PERSON FIRST - Erasmus Project

SHELTER as Emergency Services & Social Assistance

promoting accessibility - improving e-quality - reinforcing net-working

Survey on services - 2022

Santé Mentale et Exclusion Sociale
Mental Health and Social Exclusion

KU LEUVEN
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I. Introduction

'Person First' is a European project launched at the beginning of 2022 by SMES-Europa and 9 partner organizations, with the support of the EU-Erasmus+ program. The project's primary objective is to give special attention to the homeless individuals who live on the margins of society, as they are increasingly deprived of fundamental human rights, such as access to social and health services, decent housing, and jobs that provide to their circumstances. Moreover, their inhumane living conditions are often accompanied by severe mental health issues.

Building on the earlier 'Dignity and Well-being' project, 'Person First' relies on action-research that involves study visits and exchange of experiences. The project aims to respond more effectively, responsibly, and sustainably to the needs of homeless individuals. As an initial step, we seek to map the diversity of services that receive homeless people in the 9 participating countries (the countries of the 9 partner organizations: Portugal, Greece, Latvia, Italy, Poland, Denmark, Slovenia, Belgium and Finland). To achieve this, we are asking feedback from a diverse range of organizations regarding their practical experiences working with homeless individuals and those with mental illnesses, as well as their perceptions of the unique needs of these populations. By doing so, we hope to gain a better understanding of the multifaceted needs of these groups and how best to address them. In addition, we aim to identify innovative and effective practices, which is also a key objective of the Person First project.

II. Method

Approval for this survey was obtained from the Social and Societal Ethics committee (SMEC) of KU Leuven. The questionnaire was originally drafted in English and could be translated by the project partners into their native languages before being distributed to potential respondents. The project partners were responsible for the data collection process, which involved reaching out to and collecting responses from at least 50 organizations in total (with at least 6 organizations per country/project partner). Contact with the organizations was made via email, phone, and/or post/mail, although in-person, online, or phone interviews were preferred due to their advantages of no missing answers, direct assistance, and higher response rates leading to better quality responses.

The survey was conducted between May 2022 and October 2022, and all collected data (translated in English) was entered into the program Excel and analyzed by the Research Institute for Work and Society (HIVA) of KU Leuven. As the survey included many open-ended questions, both quantitative and qualitative analysis were necessary. It should also be noted that certain responses could be assigned multiple codes (i.e., multiple themes) and organizations could provide multiple answers to each question.

According to feedback from the project partners, most organizations were contacted through email or telephone. However, the data collection process experienced delays due to several reasons, including translation issues (i.e., both the survey and responses needed to be translated), overlapping with summer holidays, difficulty in involving stakeholders with a direct interest in the project (such as municipalities and local authorities), and the need for some organizations to obtain permission before participating.

III. Profile of organization

We received a total of 65 completed surveys, meaning that 65 different organizations participated in this study (see Table 1). The number of surveys per country varies from 3 (Belgium) to 12 (Portugal), with an average of about 7 surveys per country.

Table 1 Number of surveys received by country

	N	%
Portugal	12	18.5
Greece	10	15.4
Latvia	9	13.8
Italy	9	13.8
Poland	7	10.8
Denmark	6	9.2
Slovenia	5	7.7
Belgium	4	6.2
Finland	3	4.6
Grand Total	**65**	**100**

Approximately two-thirds (63%) of the organizations are privately subsidized, while about one-sixth (17%) are public organizations (see Table 2). One-fifth of the organizations in our sample have a different status, such as mixed, privately non-subsidized, and others.

Table 2 Category of the organization

	N	%
Private subsidized	41	63.1
Public	11	16.9
Mixed	5	7.7
Private, non subsidized	5	7.7
Other (religious organization, association, non-profit community-based)	3	4.6
Grand Total	**65**	**100**

About half (52%) of the organizations are locally oriented, a quarter (26%) are regionally oriented, and approximately one-fifth (20%) are nationally oriented (see Table 3).

Table 3 Level of the organization

	N	%
Local	34	52.3
Regional	17	26.2
National	12	18.5
National and regional	1	1.5
National and local	1	1.5
Grand Total	**65**	**100**

In the survey, organizations were also asked to indicate their mission or goals within their organization. Table 4 presents the various responses (each organization could give multiple answers), which we have categorized into different themes. About half of the organizations stated that they aim to help their users or

provide them with a better life (e.g., "help for deprived people (the poor, disabled and socially excluded) easing the problems of everyday life"), and two-fifths (37%) aim to rehabilitate and empower their users (e.g., "improvement of adaptation abilities in the environment and support in the process of self-empowerment and social re-adaptation of young people..."). Additionally, a quarter of the organizations aim to contribute to greater inclusion of this vulnerable group in society (e.g., "the mission is to promote full inclusion and autonomy of people in situations of vulnerability"). About a fifth of the organizations also indicate that they focus on the (mental and physical) health of users (e.g., "recovery and community integration of people with mental health problems") and on lobbying, advocacy or raising awareness of their situation to policy makers (e.g., "rights protection, awareness raising on the social marginalization problem, a contribution to the design of social policies"). Other goals mentioned include providing shelter, working preventively, strengthening the social network, focusing on employment and education, harm reduction, improving services, and collaborating with other services.

Table 4 Mission or objectives of the organizations (N= 65)*

	N	%
Better (social) life/support/treatment	32	49.2
'Assistance in the process of overcoming the crisis of homelessness and social exclusion; support in the addiction treatment process; supporting human dignity', 'Help for deprived people (the poor, disabled and socially excluded) easing the problems of everyday life', …		
Rehabilitation and empowerment	24	36,9
'Improvement of adaptation abilities in the environment and support in the process of self-empowerment and social re-adaptation of young people…', 'Rehabilitation and stabilization in housing of the most vulnerable homeless people', 'Intercultural association of Italian and migrant women with the aim of mutual self-help and mutual support for individual empowerment', 'Acquiring new social skills, abilities and knowledge that enable management of financial difficulties and debts and reduce homelessness', …		
Inclusion	16	24.6
'The mission is to promote full inclusion and autonomy of people in situations of vulnerability', 'Creating an including setting for marginalised people, particularly people who use drugs, low threshold…Building social relations and tolerate guests as they are', 'To build bridges between the street and the rest of society', 'Improving the living conditions of vulnerable people by providing assistance to those who need it most, without discrimination', …		
(Physical and mental) Health	14	21.5
'Recovery and community integration of people with mental health problems', 'Medical assistance for the people in the situation of homelessness – mostly those staying in the street', …		
Lobbying/advocacy/awareness	12	18.5
'Rights protection. Awareness raising on the social marginalization problem. A contribution to the design of social policies…', …		
Shelter	10	15.4
'To provide shelter to homeless individuals with specific social problems, such as mental illness or substance abuse, who are in need of personal and social support', 'Providing shelter in a crisis situation', 'To provide temporary safe shelter and social rehabilitation for homeless adults or adults in crisis, and to prevent wandering and homelessness', …		
Prevention	8	12.3
''Preventing social exclusion and derailment of young people…', 'To make an end to homelessness, loneliness, and mental health problems', …		
Social network	6	9.2
'Improve mutual relations within the family/partnership/with loved ones', 'Connecting all generations, creating intergenerational coexistence', 'Building social relations and tolerate guests as they are', …		
Job/employment	5	7.7

'Increasing the level of professional activity of young people at risk of social exclusion', 'The creation of bridges between lack of interest and motivation with the offers of training, employment or occupation which are available but not always used', …		
Harm Reduction	5	7.7
'Harm-reduction in a broad perspective; clean needles, condoms, food, sleep', …		
Improve services	3	4.6
'Guaranteeing a level of excellence in the services provided; Ensure that the most vulnerable population has access to a network of resources that allow them to improve their stability and decrease their suffering, 'Ensure sustainability of all projects', 'Promote innovation and entrepreneurship as means for a solid social management…'		
Education	3	4.6
'Aid, educational and cultural activities aimed at disadvantaged groups threatened with social exclusion', …		
Collaboration	2	3.1
'Establishing contact to partners, governmental and nongovernmental, psychiatry, …'		

* Multiple objectives or answers possible per organization.

IV. Profile of staff

Looking at the personnel working in the different organizations, we see that about half of the organizations have less than 20 paid staff members (see Table 5). However, there are also organizations in the sample that have significantly more paid staff members. For example, eight organizations (13%) have more than 100 paid staff members (with a maximum of 1 860 staff members). Due to the presence of extreme values, the average of 82 paid staff members is much higher than the median[1] of 18 paid staff members in our sample. This median is the most informative measure for the central tendency of the distribution of the number of paid staff members in the organization because of the presence of numerous extreme values.

Table 5 Total number of paid staff in the organizations

	N	%
0-19	33	52.4
20-39	10	15.9
40-59	7	11.1
60-79	1	1.6
80-99	4	6.3
100-1 860	8	12.7
Grand Total *	**63**	**100**
Median		**18**
Average		**81.8**

* 2 missing values.

In addition to paid staff members, there are also organizations that rely on volunteers, with 80% within this sample (see Table 6). In other words, 20% (12 organizations) do not rely on volunteers. Once again, we see large differences in the total number of volunteers within organizations. The average number of volunteers is 94 and the median is only 14. This median is the most informative measure for the central tendency of the distribution of the number of volunteers in the organization because of the presence of numerous extreme values. Furthermore, we observe a strong positive correlation (r = 0.91) between the number of paid staff members and the number of volunteers. The higher the number of paid staff members, the higher the number of volunteers in the organization.

Table 6 Total number of volunteers in the organizations

	N	%
0	12	19,7
1-19*	26	42,6
20-39	9	14.8
40-59	3	4.9
60-79	2	3.3
80- 2 459	9	14.8
Grand Total **	**61**	**100**
Median		**14**
Average		**93.5**

* 1 organization consists only of volunteers and no paid staff. ** 4 missing values.

[1] The median is the middle value of a group of numbers ranked by size.

The organizations could also indicate the proportion of staff with a particular qualification in the organization (see Table 7). The average proportion of staff with a social qualification in the organization is 40% (median of 30%), which is the highest of the three qualifications surveyed. In second place is general medical personnel with an average proportion of 12% (median of 3%). In last place is the average proportion of staff specialized in mental health, which is only 8% (median of 0%).

Table 7 Proportion of staff with certain qualifications in the organizations

	Median	Average
Social qualifications (N= 60)	29.5	40.1
General medical workers (N= 61)	3.3	11.8
Mental health specialists (N= 61)	0.0	8.1

Project partners' reflection on profile of staff

- Questions: Is there a need for more qualified staff? What kind of qualifications are needed and why?
- Answers:
  - There is a need for greater diversity in education as currently, the majority of staff are social and medical workers. Therefore, more diversity is required in organizations (e.g., film director …).
  - Shortage of staff is an issue, and it is not necessarily the lack of qualified staff. Staff turnover is also a problem because experience is crucial for building trust, but staff do not stay long due to shortages, leading to tensions. Large-scale organizations are also risky for safety.
  - The organization of work is also a critical factor.
  - All staff in homeless shelters, including volunteers, require trauma-informed training.
  - Additional training is necessary in handling mental health issues and cultural differences.

V. Profile of users

The responses to the question about the total number of users per year and per day show significant differences due to variations in organizational scale and level of operation (local versus national). The median for the number of users per year is 460 (see Table 8) and per day is 48 (see Table 9). There is a positive correlation between the number of users per year and per day, with a correlation coefficient of 0.75. As the number of users per year increases, so does the number of users per day.

Table 8 Total number of users per year in the organizations

	N	%
15-114	9	15.3
115-214	7	11.9
215-314	10	17.0
315-414	3	5.1
415-514	3	5.1
515-180 014	27	45.8
Grand Total *	**59**	**100**
Median		**460**
Average		**9081.0**

* 6 missing values.

Table 9 Total number of users per day in the organizations

	N	%
3-102	41	80.4
103-202	3	5.9
203-302	2	3.9
303-4 402	5	9.8
Grand Total *	**51**	**100**
Median		**48**
Average		**258.9**

* 14 missing values.

In the survey, organizations were also asked to indicate the average length of stay in days of their users, as well as the maximum length of stay (see Table 10). About half (48%) of the organizations either reported that users do not stay or did not respond to this question (mostly because information on the average length was not available). For the other half of the organizations, the average length of stay was 200 days (with a median of 120 days). One-fifth of the organizations reported that there is no maximum duration for user stays, and 15% did not respond to this question. For the remaining organizations (65%), the average maximum length of stay was approximately 3.5 years (with a median of almost 2 years).

Table 10 Average and maximum duration of stay in days of the users

Duration of stay	Average in days (N= 35*)	Maximum in days (N= 42**)
Minimum	0.04 (1 hour)	2
Maximum	730 (2 years)	5 110 (almost 14 years)
Median	120	720 (almost 2 years)
Average	199.9	1 246.0 (3.4 years)

*Out of 65 organizations, 31 (48%) either reported that users do not stay or did not respond to this question. ** Out of 65 organizations, 13 organizations (20%) did not apply a maximum duration of stay and 10 organizations (15%) did not respond to this question.

Table 11 and Figure 1 provide us with more information on the different categories of users within the organizations. Nearly all organizations have homeless people and individuals with mental health problems as users of their services. About 90% of the organizations have poor people, women, and migrants among their users. Approximately 70% report having LGBTQ+ users, while one-third indicate that minors are among their users. Other categories mentioned include for example refugees from Ukraine, extremely vulnerable homeless people, drug users, Roma, sex workers.

