



Santé Mentale et Exclusion Sociale  
Mental Health and Social Exclusion



FONDAZIONE ISTITUTO  
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# The Dignity and Well-Being Project: Analyses of 50 Profiles of Homeless People with Mental Illness

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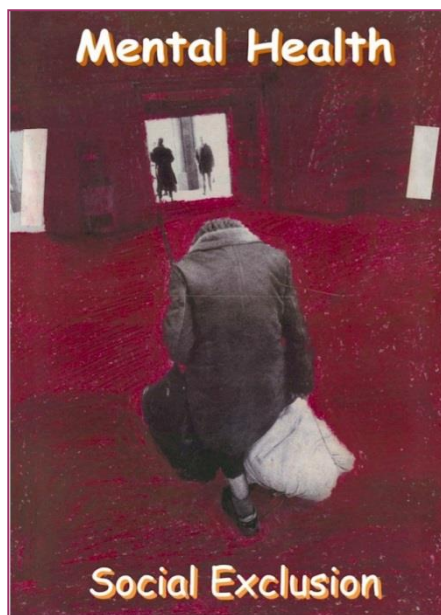
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# Santé Mentale et Exclusion Sociale

## Mental Health and Social Exclusion

1992 – 2017



STARTING PRINCIPLE of S M E S - Europa

### 1. Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

*(U.N. Resolution 46/119, 1.1, 1991)*

# CHANGING PROFILES OF HOMELESSNESS AND OF WORKERS AND POLICIES

1992 – 2017



The European SMES network started in 1992 in Rome following the 1<sup>st</sup> European seminar:

**'Mentally ill people at risk of homelessness'**  
focusing on the scandalous abandonment situation of mentally ill people, living as home-less roof-less in very poor health and social conditions



In these 25 YEARS what has changed?  
Today we focus our special attention on:

**'Homeless people at risk of mental illness'**



In 1992: an individual problem

Today: it's more a structural society symptom of malaise, injustice, individualism, broked social cohesion

# HOMELESS AND MENTALLY ILL PEOPLE'S PROFILES ARE THE RESULT OF MULTIPLE AND COMPLEX NEEDS



When a person  
has  
lost everything

- Health
- Home
- Job
- Selfestime
- Hope in future



there is no more than...  
... the body for crying  
and the street to get lost !



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# CHANGING PROFILES AND IMPLICATIONS FOR SERVICES, POLICY MAKERS, CIVIC SOCIETY

The increasing number of homeless people living in severe and chronic *social, physical, psychical* precariousness are a symptom of the malaise of our society and a permanent injury

- to democracy
- to fundamental rights
- to social cohesion and solidarity

They are almost a provocation and a challenge, for those who are working in this social and Health/MH field and for representatives of the *polis* and citizens

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# This presentation

## Five sections

- Profiles: methodological notes
- General framework
- Pathways and typologies
- Interventions and networks
- Priorities

# Profiles: methodological notes

## Profiles and profile-writing protocol

*How do health services, support services, housing services and reintegration services contribute to promoting the dignity and well-being of homeless people with mental illness?*

- 50 profiles (55 persons): an inventory of different models of interaction between services and homeless and mentally ill people in different contexts
- Protocol for profile-writing: a qualitative tool
- Wide diversity of profiles, due to: contextual conditions, writing style, position/role of the profile writer, availability of information, intervals of time covered

# General framework/1

## Age and nationality

- 24 women, 31 men; women are older than men
- 18 persons of 52 are foreign citizens (3 from EU countries)

## Physical conditions

- Physical conditions: health risks intrinsically associated with homelessness
- Drug addiction and alcohol dependence are very common (20 profiles)
- 10 profiles: no relevant problems

## Mental health conditions

- Clinical diagnosis: schizophrenias (12 profiles); Psychosis or paranoid psychosis (7); less severe mental disorders (4)
- Interaction between mental disorders and addictions



