership. The United Kingdom has gradually encouraged the private rental sector while continuing to reduce the size of social rental stock, in England, in particular; there, in 2014, private rental units represented 19.6% of the overall housing stock – the highest figure since 1961. In England, a new type of social housing is being

developed: ‘affordable rent’ below market prices. This could change the trend of the constantly reducing social rental sector that started in the 1980s, although this tenure type does not target the excluded or poor population.

In Germany, despite the prominence of rental as a tenancy system, ownership has been gaining ground. In 2001, the Housing Promotion Act (Wohnbauförderungsgesetz) brought about a paradigm change in housing policy. It has now shifted towards the rehabilitation of buildings and areas with a high level of social housing, while the new social housing allocation system focuses specifically on vulnerable groups. Since 2006, the federation has been devolving social housing policy powers to the Länder (federated states), although it has kept basic powers, such as the regulation of the rental market and the systems of residential aid. With the devolution of power, the Länder have become responsible for funding and implementing policies of promotion, conservation, renovation or sale of social housing. With this development, the federal government ceased collecting national social housing statistics, and there is now a lack of official data. The Federal Ministry of Transportation, Construction and Urban Development – in response to a parliamentary question by MP Caren Lay (Die Linke party) on the 31 July 2012 – reported that the number of social housing units at the end of 2010 amounted to 1.66 million in Germany as a whole (Cornelius and Rzezniak, 2014), representing some 4.2% of the total housing stock. This parliamentary question helped to uncover the fact that the German social housing stock had shrunk by 32.7% between 2002 and 2010.

Figure 2: Evolution of Social Rental, 1996-2013



Sources: Ghekière (2007); 1996 data by OVV (2009); Pittini and Laino (2011); Pittini *et al.* (2015)

Consequently, cross-national differences in the sizes of the social housing stock in 2013 are accounted for by the distinctive evolution of socio-political and economic contexts, leading to a dissimilar development of the respective housing provision systems. Regarding tenancy regimes, in 2013 ownership represented a majority in all the countries studied except Germany, where rental is still the main tenancy regime (54.6%). The Spanish case shows a disproportionate disparity between property and rental, as rental housing represents only 15.9% of the market, while in the United Kingdom and Finland this figure doubles (35% and 30%, respectively). If we make a distinction between private rental and social or below-market rental, we observe that Germany and Spain show very low levels of social rental (4.2% and 2.4%, respectively), while private rental dominates in both countries. Nevertheless, it should be noted that the German private rental market represents a share almost five times that of the Spanish one (50.4% vs. 13.5%) and is characterized by a greater degree of protection of the rights of tenants. In Finland and the United Kingdom, both sectors are balanced, although in 2013 in the UK, social rental was more prevalent than private rental (18.2% and 17.6%, respectively); in Finland, though, it was the other way around (16% for private rental and 14% for social rental).

Tensions in the rental market

It should be noted that nowadays, all four countries are experiencing tensions in the housing market, especially in the rental market. In England in September 2015, the annual growth rate of average private sector rents in London increased to 4.2% while rent levels were about twice the national average.⁴ Large towns and urban areas in Germany show a shortage of affordable rental housing. According to estimates by the DMB (Deutscher Mieterbund), in 2012 the housing stock fell short of the population's needs by 250,000 housing units,⁵ primarily in cities such as Munich, Frankfurt and Hamburg. Some cities, like Berlin, apply price control mechanisms to the rental market but also have a significant shortage of affordable housing "due to the expiration of the commitment clauses following repayment of the financing for subsidized housing" (Cornelius and Rzeznik, 2014).

In Finland, according to the conclusions of the study that evaluated the Programme to Reduce Long-term Homelessness 2008–2015 (PAAVO I and II), there is still a serious shortage of affordable rental housing, especially in the Helsinki area. Even though the social housing production supported by municipalities and the Y-Foundation has improved the situation in the Helsinki area, the shortage of suitable housing is threatening to undermine other aspects of homelessness work (Pleace *et al.*, 2015). In Spain in 2005, the construction of housing units exceeded

⁴ London Housing Market Report (2015) <https://data.london.gov.uk/housingmarket/>

⁵ DMB (2012) *Mieterrechte stärken, nicht abbauen*, Press Release, 6 December 2012.

that of France, Germany and the United Kingdom combined. Due to the 2008 financial crisis, many new housing units were left unoccupied, which – combined with the historical shortage of rental housing, the affordability crisis, difficulties in qualifying for a mortgage, low interest rates and historically low profitability rates – has led many investors to turn to housing, acquiring real estate and renting it out. Rental prices are growing significantly in Spain, especially in large cities such as Barcelona, which is currently the most expensive city to rent in.

Changes in social housing allocation

The recent evolution in housing provision systems shows important variations in the systems of social housing allocation. In the four countries studied, social housing systems target those who cannot satisfy their housing needs through the conventional housing market, although they differ in how they do this. Finland has taken steps to transform its social housing allocation from a generalist to a universal system; for instance, economic requisites have been dropped. However, within the framework of the national strategy against homelessness (PAAVO I – PAAVO II) and in the context of shrinking social housing stock, priority access for long-term homeless people has led to a growing trend of residualisation of homelessness policy.

Germany has opted for a generalist model of social housing, where the eligibility of people or cohabiting couples is mainly based on maximum income thresholds. Conversely, the United Kingdom, while traditionally oriented towards a residual system targeting the most vulnerable groups, has recently introduced some new social housing types: rent for so-called ‘affordable rental’ is more expensive than social housing but this housing type is targeted at population segments unable to afford market prices. Germany also provides for the direct allocation of social housing by municipalities to the most vulnerable groups. The promotion supports low-income households in particular, as well as families and other households with children, single parents, pregnant women and elderly, homeless or other needy persons.

