

ADDRESSING HOMELESSNESS IN EUROPE

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The changing role
of service provision:
Services for homeless people
and Inter-agency working

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November 2005



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European Federation of National Organisations Working with the Homeless

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- The changing role of the state
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Introduction

This report examines aspects of inter-agency working to provide services for homeless people in five countries in Europe (Austria, Greece, the Netherlands, Portugal and the United Kingdom). Over the last decade there has been a growing recognition among policy makers that the causes of homelessness include structural and institutional as well as relationship and personal factors. Strategies to deal with homelessness have thus begun to focus on individualised care plans and on prevention and re-settlement as well as on alleviation and emergency intervention. This has emphasised the multi-dimensional nature of the issue and the need for more co-ordinated or ‘joined-up’ policies and for inter-agency co-operation, networking or partnership to deliver these policies.

Whilst joint or multi-agency working on homelessness is generally seen as a necessity and a strength of current provision of services to homeless people, most initiatives have been developed relatively recently (Kennedy et al, 2002). Within the context of an emerging mixed economy of provision, public-voluntary sector coordination has been driven by the shifting role of local authorities from providers to enablers and purchasers of services. Changes in governance, changes in public sector management ethos and changes brought about by financial de-regulation, introducing new forms of resource allocation involving competitive bidding, have all led to new organisational structures of service provision including inter-agency working and collaboration. However, some would argue that the newly emerging models of inter-agency collaboration are more common in planning provision rather than in service delivery (Reid, 1997).

A plethora of terminology is employed to describe the collaborative approaches to service planning and provision: ‘inter-agency’, ‘multi-agency’, ‘inter-professional’, ‘inter-sectoral’, and ‘partnership’. Lloyd et al (2001; quoted in Warmington et al, 2004) offer useful, albeit tentative, definitions to include:

- > *Inter-agency working*: involving more than one agency working together in a planned and formal way, rather than simply through informal networking (although the latter may support and develop the former). This can be at strategic or operational level.
- > *Multi-agency working*: implying more than one agency working with a client but not necessarily jointly. Multi-agency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper inter-agency co-ordination. The terms ‘inter-agency’ and ‘multi-agency’ (in its planned sense) are often used interchangeably.

Powell and Glendinning (2002) construe *partnerships* as having more than one agency, with a common interest, undertaking joint implementation to achieve shared goals. Partnership working has encompassed the central and local state and the private and voluntary sectors. A distinction is also made between ‘networks’, ‘co-operation’ and ‘co-ordination’. According to Powell and Exworthy (2002), definitions of networks also vary. They may be fairly loose and dependent on trust or reciprocity or focused on a formal contract. The distinction between co-operation and co-ordination is suggested by Rogers and Whetton (1982) to be:

- > *co-operation*: referring to a relatively informal process involving ‘deliberate relations between otherwise autonomous organizations for the joint accomplishment of individual goals’;
- > *co-ordination*: the process whereby two or more organizations create and/or use existing decision rules that have been established to deal collectively with their shared task environment.



This paper examines the emergence and nature of inter-agency working to provide services for homeless people in five European countries. It is based on a review of existing research and literature and builds upon previous reports by the European Observatory on Homelessness Working Group on Service Provision (Edgar et al, 2003; Edgar et al, 2004).

The first section examines the social inclusion context of homeless policies and the nature of vulnerability that leads to the development of multi-dimensional policies and hence to inter-agency working. The second section uses existing literature to consider the conceptualisation of inter-agency working and possible models for analysing inter-agency working on homelessness. The third section briefly examines the emergence of inter-agency working in the five study countries and the diversity of factors that have enabled inter-agency working or resulted in barriers to its development. The fourth section highlights examples of inter-agency working in relation to homelessness in the five countries. The final section considers the lessons learnt from this analysis.

Perception of Homelessness and the Development of Policies

The European Social Agenda, agreed at Nice in December 2000, recognised the dual role of social policy both as a productive factor and as a key instrument to reduce inequalities and promote social cohesion. In agreeing the European Social Agenda at Nice, the member states agreed to develop their National Action Plans on Social Inclusion within the framework of four common objectives in order to:

- > facilitate participation in employment and access by all to the resources, rights, goods and services;
- > prevent the risks of exclusion;
- > help the most vulnerable;
- > mobilise all relevant actors.

The objective of preventing the risks of social exclusion also refers explicitly to the need for policies to prevent life crises which can lead to situations of social exclusion such as “indebtedness.. and becoming homeless”. The objective to help the most vulnerable refers to those who belong to a ‘group experiencing integration problems’. However, the understanding of vulnerability in this context is interpreted in different ways in the member states.

It may be helpful to reflect upon the causes and nature of vulnerability as it affects the risk of homelessness since this will influence our understanding of the definition of homelessness and of the nature of service provision to meet the needs of vulnerable groups and so prevent homelessness. However, different terms are commonly in use which reflect different and perhaps discrete understanding of the nature of vulnerability - for example, ‘socially vulnerable people’, ‘marginalised people’, ‘neglected people’, ‘excluded people’, the ‘disadvantaged’ and the ‘underprivileged’ are terms to be found in different documents and national action plans.

In Denmark, for example, new forms of permanent housing provision have been targeted at the group of difficult people who have failed to be re-housed in normal housing (Meert, 2005). In the Netherlands, on the other hand, the problem of ‘difficult’ people or anti-social behaviour and begging has become a more critical issue on the policy agenda. The health ministry’s Action Plan against Public Disorder and Nuisance (*Ministerie van VWS, 2004*) focuses on the highly visible group of street people who cause nuisance attributable in part to a combination of psychiatric problems, substance dependency and homelessness.

Some countries define vulnerable groups for targeted assistance within their social inclusion strategy. For example, In March 2002, the Danish government presented a programme for co-ordinated action targeting the most disadvantaged groups in Danish society entitled “Our Collective Responsibility”. Disadvantaged groups are defined as: drug mis-users, adults and children from families with alcohol misuse, the mentally ill, the homeless and prostitutes. In the Netherlands a panel of experts, which included representatives of agencies, institutions, and client organisations, has characterised this group more specifically (Bransen et al, 2001) as people who:

- > are not sufficiently capable of providing for their own necessities of life (shelter, food, income, social contacts, proper self-care, etc)
- > have several problems at once, which may include inadequate self-care, social isolation, squalid housing or living environments, lack of permanent or stable accommodation, large debts, mental health problems and substance dependency
- > do not, from the viewpoint of care professionals, receive the care and support they need to sustain themselves in society, and
- > do not express care needs that readily fit into the mainstream care system (help is usually requested by relatives, neighbours or onlookers), and therefore often experience unsolicited care or interference.

On the basis of this definition, the size of this group of vulnerable people in the Netherlands has been put at 110,000 persons (33,000 recorded and 77,000 non-recorded, making up 0.7% of the population). The estimates are strongly skewed by a high response from community health services and homeless services, and a relatively low response from ambulatory mental health care and addiction services (see Lourens et al, 2002: 51). A recent study examining the profile of vulnerable people in different sectors - community health, homeless, mental health care and addiction services - argued that they had just two things in common: care needs that did not match the available services, and involvement in problems with institutions (Bransen et al, 2001). This suggests that 'depending on where we lay the yardstick (that is, in which sector or at which location), a different specific profile of vulnerable, hard-to-reach people emerges' (Wolf, 2005; p. 3). Adapting this line of argument we may suggest a generic approach to understanding the causes of vulnerability that affect the risk of homelessness (Table 1).

Structural factors affect the vulnerability or risk of exclusion arising mainly from the effects of poverty (affected by a person's position in the labour market) and the factors that act as barriers to access to housing, services or social protection. Vulnerability is also affected by the extent to which social protection is dependent upon a person's employment situation or citizenship status, hence women and immigrants may be more vulnerable. Despite legislation to ensure equality of access to services, discrimination can create vulnerability to exclusion from the housing market for some groups.

Institutional factors can influence vulnerability. People who require support will be vulnerable to exclusion from the housing market if support is not available or does not meet their needs. Support may not be available because services do not exist (e.g. in rural areas) or are not available for particular needs. People can also lack support if their medical or psychiatric condition is undiagnosed (e.g. if they have a mild learning disability) or if they do not have contact with medical or social services (e.g. some young people). Lack of social support networks also creates an increased vulnerability for some (e.g. single people or recently arrived immigrants).

Lack of affordable housing or regulation of housing allocation is an important aspect of vulnerability for those on low income and immigrants. Often homeless people are vulnerable because they have complex or multiple problems which fall through the net of existing services. Mechanisms of resource allocation (including housing) and gate-keeping by service providers and housing managers can also leave some people vulnerable to homelessness. For example, people with an addiction may be denied access to some services (including homeless services and housing) and people who avoid or refuse to take medical prescription (e.g. for a diagnosed mental health problem) may also be excluded from services and housing.

Relationship problems or breakdown are often associated with housing exclusion or can create a vulnerability to homelessness. In particular the increase in domestic violence is associated with episodes of homelessness or temporary housing for many women and their children. Equally the increase in divorce and separation can create difficulties for the adult partners as well as for young people who may be forced to leave home at an early age. Recent research has demonstrated an increase in homelessness among older men often associated with relationship breakdown or loss of a partner later in life.

Personal problems can, of course, be a key factor leading to homelessness. However, personal circumstances can create vulnerability in other ways. Some people may simply lack knowledge about opportunities available to them (e.g. immigrants, young people). Personal problems may often be unrecognised (for example gambling addiction or personal debt) until a problem becomes manifest in the loss of a home. Even then the scale of such problems may go unrecognised by service providers. People develop coping strategies to hide the real nature of their situation.

This overview of the causes of vulnerability illustrates several distinct situations in relation to support services and the need for inter-agency working. First, people may not get the care they require either because the specialist services they need are not available where they live or they are excluded from or ignored by formal support / care services. For example, women fleeing from domestic abuse may be excluded from women's shelters if they have a drug or alcohol problem and often end up in a homeless hostel. This indicates the need for either specialist (hostel) provision or for co-operation between the two sectors to ensure that women in homeless hostels get the support they need to resolve their underlying domestic abuse problems.



Table 1 Factors of Vulnerability and Risk of Housing Exclusion

CAUSE	FACTOR OF VULNERABILITY	COMMENT
STRUCTURAL	Economic Processes	Affect on income, unstable employment
	Increasing immigration	Effects of xenophobia, racism and discrimination
	More rigorous definition of full citizenship	Growing importance of eligibility in relation to access to social protection
INSTITUTIONAL	Available mainstream services	Do not match care needs
	Lack of available services	To meet demand
	Allocation mechanisms (services and publicly allocated housing)	inappropriate to needs (spatial concentration, delivery procedures)
	Shortages of appropriate services	Prevention, outreach, etc.
	Lack of co-ordination between existing mainstream services (including housing)	Affects continuum of support and housing careers
RELATIONSHIP	Family Status	Single people more vulnerable
	Relationship situation	Abusive partners; step-parents
	Relationship breakdown	Death, divorce, separation
PERSONAL	Economic / employment status	Disposable income
	Ethnic status	Likelihood of facing discrimination
	Citizenship status	Access to social protection
	Disability / long-term illness	Includes mental health and learning disability
	Educational attainment	Low attainment
	Addiction	Alcohol, drugs, gambling
	Age / Gender	Young / old, female
	Immigrant situation	Refugee status / recent arrival

Second, many people at risk of homelessness have complex or multiple problems which fall outside the scope of existing services. Dealing with complex needs requires appropriate care planning but also involves co-ordination between services and sharing of specialist skills. Addressing complex needs to prevent homelessness (or repeat homelessness) will often involve agencies from different sectors including health, social services and housing.