Table 11 Categories of users according to the organizations (N= 65)

	Organizations where category is present			Approximate % of category in the total user group of the organization			
	N	%	Missing values	N	Median	Average	Range
Homeless	63	98.4	1	57	90.0	71.1	1.5 - 100
Persons with mental health problems	62	96.9	1	44	62.5	58.1	1.5-100
Domestic violence	37	60.7	4				
Mental suffering (loneliness, anxiety…)	48	78.7	4				
Psychiatric disorders	54	88.5	4				
Addiction (alcoholism, substance abuse)	58	95.1	4				
Poor/destitute	56	93.3	5	53	99.0	88.7	20-100
Female users	54	88.5	4	52	25.0	33.7	0.2-100
LGTBQ+	37	71.2	13	30	4.0	6.3	0.1-40
Minors (< 18 years)	21	34.4	4	20	5.0	17.2	0.1-50
Migrants	53	86.9	4	46	34.2	41.2	0.3-100
Legal residents	44	89.8	16				
Asylum seekers	27	55.1	16				
Undocumented migrants	35	71.4	16				
Other	7	13.2	11				
Examples of others: 'refugees from Ukraine', 'most vulnerable homeless people', 'people who use drugs', 'Roma', 'sex workers', …							

When we focus on the share of each user category in the total user group within an organization, we find that the average share is highest for poor people (89%), followed by homeless people (71%) and individuals with mental health problems (58%). The average shares of LGBTQ+ people, minors, women, and migrants are significantly lower, at 6%, 17%, 34%, and 41%, respectively.

Although women are users in almost 9 out of 10 organizations, they are not as strongly represented as men. The literature also shows that women are a minority and often considered 'hidden homeless' (Erasmus+

Project Dignity & Well-being, 2019). This means that they may still have a roof over their head by being in a relationship with a man, but they may experience physical and sexual abuse. They cannot leave due to the lack of alternative housing options. Women who are homeless are more likely to experience severe mental illnesses and have very complex needs, requiring specific support. Homeless women often have a very negative self-image, considering themselves to be losers, bad mothers, and the like.

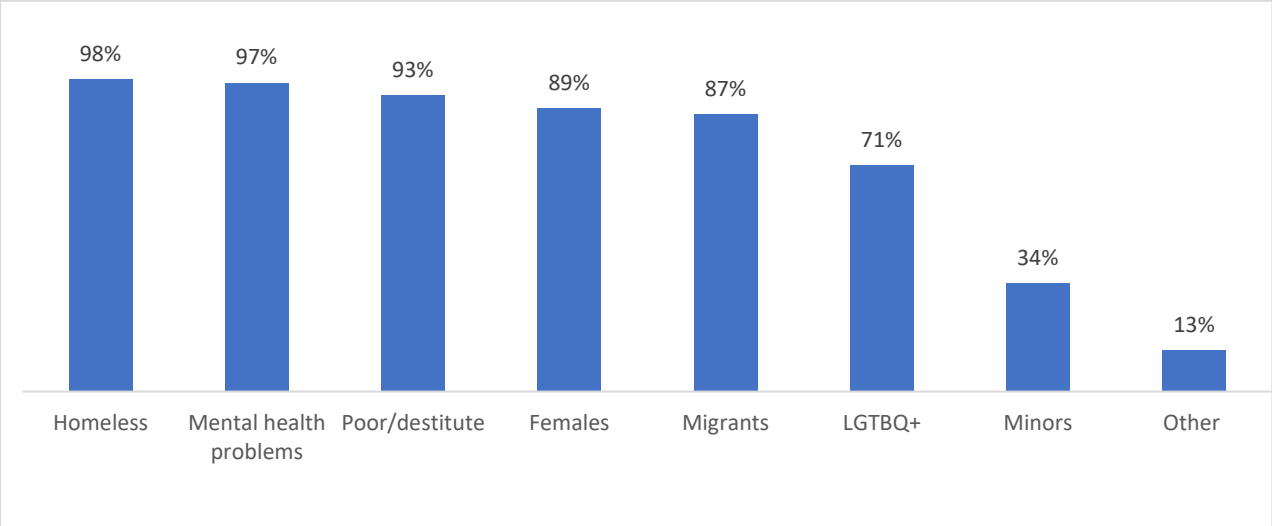

Figure 1 Percentage of organizations where the category of users is present.

As shown in Table 11, not all categories of users are present in every organization. Additionally, organizations have reasons for not admitting certain individuals. In the survey, the various reasons for non-admission could be ticked off (see Table 12). Approximately half of the organizations indicate that they refuse admission if the organization's rules are not respected. Furthermore, reasons for refusal such as age and family composition (e.g., presence of minors), violent and risky behavior, owning pets, and the use of drugs or alcohol are cited by 40% to 30% of organizations. Reasons that occur less frequently include psychiatric problems, lack of papers, and gender-based refusal. On average, an organization reports 2.3 different reasons for refusal. One in eight organizations lists more than five reasons, while one in six admits everyone and does not mention any reasons.

Table 12 Reasons for non-admission of applicants according to the organizations (N= 65)*

	N	%
Age/family composition (e.g., presence of minors)	28	43.1
Sex (e.g., no men)	11	16.9
Lack of legal residence (undocumented migrants)	8	12.3
Violent/risk behaviour	23	35.4
Psychiatric disorder	5	7.7
Pet animals	20	30.8
Use of drugs or alcohol	19	29.2
Non-compliance with rules of the organization**	28	48.3
Other	10	15.4
Examples of other: 'Being not vulnerable enough', 'lack of space', 'not in the target group', 'non-paid rents', 'when the user's behaviour is dangerous to the safety of other users, staff and volunteers', …		
Number of non-admission reasons per organization		
None	11	16.9

1	14	21.5
2	14	21.5
3	7	10.7
4	11	16.9
5+	8	12.3
Median		**2**
Average		**2.3**

* Multiple reasons or answers possible per organization. ** 8 missing values (old version of survey used)

The finding that a third of users are refused due to aggressive or risky behavior suggests that these situations may be occurring within organizations. The Erasmus+ Dignity & Well-being project notes that professional training should enable staff to anticipate and prevent aggressions, but sometimes aggression can be sudden and unpredictable. Handling aggressive and violent behaviors is one of the greatest challenges faced by social professionals. Often, they feel incapable of managing such situations, which can lead to burnout and high staff turnover (Erasmus+ Project Dignity & Well-being, 2019).

Project partners' reflection on profile of users

- Questions: Are certain groups such as women, LGBTQ+ individuals, minors, and migrants more frequently affected by homelessness due to specific causal factors? Should they be given special attention? How can we reduce the number of exclusion criteria? What are the consequences of having many exclusion criteria?
- Answers:
  - Minors are typically not allowed in shelters, and instead receive care through a separate system, although they may still end up in shelters or domestic violence shelters.
  - Migrants who have become homeless in large numbers due to war are a special group that is not well-served by the current system (e.g., short-term rented flats). Moreover, there is a large discrepancy between Ukrainian and Syrian/Middle Eastern refugees in the current system. Among staff, there is also a great need for language training.
  - LGBTQ+ individuals have unique needs that require separate accommodations from the general public.
  - Women, particularly single mothers who have experienced violence, have specific needs such as childcare.

VI. Services and needs

Services

In the survey, organizations were asked to indicate the services they provide or the domains they operate in. Within this Erasmus+ project Person First, we distinguish four pillars: social assistance, home & housing, (mental & medical) health, and empowerment & rehabilitation. The various services provided by the 65 different organizations are listed in Figure 2 and Table 13. These services can be classified into the four pillars as follows:

- Social assistance includes support/care (e.g., social services), shelter (e.g., emergency shelter), services for primary needs (e.g., food, clothes, hygiene), and administrative/legal help (e.g., social benefits).
- Home and housing includes housing services (e.g., housing first).
- (Mental & medical) health includes mental health (e.g., psychological counseling), (medical) health (e.g., medical/nursing support), and drugs or harm reduction (e.g., rehab programs).
- Empowerment & rehabilitation includes job/employment (e.g., job orientation) and education/training (e.g., language courses).

The service of street work or outreach work (e.g., outreach teams) is not included in the four pillars as it can be seen as a method of providing services. About one fifth (19%) of the organizations use this method to offer their services to their target group of users.

Approximately nine out of ten organizations (88%) indicate that they provide services within the social assistance pillar. Within this pillar, social support or care is mainly provided by 57% of the organizations. About 20% to 30% of the organizations provide shelter, services for primary needs, and administrative help, including assistance with filling out official documents. The social assistance pillar is the most strongly represented by the organizations in this sample.

The (mental & medical) health and home & housing pillars are offered by about half of the organizations, namely 55% and 51% respectively. Within the health pillar, we see that about two out of five organizations focus on the mental (42%) or physical health (40%) of users. To a lesser extent, namely one out of ten (11%) organizations provide services aimed at drugs or harm reduction.

The pillar that is least represented is empowerment & rehabilitation. However, we see that one third (35%) of the organizations offer services within this pillar. In one third of the organizations, these services are focused on work (31%), and in slightly less than one fifth (17%), they are focused on the education and training of users.

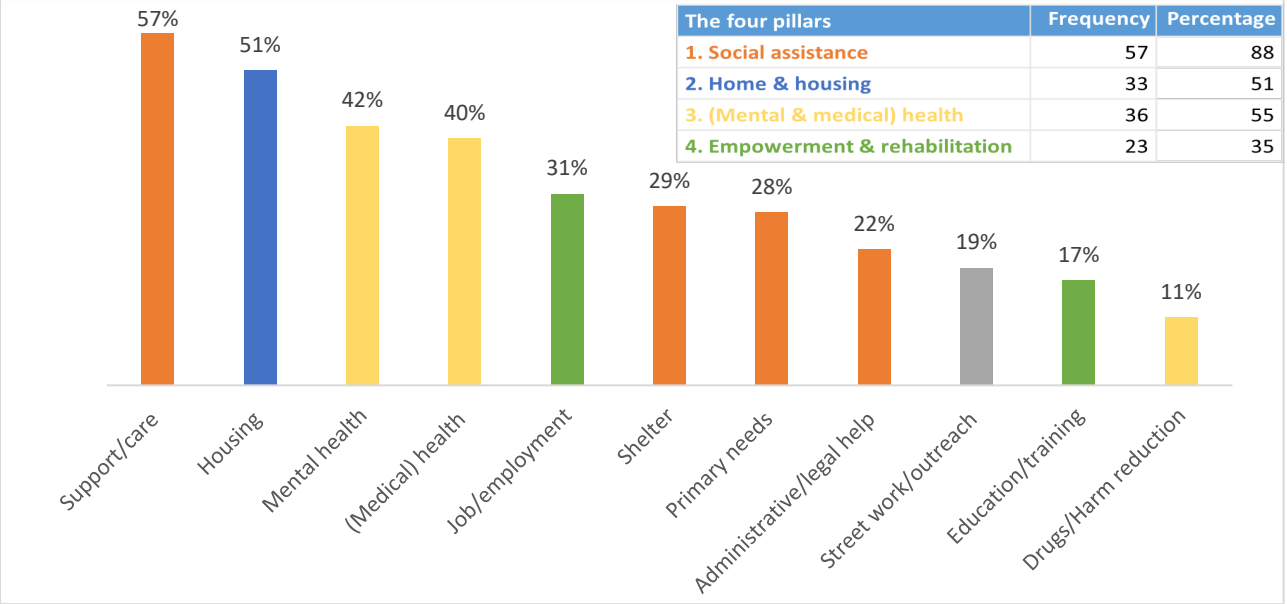

Figure 2 Percentage of organizations who offer the different services

Table 13 Services of the organizations (N= 65)*

	N	%
Support or care	37	56.9
'Accompaniment to guests in approaching medical services and /or psychiatric and/or in job placement path', 'Guidance', 'Social services', 'All kinds of social services', 'Psychosocial support', …		
Housing	33	50.8
'Housing First', 'Social Residence and Shared Apartments', 'Accommodations', 'Housing-related support and advice', 'Comprehensive housing support (for people in a crisis of homelessness, people with disabilities, leaving the foster care, refugees)', 'Housing First accompaniment', …		
Mental health	27	41.5
'Psychological assistance in the street', 'Psychological counselling', 'Psychosocial support', 'Therapeutic help', 'Psychological and emotional support', 'Psychiatry Pediatrics', 'Services range from psychological counselling to career and business counselling', …		
(Medical) health	26	40.0
'Medical assistance in the street', 'Medical (psychiatry, general medicine and stomatology) and nursing Support', 'Physical health', 'Health services (free FibroScan- is a type of liver elastography/linking patients to health care facilities/ free HCV, HBV, HIV test to prisoners)', 'Nurse services and appointments with doctors, including GPs, as needed', …		
Job/employment	20	30.8
'Job orientation and job placement support (curriculum, training, job search, etc.)', 'Project of returning women to the labour market after childbirth', 'Help in finding a job', 'Efforts to reintegrate the person into work/ society', 'Referrals to other NGOs and public structures for housing shelters and employability services', …		
Shelter	19	29.2
'Emergency shelter'; 'Shelter for the homeless', 'Temporary shelter', 'Day Centre for Children "Patvērums" (Shelter)', 'Shelter for adults under the influence of alcohol', 'In the event of natural disasters or acute phases of conflict, we intervene as soon as possible by distributing essential goods and providing shelter', …		
Primary needs (food, clothes, hygiene, medical equipment, …)	18	27.7
'Soup kitchens', 'Free homecooked food, coffee, water, etc.', 'Personal hygiene', Food (5 meals/day); Clothes and laundry', 'We help cover primary needs through the distribution of food, seeds and agricultural tools for food production and subsistence', 'Social meals service, social pharmacy, social grocery, …', …		

Administrative/legal help	14	21.5
'Legal aid', 'Generally, make sure that the women have basic- and civil rights', 'Cooperation with organizations and local government in order to end homelessness', 'Advice on paperwork and obtaining social benefits', 'Awareness-raining campaigns (about HCV/HBV/HIV and liver diseases)', …		
Street work/outreach	12	18.5
'Medical assistance in the street and psychological assistance in the street', 'Social – Outreach Team', 'Streetwork for homeless and poverty situations', 'Outreach (street units targeted on homeless and addicted people)', …		
Education/training	11	16.9
'University courses for inmates who are currently detained', 'Training projects (Italian, English, elderly assistance, digital literacy, etc.)', 'English language course', 'Through workshops of many subjects and levels of difficulty, people come to meet each other and, together, welcome each other and share their knowledge and skills', 'We promote the right to education by building or rebuilding schools, training teachers and promoting educational activities in humanitarian crises', …		
Drugs/Harm Reduction	7	10.8
'Harm reduction and prevention, rehab programmes, rehab communities)', 'Harm reduction interventions related to drug use', 'Linkage to public health care units, like HIV clinics, but also to mental health care services including drug addiction treatment units', …		

* Multiple services or answers possible per organization.