Nevertheless, in the context of a sharply reducing the housing stock, the residualisation trend is worsening. In Spain, the so-called ‘officially-protected housing’ policy (vivienda de protección oficial, VPO), which favours ownership, could be categorised as a generalist rather than a residual model. Bearing in mind that, in Spain, social housing means rental VPO, it could be said that social housing has been traditionally oriented towards the most vulnerable groups, as protected rental housing is especially used to relocate specific groups. It should be noted that Finland, Germany, and the United Kingdom specifically consider homeless people a priority group for access to social housing, while in Spain this priority group is diluted among the different types of cases channelled through the social services. In Finland, the provision of social housing to homeless people has also experienced a certain degree of residualisation because, of all homeless people, priority has



been given to those in a situation of chronic street homelessness. In Germany and England, although both countries have an instrument of priority allocation for homeless people at the municipal level, their chances of accessing social housing are scarce, especially if they live alone.

Table 1: Systems of Social Housing Allocation, 2003-2013

		ALLOCATION CRITERIA		
		Universal	Targeted	
			General	Residual
SIZE OF SOCIAL RENTAL HOUSING	> 20%			UK
	15% > 20%		Finland	
	10% > 15%			
	5% > 10%		Germany	Germany
	0% > 5%			Spain

Source: Based on Ghekière (2007); Pittini and Laino (2011); Pittini et al. (2015)

In short, we have witnessed severe reductions in social housing stocks – with the exception of Spain, which had started from a very low base. In all of those countries, we can identify a trend of residualisation in the systems of social housing allocation. The declining social housing stock in the countries studied is used to deal with emergency and urgent situations. As housing stocks shrink, situations of need are exacerbated and spread across very different social groups. In this context, administrations prioritise emergency situations. Such residualisation of the social housing stock shifts priority to new emergency situations, while some forms of homelessness, especially street homelessness, remain unaddressed.

Obstacles to Social Housing for Homeless Individuals

Twenty-three expert respondents from the four countries selected were asked to outline the pathways to social housing that their respective country would offer to someone with the following characteristics (a 'typical case'): a homeless person, male, older than 40 years of age, living alone on the streets and unemployed for years, in severe need of social aid to address problems related to mental health or drugs or alcohol abuse. This methodology had already been used in other research on homelessness, which supports its validity (Pleace *et al.*, 2011). The following table synthesises the barriers detected in each country studied for the aforementioned typical-case. 'Yes' means this item represents a barrier; 'No' means it does not; and 'Partial' means that the item needs clarification, as it depends on the particular case.

Table 2: Obstacles to Social Housing for Homeless People (as defined in the typical case)

OBSTACLES FOR STREET HOMELESS PEOPLE (CASE TYPE)		UK	FINLAND	GERMANY	SPAIN
Structural	Ladder approach	Partial	No	Yes	Yes
	Public housing scarcity	Yes	No	Yes	Yes
	Administrative status	Yes	Yes	Yes	Yes
Institutional	Local ties	Yes	No	No	Yes
	Income limits	Yes	No	Yes	Yes
	Debtors lists including rent debts	Yes	No	Yes	No
	Already occupies a housing resource	Partial	No	Partial	Partial
Relational	Anti-social behaviour	Yes	No	Yes	Partial
	Social mix	Yes	No	Yes	No
Individual	Person suffering from drug abuse or mental health problems	Yes	No	Yes	Yes

Source: compiled by the author

The table above shows that Finland is the country where our case type meets the fewest barriers. As the 'typical case' involves a chronically homeless person, he or she actually falls into the very category targeted by the national homelessness strategies PAAVO I and II. Consequently, the homeless person in a typical case can be granted social housing or a social housing unit with support services directly and as soon as possible. In the other countries, the person in a typical case would face difficulties accessing social housing. It should be mentioned that, as an exception, in Scotland the homelessness legislation establishes that someone in our typical case *would* be covered and entitled to access social housing with support services. However, the prevalence of the ladder approach prevents the direct access of homeless people to social housing in Germany, Spain and England. In the Spanish case, there is no consensus on the stability of the resources that can be accessed by homeless people living on the streets, and a treatment-first approach is applied. The Catalogue of State Social Services only includes temporary resources for homeless people, and the scarcity of social housing makes access to housing units a privilege vis-à-vis other vulnerable groups.

This is consistent with the evolution of chronic homelessness levels in each country. In Finland, the long-term or chronic homeless population fell by more than 1,000 individuals between 2008 and 2014 (32%) as a result of the PAAVO I and II strategies. In the Scottish case, the Housing (Scotland) Act 2001 and the Homelessness (Scotland) Act 2003 expanded the rights of street homeless people, introducing new obligations for local administrations. In Scotland, the number of street homeless people was reduced by more than 1,000 people (49%) between 2009/2010 and 2014/2015. The number of long-term street homeless people was also considerably reduced from 2009 to 2012, but increased slightly (35 individuals) in 2013 and 2014. This is not the case in England, where in 2014/2015, 7,581 people were found to be sleeping on the streets of London, amounting to a 16% increase when compared to the previous year. From 2010 to 2014, England saw an increase in homelessness due to new cases, relapses into homelessness and cases of people living on the streets for more than two years. Between 2005 and 2012, the homeless population in Spain showed a 4.8% increase. Moreover, individuals lacking accommodation of their own for more than three years (as a share of the total homeless population) surged from 37.5% in 2005 to 44.5% in 2012. This trend is reinforced by increases in street homeless people, as detected in night counts in Barcelona, Madrid, Zaragoza, Bilbao and Donostia.