Third, people may not receive the support they need, and thus remain homeless for longer periods or be vulnerable to repeated episodes of homelessness, because their problems remain unrecognised. For example, the link between indebtedness and homelessness is well known. However the causes of debt arising, for example, from a gambling addiction is often not recognised by service providers either because the individual hides the stigma of the problem or because the issue is not understood by homeless service providers. Once recognised, the prevention of homelessness will often involve co-ordination between housing, financial advice, family support and specialist counselling services.

Fourth, actions by institutions / organisations (e.g. prison services, foster care services, social landlords) can leave vulnerable people at risk of homelessness. The procedures to ensure accommodation for people leaving prison or foster care, for example, require co-ordinated action between different institutions and service sectors if homelessness is to be prevented. Prevention strategies, including the provision of information and advice, will also normally involve inter-agency working. Finally, re-settlement and re-housing strategies will involve the co-ordination and integration of housing and support in which housing providers and one or more support agency need to collaborate.

Conceptual Models of Inter-agency working

It has been argued that strategic directives are running ahead of the conceptualisation of inter-agency collaboration (Warmington et al, 2004). Moreover, advocacy of joined up working is rarely informed by coherent theories, or by systematic understanding, of the changing character of organisational work and service provision. At a policy level inter-agency working is promoted as a 'self-evident good' but strategy and operation both remain problematic (Atkinson, 2002). Professional boundaries between agencies, expressed in disparate goals, perspectives and priorities, have often impeded inter-agency working (Wolf et al, 2004). This section reviews the literature in order to establish a conceptual understanding of the models of inter-agency working and their role in service provision in relation to the prevention of social exclusion (including homelessness). It also uses research evidence to suggest factors that can influence the effectiveness of inter-agency working.

MIXED ECONOMY OF PROVISION

A number of different sectors of service provision and different disciplines are, of course, involved in the prevention and alleviation of homelessness including housing, social services, health, and homeless service providers. In most countries civil society agencies (NGOs) are the main providers of homeless services. Housing provision tends to be private sector dominated in all countries while social housing provision (on which most re-housing initiatives depend) is a mix of public sector and publicly subsidised provision. The landscape of social service and health service provision (especially in relation to supported housing, mental health and addiction services) exhibits greater diversity across the welfare regimes of Europe. Private sector involvement has been more common in some welfare services (e.g. care of the elderly) than it has in the provision of services for homeless people.

It is to be anticipated that the culture, experience and attitude to inter-agency working is likely to be different between these sectors of provision. At a very basic level, differences in the degree of professionalisation, organisational structures and strategic management between statutory services and NGO services can be expected to reflect a difference in attitude and learning to the challenges involved in inter-agency working.

In many countries, homeless NGOs are relatively recent in origin (often creatures of the last twenty years or so) and have undergone rapid changes during that time involving both increased professionalisation and organisational growth (see Edgar et al, 2003). The effects of such changes differ depending upon the history and nature of the organisation, which is most often reflected in a difference between church-based and non-church based organisations and in the degree of dependence upon public sector funding (Edgar et al 2004). The propensity to engage in inter-agency working will be a reflection of such factors.



Inter-agency working therefore needs to be understood within the framework of organisational structure and change that homeless agencies are experiencing. As small agencies grow, and diversify their service portfolio, they may respond to the challenges this involves in different ways. These may involve inter-agency collaboration and networking to supplement the skills or service mix available. However, they may also involve more formal structures such as partnership and group structures which may even lead to merger between cognate agencies. This can be characterised as a hierarchy involving:

- > *co-operation*: where agencies participate in an initiative (either stimulated from the outside by funding providers) or through active involvement between agencies;
- > *collaboration*: agencies work jointly but with decision-making remaining ultimately with individual service providers;
- > *partnership*: a working relationship predicated upon sharing of skills, information, accountability and decision-making, marked by shared goals and objectives and possibly involving agreed protocols, procedures and shared staff in a contractual manner;
- > *merger*: where agencies determine that shared goals, opportunities and threats mean that expansion and/or diversification is necessary and is best achieved through organizational merger.

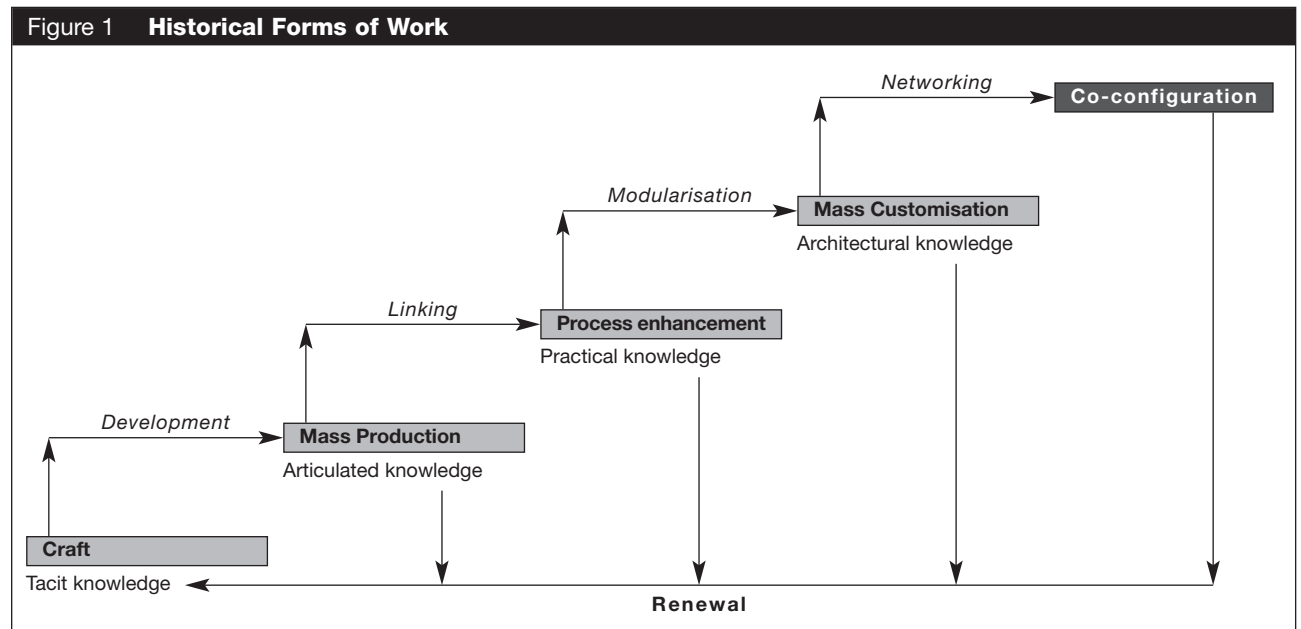
ORGANISATIONAL STRUCTURES

According to Warmington et al (2004), inter-agency working and service provision to counter social exclusion needs to be analysed against the historically changing character of organisational work and user engagement. In this context it is necessary, they argue, to understand that the models of inter-agency collaboration and client-focused practice, advocated in current calls for inter-agency social provision, constitute a historically specific form of work. They refer to the work of Victor and Boynton (1998) who identify five types of work in the history of industrial production: craft, mass production, process enhancement, mass customisation, and co-configuration (see Figure 1). The form of work currently emerging in complex multi-professional settings is characterised by Warmington et al (2004) as *co-configuration* (using Victor and Boynton's classification).

The knowledge that *craft* workers possess, of their products and processes, rests on their personal intuition and experience about the customer, the product, the process and the use of their tools. When they invent solutions, they create tacit knowledge that is tightly coupled with experience, technique and tools. This articulated knowledge is then used for the purposes of *mass production*. This articulation process is apparent in attempts to codify 'best practice' in work forms that are open to training and monitoring. The practical knowledge derived from mass production creates the work that Victor and Boynton call *process enhancement*. This involves setting up team systems that promote the sharing of ideas within the team and foster collaboration across teams and functions.

The new knowledge generated by doing process enhancement work is put into action as the organisation transforms its work to *mass customisation*. This form of work occurs as service providers begin to place emphasis on identifying with a high degree of precision their clients' requirements. Thus mass customisation is based on a nuanced understanding of provider-service-customer relationships. *Co-configuration* work is orientated towards the production of intelligent, adaptive services or products. A service is designed at least once for each client; in co-configuration services undergo constant, ongoing customisation over an extended lifecycle. This necessitates a dynamic 'relationship between multiple service providers, clients and the service; it is a relationship marked by mutual learning and by the collaborative and discursive construction of tasks' (Warmington et al, 2004; p. 8).

The key difference between mass customisation and co-configuration is that mass customisation tends to produce finished (products or) services, whereas the emphasis of co-configuration of work lies in the ongoing development of the service (Warmington et al, 2004). This implies a notion of 'inter-agency' relationships that is not confined to collaboration between professional interest groups but which includes service users as active subjects. By contrast, in *mass customisation* models, the agency of service users is highly circumscribed. While clients may have a degree of input into service design and customisation (at the point at which the service provider tries to identify precisely what it is that the client requires) ultimate decision-making in relation to service design rests with professionals.



Source: Warmington et al (2004; adapted from Victor & Boynton, 1998)

FOCUS OF INTER-AGENCY WORKING

Hudson and Hardy (2002) characterised partnerships as:

- > Vertical - involving national Government, and local government and/or other local agencies and
- > Horizontal - across local organisations, generally focusing on planning and delivery.

In further considering models for inter-agency working on homelessness, it is useful to look at both these vertical structures for collaboration and the horizontal application of inter-agency working to different policy purposes. Arguably higher, macro-levels of activity will be more concerned with prevention, while lower meso- and micro-levels of activity will be more focused on direct alleviation of homelessness and resettlement. In looking at inter-agency working on homelessness, this paper will differentiate between activities aimed at prevention, alleviation and resettlement, across the three levels of organisation.

The ‘vertical’ organisational contradictions generated where professionals are attempting to develop inter-agency work at operational level but acting within multiple institutional and/or policy frameworks requires strong strategic leadership and a collective understanding (and ownership) of collaborative working (Harris, 2003). This requires a clear strategy to encourage collaborative working at operational level and effort to allay fears and anxieties among practitioners that inter-agency collaboration would simply generate greater workloads.

Without this, inter-agency working will be partial and enacted at individual case level. Equally, strong strategic leadership can be undermined or impeded at the operational level by conflicting professional priorities (Bransen et al, 2002). Warmington et al (2004) also identify research evidence pointing to the ‘horizontal’ organisational ambivalence to the collaborative forms required in co-configuration working. In such instances practitioners from different agencies tend to accept the *rationale* behind inter-agency collaboration but development of practice is constrained by conflicts that are voiced as anxieties over differences in professional ‘cultures’, ‘identities’ and working priorities (Harris, 2003). This attitude is also reflected in the finding by Bransen et al (2002) that practitioners still collaborate most with colleagues from within their own sectors.

Hudson and Hardy (2002) characterise horizontal partnerships as involving planning and service delivery between agencies. However, an understanding of the institutional context of inter-agency working that combines the horizontal and vertical dimensions is also informative. This perspective brings together strategic, organisational and operational levels of decision-making with the planning, management and implementation spheres of action (Table 2).

