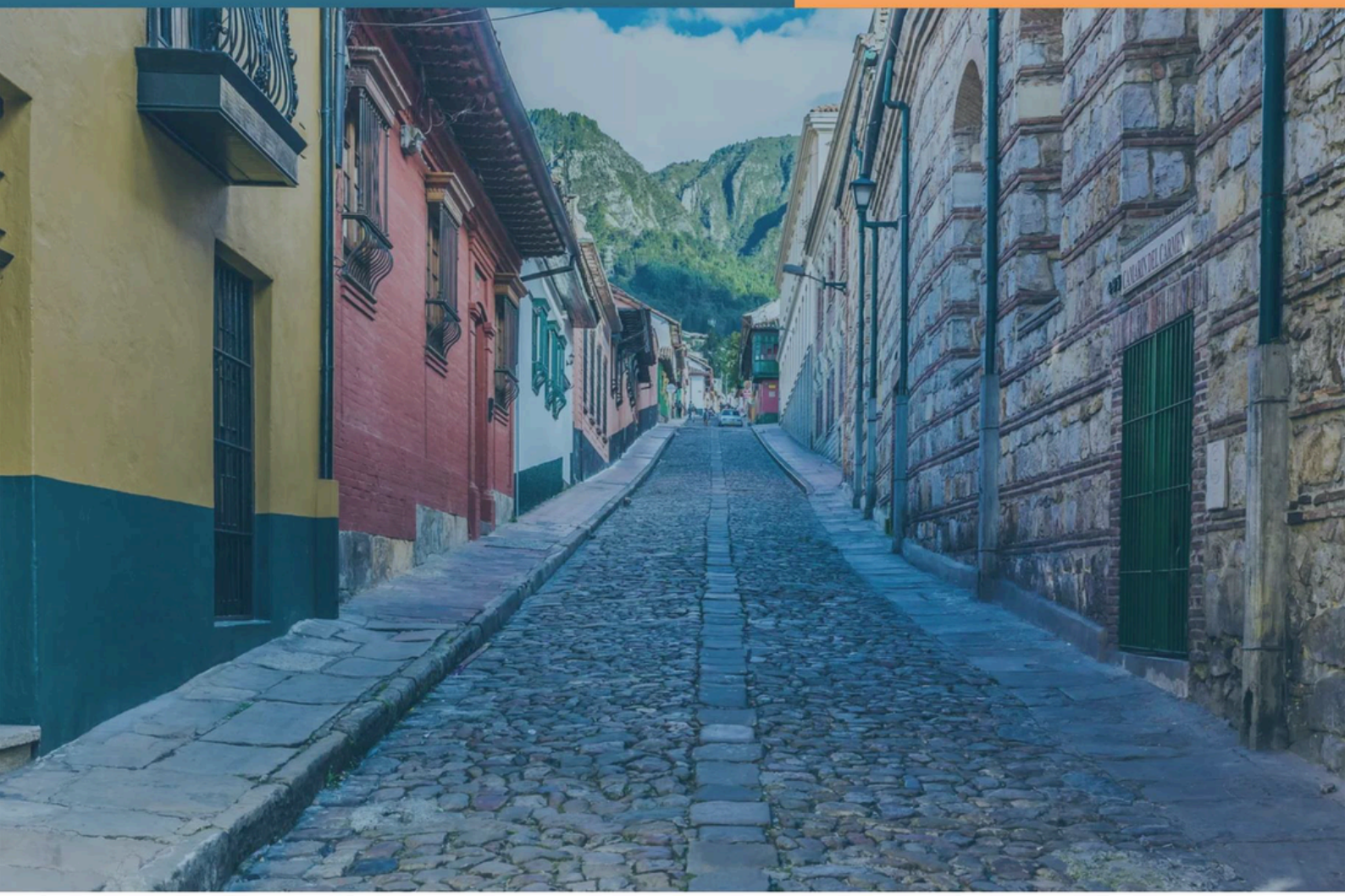
Home4Health Training Program



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Introduction

The Home4Health Project

Home4Health is a project that seeks to collaborate with civil society organisations, institutions, and public authorities to address - through a socially inclusive perspective - the challenges involved in supporting people experiencing homelessness who face complex health issues and trauma, such as addiction.

The project aims to adapt VET organisations to labour market needs, taking as its background the urgent need for a transition towards more inclusive socioeconomic systems, as well as the increasing complexity of job and skills demands across the health and social sectors. It specifically addresses complex issues such as addiction and trauma. Consequently, it seeks to increase opportunities for professional development by promoting the exchange of best practices and experiences at the European level.