The survey also included specific questions about whether the organizations provide emergency services and (mental) health services. They were also asked to indicate which services they provide exactly (see Table 14 for some examples). About three out of five services reported offering emergency services, such as 'First aid and prevention overdose', 'Crisis center service', 'Emergency care (including emergency food aid)', and 'Emergency night shelter'. As shown in Figure 2, half of the organizations provide health services, such as 'Services of a psychiatrist (office with community psychiatry)', 'Consultations of clinical psychologist', 'Accompaniment to guests in approaching medical services and/or psychiatric'. As these examples illustrate, a distinction can be made between a direct health offer and an indirect offer. The latter involves evaluating users and referring them to (specialized) medical services if necessary. About 45% of the organizations provide direct medical care, while approximately one-fifth offer indirect medical services (further analysis shows that 18% of the organizations provide both direct and indirect medical care).

Experiencing physical health problems can arise directly from the specific risks associated with being homeless, the absence of the usual social support structure for health, or can worsen due to a lack of access to medical treatment (Erasmus+ Project Dignity & Well-being, 2019). Regarding mental health issues, homelessness can be caused by psychosis, multiple trauma, and addiction, while emotional distress, anxiety, and depression can be responses to homelessness (Leng, 2007).

Table 14 Emergency services and (mental) health care in organizations (N= 64)

	N	%
Emergency services	39	60.9
'Emergency care for users of drug consumption and addiction space in municipal shelter and mobile methadone program', 'We have 7 beds for emergency filed with the Social Security', 'Crisis/emergency placement in a shelter, intervention in life-threatening situations (emergency medical condition and absence of a social network or transportation to a medical facility)', 'Emergency night shelter', 'Ready health emergency (for a limited day period only)', 'First aid and prevention overdose', 'Crisis centre service', 'Emergency care (including emergency food aid)', 'Accommodation', 'We are not an emergency service, but we sometimes work in emergency situations and respond to urgent requests and needs of the people we accompany', …		
Specific (mental) health care	32	50.0
Direct (mental) health care (N= 60, 5 missing values)	27	45.0

'The mental assistance activity takes place in our clinics, is free of charge, and managed by specialized staff (psychotherapists and psychiatrists)', 'We offer psychology and psychiatry consultation service and therapeutic counselling. These services are free for all our costumers.', 'Services of a psychiatrist (office with community psychiatry)', 'Whoever is written in our organization can have appointment with psychologist if she/he wants free of charge of course', 'Consultations of clinical psychologist. If a client has mental disorders, he is referred to psychiatrist', …		
Indirect (mental) health care (N= 60, 5 missing values)	13	21.7
'The mental health response includes the following services: evaluation consultation and referral to specialized services with a psychiatrist', 'Regarding medical care, the team streamlines participants' access to local public health centres or to specialized medical services whenever needed', 'Accompaniment to guests in approaching medical services and /or psychiatric', 'For any specialized needs we would refer to other NGOs', 'Accompaniment to guests in approaching medical services and /or psychiatric and/or in job placement paths', …		

Needs of the users

To gain insight into the extent to which services are tailored to the needs of users, organizations were also asked to report on the needs of their users. This was done through the following question: 'What are the most frequent requests for help/support received by your organization?'. Table 15 and Figure 3 show the answers provided by the organizations, which indicate a wide range of needs. Examples of the most frequent requests include the need for housing support, legal support, problem-solving, medical examinations, basic necessities (such as food, clothing, and hygiene), drop-in shelters, assistance with job searches, learning support, help with substance abuse, help with integration, and meeting activities. Research also shows that people experiencing homelessness and mental illness have diverse needs that are increasingly complex and diverse due to changing economic conditions across Europe in recent years, which have altered the demographic profile of those at risk of or experiencing homelessness (O' Sullivan, 2012).

The order of the pillars based on the most common requests of users corresponds to the order of the pillars based on the most frequently offered services: first, social assistance, followed by home & housing and (mental & medical) health, and finally empowerment & rehabilitation. However, there is one major difference regarding the themes within the four pillars. While mental health care is offered (directly or indirectly) by the organizations, they do not report it as one of the most frequents requests of users.

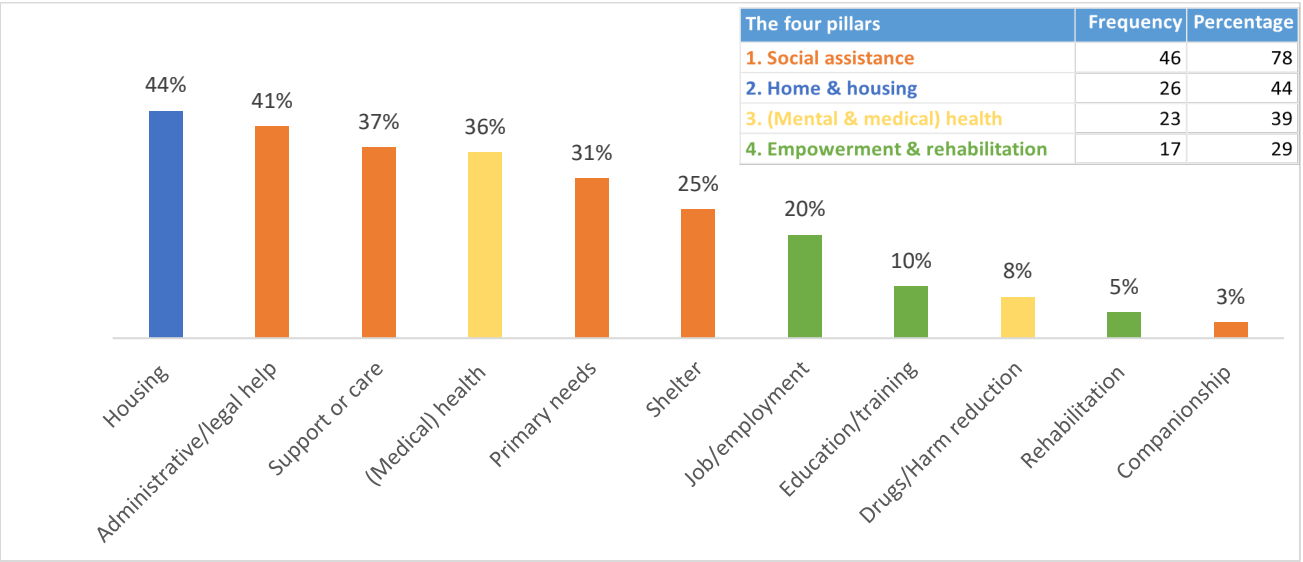

Figure 3 The most frequent requests from users according to the organizations

Table 15 Most frequent requests that organizations receive from users (N= 59)*

	N	%
Housing	26	44.1
'Assisted housing (disabled persons, refugees, people in a homeless crisis) and housing training (leaving the foster care, disabled persons)', 'Housing first services', 'Housing counselling', 'The most common are requests for housing, food, clothing and personal hygiene (laundry and showering)', …		
Administrative/legal help	24	40.7
'Assistance in obtaining rights to social assistance and social security benefits', 'Legal aid', 'Legal assistance in obtaining the documents', 'Help with renewing documents, registering as a person in need, other formalities', 'Advice on specific social situations', 'Legal support for documentation', …		
Support or care	22	37.3
'Due to the very wide spectrum of activities undertaken, the requests for assistance concern various needs. The needs of material help are certainly predominant, but many people also look for counselling and help in solving life problems', 'Support in regulating the life situation - family, legal, health', …		
(Medical) health	21	35.6
'Medical and specialist examinations, general health activities, dental, physical therapy, psychiatric, blood and instrumental examinations, and assistance in accessing physical and telematic services', 'Health problems (cancer, dialysis, female genital mutilation consequences, etc.)', 'Medical assistance is the most common request', 'Linking patients to health care facilities, free examinations (fibroscan)', …		
Primary needs (food, clothes, hygiene, medical equipment, …)	18	30.5
'Food, toilets, aluminium foil and syringes/needles, phone charging, clean clothes and shoes', 'food, shower, washing', 'Various services (soup kitchen, laundry, showers, internet, refills)', 'The needs of material help are certainly predominant', 'Shelter and needles, cleaning kits, bandages. Fresh linen for beds. They often request sweets', 'Bed, laundry, shower, new clothes, fresh cooked food, non-cooked food, medicines', 'Clothing, footwear, hygiene products, etc.', …		
Shelter	15	25.4
'Provision of shelter', 'Shelters, housing first, social residence and apartments', 'A place to sleep', 'Housing shelters and drop-in centres', …		
Job/employment	12	20.3
'Work related issues and other needs that may come up along the way', 'Job orientation and job placement support', 'We receive requests for help with job search', 'Employability services to find a job', 'The vast majority of the request concerns psychosocial support, support to find a new job as well as issuance of public documents', …		
Education/training	6	10.2
'Educational support (children, adolescents, and adults)', 'Request for learning assistance', 'Some participants also request support to find a job or initiate an educational/ training course', …		
Drugs/Harm reduction	5	8.5
'Drug harm reduction intervention', 'Stop using drugs', 'Stopping consumption', …		
Rehabilitation	3	5.1
'Adaptation after release from prison (declaration of residence, opening a bank account, health checks, etc.)', 'Integration (people, including children of disabled persons)' and 'Request for a field visit and help - prevention against loss of housing/possibility of living (debts, addictions, illness, disability, mental health problems, violence, lower incomes and poor conditions - dilapidation, without basic housing equipment, without a social network'.		
Companionship	2	3.4
'Low-threshold meeting activities' and 'Companionship'		

* Multiple services or answers possible per organization.

Organizations were also given the opportunity to indicate if there were latent needs among their users, which are needs that they have but do not express (see Table 17). In addition, organizations could also indicate if they experienced a mismatch between the needs of users and the services. As shown in Table 16,

approximately three-fourths (74%) of organizations reported the presence of latent needs among their users, while three-fifths (60%) reported a mismatch between user needs and the services offered.

Regarding latent needs, we see that the need for mental healthcare is particularly unexpressed (reported by 46% of organizations), which may also explain why these needs are not reported by organizations as the most common requests from users. One possible explanation for this is that homeless people with mental health problems often have a sense that they can solve problems on their own, give low priority to health topics, and have low levels of awareness of illness and/or motivation to change (Rees, 2009). Furthermore, according to some organizations (10 -19%), users also have a need for access to specialized or more tailored services, although they may not always express these needs themselves.

Table 16 Total number of organizations that see latent needs among users and experience a mismatch between the users' needs and the services offered (N= 65)

	N	%	Missing values
Latent needs among users	48	73.9	0
Mismatch between users' needs and the services of organization	34	59.7	8

Table 17 Latent needs that users do not express according to the organizations (N= 48)*

	N	%
Mental health needs	22	45.8
'Psychological support', 'Mental health follow-up', 'Lack of positive social interactions/context', 'Need for integration and relationship with the host citizenship, support for relational life, contrast to loneliness', 'Mental health (addictions, psychiatry....) problems', 'Psychiatric assistance and medicine', 'Mostly related with Mental Health and Psychosocial Support needs, as well as counselling on issues related to parenthood, treatment compliance, domestic violence and other forms of GBV', …		
Access to (specialized) services	9	18.8
'Special services for women, sexual minorities, young people, families and people with mental health Challenges', 'Access to specialist services', 'Substance rehabilitation services, mental health services, …', 'Access to addiction services', …		
(Medical) Health needs	7	14.6
'General health needs', 'Mainly medical needs', …		
Tailored services	5	10.4
'Special services for women, sexual minorities, young people, families and people with mental health challenges', 'Attention to individual needs', 'More adequate responses to the current profiles homeless people, and bets on the diversity of responses existing in the institution so that the intervention is always centred on people and their needs in order to respond to them in an adequate and effective way', …		
Primary needs (food, clothes, hygiene, medical equipment, …)	5	10.4
'Personal hygiene', 'For example someone who is written in social meals service, maybe needs new clothes', 'Provision of footwear and clothes', …		
Housing	5	10.4
'Support in the transition to other phases of professional and housing reintegration', 'Many of our beneficiaries are living in insecure and unstable living conditions', …		
Fearful/being reserved	4	8.3
'It varies, but young people are often afraid to talk about everything, they are afraid of refusing their request or not understanding it. We try to prevent such situations by building close relationships with participants that allow them to talk openly about their matters over time', 'Participants express their needs differently. Some clearly identify their needs while others are more reserved', …		
Job/employment	4	8.3

'Difficulties in entering the labour market', 'Most often, the person needs to deal with addiction problems first, followed by housing and employment', …		

*Multiple needs or answers possible per organization.