Table 2 An institutional framework of service provision for the homeless			
	Planning	Management	Implementation
Strategic	Planning Forum Multi-agency strategies Research / information Policy development	Priorities for investment Resource management	Assessing local needs Evaluating funding applications
Organisational	Service planning Project development Project design	Finance Project management	Defining needs of user groups User involvement
Operational	Delivery procedures and practices	Care planning and management	Needs assessment Consulting users

(Edgar et al, 1999, Services for Homeless People)

Emergence of Inter-agency working

In a recent policy paper covering the EU member states, FEANTSA (2004) concluded that the level or degree of development of inter-agency working on homelessness was associated with the overall national approach to tackling homelessness (i.e. whether this was comprehensive and integrated). Strong inter-agency working was likely to emerge where there was a strong national legal framework for homelessness. The evidence from the five countries reviewed in this paper confirms that, while this is evident, inter-agency working is relatively recent in all countries and that in some countries inter-agency working remains embryonic. This is evident both in countries with a weakly developed capacity of homeless service provision overall (e.g. Greece) and in countries with more developed structures (e.g. Austria). This section considers the factors that have been evident in the emergence of inter-agency working while section 5 discusses the nature of inter-agency working in relation to homelessness in each country.

IMPETUS FOR INTER-AGENCY WORKING

Examination of the background to inter-agency working in the five case study countries illustrates a diversity of factors and processes underlying its emergence. The following selected examples illustrate the range of factors that are evident. In the UK, the changing governance of welfare has been a significant driver of inter-agency working and co-ordination. Legislation, regulation and funding has reflected this policy discourse, for example, in relation to the co-ordination of the provision of housing and support both in the regulation of the housing association sector and in the operation of the 'supporting people' funding programme. In the Netherlands, Ministerial action at national level has been matched by research commissioned at local authority level to underpin a wide range of pilot projects whose evaluation has informed action. In Austria the segmentation and fragmentation of social welfare structures at federal and regional level has been mirrored by homeless services operating within specific geographic areas of operation. Specialisation of action at local areas of operation has led to inter-agency co-operation to complement service delivery. The importance of external drivers from EU level action is evident in Portugal and Greece. In Portugal, the EU Poverty Programme and the Social Inclusion Strategy have reinforced national action on social integration income and social networks in creating structures for inter-agency working (though these have only minimally involved the homeless sector). In Greece, apart from the development of community mental health services which have depended to a large extent upon European funding for psychiatric reform, inter-agency working is the result of organisational action at the operational level.

The emergence of increased partnership working has been described in relation to New Labour ideology and the governance of welfare in the UK following the 1997 general election (Glendinning, Powell and Rummery, 2002). Powell and Glendinning (2002) refer to the emergence of a 'collaborative discourse' under New Labour with terms such as partnership,

inter-agency working, integrated delivery, joined up government, and co-ordination all in common usage in policy, practice and research. The idea of partnership has been important for New Labour as it has been viewed as a 'third way' between the centralised, bureaucratic welfare state of 'Old Labour' and the free market of the Conservatives (Powell and Glendinning, 2002). Clarke and Glendinning (2002), have argued that New Labour policy goals have heightened the need for improved co-ordination between agencies. Across many aspects of welfare, partnership working has encompassed the central and local state and the private and voluntary sectors. Partnerships have been particularly prominent in health and social services, but are also a feature of much New Labour policy involving housing and homelessness. Joint working has been a feature of housing and homelessness service provision in the UK for some years. Housing associations play a very significant role in the provision of housing for people who have been homeless or are at risk of becoming homeless. What distinguishes social housing is that it is governed through a specific regulatory regime which plays a particular role in structuring inter-organisational relationships, in the way that it distributes power, in the form of roles, resources, and responsibilities among housing organisations (Reid, 1997, p. 27). The greater involvement of voluntary sector agencies in homelessness service provision, compared to the mainstream social housing sector, meant that issues around private finance, competition and regulation were less applicable to the homelessness sector in the 1990s. However, the introduction of *Supporting People* funding in the last five years, and the regulation of service delivery associated with this, has influenced the structuring of inter-agency working.

In the Netherlands, the health ministry's Action Plan against Public Disorder and Nuisance, approved by the cabinet in December 2004 (*Ministerie van VWS, 2004*) aims to secure firmer commitment to inter-agency collaboration within a continuum of services to vulnerable people. Efforts to target this group are designated as 'public mental health services' (*openbare geestelijke gezondheidszorg* or OGGZ). Public mental health work is not the domain of a separate service or sector.

Activities that qualify as public mental health work are undertaken by a range of agencies from different sectors, usually in some form of collaborative arrangement. Often this involves services to a client group that is difficult for mainstream agencies to reach. Also, the four largest Dutch local authorities commissioned a study in 2004 on 'how the cities of Amsterdam, the Hague, Rotterdam and Utrecht can more effectively perform their coordinating tasks at the interfaces of public mental health intervention, mental health care, addiction services, homeless services, and public safety' (Muntendam and Schutte, 2004: 2), and what instruments would be needed to achieve this. Several major policy changes are now underway that will drastically alter the legal framework for such interventions.

The Austrian welfare regime involves federal social security laws (involving unemployment benefits and social security benefits) and regional laws (involving social services). Thus, the systems of social benefit (*Sozialhilfe*) as well as the legal frameworks for youth care and social services for different target groups (e.g. disabled, poor persons and families, migrants and refugees, homeless) are a matter of regional competence. Hence social welfare provisions and services, conditions of access, and administrative rules differ widely between the nine counties. The different strains of social welfare and the different service lines are very hermetic and there are only very weak links and intersectional transitions between them. Hence, monetary dominance on the one hand and segmentation and fragmentation on the other hand are constitutive characteristics of the Austrian welfare regime. Models of interactive frameworks are therefore exceptional and there are no general structures and provisions to provide cooperation. Service provision for the homeless in Austria mirrors the general welfare regime and the general characteristics of segmentation and fragmentation.

The formalised concept of partnership has been introduced in Portugal (in the period following the 1974 revolution) through the influence of European programmes (Poverty Programme for example) and it was initially understood as co-operation between different trans-national partners. The programmes and projects based on European policies and resources mainly addressed the fight against poverty and social exclusion where it was acknowledged that the multi-dimensional nature of the phenomena demanded inter-agency working. Partnership was one of the main principles of the National Programme to Fight Poverty (PNLCP) which followed the European funded Poverty III project. Moreover, the creation of the Guaranteed Minimum Income (implemented in 1997) was an emblematic example of this process of partnership. The implementation of the GMI involved the creation of a national inter-ministerial permanent committee (a pioneer experience in Portugal), as well as Local Monitoring Committees, to which was given the management responsibility of a national policy measure (another pioneer experience). The way these local structures operated varied between municipalities although legislation established their composition. They include compulsory and non-compulsory partners. The former include local representatives of social action, employment, education and health. The latter may include municipalities, NGO's, trade unions or other non-profit making associations. Homeless service providers may be present among these non-compulsory organisations.

ENABLERS AND BARRIERS

Although it is possible to identify the factors that have led to the emergence of inter-agency working, research evidence from a number of countries suggest a number of factors that act as enablers and barriers to inter-agency working.

Clarke and Glendinning (2002) refer to 'unresolved tensions' in partnership working and contradictory demands on partnerships (p. 45). For example, 'compulsory partnerships' have emerged in the UK, where 'intense central power directs and reinforces local 'autonomy' and 'working together' (p. 45). Clarke and Glendinning therefore conclude that 'the formalisation of abstract models of governance - hierarchies, markets and networks - may have diverted attention away from more complex, compound and contradictory processes and systems' (p. 45). That is to say, account needs to be taken of actual practice, in relation to theoretical models. Finally, Clarke and Glendinning argue that analysis needs to continue to take account of state power, which is 'not shrinking but directing' (p. 46). The relevance of these ideas to inter-agency working on homelessness is demonstrated in the following section.

Kennedy, Lynch and Goodlad's (2001) study (also in the UK) revealed that agencies actively engaged in inter-agency working on homelessness were mainly from the statutory and voluntary sectors, with little involvement of private sector agencies. The most common aspects of inter-agency working were planning, information sharing, referrals and liaison, with joint service delivery and outreach work less frequent inter-agency activities. Factors which aided joint working included staff commitment, good communication, having shared aims and goals, resource availability and commitment at senior and operational levels. Difficulties in joint working included organisational and professional boundaries, lack of mutual understanding and trust and the time required to develop sustainable relationships. Their research highlights examples of good practice, which centred on organisational factors such as working relationships and having clear roles for the partnership agencies.

In 2001, the 43 Dutch local authorities charged with coordinating public mental health services in their regions (the *centrumgemeenten*, or 'central local authorities') commissioned a mapping exercise of all instances of operational-level collaboration. That report, which identified 179 projects (Bransen et al, 2002), is discussed in detail in the next section. It is relevant here to highlight the key findings in relation to the enablers and barriers to partnership working.

Strengths of the partnerships, as seen by the respondents, lay first of all in features relating to organisational qualities. More specifically, value was placed upon the right decision-making and operating structures with short lines of communication among staff members and between them and management. Features relating to the conditions under which the work was carried out, in particular the widespread perception within institutions and agencies that collaboration was necessary, and the presence of sufficient social and political support for the project in its region were also critical. Staff enthusiasm and commitment was essential and, finally, features were cited that related to the content of the available services.

The most frequently reported challenges involved service content (cited in 83% of the projects), and specifically the need to develop a more effective, preventative range of services and to improve working methodologies through measures like staff development and professionalisation.

Organisational improvements, in particular a broader, more efficient inter-agency collaboration and the resolution of snags at the interfaces between different services ranked second. A third challenge involved the operating conditions of the projects (46%), especially the need for more secure, preferably structural, mechanisms for funding the partnerships. However, research has repeatedly shown that collaboration at the operational level is usually not all that intensive, and that practitioners still collaborate most with colleagues from within their own sectors (Bransen et al, 2001; Hulsbosch et al, 2004; Wolf et al, 2003). They also rate collaboration with those colleagues the most positively.

In the early 1990's and following Poverty III Programme, a National Programme to Fight Against Poverty (PNLCP) was launched in Portugal for the promotion of local projects to fight poverty. Partnership was one of the main principles for the development of such initiatives: "the adoption of a multidimensional approach of poverty and social exclusion (...)" demanded "integrated strategies of intervention, which would not be a simple sum of multiple solutions (...) but rather the search for coherent solutions, able to mobilise, in an articulated way, different actors/institutions and resources (...)" Thus the logic of partnership, that is of inter-sectoral action, would be an inevitable consequence of the fore mentioned principle" (BIT, 2003: 61). Hundreds of different entities were involved in such projects throughout the years (PNLCP was extinguished

three years ago and a new Programme was launched at the end of 2004). Partnership was one of the main criteria for evaluating the projects but in many cases the only evaluation indicator used was the number of partners involved in the projects. Nevertheless, it was possible to identify several obstacles to the effectiveness of partnership such as the need to articulate resources, to have compatible priorities, objectives, methodologies and strategies within the project and to reinforce communication channels. Partnership was perceived as a potentially conflict-ridden process, involving complex power relationships and demanding a consistent approach where roles are clear and agreed upon from the beginning.

This research evidence suggests four types of exogenous and endogenous factors that contribute to or challenge the effectiveness of inter-agency working (see Table 3). These factors can inform an evaluation or analysis of inter-agency working. For example, Hudson and Hardy (2002) proposed six partnership principles which may be useful for the analysis of inter-agency working in the field of homelessness:

1. Acknowledgement of need for partnership
2. Clarity and realism of purpose
3. Commitment and ownership
4. Development and maintenance of trust
5. Establishment of clear and robust partnership arrangements
6. Monitoring, review and organisational learning.