## General framework/2

### Which possible interpretations of these lifestories?

- a) Need of a multifactorial perspective: complexity and multiplicity of implications
- b) Correlations, not 'causal' factors:
  - Family sphere (dysfunctional families)
  - Mental health originating the progressive detachment from proximity and labor relations
  - Loss of work and home
  - Overlap of physical and mental health problems: especially alcohol and drug addictions (problematic relations with the justice system and lack of a decent work and housing)

## General framework/3

### The issue of refusal

- 39 profiles contain notes recording hostile reactions or other forms of opposition to the proposed care, social support and housing support
- 14 profiles: rejection appears systematic; lack of compliance also in emergency interventions
- Not always the refusal to operators is aggressive
- Forms of selective opposition

# Pathways and typologies/1

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

- Improvements in the interactions with the care-system; positive impact on the health conditions
- Factors influencing these positive pathways:
  - the tenacity of a single operator;
  - organisational changes (i.e.: case manager);
  - cooperation between social services, health services and voluntary organisations
  - social service's ability to activate external resources
- The evolution of the personal stories can not at all be taken for granted and improvements observed are not to be considered as acquired nor as definitive

## Pathways and typologies/2

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

- Common feature: interlocutory paths
- Persons still living in the street but in some way attached to a supporting network
- Fragility of the support system: differently from typology 1, no integrated network
- Monitoring and observation go on, but without activating other subjects: discontinuity and precariousness of interventions
- Frequent hospitalisations (operating horizon: damage reduction)

## Pathways and typologies/3

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

- Suspension of the take-over process preventing the network of services to develop additional activities
- Two reasons:
  - a) organisational factors: lack of communication or collaboration between services; absence of a decision-making center or coordination of existing interventions; inappropriateness of a specific service; delay and response times
  - b) limitations resulting from obstacles of legal or administrative nature (documents, bureaucratic paths)