For all countries, people interviewed for this research mentioned the scarcity of social housing as a problem when it comes to addressing the needs of homeless people, although in differing senses. In Germany, the scarcity of social housing is reducing the responsiveness of municipalities in cases of an imminent loss of residence and the subsequent need for rehousing. Consequently, the bases of the

prevention system are being weakened. In Finland, top priority is given to granting access to social housing or to housing units with support services to long-term homeless people. Consequently, our case type would enjoy priority access to the necessary residential resources. Our interviewees have stressed that the other categories of homeless people (in particular, the 'temporarily living with friends or family' category), as well as a sizable part of the population as a whole, are affected by the inability of government to provide a sufficient stock of affordable social housing, especially in the Helsinki metropolitan area. In England, the private rental market has become a revolving door. On the one hand, this is the first instrument used to respond to the public duty to aid legally recognised homeless people. On the other hand, the required minimum contract term of six or 12 months implies that the end of the term leads to the filing of an application for social housing as provided by the law. In the case of Spain, social housing scarcity is structural, as this country has never enjoyed an extensive social housing stock, thus exacerbating the same problems faced by other countries, both in the rehousing of cohabitating couples being evicted, and in terms of providing accommodation for homeless people. There is also the problem of managing social housing in Spain, where there are no operators with such a long-standing tradition and nationwide presence as the Y-Foundation in Finland, the Housing Associations and the Registered Social Landlords in the United Kingdom, or the German non-profit companies.

All four countries studied currently show a severe shortfall of affordable housing, which the housing market fails to provide. An expansion of the social housing stock is unlikely in Germany and the United Kingdom, because, in political terms, both countries have mostly abandoned the very notion that social housing is necessary, and the current context of post-real estate crisis and budget cutbacks do not offer a different prospect for the coming years. Furthermore, it is known that the problem does not lie only in the scarcity of social housing, but also in the fact that there is no country where the supply of social housing matches the needs of the demand side. In Finland, Spain, the United Kingdom and, to a lesser extent, Germany, social housing is perceived as expensive. Often, social housing units have been built according to high quality standards and in low-demand areas, resulting in a social housing sector that out-prices the local market.

In the United Kingdom, especially in England, there is a shortage of accommodation for homeless people living alone and for large families, which represents indirect discrimination: in some cases, because of the very social condition of the potential beneficiaries, in others because the problem has a greater impact on certain cultural or ethnic minorities with higher birth rates. In Germany, the system of assistance to homeless families is completely focussed on providing them with permanent accommodation, but there is also a lack of small single-occupancy dwellings for single homeless individuals; these are insufficient and scarcely meet

demand. In Finland, through the programmes and strategies against homelessness from the 1990s, small social housing units were built and some shelters were transformed into housing units with support services, adapted to individuals living alone. In Spain, the Ombudsman (Defensora del Pueblo) presented a report in 2013, according to which there were at least 10,179 empty social housing units ready to be occupied immediately.

It is worth noting the role of the administrative status of individuals as a structural barrier. Immigrants with irregular administrative status or without permanent residency would be excluded from social housing in all countries. In both Finland and Scotland, if the person in our typical case had an irregular status, he or she would not be able to access social housing. Only foreigners with refugee status or having been naturalised would be able to access social housing. Nevertheless, there are some grey areas in terms of private action. For instance, in Spain a housing unit is sometimes owned by a social entity, which can grant accommodation to an individual or family with irregular status, with the goal of working on the different supports necessary: language, training, employment, housing, administrative status... In England, however, such a practice would be illegal, as in August 2015 the Government announced amendments to the Immigration Act to punish owners who do not carry out the required checks before renting a home, or who do not evict irregular immigrants.

The quantitative shortage of social housing leads, in all countries studied, to the development of selective criteria to limit the targeted population. In most cases, social housing is allocated to cohabitating couples with low incomes and no (or limited) assets that also belong to one or more of the following categories: disabled, families with children, single-parent families, people over 65 years, or young people. However, all countries show a trend towards the residualisation of the social housing stock while at the same increasing their own responsibilities in terms of other residential situations in the ETHOS typology, such as those of homeless people, female victims of male violence, evicted people or people living in overcrowded or substandard housing. In England, though, since its allocation system has traditionally been residual, there is a tendency towards expanding social housing to reach groups with economic problems, although not those with social problems. Nevertheless, all countries exclude some categories of homeless people from social housing.

The typical case profile used in this research represents street homeless people who do not normally belong to the populations targeted by social housing policies. Other non-priority sectors include those living in temporary dwellings, such as emergency shelters or transitional housing with specialised services, as it is assumed that they already have a roof over their heads. In Finland, however, as

these groups are the target of national strategies, they do, in fact, enjoy priority access. Living on the streets does not qualify a person for social housing, not even in Finland or Scotland, which have relatively comprehensive legislation or policies on the housing rights of the homeless; thus, additional institutional criteria have to be met. In the Finnish case, for example, the very fact of prioritising long-term street homeless people directly affects the resources available to address the homelessness of people staying in the homes of relatives or friends (and who, in fact, make up the main category of homeless people in the country). That is, the pressure of political priorities is transferred to the entities that provide social housing, whose ability to address other types of housing needs is hampered by their limited resources. Systems of social housing allocation often show a certain reluctance to accommodate our typical case, as his or her characteristics are related to housing management problems. The main barriers blocking the access of homeless people to social housing are the minimum or maximum income thresholds, local ties, debtors lists or recorded misconduct.