	Enablers	Barriers
<i>Environmental Context</i>	Clear demand; Agreement about goals and target population; Availability of funding; Senior political support.	Inadequate or unequal funding between the partners. Competition between organisations for funding; Unrealistic expectations
<i>Organisational</i>	Common understandings; Shared aims and goals; Expertise; Communication; Structural agreements between organisations (about task division, responsibility and exchange of clients and information).	Organisational boundaries; Lack of understanding of organisational remits, duties and limitations; Differing aims and remits; Reorganisation; High thresholds; difficult to access organisations.
<i>Professional / staffing</i>	Committed staff; Good working relationships; Adequate staff and time; Flexible and reflexive approach.	Professional boundaries; Lack of understanding or trust; Inadequate staffing; Lack of team-working.
<i>Procedural</i>	Being developed at an operational rather than a policy level.	Time involved in developing and sustaining relationships.

Derived from research findings of Kennedy (2002) and Bransen et al (2002)

Evidence in Homeless Policies in Five European countries

This section describes selected examples of inter-agency working in the five case study countries.

The intention is not to provide a comprehensive or exhaustive account of the nature of inter-agency working in each country but rather to provide illustrations of the nature of such activities and initiatives in order to identify the commonality and diversity of experience. The following section uses this evidence, and the organisational models developed in the previous section to draw some of the lessons to be learnt from this description.

1 Health care for homeless people and inter-agency working in the UK

In an overview of housing and health in the UK, Anderson and Barclay (2003) identified a growing interest in health and homelessness as an area for research and policy, very much embracing issues of joint working and inter-agency collaboration. The Acheson report to Government (1998) highlighted the importance of good housing in reducing health inequalities, and subsequent government white papers and policy documents paid increasing attention to housing as a tool for improving the nation's health. These links have been acknowledged by UK central government and have become fundamental to the notion of 'joined up government' which, has been one of the flagship mantras of New Labour, post 1997. Anderson and Barclay (2003) argued that issues of health and homelessness had become the most severe dimension of housing-related health issues. Single homeless people in hostel accommodation or sleeping rough are known to experience particularly severe health problems and increased mortality and may experience barriers to accessing to basic health care. Importantly, many studies have identified a shortage of suitable detoxification and rehabilitation facilities (and suitable move on accommodation) for homeless people with drug and alcohol dependency problems. Policy and practice increasingly recognises the physical and mental health care needs of formerly homeless people along with their general need for resettlement support in moving into and maintaining settled housing. This is increasingly a key area for joint working between housing, health and social care professionals.

The structures of UK health services have not always aided good health care for homeless people. The National Health Service (NHS) is a UK wide service, with complex regional and local structures for service delivery. National health policy and strategy is a function of central government (for England and Wales and, separately, for Scotland). The key structure for implementation is the local Health Board, but boards generally cover geographical areas larger than local government municipalities, and one Health Board often encompasses several local authorities, or parts of local authorities. Within Health Board areas, services are generally delivered by NHS 'Trust's who hold budgets for specific primary health care services such as general practitioner (GP) surgeries and secondary services such as hospitals and other specialist services. In comparison to local housing authorities, these trusts would operate at the micro, rather than meso, level. Hence the operating structures for housing and health services have not, historically, been ideal for inter-agency collaboration. Indeed, Clarke and Glendinning (2002, p. 35) have written about the 'Berlin Wall' which existed between UK health and social services in the early days of inter-agency working.

Prior to extensive inter-agency working on homelessness, the NHS and Community Care Act 1990 put the policy of Community Care into practice and mandated joint working on the National Health Service and local authority Social Services departments. This was to entail joint planning, commissioning, and service delivery at the height of the Conservative/New Right era of 'quasi markets' and contract culture. As noted by many commentators:

'GPs, housing departments and other stakeholders were largely uninvolved in any of these earlier collaborative initiatives, an exclusion whose consequences may take some time to overcome' (Clarke and Glendinning, 2002, pp. 35-36).

Policy makers gradually recognised that Community Care could not be implemented without housing in the community and local housing services (local authorities and registered social landlords) were gradually, but increasingly integrated into joint working protocols.

Although policy linkages and inter-agency working on health and homelessness pre-date New Labour, developments have accelerated post-1997. The higher priority placed on tackling health inequalities faced by homeless people has presented new challenges for housing, health and social care professionals in delivering quality services both within and across traditional professional boundaries (Anderson and Barclay, 2003, p. 178). Issues for good practice on health and homelessness, as identified in Anderson and Barclay's (2003) review (p. 180) included:

- > The provision of good quality temporary and permanent accommodation
- > Minimising time spent in temporary accommodation
- > Joint working with health services to
 - Improve access to services
 - Develop care and support packages
 - Provide better information to clients
 - Improve sharing of information between agencies.

A key challenge has been the breaking down of professional barriers across housing, health, social services and other relevant agencies.

Central government in England and Scotland have taken a strong lead in steering inter-agency working on health and homelessness. For England, the Office of the Deputy Prime Minister (ODPM) (2004) has produced guidance on what Government departments for health and housing would like to see local agencies doing, although the guidelines are not mandatory. Central Government's overall aims for England are:

- > Improvements in the health of homeless people
- > Reductions in homelessness caused by poor health
- > Reductions in poor health caused by homelessness
- > Reduced public expenditure on health and homelessness
- > Reduced repeat homelessness and increased tenancy sustainability through relevant support.

The strategy to achieve this involves the development of shared local outcomes between housing and health agencies, including the agreement of a key performance measure for each outcome and monitoring arrangements. Potential partners in inter-agency working include local authorities, Primary Care Trusts, Drug Action Teams, Mental Health Teams, and the voluntary sector. Health inequalities were made a key priority for the NHS in the Priorities and Planning Framework (PPF) for 2003-2006 and homeless people identified as a vulnerable group. The target is to reduce the gap in inequalities in health outcomes by 10% by 2010 (ODPM, 2004, p. 6).

The ODPM guidance (2004, p. 3) suggests 5 positive outcomes which can be achieved through partnership working:

1. improving health care for homeless families in temporary accommodation
2. *improving access to primary health care for homeless people*
3. improving substance misuse treatment for homeless people
4. improving mental health treatment for homeless people
5. preventing homelessness through appropriate, targeted health support.

ODPM (2004) then provides detailed guidance on these five desired outcomes, for example (p. 10):

Objective 2: *Improving access to primary health care for homeless people.*

Examples of action:

- > Reshaping GP services, providing outreach services
- > Providing information packs to agencies on how/where homeless people can register with doctors / for services
- > Implementing a hospital discharge policy to ensure a patient has accommodation on discharge

Possible performance indicators:

- > Number of GPs PCT providing enhanced services for homeless people, registering homeless people, or providing outreach services
- > Number of Accident and Emergency attendances by homeless people
- > Number of people discharged from Accident and Emergency with no known address.

The Scottish Executive (2005) has published Health and Homelessness Standards for Scotland which Health Boards are obliged to implement from April 2005. Prior to developing the Health and Homelessness Standards, initial guidance was issued to Health Boards in 2001 and they were required to prepare Health and Homelessness Action Plans for their areas in collaboration with partner local authorities. Action plans are based on a profile of homeless people and an assessment of local need and accessibility of services. They include implementation plans for improving services to meet the needs of homeless people. The new Standards are fully endorsed by Scottish Ministers for Communities, Health and Social Care, and Social Justice. They 'require NHS Boards to restate and further refine their commitment to meeting the health needs of homeless people' (Scottish Executive, 2005). The Scottish Health and Homelessness Standards were produced through an 'inclusive' process involving a multi-agency steering group which included the Scottish Council for Single Homeless.

The steering group previously undertook visits to NHS Boards in Scotland during the development of Health and Homelessness Action Plans. The steering group also worked with the Homeless Monitoring Group and local agencies/civil servants, and the proposed standards were piloted in two areas in Scotland, prior to full implementation.

The Scottish Executive (2005) recognised the importance of commitment at a senior level in NHS Boards; the importance of resource allocation; the need for multi-agency groups at the local level; and the need for effective engagement with homeless people. The value of specialist services for homeless people was recognised but they must not be the only option. Health and Homelessness has featured in NHS Scotland's Performance Assessment Framework since 2001. From 2005, meeting the Health and Homelessness Standards is expected to form the Performance Assessment Framework indicator.

The standards are strategic, aimed at the corporate level of NHS boards, in recognition of the importance of leadership in inter-agency working. However, delivery will be mainly through Community Health Partnerships at the meso/micro levels and the standards will apply to all groups of homeless people. There are six standards, each with six to nine associated performance requirements. All standards are listed below, and the associated performance requirements are given for the example of partnership working.

Scottish Executive (2005, pp. 18-24) Health and Homelessness Standards

1. The Board's governance systems provide a framework in which improved health outcomes for homeless people are planned, delivered and sustained.
2. The Board takes an active role, in partnership with relevant agencies to prevent and alleviate homelessness
Objective: to demonstrate that NHS Boards are working with, and learning from, those agencies that also have important roles in the lives of homeless people.
Performance Requirements
 - > The Board plays a leading role in a partnership group comprising voluntary and statutory sector partners, focused around Community Health Partnerships, which drives the Board's activities in relation to health and homelessness.
 - > The Board supports partnership working by ensuring that such an approach is appropriately resourced.
 - > Service users are a key partner in the Board's health and homelessness activities, and more widely are fully involved and consulted.
 - > The Board supports partner organisations in the voluntary, statutory and private sectors to improve the health of homeless people.
 - > The Board's partnership activity ensures that the Health and Homelessness Action Plan and Homelessness Strategies are complementary, reflecting common issues and aims, and reflecting Community Health Partnerships' local service plans.
 - > The Board is effectively engaged in the implementation and delivery of the Local Authority(ies) Homelessness Strategy(ies).
 - > Where a Board covers more than one Local Authority, activities relate to all Local Authorities in the area. In addition, where a Board shares Local Authorities with other NHS Boards there is evidence of joined up working to meet the needs of homeless people.
3. The Board demonstrates an understanding of the profile and health needs of homeless people across the area.
4. The Board takes action to ensure homeless people have equitable access to the full range of health services.
5. The Board's services respond positively to the health needs of homeless people.
6. The Board is effectively implementing the Health and Homelessness Action Plan.

The Glasgow Homelessness Partnership is an interesting example of inter-agency working in a city with a history of relatively poor health indicators, severe homelessness and a legacy of large scale, poor quality hostel provision. The partnership is founded on multi-agency working across housing, health and social work services and joint delivery by statutory and voluntary sectors. The partnership agencies are:

1. Glasgow City Council Homelessness Services (located within the Social Work department as the authority has transferred all of its previous housing stock to alternative registered social landlords).
2. Greater Glasgow Health Board
3. Glasgow Homeless Network, the city-wide umbrella agency for voluntary sector homelessness agencies.

This tripartite structure, involving statutory health services and the voluntary sector forum on an equal basis with the local authority, may be unique in the UK. The lack of a major housing provider in a partnership to relieve homelessness may also be a unique characteristic, and one which emphasises the need for joint working with agencies external to the core partnership. The partnership agencies need to work together to deliver the City's homelessness strategy, and to work with local housing providers to secure long term accommodation for clients of the homelessness service. This is likely to be particularly challenging as previous studies (e.g. Kennedy, Lynch and Goodlad, 2001) have found that registered social landlords have been more reluctant partnership agencies than voluntary sector homelessness service providers. The involvement of the statutory health board should give considerable leverage in terms of assisting homeless people to access health care services and in promoting public health strategies to combat homelessness in the city.

The partnership is engaged in strategic, organisational and operational activities across the spectrum of homelessness prevention and alleviation and resettlement of homeless people (Glasgow Homelessness Partnership, 2003). The Partnership receives funding from the Scottish Executive and is due to undergo independent evaluation of various dimensions of its services and the partnership overall. Such an evaluation could provide valuable evidence on the effectiveness of inter-agency working on homelessness in the UK.