The Home4Health project, funded by the Erasmus+ programme, is being implemented between January 2024 and June 2026 in collaboration with the following organisations: ABD - Asociación Bienestar y Desarrollo (Spain), as the project coordinator; CRESCER (Portugal); HVO-Querido (the Netherlands); and Cork Simon Community (Ireland).

The Home4Health project aims to promote cooperation, knowledge exchange, and the scaling up of effective practices across EU organisations that contribute to job creation within the health and social care ecosystems, particularly those supporting people experiencing homelessness and facing complex health and trauma-related challenges, including addiction. The project identifies key factors, competences, and skills required within these ecosystems, placing the needs of beneficiaries at the centre while aligning them with labour market demands.

The Training Program

The training programme is structured as a comprehensive and integrated learning package consisting of a training manual, a toolkit, and a MOOC, which together function as a unified programme. These components collectively bring together evidence-informed and practice-based knowledge on effective approaches to homelessness, presenting best practices and methodologies grounded in person-centred, harm reduction, rights-based, and trauma-informed principles.

The training programme provides the theoretical foundation that guides the training, outlining the key concepts and approaches. The toolkit complements this by offering a structured set of the practical activities presented in the manual, while the MOOC serves as a visual and interactive resource that can both reinforce the training and function as a self-learning tool.
As a whole, these learning program enable public and private VET organisations to increase and adapt their training offer to the emerging needs of the labour market from a social inclusion approach.

The program is directed to a wide range of stakeholders and VET providers, including universities, NGOs, and public administrations. Its purpose is to support the professional development of staff working directly with people experiencing homelessness who face complex health and trauma-related issues, such as addictions.

This training programme manual is organised into six modules, each comprising a set of units that address key thematic areas:

- **Module 1** – Harm Reduction
- **Module 2** – Trauma
- **Module 3** – Mental Health and Homelessness
- **Module 4** – Psychoactive Substances
- **Module 5** – Peer Work
- **Module 6** – Homelessness and Advocacy

Each module explores essential concepts, approaches, and practices that support professionals working with people experiencing homelessness and facing complex health and social challenges.

The units can be delivered independently; however, we recommend implementing the programme in its entirety, as the themes are closely interconnected and build upon one another. Delivering the full programme ensures a more coherent and comprehensive learning experience, enabling participants to develop a deeper understanding of the topics and their interrelations.

The manual is designed to provide the theoretical foundation for the training, which can be complemented by the practical activities included in the toolkit and the visual and interactive content available in the MOOC. Trainers are encouraged to adapt the content, sequence, and depth of each module according to the specific needs, experience levels, and professional contexts of the participants.
By engaging with the full programme, learners can progressively develop their knowledge and skills, strengthening their ability to integrate theory into practice and apply person-centred, harm reduction, rights-based, and trauma-informed approaches in their daily work.

Acronyms

Acquired Immunodeficiency Syndrome (AIDS) – 14
Adult Homeless Integrated Team (AHIT) – 103
Adverse Childhood Experiences (ACEs) – 89
Anterior Cingulate Cortex (ACC) – 93
Attention-Deficit/Hyperactivity Disorder (ADHD) – 148
Borderline Personality Disorder (BPD) – 158
Canadian AIDS Treatment Information Exchange (CATIE) – 31
Cognitive Behavioral Therapy (CBT) – 105
Critical Time Intervention (CTI) – 141
Disorders of Extreme Stress Not Otherwise Specified (DESNOS) – 152
Drug-Induced Cognitive Impairment (DICI) – 150
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) – 152
Eye Movement Desensitization and Reprocessing (EMDR) – 105
European Federation of National Organisations Working with the Homeless (FEANTSA) – 101
FOCUS – 157
Hallucinogen Persisting Perception Disorder (HPPD) – 164
Human Immunodeficiency Virus (HIV) – 14
International Classification of Diseases, 11th Revision (ICD-11) – 152
Integrative Harm Reduction Psychotherapy (IHRP) – 29
Light Emitting Diode (LED) Therapy – 105
Lysergic Acid Diethylamide (LSD) – 164
Managed Alcohol Programs (MAPs) – 52
3,4-Methylenedioxymethamphetamine (MDMA) – 164
Motivational Interviewing (MI) – 24
Needle and Syringe Exchange Programmes (NSP) – 49
New Psychoactive Substances (NPS) – 161
Obsessive-Compulsive Disorder (OCD) – 156
Opioid Agonist Treatment (OAT) – 49
Phencyclidine (PCP) – 164
Post-Traumatic Growth (PTG) – 108
Post-Traumatic Stress Disorder (PTSD) – 86
Self-Medication Theory (SMT) – 170
Substance Abuse and Mental Health Services Administration (SAMHSA) – 88
Supervised Drug Consumption Rooms (DCRs) – 49
Trauma-Informed Care (TIC) – 88
Vicarious Resilience (VR) – 117
World Health Organization (WHO) – 82
Hepatitis C Virus (HCV) – 242
Tuberculosis (TB) – 242
Gamma-Hydroxybutyrate / Gamma-Butyrolactone (GHB/GBL) – 246
Take-Home Naloxone (THN) – 250
Organisation for Economic Co-operation and Development (OECD) – 310