In all countries, having some income is a prerequisite to accessing social housing. Regarding the homelessness profile defined by the typical case, this includes benefits from pensions or minimum income schemes or, very simply, people deprived of any kind of income. In Spain, interviewees are aware of this reality and that setting up a minimum income threshold can lead to exclusion. In Germany, however, all social housing applicants must have a certificate (the WBS) issued by the local administration to prove their income does not reach a certain threshold; this is the only element of public control. From the point of view of social housing providers, chronic homeless persons in need of comprehensive support services are very costly in economic terms and hardly yield any profit (we must keep in mind that such profit might be used to repay the loans contracted to fund the construction or purchase of the housing unit).

In England, the requisite of having local ties is being used to hinder applications for social housing: nowadays, an individual can certify ties to the community through a job contract or family ties in the area (except for members of the military). In Spain, to access social housing one must be registered as a local resident; how strictly the criteria for local registration are interpreted in terms of access to housing and health services depends on the municipality, so it may well be that access to social rental housing takes a minimum residency of one to three years.

In Germany, the UK and Finland, with sizable rental sectors, inclusion in a debtors list or having a record of misconduct constitute significant barriers to social housing. Interviewees explained that there is some reluctance to house certain groups expected to cause trouble, so access is only possible (but not guaranteed) where support or supervision by a social entity is available.

In Finland and Germany, urban planning laws that aim to increase social cohesion and are also used to avoid rehousing certain homeless individuals in certain neighbourhoods or communities, in order to avoid a concentration of poverty; in the case of some German social housing providers, financial incentives are used instead of legal instruments. Finnish urban planning policies intended to prevent segregation and the concentration of poverty require 20% of housing projects to be reserved for social housing.

In turn, social housing in the UK and Germany is associated with areas of high unemployment, soaring crime rates, antisocial behaviour and buildings in poor condition. In this sense, interviewees referred to tensions between housing or urban planning laws and the goals of homelessness policies. On the one hand, allocating chronic homeless individuals with high support needs to 'normalised' communities may lead to new conflicts and to some neighbours leaving the area or the building, while on the other hand, placing chronic homeless persons in impoverished neighbourhoods can hamper the pathway out of homelessness.

In summary, we observe that the person in our typical case will face fewer barriers to social housing if he or she belongs to a group that has been defined as a priority. However, given the scarcity of social housing, belonging to a priority group does not guarantee access to social housing, regardless of the country. In practice, prioritising some groups over others creates permanent competition among them for social housing. Research has shown that there are inequalities in accessing social housing, which are rooted in the dominant social conception of poverty and homelessness. The barriers generated as a result are misplaced, as homeless people do not form a homogeneous group. Rather, this is a problem that needs to be approached as a housing situation.

Conclusion

This research draws attention to the privatisation and reduction of social housing stocks, as well as their residualisation. Traditionally, it has been considered that public intervention in the housing sector is determined by a country's approach to the welfare state itself, and that public intervention will take place in the case of market failures or rigidities that prevent the population from meeting its housing needs. However, in the 21st century, the main role of the state is that of an agent active in the commodification of public goods and the creation of new markets, allowing private economic and financial sectors to maximise profit as quickly as possible. In this sense, the role of the state has been to ease access to housing through economic aid that supports the market, rather than the direct provision of social housing. The neoliberal offensive has consisted of cutting public spending on housing, reducing levels of social housing production, promoting the sale and privatisation of social housing stocks, easing speculative processes in real estate, and promoting a profit-driven rental and ownership sector. In turn, this process has strengthened the role of the financial and banking sector in the housing provision system. As a result, many people are experiencing housing exclusion and homelessness, given their inability to afford housing prices, either in terms of rental or ownership.

We have pointed to the scarcity of social housing as a general problem. The larger the social housing stock enjoyed by a country, the greater its freedom to address the homelessness situation. Regardless of this, there are formal barriers to social housing (income, residence or registration requirements) as well as informal barriers (the desire to avoid poverty concentration, discrimination, debtors lists or models of intervention on behalf of street homeless people) that exacerbate the difficulties faced by homeless people looking for social housing. The scarcity and residualisation of the social housing stock is leading to 'competition' among people affected by different homelessness processes, which in turn penalises those in the worst situations of exclusion.

This paper concludes that facilitating and permitting the access of homeless people to social housing with support services actually has a direct impact in the reduction of homelessness levels. However, we have shown that barriers remain preventing certain homeless segments from accessing social housing. The countries studied have different definitions of homelessness and different levels of homelessness, social housing stocks of different sizes, and different strategies or policies with varying priorities. Nevertheless, those in certain forms of homelessness always face significant barriers in obtaining social housing, in particular,

street homeless individuals. We have also shown that inasmuch as some homeless groups are given priority in the distribution of social housing, other have seen their chances of access decrease.

Nevertheless, the right to housing is recognised in European regulations and it must be preserved, respected, protected and implemented, but in a 'progressive' way – that is, with a focus on goals rather than results. The fact that administrations do not consider housing rights an obligation with respect to results does not mean, not in the slightest, that public authorities do not have to do everything they can to realise those rights. Consequently, we have to introduce new notions, such as the social function of ownership, and conceive of social housing as a service of general interest for the public. Social housing is part of a wider policy of the structural prevention of homelessness, oriented towards primary prevention (social housing for the population in general), secondary prevention (specific measures targeted at populations at risk of losing their home), or tertiary prevention (targeted at those who have already lost their home and need immediate rehousing, or intended for the integration of people experiencing street homelessness on a frequent or chronic basis). Therefore, a full rethinking of the social housing system – from planning, regulation, production, allocation, consumption, taxation and funding – is required, with the goal of incorporating new accompaniment systems adapted to the needs of tenants, thus ensuring the affordability, security of tenancy, safety and adequacy of housing.