Table 18 presents the answers describing the mismatch between the users' needs and the services offered. About half of the organizations (55%) indicate that the services can be insufficient or inefficient. Some examples of this answer include difficulties with referring to mental health services, a need for a roof over their head for more than 14 hours a day, and a need for psychiatric care for shelter users or people living on the streets. About a quarter of the organizations (27%) report that there can be differences in perspective or goals. For instance, users may have different priorities or may request things that keep their problems the same (e.g., money for drugs, alcohol, an apartment without accountability, success in school without learning, needs for alcohol, needs for violence, needs for blackmail, and confirmation of their ideas). The literature highlights the importance of social professionals always bearing in mind that the homeless person is the main actor and often knows the solution to their problems better than anyone else. However, respecting users' choices can sometimes lead to major contradictions for social professionals (Erasmus+ Project Dignity & Well-being, 2019).

Furthermore, about a quarter (24%) of the organizations note that a shortage of (affordable) housing is also a significant cause of the mismatch. Approximately one in ten (9%) organizations indicate that certain user characteristics can prevent them from being helped, such as not having rooms for couples, not allowing pets, and not admitting victims of domestic violence into emergency shelters for homeless people.

Table 18 Description of the mismatch between the users' needs and the services according to the organizations (N= 33)*

	N	%
Insufficient/inefficient services	18	54.5
'Specific mental health services: difficulty in referral', 'There is a huge need for psychiatry to take in 'street people', 'Our users need roof over their head more than 14 hours a day, but we are closed more than 9 hours every day', 'Emergently accommodation issue (insufficient beds and resources) that worsen outside the seasonal reception', 'Psychiatric counselling is needed for users in the shelter', …		
Different perspective	9	27.3
'If they use substances actively, their priorities are different in life', 'The lack of correspondence between the needs of users and our services depends on objective limits of what we can offer, and on the expectations of users not adhering to our services', 'According to them, users need things that would keep them in the same problems as they are now. We do not offer them these things (money for drugs, alcohol, an apartment without accountability, success in school without learning, needs for alcohol, needs for violence, needs for blackmail and confirmation of their ideas)', 'The local authority , the client , and relatives of client may have different goals (e.g. care - "cheaper", "out of sight", "at home"), …		
Shortage of (affordable) housing	8	24.2
'We do not have all the resources necessary to ensure the housing of all users', 'Housing: sometimes waiting on the street because there is not enough housing', 'We are not able of directly provide a housing service due to lack of space and staff members', …		
Certain characteristics of the user (e.g., gender, pets, couples, …)	3	9.1
'We don´t have rooms for couples and we do not have conditions for receiving pets.', 'The centre was not prepared to receive people in the process of sex transition, we had to adapt our physical conditions so that people felt welcomed and understood' and 'For women we do not adapt our services and sometimes it is not appreciated' and 'Victims of domestic violence have no place in emergency shelters for homeless people'.		

*Multiple descriptions or answers possible per organization.

Difficulties in responding to needs

In the survey, organizations were also asked to indicate the main difficulties they face in responding to user requests (see Table 19). About a third (32%) of the organizations report insufficient financial resources to meet all needs, such as insufficient financing of projects and lack of funds to employ qualified staff, increasing costs of building maintenance, and lack of long-term financial support. About a third (30%) also indicate that services are inefficient, such as accessibility problems/high barriers, lack of progressive responses, long waiting lists, and complex procedures. Legal barriers are also mentioned by about a fifth (23%), such as the complexity in the process of regularizing undocumented migrants.

Difficulties related to personnel are also mentioned, namely the availability of un(der)qualified staff (15%) and understaffing (6%). For example, there may be no adequate staff training opportunities, a lack of funding to attract specialists, and staff shortages due to illness and the inability to hire additional staff due to a lack of resources.

Finally, the difficulties also relate to low user motivation (9%) or being fearful/being reserved (6%). There may be little intrinsic motivation, and it is not always easy to retain and maintain users in the intervention plan. Additionally, users may feel ashamed of their difficulties and fearful of society's stigmatizing perception. The literature suggests that sufficient time is required to arrive at a good level of relationship and understanding with users. Furthermore, rejection by users should not lead to non-treatment but rather to continued expertise services network to monitor the situation (Report 50 people profiles, 2017).

Table 19 Main difficulties in responding to requests of users according to the organizations (N= 53)*

	N	%
Insufficient financial resources	17	32.1
'Insufficient financing of projects and lack of funds to employ qualified staff, increasing costs of building maintenance', 'Lack of human, financial and social resources', 'Long-term financial support', 'Lack of financial resources', 'Amount of resources (money and people)', …		
Inefficient services	16	30.2
'Reduce the number of people in the same physical structure, in order to enable continuous and more efficient work', 'The main difficulties are the time that some public services take to respond (e.g., addition services)', 'Lack of progressive responses', 'Difficulties of access (price and geographical access: no street psychologists)', 'If the proposed help does not provide immediate relief, people often reject the proposed help due to the lack of a proper assessment of their situation', 'We do not have such capacity and long waiting list with other NGOs', 'The deterioration of the National Health System, the hostility of some health care workers towards the HIV key populations (gay men, drug users and sex workers) and the barriers to health care of the refugee – migrant population', 'In general, we are confronted with difficulties of accessibility/high thresholds of access of other services or organizations, during our referrals and accompaniments: judgements on the appearance of the people we accompany, little flexibility (schedules, accessibility), waiting lists and procedures, etc.', …		
Legal barriers	12	22.6
'The complexity in the process of regularizing undocumented migrants', 'the majority are undocumented with no hope of ever being legal on the territory (Morocco, Algerian, …) so nothing can be offered in terms of housing or work', 'Bureaucracy timings, and the complex nature of the situations we have to assess', 'Legal and administrative barriers', 'The lack of accommodation programs as well as the lack of social policies in Greece', 'Probably the main difficulty is the lack of documents', …		
Un(der)qualified staff	8	15.1
'The possibility to offer competitive salaries to maintain higher specialized professional, 'The possibility to offer adequate staff training opportunities', 'Lack of health professionals, due to the Covid-19 emergency', 'No psychiatrist available for such work', 'Insufficient organizational capacity, rooted in a lack of funding to attract specialists', 'The Centre does not have specialised medical/nursing services for a particular age group that it serves (elderly people, often with Alzheimer's disease)', …		
Low motivation users	5	9.4

'Patients do not want to be followed in mental health', 'Intrinsic motivation', 'Difficulty in the adherence and maintenance of participants to the intervention plan (social and therapeutic)', …		
Understaffing	3	5.7
'Economical resources for additional/trained staff', 'Staff members in insufficient number' and 'Understaffing (sick leave, holidays)'.		
Fearful/being reserved	3	5.7
'People be ashamed by their difficulties and do not give the right importance to the priority of intervention, difficulties in building a trustful relationship' and 'fear of returning to addictions, fear of the still accompanying schematic and stigmatizing perception of people in the homelessness crisis by the society'.		

* Multiple difficulties or answers possible per organization.

Users' needs and difficulties in responding to these needs were also asked what implications they have for staff (see Table 20). About three-fifths (59%) indicated that this creates a need for supervision and training. For example, there is a need to focus on relational skills, flexibility and creativity in intervention, skills in evaluation and observation, knowledge of different services and procedures, etc. It is advisable for the staff to have knowledge and skills that are wide-ranging yet flexible and effective in specific circumstances (Maguire, 2012). Paying attention to interpersonal and relational aspects is as important as other, more obviously 'technical' concerns. Although these are often referred to as 'soft' skills, they are capable of being learned, communicated, and measured, so they should be seen as 'hard' skills as much as any more obviously physical and technical skills (Erasmus+ Project Dignity & Well-being, 2019).

Approximately a quarter (24%) indicated that there is a greater need for qualified personnel such as psychiatrists, health professionals, physiotherapists, occupational therapists, psychiatric nurses, etc. In addition, more staff is needed (10%) and also more regular staff (5%). There is frustration with the rotating door for staff but especially for users.

Table 20 Implications for staff regarding the needs of users and difficulties in meeting those needs according to the organizations (N= 41)*

	N	%
Supervision/training needed	24	58.5
'More skills in evaluation and observation, more skills in social diagnosis techniques, more skills in listening and respect to the person timing instead of the project timing', 'These difficulties imply a high level of knowledge of the different services and respective procedures. It also implies the development of relational skills and the resilience of professionals, as well as flexibility and creativity in intervention.', 'Educating staff for an appropriate approach to working with these people, preparing staff for the complexity of the work, setting clear boundaries, structures, order, connecting staff and strong teamwork. Otherwise, the users exploit and exhaust the staff', 'There is a need of continuous education to the staff members to obtain resilience and other skills', …		
Need for qualified staff	10	24.4
'Less specialized staff', 'Psychiatrist is needed, but they are in short supply, especially for work in such environment and with such remuneration as available', 'This translates directly into difficulties in finding qualified staff and the quality of services provided', 'Difficulty in hiring health professionals, unavailable to be hired full time', 'The need for a psychiatric nurse', 'There is a need for staffing by more doctors, caregivers and possibly specialties related to the development or maintenance of skills in the above-mentioned populations (e.g. ergotherapist, physiotherapist, etc.)', …		
More staff needed	4	9.8
'Would need more staff', 'There is need for more staff to conduct a given case in an even more individual manner and, for example, to give more support in the way of visiting people after they have obtained the premises', …		
More regular staff needed	2	4.9

'Frustration with rotatory door for staff but especially for users' and 'More staff rotation'.		

* Multiple implications or answers possible per organization.

Complaints/criticisms of the users

To gain further insight into the shortcomings of the services, the most common complaints from service users were also surveyed (see Table 21). About half of the organizations reported complaints related to service inefficiency, such as the inaccessibility of public or specialized services, restrictive operating hours, extended waiting times for critical services like housing, and inadequate shelter availability. Approximately a quarter of the organizations (24%) cited dissatisfaction with rules and regulations, such as limited operating hours, restrictions on partner visitation, alcohol consumption prohibition in the shelter, and required rent payments. Additionally, user complaints often stem from differing perspectives, as some users may not fully comprehend their living situation or believe that the services do not adequately address their needs.

Table 21 The most received complaints/criticism from users according to the organizations (N= 42)*

	N	%
Inefficient services (accessibility, long waiting times, ...)	20	47.6
'Complaints are related to the challenges in accessing formal healthcare (hospitals and Primary Healthcare)', 'They request longer opening hours', 'Lack of places in the shelter', 'Access to specialist services', 'Shortage of public services', 'The people wants to stay in dormitories without documents', 'They are waiting too long to get their own housing', 'Complaints from some participants refer to the resolution of some issues don't go as quickly as they anticipated',' Long time to access public services',…		
Dissatisfaction with the rules	10	23.8
'Digitization of service request procedures', 'They wonder why they need to pay (with their own money) rent and why do they need to come every week to an appointment', 'The dissatisfaction is essentially related to internal operating rules (for example, times of entry and use of dormitories), quality of food and laundry service', 'They want a free regime and do not want to follow internal rules', 'That we restrict users' freedom - for example, not allowing them to drink alcohol in the shelter, not allowing them to invite their husbands to visit, not allowing them to disturb other residents', …		
Different perspective	6	14.3
'Sometimes we offer too much. Sometimes we offer too little. Homeless people do not get happy easily', 'Lack of understand for their life situation', 'That we are not adequate to meet their needs', …		
Physical conditions	6	14.3
'Lack of privacy - personal space', 'Necessary sharing personal spaces', …		
Experiences of discrimination	4	9.5
'Issues related to stigma and discrimination', '…the wide spread stigmatization of PWHIV, homophobic and other discriminatory attitudes', …		
Resistance	2	4.8
'Guests often look for pure welfare without wanting to discuss personally' and 'Resistance in performing some activities, specifically those in which they leave their comfort zone'.		

* Multiple complaints/criticisms or answers possible per organization.

Project partners' reflection on services and needs

- Questions: How can we comprehend the discovery that mental needs are frequently unexpressed? Furthermore, how can we address differences in perspective between service users and professionals in a people-centred and relationship-based approach? Additionally, how can we better align services with the real needs of homeless people? How to deal with legal barriers such as the complexity of regularizing undocumented migrants? What are crucial components of high-quality

staff training and care? How can we establish a positive working environment and organize work effectively, and prevent staff dropout and burnout?

- Answers:
  - The meaning of psychological support can vary greatly depending on the location and local qualifications. Typically, people require companionship and guidance more than treatment.
  - Mental health care often involves counselling.
  - Mental needs are frequently unexpressed, which can make them difficult to address. There are several reasons why homeless people may not express their mental health needs:
    - Time constraints: service providers may not always have enough time to address mental health concerns during brief interactions with homeless individuals.
    - Shame: some homeless people may feel embarrassed or ashamed about their mental health issues and may be hesitant to talk about them.
    - Lack of awareness: some homeless people may not realize that they need help for their mental health, and may feel guilty or ashamed if they are told they need it.
    - Other priorities: homeless people may have more pressing needs, such as shelter, food, and safety, and may feel that their mental health is a lower priority.
  - To better tailor services to the real needs of homeless people, it is important to:
    - Listen to the needs of homeless people themselves, rather than just focusing on the needs of service providers.
    - Address accessibility issues, such as those faced by undocumented migrants and people with disabilities.
    - Foster collaboration and partnerships between mental health and social services, public and private organizations, and policy makers.
    - Create a one-stop-shop for homeless people and related organizations, with a 360-degree scan of homeless needs and a dispatch system to connect them with appropriate services. It is important for each partner to maintain their identity while working together for the benefit of homeless people.
  - To prevent staff drop-out and burnout, it is important to:
    - Provide support and supervision, including regular intervision (weekly) and supervision (monthly).
    - Encourage good relationships and cooperation between colleagues, and ensure sufficient rest.
    - Avoid the vision of ‘rescuing all people’, which can be overwhelming and unsustainable.
    - Provide well-paying jobs and opportunities for advancement.
    - The attitude, passion, and interest of staff play an essential role. Staff members must genuinely care about the people they serve.
  - Staffing is a significant issue, with burnout and staff turnover being common. The use of security personnel to address this problem can have negative consequences. To establish more personal connections, it is essential to strike a balance between the number of staff and the number of service users, which may require a reduction in the number of users to eliminate the need for security personnel.
  - Staff training can increase staff efficiency, reducing the need for additional staff. Furthermore, creating a learning community that fosters familiarity among a smaller number of staff members can create beneficial outcomes.
  - Retaining key staff is critical to maintaining high-quality services.