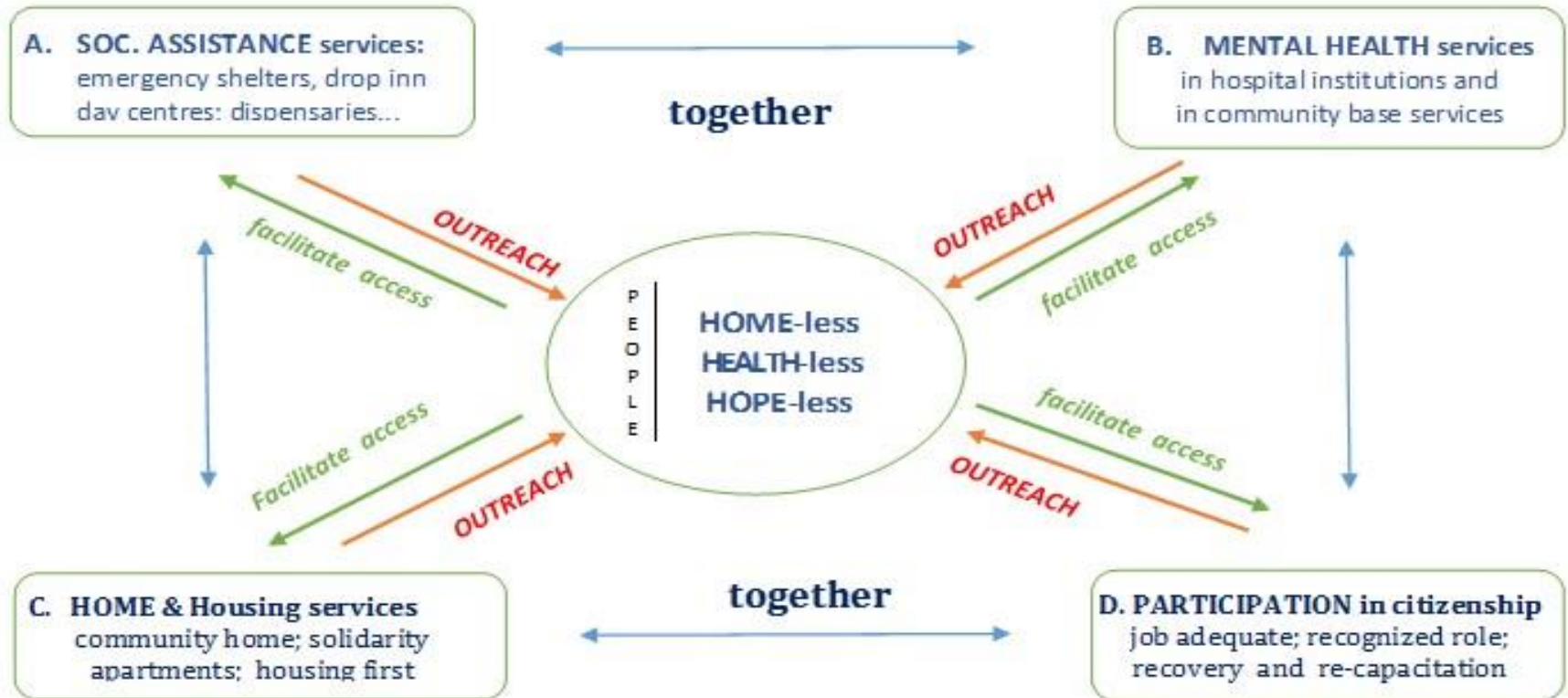
## Pathways and typologies/4

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

- Operators say they do not know what to do
- Sense of helplessness and perception of the 'illegibility' of the situation: “I do not really understand what is happening”
- Chronic situations, often 'dual diagnosis': “what will we do when she will leave the hospital?”

# TOGETHER : *outreach - welcome - accompany*

The services working together can promote the dignity and well-being of each one



# Intervention and networks/1

## Strengths and weaknesses/1

- The fundamental role played by the outreach teams, in particular for the first contact
- The issue of avoiding the 'recurrent circles': from the street to the hospital and again on the street
- The role of case managers (not to be burdened with the task of handling too many cases at the same time)
- Conflicting representations and alternative visions by professionals and involved services



## Intervention and networks/2

### Strengths and weaknesses/2

- High frequency of situations that require operators to choose between uncertain and unpredictable alternatives (“We have done the right thing?”)
- Discretionality: going beyond organisational routines (“in a vacuum of regulations, our group tries to compensate in a naive way, sometimes at the limits of legality”)
- Consent and compulsory admissions
- **“Social pressure”** and informal support networks

# Priorities/1

## 1) The networking

- the need to work in an integrated and coordinated way: “each intervention by individual institution is useless”: no organisation, professional or actor is self-sufficient
- operative implications:
  - integrating the work of outreach teams and hospital staff
  - assigning responsibility for coordination to a specific figure (case manager)
  - discussing in a participatory way cases of 'dual diagnosis' (in order to avoid liability discharges and triangulations)
  - defining continuity of care interventions capable of foreshadowing 'accompanied' paths of exit from hospital
  - balancing responsibilities between professional teams and volunteer groups

## Priorities/2

### 2) Person-centered services

- The vulnerable person must be met and welcomed in the manner and in the most relevant and appropriate times compared to his/her actual conditions
- Overcoming of organisational rigidity and consolidated routines
- Operative implications:
  - monitoring and sensitive listening (“we have to work to a good relationship with the homeless patient, respecting his will”)
  - recognizing the person's dignity (“starting from where the person is, and not from where I think he/she is”)

## Priorities/3

### 3) Operators

- Interventions cannot be based solely on a voluntary approach: need of an organised and effective response, hopefully systemic
- Burn-out and stress:
  - supervision and emotional support
  - exchange of experiences
  - training and in-depth knowledge of the general frameworks within which the phenomenon of homelessness is placed

# SYSTEMIC ATTENTION & INVOLVEMENT IS REQUESTED BY HEALTH & SOCIAL SERVICES AND POLICY MAKERS



“Overcoming poverty is not a task of charity, it is an act of justice. It is the protection of a fundamental human right, the right to dignity and a decent life.”

While poverty persists, there is no true freedom and democracy.”  
*Nelson Mandela*



*A person does not exist if his personal voice beyond the basic daily needs is not heard and understood*