2 Collaborative projects in the Netherlands

Since the early 1990s an increasing number of assertive outreach projects have arisen in the Netherlands involving collaborative working between different sectors, agencies and governmental authorities. The mapping exercise referred to above (Bransen et al, 2002) evaluated instances of operational-level collaboration in 179 projects.

Rather less than half (42%) of all projects had socially vulnerable people in general as their target group; 58% had specific target groups. The three most prominent vulnerable groups were homeless people, people with mental illness and people with substance dependency. The average duration of the projects was four years and seven months (estimated as of May 2002). Higher numbers of start-up projects were seen after 1996, the year in which the most projects were launched (37 projects, or 21% of the total).

Many organisations and agencies took part in these 'public mental health projects'. The parties most likely to participate were mental health services, addiction services, community health services, the police and justice system and the local government authorities. Those most frequently represented at the management level were the mental health sector (in 91% of the projects), followed by the community health services and addiction services (both in 79%), the police and justice authorities (78%) and the local authority (73%). Other common participants were housing associations and homeless services (both 70%) and generic social work agencies (61%). Official collaboration agreements had been signed in 127 projects (71% of the total).

The average number of funding sources was about two per project. In about three quarters of the projects, a single funding source covered 75% or more of the project costs. The ratio of structural to temporary funding sources was approximately equal over the projects as a whole. Of the projects with temporary funding (57%), slightly more than half (53%) indicated that the survival of the project would be at stake if the temporary funding were to be halted.

The average number of paid operational staff per project was 7, translating to slightly less than 3 full-time equivalents. Most project staff members were employed by the mental health sector (working in 62% of the projects), followed by the community health services (in 45%), addiction services (in 45%) and homeless services (in 41%). Only a small minority of the projects (n = 23) employed volunteers; these projects averaged 7 to 8 volunteers.

Accomplishments most frequently cited by the contact persons in the projects were 'a greater degree of contact with socially vulnerable people', 'smoother coordination of the services' and 'a better understanding of the care needs of socially vulnerable people'. Fewer accomplishments were reported that would suggest more visible improvements for the socially vulnerable people themselves and their surroundings, such as 'reduction of nuisance and conflicts with neighbours' and 'fewer evictions'.

The major obstacles experienced in running the projects were:

1. capacity problems in facilities
2. certain clients that were effectively ostracised and were no longer welcome anywhere
3. inclusion and exclusion criteria applying to services dependent upon target group
4. inadequate and/or overly constraining legislation and regulations
5. excessive staff workloads

Strengths of the partnerships, as seen by the respondents, lay first of all in features relating to organisational qualities (cited in 88% of the projects). More specifically, they reported that the right partners had been brought together into a transparent decision-making and operating structure with short lines of communication among staff members and between them and management. Ranking second were features relating to the conditions under which the work was carried out (67%), in particular the widespread perception within institutions and agencies involved with the target group that collaboration was necessary, and the presence of sufficient social and political support for the project in its region. A third strength (49%) was the staff enthusiasm. Finally, features were cited that related to the content of the available services. Interestingly, only 8% of the respondents mentioned the formalised status of partnerships as a strength of their project.

The most frequently reported challenges involved service content (cited in 83% of the projects), and specifically the need to develop a more effective, preventative range of services and to improve working methodologies through measures like staff development and professionalisation. Organisational improvements ranked second (70%), in particular a broader, more efficient inter-agency collaboration and the resolution of snags at the interfaces between different services. A third challenge involved the operating conditions of the projects (46%), especially the need for more secure, preferably structural, mechanisms for funding the partnerships.

Research has repeatedly shown that collaboration at the operational level is usually not all that intensive, and that practitioners still collaborate the most with colleagues from within their own sectors (Bransen et al, 2001; Hulsbosch et al, 2004; Wolf et al, 2003). They also rate the collaboration with those colleagues the most positively. This can be illustrated by data from the study cited above which questioned 365 practitioners from various sectors in seven Dutch cities (Bransen et al, 2001; see table 1).

The ratings given by practitioners to inter-agency collaboration with other sectors were generally not very high. The highest-scoring sectors were police and community health services, followed by homeless services. The lowest overall ratings went to the local benefits offices and other local authority services, an average score of 6. Another interesting result was the rather low level of mutual affection between mental health care services and addiction services. They rated each other at 5.7.

	MO	GGZ	VZ	GGD	Total
Police	7.0*	6.8*	6.5*	7.7*	6.8
Community health services (GGD)	6.7*	6.2*	6.8*	(7.1)	6.6
Homeless services (MO)	(6.9)	6.1	6.5*	6.6*	6.5
Addiction services (VZ)	6.5	5.7	(7.3)	5.8	6.5
Mental health care services (GGZ)	6.1	(6.6)	5.7	5.9	6.1
Social work services	6.4	5.9	5.9	5.9	6.1
Benefits offices and other local authority services	6.1	5.7	6.0	6.3	6.0
	scale: 1 = extremely poor; 10 = extremely good *: best-scoring collaborative partners per sector				

(N = 365; Bransen et al, 2001)

LOCAL AND REGIONAL EFFORTS

To improve service provision to socially vulnerable people authorities and agencies in the Netherlands, especially in the larger towns and cities, are making steady progress in creating continuums of services, often in separate frameworks for different target groups. Examples are service continuums to respond to domestic violence; integrated services for long-term drug-dependent, often homeless individuals with long criminal records; or through-care programmes for homeless street youth. A wide diversity of actors are involved in developing such continuums, in accordance with the target group. These may include the local authority (and sometimes the provincial authorities), the mental health care sector, addiction services, community health services, law enforcement authorities, housing associations, homeless services, youth welfare services, child protection agencies, probation and aftercare services, and generic social work agencies. This can make considerable time demands on the managements of organisations, especially because their organisations quite often serve different target groups, and will hence be involved in more than one continuum.

Quite a few central local authorities have since set up steering committees for public mental health services.¹ (The national authorities began pushing for the creation of local collaborative structures back in 1997; the next section reports on national-level government policy in more detail.) The local steering committees are charged with monitoring all policy and practice in their own region as it pertains to vulnerable people or groups, and with developing proposals to improve service provision and inter-agency working. Cooperation in many steering committees is based on formal voluntary agreements.

Similar tendencies are seen in the central local authorities when it comes to the actual provision of services to vulnerable people. Often in cooperation with the steering committee, joint efforts are undertaken to develop 'front offices' and 'back offices'. The front office serves mainly as a safety net and advice team - responding to the first signs of nuisance or crisis, making an initial intervention and guiding clients to mainstream services. The back office consists of the mainstream services themselves, which must then be required to take on the clients and prioritise them for services. One tendency in some localities is to create a single entry point for homeless services. Such an entity sizes up the individual's situation and determines which services are most appropriate. Many different organisations may be involved in the single entry point, particularly those specialised in homeless services.

Overall coordination is officially in the hands of the local authority, but public officials do not usually find the operations easy to manage (see Wolf, 2004):

- > To adequately carry out their tasks, local authorities need to establish working relationships with many local or regional institutions and agencies. Yet they have no authority over major institutions such as mental health or probation services, whose funding derives from other sources. In such sectors, a local authority can do little more than convene the various parties and try to secure their cooperation by promoting a vision and using other persuasive powers.
- > The local authorities are faced with a highly fragmented field of organisations, some offering more or less identical services and even competing with one another. Some organisations are very small and barely viable, while others hold virtually unassailable monopoly positions by the sheer virtue of their size. Competition between local services has become fiercer since the shifts in funding and responsibilities (see National-Level Efforts below).
- > Local authorities often do not have the information about the size and composition of various vulnerable groups, including the homeless, that they need in order to develop policy. They often have to rely on information supplied by the organisations themselves.

¹ A 1999 poll showed that the majority of the central local authorities (60%) had not yet made agreements and collaborative arrangements to operationalise their responsibilities for public mental health services in their region (Mulder and Smeets, 2001). That was only two years after the national government policy was put in place (see National-Level Efforts). No tally has since been made, but the current percentage will certainly be lower.

NATIONAL-LEVEL EFFORTS

Since 1997, the Dutch government has pursued explicit policies to strengthen public mental health work. It also appointed a two-year National Platform on Public Mental Health Services. The participating organisations were the Ministry of Health, Welfare and Sport (VWS), the Association of Netherlands Municipalities (VNG), the professional trade organisation for mental health and addiction services (GGZ Nederland), the Netherlands Association for Community Health Services (GGD Nederland), the Dutch Association of Health Insurers (Zorgverzekeraars Nederland) and the Dutch Federation of Shelters (Federatie Opvang). In October 1999 they signed the nationwide Policy Implementation Agreement on Public Mental Health Services.² The aim of both the platform and the agreement was to support the development and implementation of a basic range of public mental health services at local and regional levels, in part by encouraging stakeholders to conclude local public mental health agreements. An evaluation carried out by the national platform in 2002, however, revealed that local agencies were still making little structural use of one another's resources and instruments, and were expressing needs for more guidance and incentives in implementing government policy on public mental health services (KPMG, 2002). When the national platform was dissolved in September 2002, one of its parting recommendations was to create a research and information resource focusing on public mental health services.³

The public mental health services acquired a legal basis in 2003 with the adoption of the Public Health (Preventive Measures) Act (WCPV). This legal framework helped to strengthen the cohesion between national and local health policies. Now, two years later, the central government is to incorporate public mental health services into the Social Support Act (WMO), a law most likely to take effect on 1 July 2006. Its aim is to promote the development of a cohesive range of locally embedded services to support people with functional limitations. The immediate reason for incorporating the public mental health services into the WMO is the transfer of the monetary resources for such publicly funded activities from the mental health care agencies to the local authorities. The purpose of that transfer is to tighten local government control over mental health care, thereby strengthening its coordinating role. Many local officials and service providers fear that the new system will result in a further neglect of vulnerable people, especially those with serious mental problems.

The tasks of public mental health work are defined in the WMO as identifying and addressing risk factors that affect public mental health, reaching and supporting vulnerable individuals and risk groups, serving as a safety net and advice centre to detect signs of current or threatening crisis in vulnerable individuals and risk groups, and reaching agreements between stakeholder organisations for the implementation and delivery of public mental health services. The collective prevention of serious psychosocial problems is also included.⁴

Homeless services, women's refuge services and addiction policy will also be incorporated into the WMO. A key national-level factor that should benefit the homeless and women's services is the cooperation initiated between various government departments in an interdepartmental working party.⁵ It meets twice a year to monitor progress on the policy measures relating to these two sectors and to decide whether modifications are needed. Included in the working party are representatives of the health, interior, justice, housing and social affairs ministries. Among the other participants are the umbrella organisations for the Dutch homeless services (Federatie Opvang) and housing associations (Aedes), the Association of Netherlands Municipalities (VNG), the National Association of Homeless People (LVT) and the Salvation Army.

2 *Convenant tot uitvoering van het beleid inzake Openbare Geestelijke Gezondheidszorg. This formal voluntary agreement specifies conditions that must be fulfilled in terms of basic provisions before the public mental health services in a particular locality or region qualify as adequate.*

3 *Letter of 5 September 2002 from the platform chair Veldhuijzen to the Dutch health ministry.*

4 *Under the WMO, psychosocial intervention after disasters will no longer be classified as public mental health work as they were under the WCPV.*

5 *The working party was set up after the publication in 2003 of an interdepartmental policy study (IBO) on homeless services and women's refuge services, which investigated the state of affairs in those two sectors (IBO MO, 2003-2004).*

One aim of interdepartmental policy is to curb nuisance and social decay (see the introduction of this paper). The policy document entitled *Action Plan against Public Disorder and Nuisance* explicitly discusses the vagaries of cooperating in service provision to vulnerable people. It argues that the cooperation is not sufficiently binding. 'Some causes of this are the fragmentation of services and funding streams, the real or presumed constraints imposed by privacy legislation, the varying definitions and information regimes, problems with capacity (sanctions/care), not firmly arranged client transfers and poor continuum management and coordination' (p. 4). It also raises the question of whether agencies might be hiding behind these arguments too much.