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Book Reviews



Part E

Padgett, D.K., Henwood, B.F.
and Tsemberis, S.J. (2016)

***Housing First: Ending Homelessness,
Transforming Systems, and Changing Lives***

Oxford: Oxford University Press, pp.228, £19.99

**Panacea against Futility?
Between System Change and a Shop-Window Strategy**

The new book by Deborah Padgett, Benjamin Henwood and Sam Tsemberis, *Housing First*, is a must read for several reasons. I will, in this very short review, focus on three of the reasons this book is worth reading. I will also bring up one critique, one dilemma and one challenge. In my opinion, one of the most important reasons to read it is that it truly takes a position regarding the importance of listening to the people that have had a lived experience of homelessness (see especially chapters five and six). The starting point in the book is that if you ask the people that are affected by homelessness services about their experiences, you must be ready to accept the answer. Psychologist Dr. Sam Tsemberis did just that, and the answer that the homeless people gave was that they needed a place to live – a home, or as one homeless respondent, Alfred, puts it: “It was the only place that I ever had that was mine. That had my name on it [...] It was home” (p.81). The role of peer-support will probably be one of the most important areas of future research, as it seems to have very positive effects. Peer-support, or involving people with lived experience, has always been a key component of the work done by the organization Pathways to Housing.

Having conducted research on homelessness myself, you often get the feeling of kicking in open doors. We come up with the same results again and again – that a house, a home is the key solution to end homelessness. For some reason, it comes as a surprise that homeless people share the same basic needs as any other human being. In a way, you get the feeling that people think that homeless people are different than us. One of the main causes of people ending up in homelessness is that they are poor. Unfortunately, this fact is often neglected. Instead, individual problems are brought to the fore, like addiction or mental health issues. Research from Australia has shown that there is a very high risk that people who become homeless will end up with addiction and mental health problems because of homelessness (cf. Johnson and Chamberlain, 2008). Prevention is a must.

The second reason that this book is worth reading is that it gives us the story of how Housing First started and how it has spread through different states and cities in America and Canada, different cities and countries in Europe, and to Australia. It is an amazing story with remarkable results. And the story is told both by the very people that started the original programme and those who have conducted several of the important studies over the years. In that way, this is the story about Housing First by the book. However, if you are looking for a more detailed description about what Housing First is and how the different core principles are applied in practice, you should also read the Housing First manual (Tsemberis 2015; it has just been reprinted in an updated version). The key story is that there are two different models: 'continuum of care' or the treatment-first model, and Housing First. In the treatment-first model, housing is a goal and the client can reach the goal by proving himself housing ready. Research has shown that uncertainty is a constant problem in this model (p.74). It is often the case that the client does not know when he or she will be able to progress to the next step, and there is also uncertainty around what one must do to progress. For many clients, the continuum of care model leads to an institutional loop (Knutagård, 2009) or, as the authors write, "a cruel and costly circle of futility" (p.8). In the Housing First model, housing is a means – a precondition that will enable the individual to deal with any other problem that he or she might have. The two different models can be seen as competing institutional logics. Housing First is described as a paradigm shift. In many ways, treatment first is still the dominant model in many parts of the world, and from this perspective it is difficult to see Housing First as a paradigm shift. On the other hand, Housing First has initiated a mind-shift that, in its consequences, could result in a paradigm shift. Today, the models live side by side and their respective logics could, in one way, be described as incommensurable. Four components of Housing First are: (1) consumer choice; (2) community-based mobile support services; (3) permanent scatter-site housing; and (4) harm reduction (p.3). It is worth mentioning two points that have been demonstrated in recent research. First, research has shown that it is almost impossible to know beforehand if a client will succeed or not. This means that the client you believe – as a professional social worker – will succeed might fail and the client that you do not have any hope for is the one that will become another one of Housing First success stories. Secondly, research has pointed out that social workers that work in treatment-first programmes work less with treatment since they have to find housing for their clients. On the other hand, Housing First support workers work a lot more with treatment and other support services, since the housing situation for the client is already sorted out.

The historical background also covers three key movements. The first is that homelessness organisations started to be given extended missions; the second, that advocacy became connected with action; and the third, that a business model

approach was introduced. In other words, homelessness services have evolved from charities to social movements to business models. Today we can also see a growing number of so-called 'hybrid' organizations, which have been successful in sustaining capital through contracts, low-interest loans, wealthy donors and so on. There are some key elements that seem to have opened the window of opportunity for the Pathways to Housing model to spread both nationally and internationally. I will only mention three of them here. The first example is Kuhn and Culhane's article from 1998, which shows that about 10 percent of the homelessness population use 50 percent of all the shelter nights. This finding showed that if you could target the 10 percent – the so-called chronically homeless – society could halve the costs of homeless accommodation. The second example is the very special court case that indirectly helped to spread the model of scattered-site apartments: the Olmstead decision from 1999. The third was Malcolm Gladwell's essay from 2006 on 'Million Dollar Murray'. The focus of the article was on the costs of homelessness and it used Housing First as an example of how public money could be saved.

Another great benefit of this book (my third reason to recommend reading it) is that it also applies a theoretical understanding of Housing First. Previous research has focused on 'the facts', looking at housing retention rates (80% plus) and how the use of drugs changes over time (even though Housing First was not designed to end addiction), and the sort of fidelity the different programmes have. Happily, in this book a more theoretical position is taken. One of the theoretical concepts introduced in relation to Housing First is 'institutional entrepreneur'. This is a suitable concept to be used, but it is in many ways used as a concept for individual actors that change institutions or try to change systems. Connecting institutional entrepreneurship with individuals is probably connected to the importance of individual change agents and the focus on individual actors in America. In the book, we get to meet institutional entrepreneurs like Sam Tsemberis, Roseanne Haggerty and Philip Mangano (p.46). From a theoretical perspective, the concept of institutional entrepreneurs is often used to describe a group of actors that manage to change institutions over time. Even though a lot of attention is given to individual agents of change, the book also brings forward the importance of other type of change agents, such as changes to an Act, the section 8 programme or the founding of Common Ground. There are also structural constraints that hinder the choice of Housing First over the Staircase model.