Module Durations

Module 1	Module 2	Module 3	Module 4	Module 5	Module 5
Unit 1 (120 min.) *Activity 1.1: 15-20 min.* *Activity 1.2:*	Unit 1 (180 min.) *Activity 2.1: 15 min.* *Activity 2.2:*	Unit 1 (120 min.) *Activity 3.1: 10 min.* *Activity 3.2:*	Unit 1 (170 min.) *Activity 4.1: 40 min.* *Activity 4.2:*	Unit 1 (195 min.) *Activity 5.1: 30 min.* *Activity 5.2:*	Unit 1 (155 min.) *Activity 6.1: 25 min.* *Activity 6.2:*
Unit 2 (180 min.) *Activity 1.3: 30 min.*	Unit 2 (90 min.) *Activity 2.4: 40 min.*	Unit 2 (170 min.) *Activity 3.4: 40 min.*	Unit 2 (180 min.) *Activity 4.3: 60 min.*	Unit 2 (110 min.) *Activity 5.4: 50 min.*	Unit 2 (265 min.) *Activity 6.3: 35 min.* *Activity 6.4:*
Unit 3 (180 min.) *Activity 1.4: 30 min.* *Activity 1.5:*	Unit 3 (90 min.) *Activity 2.5: 30 min.*	Unit 3 (160 min.) *Activity 3.5: 30 min.* *Activity 3.6:*	Unit 3 (60 min.)		
	Unit 4 (120 min.) *Activity 2.6: 30 min.*				
Total Duration: 8 hours	**Total Duration:8 hours**	**Total Duration: 7.5 hours**	**Total Duration: 7 hours**	**Total Duration: 5 hours**	**Total Duration: 7 hours**

Home4Health Training Program

Module 1
Harm Reduction

Module 1: Harm Reduction
Module Overview

Coordinated by: ABD

In partnership with: CPES CER, HVO Querido, Caritas Slovenia

Co-funded by the European Union

2023-1-ES01-KA220-VET-000158754

a) Learning objectives and outcomes

- Define harm reduction and explain its relevance across different areas of intervention.
- Describe the origins, principles, methodology, and core strategies of harm reduction.
- Identify harm reduction strategies for supporting people experiencing homelessness and facing complex health and trauma-related challenges, including addictions.
- Analyse how harm reduction strategies can be applied across diverse intervention contexts.

b) Competencies addressed

- Cultural Competence: Understanding and respecting the diverse applicability of harm reduction in interventions addressing people experiencing homelessness, struggling with substance use or addiction, and/or trauma across different countries and cultural contexts.
- Analytical Skills: Ability to analyse behavioural patterns related to psychoactive substance use and/or trauma among people experiencing homelessness.
- Critical Thinking: Evaluating the effectiveness and adequacy of various harm reduction strategies for psychoactive substance use, addiction, and/or trauma, while considering context-specific needs and solutions.
- Communication Skills: Effectively communicating findings and insights regarding psychoactive substance use among people experiencing homelessness to diverse audiences, as well as communicating in ways that promote understanding, engagement, and positive change.

c) Methodology

- Lectures and presentations.
- Group discussions.
- Case studies and real-world scenarios.
- Interactive activities.
- Multimedia resources (video, documentaries, etc.).

d) Materials

- Textbooks, reports and articles; Statistic information; Case study materials; Multimedia resources; Presentation slides; Paper and pens.

e) Infrastructure

- A suitable classroom setting equipped with a projector, whiteboard, and seating arrangement conducive to group work and discussions.

Unit 1 | An Introductory Overview

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Section 1 | Introduction to the Course and Participant Introductions

Activity 1.1 | Icebreaker "Introduce One Another" (10-15 min)

Objective:

To help participants build trust/foster connection through active listening and sharing. This activity helps participants get to know each other on a personal/professional level and build empathy by speaking on someone else's behalf.