The health ministry's action plan argues for a person-centred approach, in which the central local authorities run the best possible continuum of care and service provision for vulnerable people in their region. For the first time in this context, it argues that the transfer of mental health care funding to the local authorities is a necessary measure to bolster their coordinating role (see above). The government is also proposing steps to ensure the safe exchange of client data, in order to keep client privacy from being used as an excuse for poor cooperation. More concretely, the health ministry is supporting the development and implementation of a checklist for 'managing personal data in an assertive outreach context'. The checklist will specify the client group and the purpose of the data sharing. It is a joint product of GGZ Nederland, the Netherlands Association for Community Health Services (GGD Nederland) and the Royal Dutch Medical Association (KNMG).

In the study cited above (Bransen et al, 2003), a large majority of the social vulnerable people (71%; based on n = 154) reported that services take their privacy sufficiently into account. A substantial number felt that the communication between workers and agencies needs improvement, and that they should pass on information to one another. Some suggestions were:

'Pass everything on! Take notes! Read the notes.'

'Workers and agencies should share client files at an earlier stage.'

'They should all be hooked up together through computers.'

'Workers and agencies should work together and also check up on each other, not just on their clients.'

'There should be a central registration point where they know everything about me - subject to certain rules, of course.'

3 Austria

The different strains of social welfare are divided into different bodies with very special frameworks, standards and models of operation. These different service lines are very hermetic and there are only very weak links and intersectional interactions between them. Monetary dominance at the one hand, segmentation and fragmentation on the other hand are constitutive characteristics of the Austrian welfare regime. The outputs of the different systems of services are not systematically linked and / or adjusted to each other. Communication and cooperation between services of different spheres (in relation to target groups or working methods) occur only exceptionally. There are just a few models of interactive frameworks but there are no general structures and provisions to provide cooperation.

Services for the homeless in Austria are mostly provided by NGO's working in a restricted regional or local area of activity. There are only a few services provided by municipal authorities (e.g. therapeutic residual homes and asylums in Vienna, residual home for homeless men in the city of Graz, asylum in Innsbruck). Except for these municipal services the situation of services for the homeless in Austria can be described in relation to two main characteristics. First, they are provided by large welfare bodies, most of them are organised in separated associations at a regional level but connected with a federal umbrella organisation. These services do not have autonomy to cooperate with services for homeless persons in the same regional or local context. Secondly, in most Austrian cities there are single associations which are specialized to provide services for homeless persons and families, more or less strictly focused on activities in the communal / regional area (e.g. Innsbruck, Bregenz, Salzburg, Linz). These private associations at local level have developed a whole range of different services, specialized according to different issues and / or target groups (e.g. homeless men, women) and / or according to different methods (e.g. residual homes, supported housing, prevention of eviction).

Furthermore, service provisions for the homeless in Austria are in a way a reflection of the general system of the welfare regime and the general characteristics of segmentation and fragmentation. For example, the Volkshilfe in Vienna is a very important provider of services for homeless persons - in Vienna but regional members of the Volkshilfe in other cities/regions (Salzburg, Styria, Tyrol) do not provide any services for the homeless. Many service providers therefore have chosen a strategy of diversification so in effect their services will cover a wide range of different needs. As a result of these developments some service providers have created networks of different services on their own. Finally these providers can cope with some of the deficits according to structural provisions for inter-sectoral coordination and for cooperation at an inter-agency level.

Additionally, it is necessary to focus on the fact that in some counties and regions of Austria services for the homeless are handicapped by poor resources and standards. Services in some cities / counties (particularly in Graz / Styria, Klagenfurt / Carinthia) lack the resources to realize adequate standards of housing and / or individual support. Under these conditions it is almost impossible to realize cooperation with other service providers (e.g. from parts of the social system which are traditionally at a higher level of resources and standards). In counties and regions with structural deficits in provisions for the homeless, inter-sectional cooperation can be found only in the range of informal networking on issues of lobbying.

Cooperation in relation to social casework is the most common method of cooperation - also in inter-agency affairs dealing with inter-sectional issues. Mostly these experiences of inter-agency cooperation are founded only at an informal and very personal level and even at the level of social casework between the most important services there are no provisions and / or structures for coordination. To date there are no models and provisions how to develop new ways of cooperation between different sectors of the social system - i.e. approaches such as an integrative social planning process, a planned form of inter-sectional development of resources and standards of integration and intersectional treatment and support are simply missing.

Looking at the extent of communication and cooperation between different parts of the social, health and housing systems it is possible to distinguish large differences between counties and cities, for example:

- > networking of services for homeless persons and families at the level of different services provided by the same organisational body is the most common form of cooperation which can be observed in Austria;
- > networking of services from different parts of the social, health and housing system at the level of single service providers (e.g. between supported housing services and health services, between psychiatric services and residential homes for homeless persons);
- > cooperation between services for homeless persons and families between different service providers (lobbying, developing standards etc.);
- > communication and cooperation between different service providers from different parts of the service systems at the level of case work (including case conferences);
- > cooperation between service providers from different parts of the service systems on issues like social welfare and housing at the level of counties and / or cities;
- > networking and cooperation between large service providers at a federal level (e.g. in relation to standards and working conditions in the social professions);
- > cooperation and lobbying between NGO's from a whole range of social, health and labour market issues at federal level such as the 'anti poverty network' and the BAWO homelessness network.

The following section illustrates some of this diversity between the counties by reference to examples of inter-agency cooperation and networking.

VIENNA

In Vienna services for homeless persons and families are thoroughly connected into a staircase system of provisions, starting with low threshold services and prevention of eviction at the first level; the second level consists of a broad range of specialized services, mainly focused on supported housing; and at the third and last level the clients of the services for the homeless will be allocated affordable accommodation from the communal housing stock. This diversification of services is the result of a planning process, started about ten years ago, which finally succeeded in a paradigmatic change of the former very general approach. Instead of large (total) institutions and asylums without resources for individual support and / or professional social work, now there is a network of small facilities with a focus on individual support and specialized provision. Cooperation is mainly realized at the level of case work and, to a lesser extent, in relation to the areas of access to services and / or detachment into follow up services.

Supported housing in Vienna is based on a public / private partnership. Since the project started, about ten years ago, it has been possible to build up an increasing number of housing places, provided by a consortium of different service providers. Under the aegis of the welfare administration of the city of Vienna, the service providers defined standards and implemented a common system of documentation. During the period of development and implementation of supported housing in single flats, the municipality of Vienna charged the Austrian umbrella organisation of services for the homeless, BAWO, to build up a documentation scheme and to evaluate the effects of this service line.

Meanwhile the municipal services for the homeless were placed into a special organisation, still within the administration of the city but with some degree of autonomy. This newly created administrative body, 'Fonds Soziales Wien' (social funds of Vienna), encompasses services from a broad range including social and health services. Therefore, there are changes in the whole structure which make it necessary to establish new models and strategies of communication and cooperation between different branches of the system of social services. Until recently the reorganisation of public services has led to insecurity in relation to cooperation and partnership. At least it can be observed that services such as supported housing have to work out and to establish their base for cooperation with administrative bodies of psychiatric outreach services and other related services. A member of the workshop on inter-agency cooperation put the new situation as follows:

"In the case of networking and cooperation - we have been better off before the reorganisation."

Several years ago the providers of services for homeless persons and families came together to develop a common lobbying campaign to close a gap in the fight against homelessness. As a result, the city of Vienna commissioned a service provider (FAWOS) to build up a new service scheme to prevent evictions. This service can build on a cooperation schema / contract in two ways:

- > the Justice department is obliged to inform the prevention service in advance of eviction procedures;
- > the office of social welfare in Vienna has to provide the money, as far as it is possible, to retain the tenancy contract if the rent arrears are paid;
- > the municipal office of social benefits has commissioned FAWOS to administrate the funding of rent arrears under the access scheme of social benefits.

INNSBRUCK / TYROL

Social services in Innsbruck / Tyrol are handicapped by the fact that some service branches are dominated by large service providers. Besides, services for homeless persons are provided by small associations. So the homeless services depend on cooperation with small parts of the dominant providers which often do not have the autonomy to realize reliable contracts of communication and / or cooperation on their own behalf.

Networking and cooperation even at the level of case work is in a way complicated by the main players of the organisational context. Networking and cooperation at the level of more general aspects of service provision is almost impossible. It does not become easier if one considers the further fact that some of the services for homeless persons operate on quite a low standard of provision. Especially between services from different branches, such as health services on the one hand and services for the homeless on the other, reliable communication and cooperation is often impossible due to this unequal level of organisation and resources. A lack of general frameworks to develop comparable standards of services and / or to establish reliable inter-agency structures of communication and cooperation hinder the implementation of formal agreements between services from different branches and / or providers.

SALZBURG

Services for the homeless in the city of Salzburg are mainly provided by one agency (SAG). Probably this is the reason why this service provider has engaged in the development of an interfacial service - the integrative counselling of homeless persons.

In this context where there is a sole provider of services for homeless people, the organisation has built up an integrative structure related to the fact that services for the homeless have to deal with different needs involving (inter alia) social benefits, the provision of accommodation, individual support and access to the labour market. In effect the integrative counsel office in Salzburg provides a systematic clearing-house for their clients to assess their needs, opportunities and, last but not least, legal claims on benefits from the different lines of social welfare (e.g. social benefits, housing subsidies). Together with the clients the counsellor will establish contacts with the competent bodies and offices and will encourage and assist them to realize their claims. In this way the counselling office can establish an interface (or one-stop-shop) between the different services provided by the SAG agency itself as well as between the different social, housing and health bodies.

In order to realize the challenge to provide homeless people with multiple needs with support from different parts of the welfare system in the purview of the counselling office of the SAG, an inter-agency team of social workers was implemented. Employees from different services are now working together to provide the mix of services required by people with multiple needs. In this inter-agency team services like psychiatric outreach, probation office, service for ex-convicts and unemployment services are working together on a regular but informal basis. So, in effect, the cooperation between the different services depends on the individual engagement of the social workers and is burdened by structural deficits.

VORALBERG

Vorarlberg is a small county with only a few professional services for homeless people. These services work closely together and have built up a common platform to develop standards and to cooperate on issues of social planning and political lobbying. Recently they have commissioned a study on the feasibility of a professional service to prevent evictions in a mainly rural county⁶. In the course of this study the authors analyzed the state of communication and cooperation between the public bodies of social benefit and youth welfare, on the one hand, and private housing agencies and non-profit service providers from different parts of the welfare system on the other hand. The main findings of this study are typical for the whole of Austria:

All public and private bodies participating in the study declared that there is a need for procedures for communication and cooperation between the different parts of the welfare system as well as the housing system. The common findings for all respondents indicate that:

- > communication and cooperation between the different systems are poor and focused on informal and individual engagement of some social workers but not based upon reliable structures and frameworks;
- > it is necessary to improve the cooperation at the levels of casework;
- > agencies are willing to improve cooperation and to acknowledge their role in a new partnership between different services;
- > it will be necessary for prevention of eviction to be based on a formal partnership structure and agreed procedures.