One critique that I have of the book is the difficulty of giving a more specific account of the diffusion of Housing First in the European context, and the lack of a more sensitive description of the very different welfare regimes, welfare states or welfare markets in Europe. By making the section about the European case a bit compressed, the discussion doesn't quite do justice to the complexity of the reality – for example, in the Nordic countries. While one of the key challenges is, of course,

that research produced in languages other than English is difficult to access, the focus on research in the English language nonetheless becomes very evident and, more specifically, the book tends to focus on an American knowledge-base. Some crucial research findings from other countries get lost in translation.

Sometimes it might be more relevant to analyse the similarities and differences of cities rather than countries. The local scale has gained traction in social policy, since some aspects of macro-level comparisons of welfare regimes do not make sense in today's world, where several different strategies can be adopted in different regions or municipalities within a welfare state.

The book brings many advantages and is, in many ways, a must read in order to understand the birth, evolution and dissemination of Housing First, from the original Pathways to Housing model to the different variations of the model that we can see popping up in many different countries around the world.

One dilemma that comes to my mind when reading this book is the dissonance between evidence-based research, robust results and fidelity on the one hand and contextual or local adaptations on the other. We do know that the context is of great importance, but at the same time we argue about the idea of fidelity. Fortunately, the book gives us a great starting point for addressing the challenges for future homelessness research, where questions about both fidelity and local adaptation have their place.

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Craig Willse (2015)

***The Value of Homelessness:
Managing Surplus Life in the United States***

Minneapolis: University of Minnesota Press, pp.213, appr €25.

Craig Willse and I have had similar career paths. At loose ends after college, we both got jobs that immersed us in homelessness: I, in the mid-1980s when there was still an air of crisis surrounding this emergent phenomenon; and he, about a decade later when homelessness had become a well-entrenched feature of the urban landscape. For both of us, jobs working with homeless individuals were formative to our returning to academia. And here our paths diverge. My research has sought to understand homelessness in terms that are amenable to public policy responses. Willse, in contrast, in this book positions himself “outside the bounds of policy frames” (p.179) and argues that mainstream research and policy have rendered homelessness, at best, a manageable and marginal sideshow in a revanchist redrawing of the contemporary city and, at worst, the raw material that fuels a cottage industry of more research and services.

So what do we do when we research, study and craft policy towards homelessness? Willse has enough of an insider’s perspective to understand this world, yet takes an academic perch by bringing critical theory to bear on this praxis. While this is not the first time that work around homelessness has been portrayed as an industry that is self-serving and ultimately functions to deepen the social exclusion of homeless persons, this portrait sets out to be more systematic than most. As such, it offers an opportunity for reflection that should not be ignored.

If the reader has indeed come to this book interested in a praxis-based reflection on homeless research and services, as opposed to examining homelessness as grounds for exegesis on Foucauldian theory, then I recommend starting your read at chapter 4. Here the ideology of the first three chapters (more on these in a minute) eases and the heretofore turgid writing style clears as Willse hones in on two recent developments that have had profound impacts on current responses to homelessness. In chapter 4, Willse examines the ‘databasing’ of homelessness and the fundamental policy changes this has brought on, and chapter 5 focuses on the yin and yang of chronic homelessness and Housing First. Although the focus of both of these chapters is the US context, these two topics are universal enough to be readily translatable to European contexts. Willse shows an astute understanding of

both of these topics so that the chapters can each serve as primers, but he goes beyond this when he lays out dilemmas and offers a degree of ambivalence as to the larger implications of these policy shifts, which is otherwise missing in the book.

The key dilemmas are worth pointing out further. In chapter 4, Willse argues that mandatory data reporting, and resulting data-driven policy, has been instrumental in a shift from the traditional focus on homeless individuals to focusing on agency performance. Yet Willse questions whether the potential easing of such individual stigma actually leaves homeless persons better off. Similarly, in chapter 5 Willse readily sees the benefits of prioritizing long-term, chronically homeless households for housing that is delivered in a quick and relatively unfettered fashion. Yet, while applauding the inversion of a system that typically was least responsive to those who were homeless for the longest periods, he argues that this positive turn is mitigated by an underlying policy to facilitate “clear[ing] space in city centers to improve opportunities for capital reinvestment and growth” (p.154). Here, Willse provides new perspectives and thereby opens spaces for considering the broader impacts that these shifts in data collection and housing provision have had on the homeless population. For those readers at all involved or interested in Housing First, or who know what the acronym HMIS stands for, this is a rare opportunity to look at these topics beyond their utilitarian ends and more at how they fit into a broader picture.

For those readers with little interest in social theory, I offer a trigger warning of sorts that if you start this book from the beginning you may find the temptation to abandon it overwhelming. Absent an empirical agenda, the prose in the first three chapters are jargon-laden and ideological, more in the wheelhouse of those with a bent for cultural studies than policy. Homeless services get written off as “integrative projects of a homogenizing racial state... [that] have secured heteropatriarchal arrangements of labor and family along with the subordination of internally colonized populations,” (p.81) and the reader must adjust to being constantly bludgeoned with variants of ‘neoliberal’, with single paragraphs containing as many as seven mentions of this term (e.g., pp.102-103). Even to those inured to the excesses of sociological rhetoric, considerable labour is necessary for mining this swollen prose in search of some useful critique. I will leave it to someone better versed in social theory to evaluate the merits of Willse’s theoretical arguments, but as a monograph on homelessness the text is poorly documented and questionably accurate to the point of qualifying as polemic.