VII. Collaboration

The organizations were also asked to indicate which other organizations or services they collaborate with to meet the needs of the users. In other research projects, it has been found that an important factor is a support network capable of working in an integrated, coordinated, and complementary way, as homeless people tend to have needs in multiple domains at a single point in time, which reinforce each other. No organization, professional, or actor can declare themselves self-sufficient. Furthermore, continuity of care is needed (Report 50 people profiles, 2017).

As Figure 4 and Table 22 show, nine out of ten organizations collaborate with social services, such as public welfare, center for social services, social security services; and (medical) health services, such as hospitals, GPs, health centers, outpatient clinics, emergency services. Three-quarters of the organizations indicate that they collaborate with outreach services or street work, mental health services, and housing services. This includes, for example, municipality street work, medical street work, mobile units of risk reduction and harm minimization programs, psychiatric hospitals, public mental health facilities, psychiatrists, substance abuse services, private home search agencies, public shelters and housing first, housing departments of the city authority, outreach housing services, etc.

Compared to the different types of services, the least collaboration is seen with job services. Nevertheless, three-fifths of the organizations collaborate with, for example, labour offices, municipal job centres, public employment offices, local entrepreneurs, state employment agencies, etc. Nineteen organizations also mentioned other services with which they collaborate to meet the needs of the users, such as services for immigrants, lawyers, cultural services, volunteer associations, and civil society (e.g., police).

The survey also allowed organizations to indicate how they collaborate with other services, but little information was provided in the responses. In most answers, it mainly concerns referrals and exchanging experiences or observations, and guidance and physical accompaniment of the users to the other services.

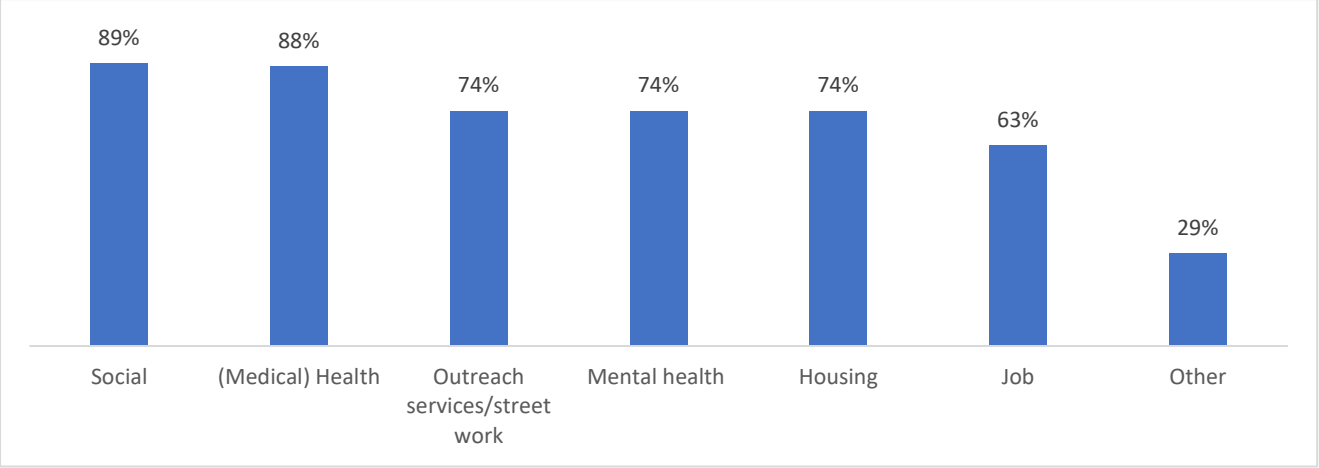

Figure 4 The type of organizations or services with whom they collaborate

Table 22 The type of organizations they collaborate with to meet the needs of users (N= 64)

	N	%
Social services	58	89.2
'Access to benefits and social support', 'local administration', 'public welfare', 'social security services', 'We frequently refer to social workers', 'Center for social services', …		
Health services	57	87.7
'Hospitals, 'General practitioners', 'Red cross clinic', 'outpatient clinics', 'Health centres', 'therapeutic communities', 'Personal doctors', 'Outpatient clinic, emergency services, community work, addiction treatment clinic', 'Hospitals', 'Medicines du Monde, Social Medical Units, HIV clinics etc.', 'GPs, any doctors the person needs, ERs, hospitals, etc.', …		
Outreach services/street work	48	73.8
'Medical street working', 'street technical teams in terms of social and health monitoring', 'mobile units of risk reduction and harm minimization programs', 'Different types of outreach works use our facilities to meet with their users/deliver messages through staff', 'we have our own outreach mobile teams, but we collaborate with all the street actors in Brussels', 'OKANA streetwork, Municipality streetwork', …		
Mental health services	48	73.8
'Outreach/street psychiatric nurses, 'Psychiatric hospital', 'The doctors employed try to pass on a person if needed for further treatment in public mental health facilities', 'General and psychiatric hospital, treatment centres, day care centres, substance abuse services', 'Psychiatric outpatient clinics', 'Psychiatric hospital of Ljubljana', 'Cooperation with mental health facilities', 'Psychiatrists, psychologist at the Day Centre of Riga Shelter', …		
Housing services	48	73.8
'Private home search agencies', 'Housing departments of the city authority', 'Public shelters and housing first', 'Outreach housing services', 'Housing and Work programme', 'Housing fund, local authority, ministry', 'State Employment Agency', …		
Job services	41	63.1
'Labour offices', 'Municipal job centres', 'Public employment office', 'Local entrepreneurs', 'Informal network', 'Odyssea NGO', …		
Other	19	29.2
'Services for immigrants', 'Lawyers', 'Cultural services', 'Volunteer associations that promote activities', 'Civil society (police, STIB/SNCB agents, etc.)', 'Legal services: European Lawyers in Lesvos (ELIL – Athens), Caritas Hellas', …		

Project partners' reflection on collaboration

- Questions: How is cooperation facilitated, such as through formal monthly meetings, case discussions, shared action plans, joint visits, or informal contacts? How is an individualized approach ensured, such as through a dedicated case manager? What can be done to strengthen networks and collaborations, and which networks and collaborations are most critical?
- Answers:
  - Collaboration can take various forms across different countries. For instance, in Slovenia, social workers in the social care system provide continuity of care. In Italy, a municipal social worker serves as the primary point of contact. These contacts may be both informal and formal, but they are not prescribed by law.
  - Cooperation practices may differ between organizations, but not necessarily at the individual 'case' level. The extent of cooperation also depends on the seniority of staff members involved. In Portugal, there is a national strategy for homeless people, and each homeless person is assigned a "manager" who follows their case.
  - One effective approach to cooperation is through a tandem outreach and case management model, where a designated case manager serves as the hub between different service providers.

Social services often serve as the first point of contact for homeless individuals who have no residence.

- Overall, building and maintaining strong networks and collaborations is essential for addressing homelessness effectively. It requires ongoing communication, coordination, and cooperation among service providers, policymakers, and community members.

VIII. COVID-19

One of the objectives of the survey was to assess the impact of COVID-19 on both the services and the users, and whether this impact is still being felt. What changes have been innovative and have transformed the organization? What lessons have we learned from the COVID-19 pandemic?

Are there consequences of the COVID-19 crisis?

Approximately half of the organizations (48%) reported that the COVID-19 crisis had a negative impact on their users (see Figure 5), which was the most commonly reported response. The second most common response was that the COVID-19 crisis had both a negative and positive impact on users, reported by 36% of organizations. About one in ten organizations (11%) reported that the COVID-19 crisis had no impact on users, and a small minority (5%) reported that it had only a positive impact. In summary (see also Table 23), approximately four-fifths (84%) of organizations reported that the COVID-19 crisis had a negative impact on users. Of these organizations, three-fifths (57%) reported that these negative consequences are still being felt. On the other hand, approximately two-fifths (41%) reported that the COVID-19 crisis had a positive impact on users. About half of these organizations (52%) reported that these positive consequences are still present.

The picture for service personnel differs from that of users. Although the most commonly reported response is still a negative impact (by 35% of the organizations), approximately the same number of organizations reported that the COVID-19 crisis had both a positive and negative impact on staff or no impact at all, namely 27% and 28%, respectively. The proportion of organizations that reported no impact on staff was higher than the proportion that reported no impact on users (28% versus 11%). Moreover, the proportion of organizations that reported that the COVID-19 crisis had only a positive impact on staff was higher than that for users (10% versus 5%). In summary, about three-fifths (62%) reported negative consequences for staff, of which 44% indicated that these negative consequences are still present. Just under two-fifths (37%) reported positive consequences for staff, of which three-quarters (74%) indicated that these positive consequences are still present. Compared to the COVID-19 impact on users, there are more reports of no consequences for service personnel and fewer reports of negative consequences. The proportion reporting positive consequences is the same, but for service personnel, these positive consequences appear to be more enduring.

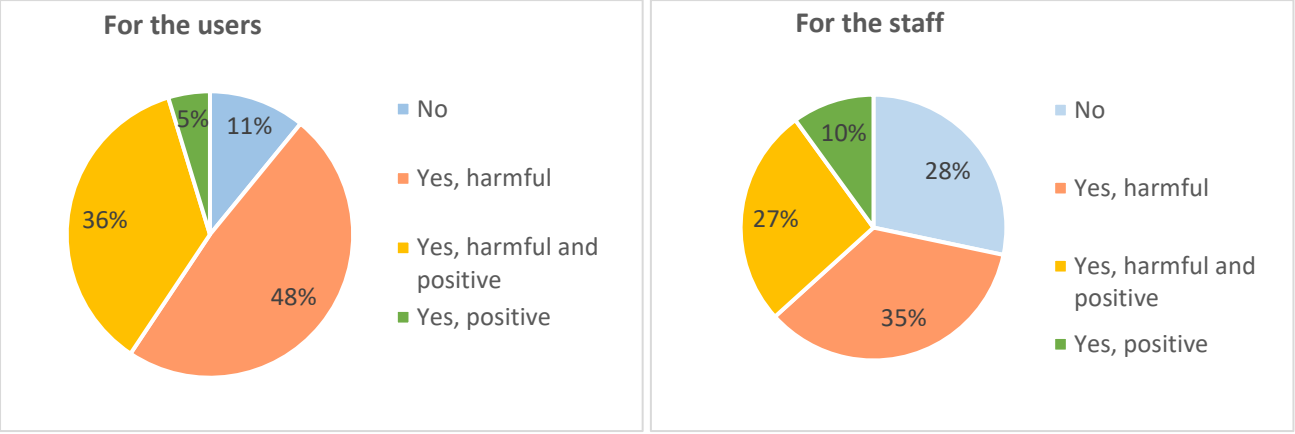

Figure 5 The impact of the COVID-19 crisis on users and staff

Table 23 The (direct or indirect) consequences of the COVID-19 crisis according to the organizations

	N	%
For the users/guests		
Are there any consequences? (N= 64)		
No	7	10.9
Yes, harmful	31	48.4
Yes, harmful and positive	23	35.9
Yes, positive	3	4.7
Do the harmful consequences persist? (N= 44)		
No	16	36.4
Yes	25	56.8
Not clear (yet)	3	6.8
Do the positive consequences persist? (N= 25)		
No	6	19.0
Yes	13	52.4
Not clear (yet)	6	28.6
For the staff		
Are there any consequences? (N= 60)		
No	17	28.3
Yes, harmful	21	35.0
Yes, harmful and positive	16	26.7
Yes, positive	6	10.0
Do the harmful consequences persist? (N= 32)		
No	12	37.5
Yes	14	43.8
Not clear (yet)	6	18.8
Do the positive consequences persist? (N= 19)		
No	3	15.8
Yes	14	73.7
Not clear (yet)	2	10.5
Opportunities for transformation and innovation in the organization (N= 64)		
No	23	35.9
Yes	41	64.1

The consequences of the COVID-19 crisis for the users

Table 24 presents the negative impacts of the COVID-19 crisis on service users, as reported by organizations. More than half (55%) of the organizations identified limited accessibility of services as a major barrier caused by the COVID-19 crisis. This resulted in restricted access to shelters, emergency services, and other essential services such as medical, nutritional, and housing services.

Around one-third of the organizations reported that the COVID-19 pandemic had a negative impact on the mental health of service users (32%) and led to experiences of loss (28%). Examples include increased drug and alcohol abuse, higher rates of double diagnoses, medical issues, losing loved ones, coping with anxiety and uncertainty, interruption of activities (such as jobs and social activities), and removal from support networks.