UPPER AUSTRIA

In the last few years the government of the county of Upper Austria has started a social planning process in order to amend the law on social benefits and to develop new administrative frameworks for the social services. The social services were invited to take part in a working group and to participate in this process. When the law of social benefits and services was amended this working group started a new process: to discuss standards of services and to develop measures of quality management and instruments for social planning. A few years later the participants of this cooperative process have criticised the fact that important players in the welfare system were not integrated (e.g. the agency of labour market policy and administration).

Furthermore the social planning process was focused on very pragmatic aspects like a normative description of services as 'products'. This was meant to ensure that the clients of social services should be able to choose the services they need for themselves. At the same time important questions concerning frameworks for communication and cooperation between services from different parts of the welfare system were neglected. The experience of cooperative social planning therefore did not result in frameworks for communication and cooperation but in instruments to control the services by the social planning board which is now established.

These examples demonstrate that, in the counties of Austria, there are different models and more or less formal structures implemented to realize intersectional communication and cooperation. These provisions for intersectional cooperation have in common that they have difficulty dealing with inadequate structures and resources. To a large extent, these models are focused on informal agreements depending often on personal relationships instead of institutional cooperation schemes. So we can observe that inter-agency working often involves an informal division of labour at the level of case work (e.g. exchange of information, referring a client to another service). There are only limited examples of formal agreements on division of labour between some service providers involving:

- > adjustment of provisions according to the demands in handling the needs of common clients;
- > mutual delegation of specific additional services;
- > definition of mutual competencies in cooperative case work;
- > provision of intersectional teams.

Hence it can be concluded that in Austria, despite the limited examples given above, there is an effective absence of real cooperative structures of provision and services for homeless people and families.

6 Ströhle / Meier, 2004

4 Inter-agency initiatives and partnership working in Portugal

The background, against which inter-agency working and partnership initiatives have emerged in Portugal, particularly the fact that most of them are not directly linked to the homeless sector, is strongly affected by the lack of any national policy to support homeless people at the strategic level in Portugal. In practice, most collaborative working in the social field has mainly been dependent on individual and informal links and very rarely on more structured forms of partnership demanding the active involvement of the partners. Although not specifically in the homelessness sector, a number of initiatives, developed and enhanced in recent years, have encouraged and strengthened the emergence of partnerships structures.

PARTNERSHIP WORKING

The EQUAL initiative, for example, has had a clear impact on the ways of working in the social field. Most of these projects have targeted areas linked to the reinforcement of professional or training opportunities either for disadvantaged groups or for disadvantaged territories. Very few of them have targeted specific populations such as prisoners, immigrants and refugees and only one specifically targeted - among other groups - the homeless population. The programme requires the involvement of agencies in the so-called Development Partnership. In practice, however, most collaborative working in this area has mainly been dependent on individual and informal links and very rarely on more structured forms of partnership demanding the active involvement of the partners.

The second initiative involves the establishment of the Local Social Networks. Created in 1997 through governmental initiative and now expanded throughout the whole country, these networks are now no longer dependent upon social security funding but rather are promoted by municipalities. They aim to bring about a significant impact on the role of municipalities in the definition and implementation of social policies. In fact, municipalities have been playing a growing role in the implementation of social policies and in the relationship with the State and with Social Solidarity (civil society) NGO's. The Social Networks, which are still being implemented, are a range of different forms of mutual support and of private non-profit making and public sector agencies working in the field of social action which co-ordinate their activities, among themselves and with the Government, with

a view to the eradication or attenuation of poverty and social exclusion and promoting social development. The dynamics of such networks, although differing from territory to territory, is clearly gaining a growing recognition and relevance both at a local and at a central level. These networks have been responsible for setting up a local participative diagnosis of the major problems, challenges and potentialities of their respective territories and for defining a Social Development Plan with established goals and targets. Partnership work is the basis of these local structures and significant improvement may be witnessed in several territories.

A third initiative, also established by governmental initiative in the beginning of 2005, is the PROGRIDE Programme. This Programme for Inclusion and Development follows the already defunct national Projects to Fight against Poverty (PLCP). PROGRIDE's goals are to promote social inclusion in marginalised and degraded areas, to combat isolation and exclusion in depressed areas, and to work with people facing persistent exclusion, marginalisation and poverty. It is operationalised through the provision of support to local projects⁷ in defined priority territories. One of the main criteria for eligibility is that the projects presented are developed by local partnerships. Most of the forty projects that have been approved, so far, have been promoted by local municipalities.

One of the interesting features regarding these three examples is the fact that the impetus for inter-agency working was either at a national or European level. On the other hand, the link between funding and the need to co-operate is also obvious in the three cases. Access to funds has been dependent, in all three situations, on engaging in partnership working. However this top down approach has in some cases, especially in the case of the Local Social Networks, served to strengthen already existing local dynamics, or even initiate others, which has had a clear positive effect on the consolidation of partnership working in the field of social policy. The availability of specific funding has of course played a major role in the whole process.

7 Eligible organisations are: municipalities and private non profit organisations working in the field of social solidarity, namely IPSS, "misericórdias", NGO's and social solidarity co-operatives.

Finally, in the area of domestic violence there is one relevant initiative, which can be considered in this category although it is still in its early development. The first Local Forum against Domestic Violence started two years ago in Portugal in an attempt to overcome the lack of co-operation between the several institutions working with women and children experiencing domestic violence. The Forum has managed to actively involve several local organisations and sectors (including justice, health, social services, police forces and NGO's) and has developed new responses (e.g. local counselling centre, a training programme, sensitisation campaigns) at the local level. At the same time, it has become more visible at the national level and has managed to influence the work that is being developed by the central entity responsible for implementing the National Plan Against Domestic Violence. The experience of the Cascais Municipal Forum against Domestic Violence is a good example of a bottom-up approach regarding a specific group of clients, that directly benefited from the previous accumulated local experience in partnership working, namely through the Local Social Network, that has enhanced inter-agency working at the local level. The municipality has been the main financial supporter of the work of the Forum, although all the services have contributed with the work of their professionals who have been increasingly involved in the different activities developed by the working groups established within the Forum.

As far as homelessness agencies are concerned it must be stressed that their involvement in any of these initiatives has been extremely scarce if not totally absent. The fact that those organisations have not been involved may be explained by several factors. One of them is clearly the fact that the development of services targeting the homeless population is funded directly by the Ministry of Labour and Social Solidarity through the establishment of protocols. These protocols define the financing structures on the basis of the number of users of each institution. The proposals are analysed by the staff at the regional level and they do not depend on the level of collaborative or partnership work developed by the institution. Many institutions in this area continue to work in a very isolated way, although most of them have informal contacts with other organisations whenever they consider necessary.

It should be stressed that the fact that many Local Social Networks, together with many of the new PROGRIDE initiatives, are now promoted by local municipalities which have been acquiring increasing responsibility for the provision of social housing, rehabilitation and re-housing in their own territories. This may enhance, and in some cases it already has, more co-ordinated responses in the field of eviction prevention which is being developed between different sectors (namely housing and social services). Nevertheless, the issue of linking the existing homeless services to these networks is far from being accomplished. Emergency responses to homelessness, as well as the lack of resettlement alternatives, continues to prevail.

CONTINUUM WORKING

One common form of co-operation at the operational level among homeless agencies is the so-called "encaminhamento" (translated as referral). Most institutions provide this type of service to their clients in order to be able to respond to their needs. However, very often this process does not necessarily mean that those needs are adequately addressed. It just means that the client has been directed to the service that is, theoretically, supposed to be responsible to provide that type of support.

A programme being developed by the Lisbon Municipality regarding "supported housing" may provide a more coherent approach to inter-agency working in this manner. Through this programme there is a close link between the housing services of the municipality and the social services entity in the city of Lisbon (Santa Casa da Misericórdia de Lisboa - SCML). The process for allocating an apartment depends on the information given by the SCML team accompanying the person (or family) receiving support and on the evaluation by the municipal housing team. Where accommodation is provided the social support team of SCML is responsible for the continuation of support (while needed) and to co-operate with their housing colleagues of the municipality who will also have responsibilities regarding the new tenants.

NEW MANAGEMENT STRUCTURES

In this specific area there is no experience one might call a 'one-stop-shop' approach. However, there is one rather innovative experience that may be considered a new management structure which has arisen from the dynamics created by the partnership work developed in the early 1990's, following the implementation of community development projects, and later expanded and consolidated through the Local Social Network programme in a municipality in the north of Portugal (Matosinhos).

This new experience - called Integrated Attendance (AI) - has been created in order to increase the capacity and the efficiency of the work already developed by the local partnership network through the creation and sustainability of a co-ordination platform for all the actions aimed at an integrated approach of the disadvantaged population. The AI has two main objectives: to implement integrated responses and avoid their fragmentation; to optimise resources at the level of attendance to the population and reduce the waiting time between the diagnosis and the solutions to the identified problem(s). This service is targeting the population of the Matosinhos municipality who are in a situation of social disadvantage and who resort to the existing counselling centres in areas such as employment, housing, social support, health and justice among others.

The AI is not translated into any physical structure but rather into a procedural structure, supported by an innovative service organisation through the creation of a technical platform where several different entities are represented. The AI is based on a multidimensional approach which should cut across the whole spectrum of intervention and should be centred on the needs of the persons and families and not on the existing services and on their respective working philosophies. This is expected to have a strong impact on the existing institutional practices which, historically, have been strongly fragmented.

5 Greece: de-institutionalisation and inter-agency working

On the strategic level there is no national policy to support homeless people as such in Greece. In the absence of a strategic plan to combat homelessness, the safety net for those in need consists of a number of relevant policies which have been elaborated and implemented by different central and sometimes local government agencies for specific vulnerable social groups. It must be noted that, apart from a few exceptions, as for example policies for young ex-offenders, the policy-making stage is characterised by very little inter-agency teamwork.

Being typically less bureaucratic, the lower levels of service provision are characterised by increased levels of teamwork. Thus at the organisational and operational levels, cooperation among different bodies usually occurs in the form of specialists' contribution to the various facets of the multidimensional needs of homeless people. The input of counsellors and other experts is often apparent in the planning and, above all the implementation stage of service provision which frequently involves excessive consultation. Naturally, a very common form of collaboration at the operational level is the link that exists between different services in order to provide the suitable solution to the users' specific needs. The outcome of such group effort may merely be in the form of a simple referral to another institution.

Greece is one of the few European Union member states that are currently undergoing what is officially called psychiatric reform. The campaign started nearly two decades ago as a reaction to the conditions in a number of psychiatric hospitals and the obsolescence of the psychiatric care system as a whole (Gionakis, Hondros, 2005). At the time, there had been evidence to believe that an undefined number of people living in psychiatric hospitals were capable of resettlement in the community but had no access to a proper home. Thus, since the mid-1980's and in line with the EEC Regulation 815/84, which funded psychiatric reform in Greece, a number of rehabilitation and community mental health services have been launched in all nine public psychiatric hospitals in the country. The implementation of the individual programmes has been undertaken either by the hospitals themselves or by non-governmental mental health organisations.

The programmes generally combine housing rehabilitation with some form of vocational training. The housing provided is either in short-stay guest-houses or in long-stay residential care hostels, with a longer term view of moving patients on to private-rented supported flats. At the same time there have been special schemes offering vocational training, according to people's capacities, leading on to work placements, either arranged specially with employers in the private sector, or in special projects that are part of the rehabilitation programme. Long-term housing resettlement, at least in theory, amounts to the former patient being able to live - either alone or with others - in private-rented accommodation, the rent of which is covered either by a disability pension or by the earnings or other income of the patient, with the supervision and support of community mental health services, unless he/she can be rehabilitated within their family environment.