All the instructions and materials for the activity are available on the Toolkit.

Section 2 | Definitions

Harm reduction can be understood as the everyday strategies we use to reduce the risk of harm from the world around us - even if we don't consciously recognize them as such. Examples include:

- Wearing seatbelts to prevent injury in the event of a car accident;
- Using sunscreen to reduce the harms associated with prolonged exposure to the sun.

Today, harm reduction is most commonly associated with substance use. It is a pragmatic and humanistic set of principles and practices designed to reduce the harmful consequences of addictive behaviours - for both people who use drugs and the societies in which they live (Marlatt, 1996).

Although harm reduction is usually linked to psychoactive substance use, it is a transversal approach that can be applied across many areas of intervention, including work with individuals who:

- Experience homelessness;
- Live with psychiatric disorders;
- Have intellectual disabilities;
- Are deprived of liberty and/or affected by the consequences of imprisonment;
- Face gender-related vulnerabilities.

Harm reduction is more than a methodology, a set of principles and strategies, or a theoretical framework. It can also be understood as a philosophy: a way of being and positioning oneself alongside others and in life.

The Origins of Harm Reduction

Harm reduction originated in Europe as an alternative to the traditional War on Drugs model and the disease model of substance use or addiction (Marlatt, 1996). This approach gained traction as a more pragmatic response to drug-related issues, prioritizing public health over moral judgment or punitive measures.

The War on Drugs model, which originated in the United States, can be defined as a policy framework aimed at criminalizing substance use and drug trafficking. Today, this punitive model is widely criticized because it has led to several negative social and public health consequences. It failed largely because it framed substance use as a criminal issue rather than a public health concern, or one rooted in exclusionary and insufficient social policies.

Key negative outcomes of the punitive model include:

- A dramatic increase in the number of people incarcerated for drug offenses;
- Disproportionate impacts on minority and marginalized communities;
- The reinforcement of cycles of poverty and social disadvantage;
- Increased stigma surrounding psychoactive substance use and addiction;
- Reduced willingness among people who use drugs to seek treatment or support, due to fear of criminalization.

Early Shifts in Drug Policy: The Netherlands

Changes in traditional drug policy began in the 1970s in the Netherlands. A significant shift occurred, moving from a moralistic perspective to a more realistic and pragmatic approach to drug-related issues. This new perspective framed drug use primarily as a matter of health and social well-being, rather than solely a concern for law enforcement or the criminal justice system (Marlatt, 1996).

The Role of Dutch Substance Users in Policy Change

This shift in drug policy was strongly influenced by the direct involvement of Dutch substance users. In 1980, the Junkiebond (“Junkie League”) was established in Rotterdam as a trade union aimed at supporting one another and improving the overall living conditions of its members.

The group's philosophy was grounded in the belief that substance users themselves are best equipped to understand and address their own problems. One of their early initiatives was to distribute disposable materials - such as needles and syringes - within the drug-using community. This intervention played a crucial role in combating the AIDS epidemic by reducing HIV transmission associated with needle sharing.

The Junkiebond was instrumental in advocating for policy changes that legalized needle exchange programs, which later became a key harm reduction strategy for addressing injection-related HIV risks.

Other milestones in the history and origins of harm reduction include:

1920s – United Kingdom (Merseyside)

- Introduction of a "medicalization" approach, allowing people who use drugs to receive prescribed substances such as heroin or cocaine on a maintenance basis.

1960s–1970s

- **1967 (UK):** First provision of sterile injection equipment to people who use drugs (PWUD).
- **1968 (Netherlands):** Introduction of methadone for the treatment of people dependent on morphine.
- **1972 (Netherlands):** Methadone began to be used for the growing number of heroin users.
-

1980s

- **1985 (UK):** First needle exchange program opened in Merseyside.
- **1985 (Netherlands):** The Junkiebond opened its first needle exchange program in Amsterdam.
- **1989:** The first supervised consumption sites opened in the Netherlands, Switzerland, Germany, and Australia.

Note for Trainers: *In this section of Unit 1, each trainer may adapt the content to their own country's context, highlighting the main milestones and historical developments associated with Harm Reduction locally.*

Societal Impact

Beyond individual benefits, harm reduction also has significant societal implications. In the case of homelessness, for example, we observe both an increased humane involvement from sectors of civil society and policymakers, and simultaneously, considerable resistance to adopting more pragmatic, humanistic, and individualized intervention policies. This resistance often stems from moral preconceptions or misconceptions that such approaches would require disproportionate public spending.