With the exceptions of chapters 4 and 5, this ideology-laden book is unlikely to bridge the gap between our respective academic paths. Few fellow denizens of what Willse terms the “nonprofit industrial complex” (p.167) will be predisposed to see something like Housing First through “the basic premises of Michel Foucault’s

thought" (p.181), and Willse gives no compelling reason for doing so. Willse is obviously capable of posing these issues in a manner that can engage a broader audience, and I hope that he will steer his future work in that direction. For this book, however, its overall appeal is limited by Willse's apparent lack of interest in making this material accessible to anyone beyond a small academic coterie that will already be predisposed to his views.

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Tom Gill (2015)

Yokohama Street Life: The Precarious Career of a Japanese Day Laborer.

London: Lexington Books, pp.149, £44.95

Tom Gill's *Yokohama Street Life* was published as part of the *Asia World* series edited by Mark Selden that sought to chart the political, economic, social, cultural and historical dynamics of the region in a global perspective. Set in the Kotobuki area of the sprawling city of Yokohama, Japan, Gill returns to the area he conducted fieldwork for his PhD and subsequent book *Men of Uncertainty* (2001). This in-depth foray into the world of the *doya-gai* (cheap lodging area) or *yoseba* (a place where day labourers gather), inspired Gill to return, this time to chart an ethnographic account of one particular, and very special, day labourer.

Having lived for many years in Kanagawa Prefecture, in which Yokohama is the largest city, the areas Tom Gill describes are very familiar to this reviewer. Yokohama is a pristine coastal city and anyone who has visited it, with its impressive skyscrapers and clean and organised urban commercial landscape, may be surprised to read of an area in which conspicuous poverty and homelessness are prevalent. In *Yokohama Street Life*, Gill provides insight into such a district – a district that few visitors, not to mention Japanese, are likely to have experienced. At the heart of the Kotobuki district, for Gill, is one homeless man, Kimitsu-san, a 'resident' of a *doya* (flophouse / temporary lodging) befriended during the course of his earlier research.

Homelessness in Japan, even street homelessness, is rarely encountered and far more hidden from public view than, for instance, homelessness in a city such as Paris or London. Japan's homelessness is, arguably, unique and distinct. For instance, the discrete and well-maintained, often blue, tarpaulin 'homes' of much of Japan's street population, found under trees in a park or by a riverside, are fundamentally different to anything one would experience in Europe or the West. Homelessness in Japan has an air of privacy, of seclusion, and it is this that makes it all the more remarkable that Gill accessed this 'hidden' world for over two decades in order to bring us this illuminating narrative of one man's life in a day-labouring district.

The book begins with an exceptionally short Introduction in which Gill encapsulates the very essence of the volume:

Day labourers have a certain look about them – weathered faces, blue overalls, baseball caps, broken-down sneakers, sometimes a slightly crabbed way of walking from industrial accidents. From a distance they blend together. But seen up-close, and listened to at length, they emerge as unique individuals, each with his own story to tell. (p. x)

Reflecting on how Gill spent the years 1993-1995 researching in Kotobuki for his doctoral dissertation and consequent meeting of Kimitsu Nishikawa, Chapter 1 introduces the reader to life in the day-labouring district and that of Gill's subject matter, the man he describes as a 'self-taught philosopher': Kimitsu-san.

Chapter 2 gives an account of the genesis of the book. After accidentally bumping into Kimitsu again, some nine years later, Gill notes how things had changed in Kotobuki. At this point, day labouring had all but dried up and the average Kotobuki resident was now aged 56. No new blood came as they knew casual work here had long disappeared. Kimitsu himself was somewhat surprisingly able to claim a little money from the Japanese welfare system – *seikatsu hogo* ('livelihood protection'). This is notoriously difficult to obtain as those in Kotobuki are considered voluntarily homeless (prejudicial views of homelessness as laziness with bad habits abound) and an address is needed to make a claim – things had changed in the intervening period of Gill's visits as, previously, a *doya* had not been considered a residence (this was, however, amended later in the 1990s).

In this chapter, Gill presents Kimitsu as a fascinating, incredibly bright and well-read individual and also provides a little context to Kimitsu's situation, offering a narrative of the sometimes bewildering and contradictory sections of the Japanese welfare system that were set up to assist those that were homeless during this period. In Japan, this consists largely of a graduated step approach offering emergency (*ichiji hinanjo*), then interim accommodation aimed at moving people one step closer to 'mainstream living' (*jiritsu shien sentā*), then support for a few months once an individual has found employment. The maximum time one is allowed to remain in these facilities is typically two to six months, and the quality of service and intensity of support varies regionally (Okamoto and Bretherton, 2012).

In this section of the book, Gill's admiration and near reverence for Kimitsu begins to emerge:

One day I mused... Kimitsu Nishikawa is going to die... and a great big library is going to go down in flames. (p.27)

Gill then jumps forward to 2007 and the centrepiece of the book, the '2007 Conversations', which documents each of the 15 conversations Gill had with Kimitsu during what appears to be the investigative period for the book. Interspersed

with Kimitsu's drawings, Gill presents an insight into his subject's life-history, thoughts and motivations, allowing the reader to understand how he came to be part of the street life of Yokohama.