Additionally, less than one-fifth (19%) of the organizations reported that the COVID-19 crisis resulted in a professional and economic downturn for many service users due to job loss and the absence of informal sources of income, such as daily paid activities. Finally, about one in ten organizations reported that the COVID-19 crisis caused increased inequality (11%), worsening physical health (11%), and increased poverty and homelessness (10%). Examples of these impacts include disadvantaged groups experiencing larger and longer-lasting shocks and having to adopt coping mechanisms that affect their economic prospects and ability to weather future shocks, increased risk of COVID-19 infection among those living in shelters (an average of 10-12 people per dormitory), and an increase in unemployment and poverty.

In summary, the COVID-19 crisis had significant negative impacts on service users, including limited accessibility to services, mental health deterioration, loss experiences, professional and economic downturn, increased inequality, worsening physical health, and increased poverty and homelessness.

Table 24 The negative (direct or indirect) consequences of the COVID-19 crisis for the users according to the organizations (N= 53)*

	N	%
Limited accessibility of services	29	54.7
'Poorer access to services – public health and mental health care', 'Restriction of access to health care facilities, restrictions on leaving the facility, restrictions on access to aid institutions and offices, which in turn made it much more difficult, or even completely impossible, to become independent', 'Restriction of access to emergency services, difficulties in getting to the shelter due to municipal and government procedures', 'Greater difficulties in accessing a variety of services - including medical, nutritional, shelter, and housing', 'On the negative side, there were periodic outbreaks of COVID, during which the shelter was quarantined, and new users were denied access to shelter services', 'Difficulty in accessing health services', 'Access denial to public and private service (mostly health services)', 'Raising of access thresholds (including the need for a covid test) and occasional closure of hygiene, sanitary services, food banks, etc.', …		
Worsening mental health	17	32.1
'The epidemic also had a significant impact on the individual's psychophysical well-being (depression and other mental health problems)', The widespread contagion and lockdown will inevitably have a psychological effect. Furthermore, specific populations like homeless, psychiatrics, the elderly and the children might report different level of psychological distress', 'The time in the first wave was especially harmful - lack of human contact, there were no people in the user's personal space, there was an increase or new problems in mental health, psychiatric distress also deepened, some users gave up taking care of themselves and their home', 'More drug and alcohol abuse, double diagnose increase', 'Medical issues and mainly losing a loved one and mental health issues coping with the loss and anxiety / uncertainty of the situation', …		
Several losses	15	28.3
'They had to interrupt their activities (jobs and social activities)', 'Removal from the support network (for those who still had)', 'Job loss', 'Loss of street support', 'Loss of street support due to teleworking and team quarantines; loss of street income, …', …		
Professional and economic downturn	10	18.9
'Loss of job or house', 'Unemployment', 'Individuals or families lost their jobs due to the epidemic and were thus left without a regular income, which had a significant impact on their financial situation', 'People lost informal sources of income such as daily paid activities. It is important to highlight that social income in Portugal is approximately 200 euros per month and for that reason, informal sources of income are very important for people experiencing homelessness', …		
Increased inequality	6	11.3
'The immediate impacts of the pandemic posed longer-term risks to inequality and social mobility, widening pre-existing inequalities of opportunity. As disadvantaged groups suffer larger, longer-lasting shocks, they are also more likely to adopt coping mechanisms, such as running down their savings, which affect their economic prospects and ability to weather future shocks', 'Vulnerable people became		

even more vulnerable, with no access to informal ways of finding money', 'They got even more separated from society (social excluded)', 'Increased marginalisation', …		
Worsening physical health	6	11.3
'Services were not responding, heath issues became even worst, screening for HCV, HIV and Tuberculosis was interrupted on our projects. Loss of the most basic conditions, people living with nothing to eat', 'Being hungry', 'The worsening of health problems - both among addicted and disturbed people', 'Also, living in the shelter was more likely to be infected with COVID, with an average of 10-12 people per dormitory - a higher risk of infection', …		
Increased poverty and homelessness	4	10.0
Unemployment and poverty scale up', Since 2020, on the other hand, people in economic difficulty have increased, there has been a strong loss of work, mental distress and stress. The youngest have had difficulty in completing the training courses and the financial condition of many has become more serious', …		

* Multiple consequences or answers possible per organization.

Table 25 displays the positive outcomes of the COVID-19 crisis for service users, as reported by organizations. Just over two-fifths of organizations (42%) cite increased funding, new programs, or expanded opening hours as significant benefits of the crisis, such as financing for additional shelter beds and establishing housing facilities for homeless people who use drugs. In some cases, night shelters transitioned to 24/7 shelters.

A little over a quarter of organizations (27%) report 'increased proximity of closeness' as a positive impact on users, such as the establishment of closer relationships between staff and users or a reduced number of users. Other positive outcomes reported include less pressure and temptation from the environment (15%), distance work (such as online meetings and communication) (12%), and increased public awareness (12%). Examples include the courts and related services operating on a limited scale, which allowed people to breathe a little easier, services finally embracing email and scanning to expedite processes, and a slight increase in public awareness towards homeless individuals with psychiatric disorders.

Table 25 The positive (direct or indirect) consequences of the COVID-19 crisis for the users according to the organizations (N= 26)*

	N	%
Increased funding/new programs/longer opening hours	11	42.3
'Increased funding', 'The positive consequences were that we were financed for more beds to shelter the homeless, we were given more medical resources and cleaning resources. Rather than night shelters we became 24h/7 shelters and we saw the added value for the user's well-being. People had time to rest. We had access to much better-quality accommodation f.ex. empty hotels. Extra mobile teams were put in place to survey squats', 'During the pandemic, by contrast, there was a period when patients were housed for 24 h in facilities, limiting street life', 'Positive consequences were that during the strict lock-downs, we opened 24/7, which is 9 hours more than usual', 'the creation of various reception centres that after restructuring will remain in place until 2023 as a COVID measure', 'There was finally a housing facility for homeless people who use drugs', 'Rehousing possibilities (hotels, Cohabs... - individual, furnished, comfortable, often free reception, which allows to move forward in the procedures and to put situations in order)', …		
Increased proximity/closeness	7	26.9
'Establishing a closer relationship between staff and users', 'New friendships between isolated users', 'Greater proximity to the technical team in times of social isolation', 'Reduced number of users', …		
Less pressure and temptation from environment	4	15.4
'During the epidemic, the courts and related services (debt collectors, banks - executions) worked on a very limited scale, and therefore people could breathe a little easier', 'Mainly positive consequences, in the way that jobcentres were closed, so residents were left alone and not all the time called into meaningless meetings etc. Also, in the shelter we cancelled all visitors from outside, which made the		

shelter very calm and quiet for a change', 'A break from pressure from authorities' and 'less use of drugs'.		
Distance work (e.g., online meetings, online communication)	3	11.5
'Distance learning - we can help many children remotely, which was not an option before. But there is no comparison between live assistance and remote assistance', 'Pandemic forced the handling of certain official matters at a distance, and now it has become the norm in the operation of some offices. Similarly, organizing meetings and conversations at a distance has become a common practice in many entities, not only public ones' and 'Some services finally started working with e-mail, scan, etc. to speed up things.'		
Increased acceptance of help	3	11.5
'Greater acceptance of treatment for people with active consumption', 'We have been contacted by people who previously did not want to use help, but since COVID limited their ability to survive (e.g., empty stations where it is no longer possible to obtain funds from travellers), they were forced to come for help. In some cases, it had a positive effect - people confronted their problems, started education, work', …		
Increased public awareness	3	11.5
'There was a slight increase in public awareness towards the homeless people living with psychiatric disorders', 'Easier access to doctors - doctors have become accessible and responsive online and receptive to further research and the needs of the homeless' and 'More attention for homelessness, more visibility; some organizations have put more action on practical/humanitarian aid (flexibility of the sector); financial aid for certain target groups (sex workers, homeless people...).'		

* Multiple consequences or answers possible per organization.

The consequences of the COVID-19 crisis for the staff

In addition to the negative impact of the COVID-19 crisis on users, there are also negative consequences for the staff of organizations (see Table 26). Approximately one-third of the organizations mentioned the risk of becoming sick themselves (32%) and the fatigue caused by the COVID-19 crisis (27%). The pandemic caused more stress and emotional exhaustion among staff due to, for example, a focus on physical health and mask mandates. It was very stressful to keep the organization open for many hours, while being understaffed, and staff experienced stress and fatigue dealing with users who were not always compliant with social distancing and mask usage.

About one in five organizations (22%) also indicated that understaffing was a negative consequence of the pandemic. For example, some volunteers no longer came to serve, and workers were often absent due to illness. Other negative consequences are telework (16%), increased isolation (16%), and more layoffs (8%). Although telework can have a positive impact on the staff (see below), the nature of their work is based on relationships and trust, so working remotely with users was difficult. Furthermore, not only the lives of users but also the personal and professional lives of staff were affected by the pandemic, resulting in concerns about social isolation. The increased (temporary) layoffs, for example, affected staff working in the outreach context. In addition to involuntary departures, voluntary departures were also reported as some staff took advantage of the epidemic to leave the organization.

Table 26 The negative (direct or indirect) consequences of the COVID-19 crisis for the staff according to the organizations (N= 37)*

	N	%
Risk of getting sick	12	32.4
'Getting sick of Covid 19', 'This exposed the healthy colleagues to a higher risk of contracting the virus while also increasing the workload', 'Health issues connected with catching the virus', …		
Tiredness	10	27.0
'Increased stress levels and emotional exhaustion', 'The harmful consequences were increased stress/fatigue with users who aren't always compliant with social distancing and use of masks',		

'discomfort, strain, pressure regarding measures, wearing masks, increased and differently expressed needs of users', 'It was very stressful to be open so many hours, while being understaffed', 'Burn-out', 'Due to a focus on physical health and mask mandates, some people were feeling stressed', …		
Understaffing	8	21.6
'Teamwork and organization became more demanding, and people had to spend long hours for some periods of time to compensate colleagues who got COVID-19 or were isolated', 'Some of our volunteers no longer came to serve our association', 'The 'healthy' staff had to cover for the staff who fell sick to COVID especially with Omicron', 'Workers were often absent due to illness. Less volunteers', …		
Telework	6	16.2
'For field workers: telework perceived as negative (because less opportunity to exchange)', 'It was stressful and dissatisfying to work remotely from the users (contact by SMS and telephone)', 'Remote work has both positive and negative effects', 'The nature of our work is based on relationship and trust, so working remotely with users was difficult', 'Skills to work remotely/willingness to have less communication with the client', …		
Increased Isolation	6	16.2
'People's personal life was affected, many report feeling some feelings of distress at being isolated and not having access to moments of socialisation and sharing with colleagues, personally', 'Social isolation', …		
More layoffs	3	8.1
'Some staff elements had to be dismissed and some projects were suspended', 'Some staff took advantage of the epidemic to leave the organization' and 'The staff working in the outreach context had to suspend the activity temporarily (lay-off for a few months)'.		

* Multiple consequences or answers possible per organization.

Looking at the positive consequences of the COVID-19 crisis on personnel (see Table 27), 'increased invention of innovation' is mentioned most frequently, by 41% of organizations. Examples of this include finding new solutions to connect with guests and utilizing distance meetings and training to better manage time. It is clear that the innovation is mainly related to a new (digital) and more efficient way of working. This is also reflected in other responses, such as 'increased digital education' (23%) and 'telework' (23%). Some examples include video meetings, online work (e.g. setting up a shared drive), and employees working from home for additional training and professional literature reading.

Additionally, it is reported that the COVID-19 crisis has led to increased cohesion and togetherness (23%) and increased cooperation (18%). Strengthening relationships between colleagues or with users (as seen in the positive consequences for users) can be explained by being labeled as an 'essential service' which had a positive effect on morale and brought organizations closer together. For some organizations, the COVID-19 crisis also provided an opportunity to more closely cooperate with other organizations or authorities.

Although understaffing was a significant negative impact of the COVID-19 crisis for some organizations, a few organizations (14%) were able to benefit from increased personnel. This was due to more funding for, for example, an expansion of the housing first program. Additionally, there were young people who wanted to volunteer during the COVID-19 crisis.

Table 27 The positive (direct or indirect) consequences of the COVID-19 crisis for the staff according to the organizations (N= 22)*

	N	%
Increased invention/innovation	9	40.9
'Reinvent new ways of working', 'On the other hand, new solutions were found to be with and to connect with our guests', 'The development and diffusion of smart working protocols that allowed the periodical meetings to take place without being physically present', 'Distance meetings and training with better use of time', …		
Increased digital education	5	22.7
'The staff also learned to work using electronic devices and above all to better organize their working time', 'Again implements digital education projects for seniors', 'Video meetings, online work (e.g. setting up a shared Drive)', …		
Telework	5	22.7
'Employees also used to work from home for additional training and reading professional literature', 'Positive, increase in telework', …		
Increased cohesion/togetherness	5	22.7
'The team connected a lot with each other - as if they were protecting themselves and the rest are really those who want to work with their hearts', 'Being labelled "essential service" had a positive effect on morale and brought us closer together. We also learned how much we rely on the other as colleagues, and each and every one stepped up!', 'they built good relationships between them and with the guests, with more solidarity and closeness', …		
Increased cooperation	4	18.2
'Improved network', 'The staff of the facility consistently worked to protect residents and closely cooperated with authorities crisis', 'New paths of cooperation and communication between individual organizations have been developed', …		
More staffing	3	13.6
'During the COVID-19 crisis, our Housing First program grew, so as the support team. New staff were recruited and trained on Housing First approach', 'More young people approached volunteering', …		

* Multiple consequences or answers possible per organization.