However, cost-effectiveness studies on housing-led solutions - such as the Housing First model - consistently demonstrate superior cost-effectiveness compared to traditional approaches (Tsemberis, 2010; Currie et al., 2014), reinforcing harm reduction principles.

Furthermore, what is often perceived as an overwhelmingly large problem has been challenged by analyses indicating that homelessness does not follow a “normal curve distribution” but rather a power-law pattern, where activity concentrates at one extreme (Gladwell, 2018). This shows that chronic homelessness accounts for a relatively small proportion of the overall homeless population.

A well-known illustration appears in a New Yorker article (Gladwell, 2018) describing research by Dennis Culhane for his dissertation. He documented the case of a man living in homelessness in Reno for more than a decade, who generated approximately one million dollars in public expenditure through repeated episodes of emergency healthcare, social services, and jail time - interventions that ultimately perpetuated his homelessness. Yet, during a period in which he was placed in a treatment program that provided stable housing and close professional support, he succeeded in managing daily tasks, maintaining relationships, fulfilling work responsibilities, budgeting his money, and even reducing or stopping his alcohol use. Unfortunately, when the time-limited program ended, he returned to the streets despite his progress.

In the same article, Gladwell highlights evidence from a housing-led program in Denver showing that providing housing and support to chronically homeless individuals costs roughly one-third of what it costs to leave them on the street, once emergency services, health care, and justice system involvement are taken into account.

Section 3 | Applied Principles

Harm reduction emphasizes practical, non-judgmental, and inclusive strategies that center on an individual's needs and goals, acknowledging the complex and diverse experiences people face in managing their health and behaviour. It moves away from moralistic and disease-based models of substance use or addiction, offering a more holistic and humane response to substance use and other high-risk behaviours.

This philosophy focuses on empowerment by involving individuals in decisions about their own care, fostering autonomy, agency, and respect.
Some core principles of Harm Reduction include:

- **Pragmatism –** acknowledging that substance use and risk behaviours are part of our world and must be addressed realistically.
- **Non-imposition of abstinence –** supporting individuals whether or not they choose to stop using substances.
- **Humanism –** treating people with dignity, compassion, and respect.
- **Proximity –** staying close to individuals and communities, providing low-threshold, accessible support.
- **Flexibility –** adapting interventions to each person's circumstances and needs.
- **Gradualism –** recognising that change often occurs in small, incremental steps.
- **Horizontality –** promoting egalitarian relationships between professionals and service users, where different roles do not imply different rights or levels of power.
- **Autonomy –** upholding individuals' right to make informed choices about their lives.
- **Responsibility –** encouraging shared responsibility between individuals, communities, and services.
- **Non-judgment –** avoiding stigmatizing attitudes and creating a safe environment for support.

Applying Harm Reduction Principles

Examples:

- **Autonomy**

A client who injects drugs chooses not to enter abstinence-based treatment. Instead, they work with a harm reduction service to access sterile injection equipment and regular health check-ups. The service respects the client's choice while supporting safer use.

- **Gradualism**

A client who uses stimulants daily discusses their routine with a support worker. Together, they agree on small changes—such as staying hydrated, sleeping after use, and avoiding mixing substances—to reduce immediate health risks.

- **Pragmatism**

A shelter allows a resident who is intoxicated to stay overnight instead of expelling them, prioritising immediate safety from cold weather and street violence while continuing to engage the resident in safer substance use practices.

Individual-Centered Care

Harm reduction aims to prioritize each individual's needs and goals, making them the driving force behind all health and social care decisions. The philosophy of *"meeting people where they're at"* not only refers to physically bringing services directly to those who need them, but also to providing personalized care that recognizes each person's unique circumstances and objectives. This approach allows individuals to set the pace and direction of their own well-being.

Harm reduction acknowledges that while abstinence may be an ideal goal for some, it is neither a requirement nor the only viable option. Instead, it focuses on reducing harm in a way that respects an individual's readiness to change. The person sets their own pace, which may range from complete abstinence to reducing risk behaviours. This flexible and pragmatic approach stands in contrast to the moral model, which often insists that complete abstinence is the only acceptable goal (Marlatt, 1996).

Bottom-Up Approach

Harm reduction emerged as a bottom-up approach, largely driven by the advocacy of people who use drugs. For example, the creation of needle-exchange programs in the Netherlands resulted from direct input from local substance users who advocated for policies to reduce the harms associated with unsafe injection practices. This grassroots advocacy is considered foundational to the practice of harm reduction (Marlatt, 1996).