The campaign for psychiatric reform has been characterised by a strong urge to develop and sustain peripheral institutions that will act complementary to the aims of the programme and support the patients' resettlement effort. Undoubtedly, this spread of actions among a number of different bodies is a direct reflection of the issue's composite nature. In this respect, inter-agency working is an inherent characteristic of the de-institutionalisation process.

Thus, as early as 1990, an agricultural co-operative has been established on the island of Leros employing a sizeable number of members/patients while, later, patients were moved to supported flats and guest-houses operating on the island. In addition to these, patients attended pre-vocational training programmes in order to improve their skills. This stage of the programme has asked for a certain degree of collaboration of doctors with other specialists and agencies of the voluntary sector.

Since 1997, psychiatric reform has been codified under the continuous programme 'Psychargos' which has undertaken to organise the transition from hospital to community based mental health services. The programme develops in two distinct branches, the first relates to the actions and measures that are needed to de-institutionalise patients from the psychiatric institutions and the second relates to the new structures that must develop in the community in order to cover the needs in the mental health field as these are spread across the country geographically.

The programme and psychiatric reform in general, have been supported by novel legal instruments. Law 2716/99 provided the foundations for the development of psychiatric health services in the country and set the basis for the establishment of peripheral units for psychosocial resettlement, like shelters, boarding houses and protected flats. These units should be both technically and institutionally capable of providing temporary shelter for the multitude of chronic patients who have been staying in psychiatric institutions. Thus, one of the most important objectives of the planned psychiatric reform is to develop mental health services that will aim to prevent, to diagnose, to heal as well as to provide psychosocial resettlement to psychiatric patients.

The implementation of the first phase of 'Psychargos' took place during the period 1997-2001, while the second phase is currently being implemented and will last until the end of 2006. The programme's next phase for the period 2006-2015 will be decided after the completion of the current stage.

During the first phase, the emphasis has been placed on the actual process of de-institutionalisation. Thus as many as 66 new shelters, 14 boarding houses, 10 protected flats and several specialised units have developed across the country to house nearly 1000 former mental patients. At the same time, 35 vocational training units have been established. Thus intervention covers transitory housing, health, development of skills as well as psychosocial support. In this effort, inter-agency working has remained minimal apart from several noted exceptions, as for example the case of Leros.

Most of these actions and measures have been undertaken by the agencies of existing psychiatric hospitals, while the contribution of the voluntary sector and other institutions has remained minimal. Funding has generally tended to follow a similar pattern as expenditure has mainly been drawn from the hospitals' budget.

The evaluation of the initial phase of Psychargos had been commissioned to independent experts (Grove, Henderson, Marturini, 2002). The overall impression of the psychiatric reform procedure has been assessed as very positive. More specifically and in as much as inter-agency working is concerned, the report stresses the significance of the development of a differentiated network of services and mental health structures in the community.

Thus, apart from the continual de-institutionalisation process, the second phase of the programme aims at the improvement of the network of complementary structures and services as well as the establishment of specialised units for target groups whose needs are not attended to satisfactorily by existing structures. These additional units will cater for the needs of people suffering from Alzheimer's disease, autistic disorders, substance abuse and especially alcohol etc.

A most important aspect of the approach adopted at this stage is the reinforcement of the contribution of voluntary organisations based on the need to develop new structures and services that will embrace the community. The voluntary sector has already been involved in the organisation of services of transitional accommodation for psychiatric patients.

Law 2716/99 sets out the framework of their operation on novel grounds based on the need to support resettlement of mental patients in the labour market. The novel instrument is described in article 12 and concerns the establishment of what is termed as 'Social Cooperatives of Limited Responsibility'. These new structures aim to develop the users' vocational capacity on specific skills based on the close cooperation of public and voluntary agencies.

The necessary procedures for the establishment of these cooperatives are currently under way. As it is almost the first time ever in Greece, that inter-agency cooperation is supported by law, it is hoped that the usual bureaucratic obstacles will be overtaken in view of the need to cooperate for a well defined cause.

Being the outcome of a specific department, the Department of Mental Health of the Ministry of Health and Social Securities, the Psychargos programme and the issue of psychiatric reform in general retain the characteristics of a typically introvert campaign even though the users' needs have multifaceted characteristics. The highly centralised character of the Psychargos approach has already left its traces on its users who remain reluctant to receive novel stimuli and develop an energetic perspective to life. After several years of change, they tend to live in the same manner they used to when still in the hospital.

The long and tedious path for the final resettlement of ex-psychiatric patients has to undergo a phase in which users become gradually familiar with the outside world. From what has been analysed so far, it appears that the proposed 'Social Cooperatives of Limited Responsibility', which involve enlarged partnership cooperation, may play exactly this delicate role. The question is whether the contribution of these novel structures in the campaign for resettlement will finally be as supportive for the users as anticipated.

De-institutionalisation complexities are faced not only by mental health patients under the psychiatric reform programme but also by young people leaving care homes as well as prisoners coming out of jail. Unlike the psychiatric reform programme and its organised approach to resettlement described above, the other two vulnerable groups do not benefit from comparable attention. Thus, in the absence of a systematic statutory approach, their specialized needs are either dealt with by fragmented contributions of usually voluntary services or by themselves individually.

Young offenders constitute a specific target group which involves additional difficulties. While in the institution they faced problems such as minimal understanding, self destruction tendencies, high levels of violence, sizeable percentage of immigrant youths, while if they are near twenty they also face the threat to finish their deed in an adult prison. Evidence shows that the majority of these people are homeless when leaving the institute, while as many as two out of three eventually end up returning after being offensive again.

The majority of young ex-offenders lack family support and have particular difficulties in getting a steady job that would allow them to pay for proper rented accommodation. Some people in the above categories may find temporary accommodation in the shelters and hostels, yet not only suitable services are few but there also exists very little provision of long-term accommodation. The only service providers currently addressing the needs of young ex-offenders are Arsis, Perissos Youth Shelter and to an extent Onissimos. Lack of funding however, an issue pertinent to NGO's of the voluntary sector, has kept the output of these bodies minimal and primarily operational despite the rising needs.

The interest in enhancing resettlement opportunities for young people has risen recently, especially in relation to the improvement of the legal framework concerning the youth. Novel legal instruments pertaining to this specific issue have been the outcome of cooperation among specialists who originate from different backgrounds such as educators, criminologists, psychologists, legal advisors etc.

The main problem concerning the legal framework related to the resettlement of young ex-offenders is that the structures that are anticipated to carry out and support its provisions have not yet developed in Greece. Thus, even though local authority agencies are required to support young ex-offenders by offering them a steady job, in practice they are unable to do so. In addition to this, the situation in reformatories is so backward that only very recently NGO's have been allowed to enter the premises in order to offer elementary tutorials to the captives. Thus although skill developing programmes and other training courses to facilitate access to the labour market are provided by law, in practice they are not allowed due to bureaucratic complexities and, above all, the reactionary attitude of the statutory authorities.

As a result, despite the favourable legislation which has been the outcome of multidisciplinary cooperation, the somewhat 350 young detainees in Greece still face a multitude of problems in the reformatory. In addition to these, they are expected to confront severe obstacles in their strife for proper insertion in the labour and housing market.

Conclusions

This review of the development of inter-agency working in relation to homeless services demonstrates a number of important common issues between the countries regarding its emergence, sustainability and effectiveness and also to some important differences.

The first important point to draw out is that inter-agency and partnership working in relation to homelessness services is of relatively recent origin in most of the five countries studied (compared perhaps to other service sectors). It is only in the Netherlands and the UK where inter-agency working is of significance in the planning and implementation of homeless services. The importance of exogenous, top down, drivers is also evident although in some countries (e.g. the Netherlands, the UK) this comes from national government and legislation, while in other countries (e.g. Greece and Portugal) it is driven more directly by EU policies and action. Although there is clear evidence of the effect of these European programmes on national policy and the development of inter-agency methods of working in Portugal, it is less certain in Greece that new approaches and methods of working will survive the European programmes. Austria is distinctive to the extent that, as a federal state, the segmentation and fragmentation of policies and structures, both in the state sector and in the civil society sector, have resulted in specific regional or local initiatives and bottom-up approaches to inter-agency working. Secondly, inter-agency working is more likely to occur where it is a condition of funding. This often occurs in relation to time limited programmes and, unless it is linked to strict guidelines of operational procedures or performance monitoring, the effectiveness is difficult to guarantee or to sustain. Although there may be examples of inter-agency working emerging as a result of endogenous change occurring within organisations, in response either to unmet needs or organisational imperatives, these factors have not been so evident in the homelessness sector to our knowledge.

The presumption in policy is that inter-agency working is a necessary development since homelessness, as a complex problem, requires multi-dimensional responses. Inter-agency and partnership working is also perceived to be a good thing when the prevailing policy approach recognises that service provision should be needs-led and not resource-driven. On this basis one might expect that inter-agency working would emerge in complex multi-dimensional settings that are ori-

ented towards the production of intelligent, adaptive services designed around an ongoing understanding of the customers' needs and resulting in continuing development of the service. This theoretical model implies a notion of inter-agency relationships that is not confined to collaboration between professional interest groups and includes service users as active subjects. However, this form of working (described as co-configuration by Warmington et al, 2004) is not evident from our analysis of inter-agency working among homeless service providers in any of the countries studied.

At one level, it could be argued that the development of homeless services remains at the craft stage in some countries (e.g. Greece), where the provision of (emergency) services is dependent upon professional experience and responses are driven by understandable techniques that are appropriate to the limited available resources. The scope for inter-agency working in such situations can perhaps only be applied to limited situations of referral and co-operation or linking of discrete services. The development of articulated and practical knowledge is required to allow the emergence of more complex forms of partnership working.

There is reference in several countries to the difficulty of inter-agency working between homeless services and other service sectors as a result of the unequal situations in relation to the level of professional staffing and resources. This implies the need to develop best practice models that are open to training and monitoring before inter-agency working can occur (or be effective). The establishment of team systems that promote collaboration across teams and functions hence requires both procedures (based on practical knowledge of the problem) and shared levels of professional understanding. The examples of inter-agency working in the UK show strong evidence of the establishment of good practice guidelines and the establishment of procedures and protocols as a necessary pre-cursor to inter-agency working. In the Netherlands, on the other hand, local pilot collaborative projects have tested and evaluated methods of working. The experience of local social networks in Portugal, however, indicates that the knowledge generated by doing process enhancement work in one sector is not necessarily put into action to transform organisational structures or methods of working in the homeless sector.

It has been argued (Harris, 2003) that the vertical organisational contradictions generated where professionals attempt to develop inter-agency work at operational level, acting within multiple institutional and policy frameworks requires strong leadership and a collective ownership of collaborative working. The evidence in the Netherlands demonstrates the efforts necessary to overcome these contradictions. It also points to the professional inertia or barriers that must be overcome. However, in Austria the vertical fragmentation of services impedes collaboration not only between policy areas but between cognate institutions. This can be seen in two different organisational contexts. First, the example is presented of large national agencies with limited internal vertical integration and where local entities are given limited autonomy, by the parent organisation, to engage in collaborative work. Second, the example is given of counties where single agencies are the dominant or sole service providers and respond by the creation of specialist linked teams.

This paper has attempted to examine the emergence and nature of inter-agency working in the five countries concerned. It has been beyond the scope of the paper to consider in any detail the more evaluative aspects of inter-agency working. For example, does inter-agency or partnership working lead to service innovation and to more effective outcomes for homeless people? What procedures of organisational learning are necessary (or effective) to ensure ongoing service development involving multiple agencies? As homeless agencies grow and diversify and become more involved in inter-agency working what impact may this have on organisational structures and what pressures may it create for organisational merger? These and related questions demand further research.

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