The consequences of the COVID-19 crisis for the organization

In addition to questions about the impact of the COVID-19 crisis on users and personnel, organizations were also asked whether the crisis created opportunities for transformation and innovation in their operations (see Table 28). Just over three out of five organizations (64%, see Table 23) reported that transformation or innovation had taken place. The most common responses related to starting new projects, programs, or services (45%) or an increase in online communication/digitalization (40%). Examples of new services include integrating homeless families with babies and children and transgender people into a program, upscaling the housing first project from 30 to 120 houses, creating an outreach team specializing in screening and treatment of Hepatitis C, opening two social businesses to promote the employability of vulnerable populations, transforming a night shelter into a shelter open 24 hours, and providing more flexible and effective services under crisis conditions. The examples of online communication not only involve utilizing online communication channels with colleagues or other partners but also with users, thereby increasing the digital skills and competencies of users. Additionally, conducting online meetings allows for more time to be available for direct contact with users.

Other forms of innovation include increased knowledge and training (18%), new mindsets (5%), more regular meetings (5%), and more effective cooperation (5%). The expansion of knowledge, for example, was caused by the increase in the diversity of participants and support needs that need to be addressed, as well as the frequent communication with the community and the development of social networks, websites, and

newsletters. The introduction of online meetings has had a positive effect on the exchange of information, resulting in some organizations organizing more regular meetings.

Table 28 The opportunities for transformation and innovation in the organizations due to the COVID-19 crisis according to the organizations (N= 40)*

	N	%
New projects/new programs/new services	18	45.0
'New projects were created to maintain the connection with the people we serve, with alternative ways of interaction', 'The expansion of the program has contributed to increasing the diversity of participants and of the support needs that need to be addressed. For example, the program integrated homeless families with babies and children and transgender people. This implied the strengthening of the team's capacities to respond adequately to new support needs', 'We scale up our Housing First project (from 30 to 120 houses), created an Outreach Team specializing in screening and treatment of Hepatitis C, and opened two social businesses to promote the employability of vulnerable populations', 'We transformed the night shelter in a shelter open 24h', 'Adaptation of services', 'Rethink how we offer our services and how to be more flexible and effective under crisis conditions', 'The crisis created the structure itself, around which the provision of multiple services and the hosting of a large (larger than ever) number of homeless citizens was organised', …		
Increased online communication/digitalisation	16	40.0
'Online meetings with partners, staff and users', 'Remote work. Working with digital tools', 'New ways of contacting users: zoom, video call, phone call (digitalization of communication)', 'More digital skills due to more online meetings', 'We work largely for routine and updating work in online meetings, maximizing the time available for direct contact with users', 'In terms of digital skills and competences', 'We could make digital a lot of our services and also our beneficiaries would learn new digital techniques', …		
Increased knowledge & training	7	17.5
'The expansion of the program has contributed to increasing the diversity of participants and of the support needs that need to be addressed', 'We had to learn a new way to communicate our reality to the community, developing social networks, website, newsletters', 'Greater investment in training the entire team from assistants to technicians', …		
New mindsets	2	5.0
'The philosophy of care. Rather than "make them the least comfortable possible so that they don't want to stay" it became, make them comfortable so that they can rest, gain self-esteem and therefore face the world with a different mind-set' and 'Greater involvement of users in the institution's services as part of the program of greater accountability and change of their lives.'		
More regular meetings	2	5.0
'We now organise more meetings between the different components of the association, because we use now to meet through the web meeting platforms' and 'Online team meetings were introduced, which had a positive effect on the exchange of information and made it possible to introduce regular meetings (it was difficult when we met in a traditional form)'.		
More effective cooperation	2	5.0
'Better and more efficient cooperation among organizations working for the people in crisis' and 'We collaborated with the substances centre to make sure, that our users could get their medicine (methadone, suboxone) without going there'.		

* Multiple opportunities or answers possible per organization.

Project partners' reflection on COVID-19

- Questions: What are the most significant lessons you have learned from the COVID-19 crisis? Which changes in your organization, as a result of COVID-19, have been retained?
- Answers:

- The excessive number of Zoom meetings has brought attention to the undervalued brevity of communication. It is challenging to separate personal time from work time.
- Access to equipment capable of participating in online education or services is crucial. Unfortunately, not everyone has equal access to digital education.
- Providing care for vulnerable groups is essential in times of crisis. Municipalities that lacked plans for these groups were unable to provide even the most basic services.
- COVID-19 led to the creation of specialized shelters and some shelters applied isolation protocols.
- During the pandemic, we had to intermittently start and stop services. Consequently, we implemented a system that enables us to track guests, regardless of how or when they use our services.
- Unnecessary fear of vulnerable populations must be avoided, as it contributes significantly to the poor treatment of these groups during a crisis.
- Greater focus on cleaning staff is necessary to maintain a safe and healthy environment.
- The crisis has led to a new awareness, shifting from 'get out as soon as possible' to 'invest in rest'.
- Lessons learned:
  - COVID-19 has blurred the line between work and personal life.
  - Alternative ways of working, such as digital communication, have emerged, benefiting not only the organization but also the users.
  - More online education has been implemented, except for migrant children who face significant barriers to access.
  - There is a general awareness that vulnerable groups require specific plans in times of crisis.
  - Prevention is essential, albeit under pressure from health risks. However, it is necessary to look beyond short-term solutions, as large-scale shelters are once again implemented.

IX. Lobby & giving a voice

Finally, the organizations were given the opportunity to indicate whether they influence public authorities, the media, and/or public opinion in order to effectively combat poverty and homelessness. Moreover, they were also asked to specify how they lobby for their recommendations.

Enabling users to be more empowered can be accomplished through a variety of methods, such as providing employment opportunities, offering training courses, providing access to rehabilitation therapy, and ensuring that their voices are heard. The survey also inquired whether organizations provide a platform for their users to have a say in the development of services, and if so, how. Table 29 demonstrates that around 83% of the organizations exert an influence on public authorities or public opinion, and an overwhelming 91% of the organizations affirm that they provide their users with a voice in the development of services.

Table 29 Total number of organizations that influence public authorities and/or public opinion and that give a voice to users (N= 65)

	N	%	Missing values
Influencing public authorities/public opinion	54	83.1	1
Giving a voice to users	59	90.8	1

Influencing public authorities/public opinion

There are various ways in which organizations exert influence on public authorities, the media, and/or public opinion. Some examples include participating in forums, focus groups, discussion groups, or meetings (34%), providing policy recommendations or advocacy (30%), engaging in dialogue with government or politicians (30%), collaborating with other organizations (28%), participating in public debates in the media (26%), writing articles and reports (23%), being involved in international networks or projects (13%), and using social media (9%). Further information on these various ways can be found in Table 30.

Table 30 The way organizations influence public authorities/public opinion according to the organizations (N= 39)*

	N	%
Forums/focus groups/discussion groups/meetings	18	34.0
'Very regular follow-up meetings with the technicians of the Lisbon City Council have been fundamental for innovation and implementation of new projects', 'At various meetings and congresses, we advocate an integrated approach to solving homelessness', 'We participate in regular meetings of professionals from various organizations working against homelessness. These meetings are frequented by city authorities. From time to time this body presents requests, conclusions etc. to the public authorities at a higher level', 'Through joint meetings or bilateral meetings with the public authorities', …		
Policy recommendations/advocacy	16	30.2
'Several times, some Ministries asked us if we had identified the need for changes to the act that is being amended', 'Communication and advocacy, sometimes working with lawyers (immigration law)', 'ORIENTAR as NPISA partner actively participate in implementation of common public and social policies in the fight against poverty and social exclusion', 'Through advocacy and pressure to State Officials. Also, by providing recommendations to the Ministries and Organisms for combatting poverty', …		
Contact with government/politicians	16	30.2
'Visits and meetings with politicians', 'Providing expert knowledge in political and legislative processes, as well as participating in the public debate in the media', 'We conduct a dialogue with the government and local governments, NGO partners and entrepreneurs at local, regional, national and international levels', …		

Cooperation with other organizations/networking	15	28.3
'During the pandemic we had the follow-up of a public health team and we believe that cooperation and networking was fundamental', 'Taking part in collaborative lobbyism with other stakeholders', 'Cooperation with the Welfare Department of Riga City Council, the State Probation Service and the Prison Administration', …		
Public debate/the press	14	26.4
'Writing debate posts and chronicles', 'Providing expert knowledge in political and legislative processes, as well as participating in the public debate in the media', 'We also occasionally get media coverage when we try to change public perceptions about the shelter and homeless people', …		
Publishing articles/reports	12	22.6
'We also publish a magazine called "Spiragli" regarding our projects inside the Dogaia prison of Prato', 'Evaluation and research reports as well as personal recovery narratives of those for whom the program has been beneficial were very useful for communicate successful project outcomes, and to obtained environmental support for the project', 'Publications', 'Articles in various publications', …		
International networks	7	13.2
'Participation in networks, trainings, events and international and national meetings', 'AEIPS has also participated in several HF research projects at European level', 'Through local, national and international networks', …		
Social media	5	9.4
'We influence in social media, we make statements and make our work apparent', 'Info in the media and social media', 'Targeted communication activities i.e., social media campaigns etc.', …		

* Multiple ways or answers possible per organization.

Giving a voice to users

Although there are various ways to involve users in the development of services, the vast majority of organizations (81%) indicate that they do so through complaint procedures, evaluation forms, meetings, interviews, or surveys (see Table 31). About one in seven (14%) organizations report that services are adapted to the needs of users through daily or informal contacts. Some organizations (12%) go further by paying close attention to the active involvement and participation of users. For example, they hold regular User Assemblies, emphasizing the agency of users in the current life of the shelter and do not make decisions for them without their involvement. Other less common methods include writing reports or magazines by users (7%), involving peer workers (5%), and involving users in advocacy (4%).

Table 31 The way organizations give voice to users according to the organizations (N= 39)*

	N	%
Complaint procedures/ evaluation forms/meetings/interviews/surveys	46	80.7
'Complaints and applications procedure, the possibility of individual evaluation and opinion on the services offered', 'Evaluation forms', 'By filling out surveys, having interviews and making users participate in group sessions', 'Each semester an evaluation is carried out in the form of a survey completed by the users', 'At the end of the service, the client completes an evaluation form', 'Box of complaints, evaluation forms', 'There are evaluation and feedback forms for the services we provide. Also interviews from social services in the presence of interpreters', …		
Daily/informal conversations with users/guests	8	14.0
'We talk with our street patients, listening to them', 'Thanks to our very close relationship with the users of our services we have many opportunities to talk with them and gather information about their needs to better develop our services.', 'Our association focuses on the personal relationship with the user we take charge. The constant and direct conversation between our association and the user facilitates the comparison of how the service is developed', …		
Active involvement/participation	7	12.3
'This response promotes the active participation of residents, through the regular holding of User Assemblies, as well as their involvement in the daily dynamics of the Centre', 'Work based on the		

relationship with the supported people, listening to them and emphasizing their agency in the current life of the shelter', 'We take their opinion seriously in our requests and of course we do not make decisions for them without them', …		
Reports/magazines	4	7.0
'We participate in a magazine where users can write articles on what they want', 'a book of praise and complaints', …		
Peer workers	3	5.3
'All GAT services include in their teams peer workers from the target communities therefore the voice of users is always present', 'providing access to paid and unpaid work in the day to day', and 'engagement of a peer helper'.		
Policy recommendations/advocacy	2	3.5
'The people with whom we work are also frequently invited to be present in meetings with political representatives and at conferences as speakers' and 'We have a self-representative group that participates in regular meetings with users of other HF programs at the national level, as well as in public hearings with policy makers'.		

* Multiple ways or answers possible per organization.

X. Summary

The 'Person First' project is a European initiative launched in 2022 by SMES-Europa and 9 partner organizations, with the support of the EU-Erasmus+ program. The project aims to give special attention to homeless individuals who are increasingly deprived of fundamental human rights, such as access to social and health services, decent housing, and jobs that provide to their circumstances. The project builds on the earlier 'Dignity and Well-being' project and relies on action-research that involves study visits and exchange of experiences. The goal of the project is to respond more effectively, responsibly, and sustainably to the needs of homeless individuals.

The survey within this project was conducted between May 2022 and October 2022, and all collected data was entered into the program Excel and analyzed by the Research Institute for Work and Society (HIVA) of KU Leuven. Approval for the survey was obtained from the Social and Societal Ethics committee (SMEC) of KU Leuven. The questionnaire was originally drafted in English and could be translated by the project partners into their native languages before being distributed to potential respondents. The project partners were responsible for the data collection process, which involved reaching out to and collecting responses from at least 50 organizations in total. Contact with the organizations was made via email, phone, and/or post/mail, although in-person, online, or phone interviews.

The survey involved 65 organizations, with survey participation ranging from 3 organizations in Belgium to 12 organizations in Portugal, averaging about 7 surveys per country. Among the surveyed organizations, approximately 63% are privately subsidized, while 17% are public organizations. In terms of geographical orientation, 52% of the organizations have a local focus, 26% have a regional focus, and around 20% have a national focus.

Half of the organizations surveyed have the objective of assisting their users or improving their quality of life, particularly those who are disadvantaged, disabled, or socially excluded. Additionally, 37% aim to rehabilitate and empower their users by enhancing their adaptation skills and supporting their self-empowerment and social re-adaptation. About 25% of the organizations focus on promoting inclusion and autonomy for vulnerable individuals in society. Furthermore, approximately 20% prioritize the mental and physical health of their users, and 20% also engage in lobbying, advocacy, and raising awareness about their situation to policymakers. Other mentioned goals include providing shelter, preventive work, strengthening social networks, emphasizing employment and education, implementing harm reduction strategies, enhancing services, and collaborating with other organizations.