The success of harm reduction policies depends on listening to the individuals most affected by them, thereby creating more inclusive and effective systems. It is essential to ensure that people with lived experience are involved in the development and implementation of programs and policies, helping to shape measures that genuinely align with the needs of substance users themselves.

Harm reduction therefore:

- Ensures that people who use drugs - and those with a history of drug use - routinely have a meaningful voice in the creation of programs and policies designed to serve them.
- Affirms people who use drugs as the primary agents in reducing the harms associated with their drug use.
- Seeks to empower people who use drugs to share information, support one another, and develop strategies that reflect their actual conditions of use.

Low-Threshold Services

A low-threshold approach is integral to the harm reduction context, meaning that services must be accessible and inclusive, removing barriers to care. This approach makes services available to individuals who may not be ready for abstinence or traditional treatment by offering a range of options that reflect the diverse goals of the target population. It ensures that support is available when and where people need it.

Examples of low-threshold practices include:

- Providing same-day access to detox or treatment services.
- Offering walk-in models of care.
- Implementing flexible policies for late or missed appointments.
- Bringing services directly into the communities that need them.
- Supporting both individuals who are actively using substances and those who wish to maintain abstinence.

This approach stands in contrast to high-threshold policies, which require individuals to be abstinent before entering treatment programs.

Because harm reduction recognizes that complete abstinence may not be a realistic or desirable goal for everyone, it accepts gradual, incremental steps toward safer behaviours - such as using less harmful substances or adopting safer injection techniques. These steps still represent meaningful progress in reducing harm. This approach provides individuals with practical solutions that respect their current stage in the recovery process (Marlatt, 1996).

Non-Judgmental Approach

Harm reduction seeks to eliminate the stigma and judgment associated with substance use. It treats individuals with respect and recognizes that each person's situation is unique.

Harm reduction reframes substance use as a behaviour that can be managed with care and dignity, rather than pathologizing or criminalizing individuals who use drugs. This approach is grounded in non-judgmental, person-first language - for example, referring to people who use drugs or people with substance use disorder instead of stigmatizing terms such as junkies, abusers, or addicts. The goal is to reduce stigma and make it easier for individuals to seek help without fear of being labeled or ostracized.

Unlike the moral model, which frames substance use as "wrong" or immoral, harm reduction focuses on the consequences of behaviours and seeks to minimize harm regardless of the perceived morality of those behaviours. This principle aligns with harm reduction's emphasis on assessing behaviours in terms of their potential to cause harm - to the individual and to society - rather than in terms of their legal or moral status (Marlatt, 1996).

By focusing on the negative consequences associated with substance use - rather than on the act of using substances itself - harm reduction represents a shift from a purely clinical model to a biopsychosocial model.

The integration of core principles creates a comprehensive and compassionate framework for addressing substance use, including:

- Individual-centred care;
- Bottom-up approaches that value lived experience;
- Access to low-threshold services;
- Non-judgmental, stigma-free environments.

Harm reduction also recognizes that broader social determinants - such as poverty, class, racism, social isolation, past trauma, and sex-based discrimination - shape both people's vulnerability to harm and their capacity to effectively cope with drug-related risks.

Activity 1.2 | Case Studies (20-30 min)

Objective

To support participants in applying harm reduction principles in practice by analyzing case studies. Participants will identify existing harm reduction strategies, reflect on which principles are demonstrated, recognize barriers, and explore opportunities for more inclusive, realistic, and empowerment-focused interventions.

All the instructions and materials for the activity are available on the Toolkit.

Unit 2 | Models and Methodologies of Intervention

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Section 1 | Models of Intervention

In this first section, the aim is to present key features of the main models that compose the theoretical framework for the harm reduction approach applied to people experiencing hoIn this first section, the aim is to present key features of the main models that compose the theoretical framework for the harm reduction approach applied to people experiencing homelessness, substance use or addiction, and trauma. These models include:

- Person-Centered Humanistic Approach
- Transtheoretical Model – Stages of Change
- Relapse Prevention Model

Additional and more detailed information on these models is provided in Appendix 2, which may be given to trainees either before or after the training session.
It should be noted that two other relevant components of the theoretical framework for interventions with people experiencing homelessness and complex health, trauma, or addiction issues are:

- Harm Reduction Approach to Hoarding
- Trauma-Informed Care

However, these topics will be addressed in separate modules of this training program (Mental Health and Trauma modules).