This clever, and often moving, chapter demonstrates how this exceptionally intelligent retired day labourer has navigated his way through his life of 66 years. It is here that Gill allows Kimitsu to articulate his past, his beliefs and the influences that brought him to where he is today. This chapter is very distinctive, and by way of its utter simplicity, ensures that the voice of Kimitsu – of a man with a life that many would shun as a meaningless existence – is at the fore; there is no unnecessary theorizing of causation, through which most homelessness voices are interpreted, no attempt to bend the material to emphasise structural causation or individual pathology. Instead, Gill offers a refreshing alternative, a more appropriate phenomenological approach, placing Kimitsu's experiences at the very heart of the book.

Chapter 4 moves on to the post 2007 *Conversations* period and to document briefly Kimitsu and Kotobuki up until 2014. At this point, we find Kimitsu in a rather sad and sorry state having had a stroke and being looked after in a Red Cross hospital. The chapter is rather bleak at times as we see Kimitsu deteriorate, first physically but with his intellect and humour still intact, and then progressing to a state of mental decline, which for the reader of his philosophising and insight is a more difficult aspect to absorb.

Here, Gill turns to explore the recent changes in Kotobuki, applicable to other similar areas in other Japanese cities, exploring demographic change in an ageing population, the increase in welfare recipients (83% of the population as of 2011) and the broader changes to Japanese social welfare policy. He describes Kotobuki as "on its way to becoming a giant welfare centre" (p.102). This is a look, albeit too brief, into wider homelessness policy in Japan. As Gill notes, private landlords require a personal guarantor, which has always been a hurdle for housing homeless people and, thus, in recent times, *doya-gai* such as Kotobuki fit the bill perfectly for Japanese welfare agencies seeking to find homeless people accommodation.

The chapter moves on to 2013 with Kimitsu at the age of 74 and with Gill surprisingly reassessing his perception of the Japanese social welfare system, as it had kept Kimitsu, an ailing homeless old man, alive and in comfortable surroundings. His family no longer wished to know him and he was effectively alone and at the hands of the Japanese State.

Concluding in 2014, the chapter leaves Kimitsu-san suffering from dementia, being cared for in a hospital with nowhere else to go and with no access to supported accommodation for the foreseeable future. While unfortunately not expanded upon, this is possibly a more realistic vision of the Japanese welfare system than the previous view held by Gill (see Iwata, 2003).

In the final chapter, Gill acknowledges that it would be remiss of him to not apply his experiences with Kimitsu to the wider social context in modern Japanese society. Gill accurately notes how in post-war Japan, for some of those men who were unable to achieve typical aspirations of secure employment, housing and married life or who had failed to fulfil familial obligations, particularly in the case of those who are eldest sons, one of the few options was day-labouring. Becoming a day-labourer meant finding themselves to be exposed to the '*brutal*' practices of construction and dockyard industries, being used only as and when useful. Although where once the life of a day labourer meant homelessness and likely death on the street, Gill points to some of the positive changes in Japanese social welfare and how, in the end, Kimitsu himself was cared for by the State.

Importantly, this commentary chapter moves on to talk about current difficulties around insecure employment practices in Japan and compares the day-labouring life of those in Kotobuki with dispatch agency work, which is increasingly popular in Japan. The most significant difference being that the solidarity felt amongst day labourers is lacking in its contemporary equivalent. However, Gill's point seems to be that people like Kimitsu were once an anomaly in Japanese society but are now part of an increasingly expanding realm of workers with little security or status in the job market, claiming later that almost half of those in the Japanese labour market undertake *irregular labour*.

While this is an important addition to the narrative of Kimitsu, the content of this chapter would have served the book better if it had come earlier, before our introduction to Kimitsu, allowing the reader to understand the context in which we find him.

Yokohama Street Life provides a thoroughly fascinating insight into not only the life of Kimitsu, but the complex lives of many who find themselves in a position of homelessness, be it in a *doya*, on the street or in more hidden forms such as sofa-surfing. One of the real strengths of the volume is that it illuminates the simple fact that, like any other member of society, those on 'the margins' can still be passionate about philosophy and the arts. This volume presents a homeless human being and not a set of statistical associations or an ethnographic attempt to explore homelessness in terms of trigger factors or supposed sets of characteristics or behaviours. The book presents an antithesis to modern media with its all too common negative cultural imagery and assumptions about people on the streets and around homelessness *per se*, presenting intelligent and subtle insights into the lives, expectations, interests, vulnerability and precarity of those that find themselves marginalized in what, at first sight, could seem an exemplary model for urban living.

The book does have several limitations. There is little wider discussion of the literature – just a cursory glance at very similar titles and, while it is understood that this is a one-man ethnography, a broader discussion of current evidence would contextualise the narrative; this is something that is absent from the book.

The book is very similar to Gill's earlier work, *Men of Uncertainty*, and it is easy therefore to ask whether Gill should have broadened his approach to look at Japan's contemporary homelessness population. Homelessness in Japan has long been associated with day labourers (Ezawa, 2002) and these have been the mainstay of Japanese homelessness studies, but the context has shifted, particularly towards the oft-cited increase in young people who are homeless and the usage of 24-hour venues such as manga or internet cafés (sometimes referred to as cyber-homeless) as a form of accommodation. Of course homelessness stretches far beyond street dwelling populations and, while Gill does broaden the focus in Chapter 5 slightly, one could question his focusing on street / *doya* dwelling populations for the second time. While Gill's intentions are clear, even a brief mention of wider homelessness in Japan would have added depth to the discussion and allowed Gill to say more about how Japanese homelessness is changing.

Having said this, there is great virtue in what Gill has achieved in exploring the human dimension of homelessness in such detail. The book is an invaluable observation that would appeal not only to social anthropology academics or students but to anyone interested in aspects of social policy, sociology and political science.

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