The median number of paid staff members in the organizations is 18, while the median number of volunteers is 14 (20% of the organizations do not rely on volunteers). On average, 40% of the staff members have a social qualification, making it the highest proportion among the three qualifications surveyed. General medical personnel follow with an average proportion of 12% (median of 3%). Specialized staff in mental health have the lowest average proportion at 8% (median of 0%).

The survey responses regarding the total number of users per year and per day reveal notable discrepancies attributed to differences in organizational size and scope of operations, particularly between local and national entities. The median number of users per year is 460, while the median number of users per day is 48. Nearly all organizations surveyed serve homeless individuals and those with mental health problems. About 90% of the organizations also support poor individuals, women, and migrants. Additionally, approximately 70% of the organizations have LGBTQ+ users, while one-third reported serving minors. Other user categories mentioned include refugees from Ukraine, extremely vulnerable homeless individuals, drug users, Roma, and sex workers. When examining the distribution of user categories within organizations, it is found that, on average, poor people constitute the highest share (89%) of the total user group. They are

followed by homeless people (71%) and individuals with mental health problems (58%). The average shares of LGBTQ+ individuals, minors, women, and migrants are considerably lower, at 6%, 17%, 34%, and 41% respectively. Approximately half of the organizations surveyed state that they refuse admission if their rules are not respected. Common reasons for refusal include age and family composition (e.g., presence of minors), violent and risky behavior, pet ownership, and drug or alcohol use. These reasons are cited by 40% to 30% of organizations. Less common reasons for refusal include psychiatric problems, lack of documentation, and gender-based refusal. On average, organizations report 2.3 different reasons for refusal.

In the survey, organizations were asked to indicate the services they provide or the domains they operate in. The services can be classified into four pillars: social assistance, home & housing, (mental & medical) health, and empowerment & rehabilitation. Social assistance is the most common pillar, with 88% of organizations offering services in this area, particularly social support or care. Approximately half of the organizations provide services in the health and home & housing pillars. Within the health pillar, mental and physical health services are the focus, while a smaller percentage offer services related to drugs or harm reduction. The empowerment & rehabilitation pillar is the least represented, but still one-third of organizations offer services in this area, with a focus on work and education/training. Additionally, about 19% of organizations use street work or outreach teams as a method to provide services to their target group.

To understand the alignment of services with user needs, organizations were asked about the most frequent requests for help/support they receive. The responses reveal a wide range of needs expressed by users. These include requests for housing training, legal support, problem-solving, medical examinations, basic necessities (food, clothing, hygiene), drop-in shelters, job search assistance, learning support, substance abuse help, integration assistance, and social activities. Interestingly, the order of the pillars based on the most common user requests aligns with the order of the most frequently offered services: social assistance, home & housing, (mental & medical) health, and empowerment & rehabilitation. However, it's noteworthy that mental health care, although offered by organizations, is not reported as one of the most frequent requests from users. This suggests that while mental health support is provided, users may not explicitly seek it as frequently as other forms of assistance.

Organizations were asked to identify latent needs among their users, which are needs that users have but do not express. About three-fourths of organizations reported the presence of latent needs among their users. Among these latent needs, the need for mental healthcare was particularly prominent. This could explain why mental health needs were not reported as the most common user requests. Additionally, some organizations noted that users have a need for specialized or tailored services, which they may not express themselves.

Regarding the mismatch between user needs and services offered, 60% of organizations reported experiencing this issue. About half of these organizations stated that services can be insufficient or inefficient, facing challenges with referring users to mental health services and the need for more comprehensive support. Approximately one-third of these organizations mentioned differences in perspective or goals, indicating that users may have different priorities or request solutions that may not address the root causes of their problems. Respecting users' choices can sometimes lead to contradictions for social professionals. A shortage of affordable housing was identified as a significant cause of the mismatch by one-fourth of these organizations. Additionally, one-tenth of these organizations reported that certain user characteristics, such as couples, pets, or victims of domestic violence, can pose obstacles to providing assistance. These findings underscore the complexity of meeting user needs and the challenges faced by organizations in effectively addressing them.

In the survey, organizations were also asked about the main difficulties they face in responding to user requests. The findings reveal several challenges. Approximately one-third of organizations cited insufficient

financial resources as a major obstacle, including inadequate project funding, a lack of funds to employ qualified staff, increasing building maintenance costs, and a lack of long-term financial support. Another third (30%) reported inefficiency in their services, such as accessibility issues, high barriers for users, long waiting lists, and complex procedures. Legal barriers were also mentioned (23%) referring to the complexities of regularizing undocumented migrants. Personnel-related challenges were also identified, including the availability of unqualified or underqualified staff (15%) and understaffing (6%), which can be attributed to a lack of training opportunities, insufficient funding to attract specialists, staff shortages due to illness, and the inability to hire additional staff due to limited resources. Finally, difficulties related to user motivation (9%) and fear/reservation (6%) were mentioned, indicating the need for building trust and understanding, as well as addressing societal stigmas. These findings again highlight the multifaceted nature of the challenges faced by organizations in meeting user needs effectively.

In the survey, organizations were asked about the implications of users' needs and the challenges in responding to these needs for their staff. The findings reveal that about three-fifths of organizations indicated a need for supervision and training. This includes focusing on relational skills, flexibility, creativity in intervention, evaluation and observation skills, and knowledge of different services and procedures. Approximately one-fourth of organizations highlighted the need for qualified personnel such as psychiatrists, health professionals, physiotherapists, occupational therapists, psychiatric nurses, and others. Additionally, there is a need for more staff (10%) and regular staff (5%), as the rotating door can be a source of frustration, especially for users. These findings emphasize the importance of providing adequate support, training, and qualified personnel to address the complex needs of users effectively.

In the survey, organizations were asked about the most common complaints received from service users. The findings indicate that approximately half of the organizations reported complaints related to service inefficiency. These complaints include issues such as the inaccessibility of public or specialized services, restrictive operating hours, extended waiting times for critical services like housing, and inadequate availability of shelters. Around a quarter of the organizations (24%) mentioned dissatisfaction with rules and regulations. Examples of these complaints include limited operating hours, restrictions on partner visitation, prohibition of alcohol consumption in shelters, and required rent payments. Furthermore, user complaints often arise from differing perspectives, where some users may have difficulty understanding their living situation or feel that the services provided do not adequately address their needs. These findings highlight the importance of addressing service inefficiencies and taking user perspectives into account to improve the overall quality and effectiveness of services.

In the survey, organizations were also asked about their collaborations with other organizations or services to meet the needs of their users. The findings highlight the importance of a support network that works in an integrated, coordinated, and complementary manner, as homeless individuals often have multiple needs across different domains that reinforce each other. No single organization or actor can claim to be self-sufficient in addressing these complex needs. Continuity of care is also emphasized as a crucial aspect. The results show that the vast majority of organizations (nine out of ten) collaborate with social services, such as public welfare, center for social services, and social security services. The vast majority also collaborate with (medical) health services, including hospitals, general practitioners, health centers, outpatient clinics, and emergency services. Three-quarters of the organizations collaborate with outreach services or street work, mental health services, and housing services. This includes collaboration with various entities such as municipality street work, medical street work, mobile units of risk reduction and harm minimization programs, psychiatric hospitals, public mental health facilities, psychiatrists, substance abuse services, private home search agencies, public shelters, housing first initiatives, housing departments of the city authority, outreach housing services, and more. Collaboration with job services was relatively less common compared to other types of services, but still, three-fifths of the organizations reported collaborating with

labor offices, municipal job centers, public employment offices, local entrepreneurs, state employment agencies, and similar entities. Additionally, some organizations mentioned collaborations with other services not specified in the survey, such as services for immigrants, lawyers, cultural services, volunteer associations, and civil society, including the police.

While the survey allowed organizations to provide information on how they collaborate with other services, there was limited detail provided in the responses. The most common forms of collaboration mentioned include referrals and the exchange of experiences or observations. Some organizations also mentioned providing guidance and physical accompaniment of users to other services. Overall, these findings highlight the importance of collaboration and coordination among different service providers to effectively meet the diverse and complex needs of homeless individuals.

The survey also aimed to assess the impact of the COVID-19 pandemic on homeless services and their users, as well as identify innovative changes and lessons learned. Approximately half of the organizations (48%) reported only a negative impact of the COVID-19 crisis on their users, while 36% reported both negative and positive impacts. Only 11% reported no impact on users, and 5% reported only a positive impact. In contrast, for service personnel, approximately 35% reported only a negative impact, while 27% reported both positive and negative impacts, 10% reported only a positive impact and 28% reported no impact. Overall, there were fewer reports of negative consequences for service personnel compared to users (62% versus 84%), and positive consequences were more enduring for staff.

The COVID-19 crisis had several negative impacts on service users, as reported by organizations. Limited accessibility of services was identified as a major barrier, affecting access to shelters, emergency services, and essential services like medical and housing assistance. The pandemic also negatively affected the mental health of users, leading to increased drug and alcohol abuse, higher rates of double diagnoses, and coping with anxiety and uncertainty. Users also experienced loss, including losing loved ones and interruption of activities and support networks. The crisis resulted in a professional and economic downturn, with job loss and a lack of informal income sources. Increased inequality, worsening physical health, and heightened poverty and homelessness were also reported. These impacts highlight the significant challenges faced by service users during the COVID-19 pandemic. The COVID-19 crisis also had some positive outcomes for service users, as reported by organizations. Increased funding, new programs, and expanded opening hours were identified as significant benefits, resulting in additional shelter beds and housing facilities for homeless individuals. The crisis also fostered a closer relationship between staff and users, with a reduced number of users in some cases. Other positive impacts included less environmental pressure and temptation, the adoption of distance work through online meetings and communication, and increased public awareness. These outcomes provided some relief and improved support for service users during the crisis.

The COVID-19 crisis had negative consequences for the staff of organizations as well. The risk of becoming sick themselves and the resulting fatigue were mentioned. The pandemic increased stress and emotional exhaustion among staff due to health concerns and the challenges of maintaining operations while understaffed. Understaffing was reported as a significant negative consequence, as some volunteers stopped serving and workers were absent due to illness. Other negative impacts included telework, which posed difficulties in maintaining relationships with users, increased isolation, and a rise in layoffs. The pandemic affected not only the lives of users but also the personal and professional lives of staff, leading to concerns about social isolation and voluntary departures from the organization.

The COVID-19 crisis had some positive consequences for the personnel of organizations as well. The most commonly mentioned positive impact was the increased invention of innovation by personnel. This involved finding new solutions and utilizing digital tools to improve efficiency and communication. Increased digital education and telework were also cited as positive outcomes, allowing for remote meetings, online work,

and professional development opportunities. The crisis also fostered increased cohesion and togetherness among staff and enhanced cooperation with colleagues and users. Some organizations benefited from increased personnel, either through additional funding or the willingness of young people to volunteer during the crisis. Overall, the crisis presented opportunities for innovation, collaboration, and professional growth within organizations. Related to this, the COVID-19 crisis also created opportunities for transformation and innovation in the operations of organizations. The most common changes include starting new projects, programs, or services and increasing online communication and digitalization. Examples of new services include integrating specific populations into programs, expanding existing projects, and creating specialized outreach teams. Online communication has not only improved collaboration with colleagues and partners but also increased digital skills and competencies among users. Other forms of innovation mentioned include increased knowledge and training, adopting new mindsets, holding more regular meetings, and enhancing cooperation. The crisis has prompted organizations to explore new approaches, improve communication, and expand their knowledge base.

Organizations working to combat poverty and homelessness have a significant influence on public authorities, the media, and public opinion. Approximately 83% of organizations exert influence in these areas to effectively address the issues. They employ various methods, such as participating in forums and meetings, providing policy recommendations, engaging in dialogue with government officials, collaborating with other organizations, participating in media debates, writing articles and reports, and utilizing social media. Moreover, 91% of organizations ensure that their users have a voice in the development of services. The most common methods for involving users include complaint procedures, evaluation forms, meetings, interviews, and surveys. Some organizations actively involve users through daily interactions, user assemblies, and decision-making processes. Other methods include user-authored reports or magazines, involving peer workers, and engaging users in advocacy efforts. These practices aim to empower users and ensure their needs and perspectives are considered in service development and decision-making.

XI. References

Analyses of 50 Profiles of Homeless People with Mental Illness: REPORT PROFILES D-&-WB_SMES.pdf (smes-europa.org)

Barreto, Elias & Bento, António & Leonori, Luigi & Raimondi, Silvia & Timms, Philip & Ryckmans, Pierre & Brandt, Preben & Glad, Per & Aalbæk, Gitte & Fitsiou, Panagiota & Darmogianni, Niki & Tataridis, Sofoulis & Pournara, Renia & Lascialfari, Jacopo & Czarnocki, Andrzej & Boczkowska, Anne & Soto, Victor & Martínez, Isabel & Campo, Inés & Mcevoy, John. (2019). Dignity and Well-Being - Practical Approaches to Working with Homeless People with Mental Health Problems. Erasmus-English.pdf (caritasaw.pl)

Leng (2007). The impact on health of homelessness. Local Government Association, London.

Maguire, N. (2012) Training for front-line homeless workers: practicalities and ethics of teaching cognitive behavioural and dialectical behavioural psychological therapeutic techniques, Housing, Care and Support, 15 (4), pp.177 – 185.

O'Sullivan, E. (2012) Ending homelessness – A housing-led approach. Dublin. School of Social Work and Social Policy, Trinity College Dublin.

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