Person-Centered Humanistic Approach

Author: Carl Rogers
Objective: Carl Rogers developed this humanistic perspective, emphasizing the importance of building a trusting relationship as the foundation for change and personal development (Rogers, 1961). Applying a person-centered and humanistic approach requires professionals to understand who people are, what their life history has been, what they have experienced, and what is meaningful to them.

People are the experts on their own lives. They live within unique ecosystems shaped by their personal stories, relationships, identities, values, and aspirations. They understand what has happened to them and what holds meaning for them. The goal of this approach is to recognize and value the individuality of each person's journey and perspective.

Key Tools and Principles:

According to Rogers, a trusting relationship is grounded in three core principles:

- ***Genuineness and authenticity:*** being real, transparent, and present with the person; allowing them to feel safe, aware of their own feelings, and able to express them.
- ***Unconditional positive regard:*** accepting the person's condition, behaviours, and feelings without judgment; seeing them as a separate individual with inherent worth, regardless of their circumstances.
- ***Deep empathic understanding:*** understanding the person's experience from their perspective, allowing them the freedom to explore all feelings - conscious and unconscious - that may arise.

Rogers believed that each individual possesses an inherent motivation for change and the capacity to grow and mature, even when this is not immediately visible. The helping relationship becomes a powerful tool to support and facilitate that growth.

The Transtheoretical Model - Stages of Change

Authors: James Prochaska & Carlo DiClemente

Objective: The Transtheoretical Model for Behavioural Change is based on the assumption that successful self-directed change relies on applying the right strategies at the right time. It focuses on individual decision-making, rather than sociobiological determinants of behaviour, and is grounded in the principle that behavioural change is a process in which people move through distinct levels of motivation.

This model aims to support individuals in changing personal behaviour patterns while helping professionals understand the person's experience and life context. The stages of change reflect the implicit or explicit activities through which individuals modify their emotions, thoughts, behaviours, or relationships related to the problem behaviour.

Key Tools and Principles:

- **The model conceptualizes five core stages of change:**
  1. Pre-contemplation
  2. Contemplation
  3. Preparation
  4. Action
  5. Maintenance
- **Additionally, individuals may experience a 6th stage, which includes:**
  A. Lapse – a brief return to previous behaviours; or,
  B. Relapse – a more sustained return that leads the person back into one of the previous stages
- **The process of change is not linear; individuals frequently cycle through stages multiple times before achieving stable change.**
- **Motivational Interviewing (MI) strategies are the most relevant tools for intervention during stages 1 to 4 (Pre-contemplation to Action).**
- **During stages 5 and 6 (Maintenance and Lapse/Relapse), practitioners primarily use Relapse Prevention strategies.**

Relapse Prevention Model

Authors: : Alan Marlatt & Judith Gordon

Objective: : : The Relapse Prevention Model is a cognitive-behavioural approach that includes both specific and broad intervention strategies, enabling professionals and clients to address each step of the relapse process. It applies to relapses occurring in treatment contexts that aim for abstinence, as well as to relapses in risky behaviours.

This model can be used across the entire continuum of substance use, as it aims to:

- prevent an initial lapse and support the maintenance of abstinence;
- maintain harm reduction treatment goals;
- promote effective lapse management in order to prevent a full relapse.

The approach focuses on collaboratively identifying the conditions that may potentiate the behaviour and increase vulnerability to relapse. Once these high-risk situations or factors are identified, the goal is to establish and rehearse cognitive and behavioural strategies that help the person overcome these triggers and prevent future relapse under similar circumstances.

Key Tools and Principles:
A first step in collaborative work with the individual may be to provide them with a general overview of the Relapse Prevention Model and of the relapse process.

The model integrates two types of strategies:

- Specific intervention strategies, which focus on the immediate determinants of relapse; and
- Global self-management strategies, which target the underlying or covert antecedents of relapse.

These strategies are taught to the client to help them anticipate the possibility of relapse, recognize high-risk situations, and develop coping skills. Key components include:

Specific Intervention Strategies

- **Enhancing self-efficacy:** Strengthening the individual's sense of mastery and their confidence in managing difficult situations without lapsing.
- **Eliminating myths and placebo effects:** Using cognitive restructuring and education based on research findings to correct unrealistic beliefs about substance use.
- **Lapse Management:** Developing a plan to prepare for possible lapses, enabling the individual to stop using, safely exit the lapse-triggering situation, and prevent a progression to relapse.
- **Cognitive restructuring:** Helping clients modify their perceptions and attributions regarding the relapse process.

Global Lifestyle Self-Management Strategies

- **Lifestyle balance and positive coping:**

1. Assessing lifestyle factors associated with stress and imbalance.
2. Incorporating relaxation training, stress and time management, and other cognitive-behavioural skills.

- **Stimulus-control techniques:** reducing urges and cravings by limiting exposure to cues previously associated with substance use.

- **Urge-management techniques (e.g., "urge surfing"):** teaching individuals to anticipate urges and to interpret craving as a normal emotional or physiological response to a previously conditioned stimulus.

- **Relapse road maps:** Conducting cognitive-behavioural analyses of high-risk situations, identifying the different choices available to avoid or cope with these situations, and exploring the likely consequences of each decision.

Section 2 | Methodologies and Tools of Intervention

After addressing the main theoretical models that compose the framework of a harm reduction–based approach, this section aims to provide knowledge on the key methodologies and tools useful for professionals working with people experiencing homelessness and complex issues related to health, trauma, and addiction. These tools support the development of a helping relationship that promotes engagement and positive change.

For further detail, extended information is provided in Appendix 2, which may also be distributed to trainees before or after the training session.

Some of the methodologies and tools presented here are drawn from two central models: Motivational Interviewing and Integrative Harm Reduction Psychotherapy. Additional transversal tools will also be addressed in the final part of this section, which focuses on communication techniques within a supportive intervention context.

Motivational Interviewing (MI)

Authors: William R. Miller & Stephen Rollnick

Objective: Motivational Interviewing is a person-centred counselling approach that helps individuals discover their own internal motivation for positive change. Its core premise is that everyone has the potential to change, and that professionals act as facilitators in this process. It is a well-researched and structured methodology that provides clear guidelines and techniques for effective intervention, while also highlighting common ineffective practices that professionals may inadvertently adopt.

Key guidelines include:

- Focusing on strengths rather than difficulties, helping to build confidence and promote self-efficacy.
- Understanding ambivalence as a natural human experience, without moral judgment.
- Viewing resistance as a form of communication, and therefore as an opportunity to explore the person's perspective and continue constructive work.

Key Tools and Principles

Motivational Interviewing is built on four basic principles:

- Express empathy through active listening.
- Develop discrepancy by implementing strategies that gently highlight cognitive dissonance and the gap between current behaviour and future goals.
- Roll with resistance, avoiding direct confrontation and using the person's resistance as information and an opportunity for collaboration rather than arguing against it.
- Support self-efficacy, reinforcing the individual's belief in their capacity to change and strengthening hope and confidence.

Core Methods in Motivational Interviewing

These core communication skills - often referred to as OARS + Change Talk - should be applied from the very beginning of the interaction and sustained throughout the entire process. They create a collaborative, empathic, and empowering environment that supports the individual's own motivation for change.

1. Asking open questions

Open questions invite reflection and encourage the person to speak freely about their experiences, values, concerns, and goals. They avoid yes/no answers and give the individual space to express what matters to them.

Examples:

- *"What concerns you most about your current situation?"*
- *"How do you see things changing in the future?"*

2. Reflective listening

Reflective listening demonstrates that the professional is genuinely trying to understand the person's perspective. It involves actively listening and then reflecting back what was said - sometimes adding slight meaning or nuance to deepen the exploration. This strengthens rapport, reduces resistance, and helps the person hear their own thoughts more clearly.

Examples:

- *"You're feeling unsure because change seems overwhelming."*
- *"You want things to be different, but you're not sure where to start."*

3. Affirming

Affirmations are statements that highlight the person's strengths, efforts, resilience, and successes. They help build self-efficacy and encourage individuals to see themselves as capable of change.

Examples:

- "*You've shown a lot of persistence despite everything you've been through."*
- *"It took courage for you to talk about this today."*

4. Summarizing

Summaries gather key points from the conversation and reflect them back to the person in an organized way. They reinforce what the individual has said, show that the professional is actively listening, and help maintain direction and structure within the conversation. They are especially useful when transitioning between topics or before inviting the person to discuss next steps.

Examples:

- *"Let me summarize what I've heard so far…"*
- *"So you want to reduce harm, stay healthy, and feel more in control."*

5. Eliciting change talk

Change talk refers to the person's own arguments, ideas, and desires for change. Encouraging it is a consciously directive aspect of Motivational Interviewing: the professional guides the conversation toward exploring the person's own reasons for change, while still maintaining a collaborative and respectful stance. Change talk helps resolve ambivalence and increases the likelihood of actual behavioural change.

Examples:

- *"What would be the benefits if things changed for you?"*
- *"On a scale from 1 to 10, why aren't you at a lower number?"*

Tools for Exploring Ambivalence

Exploring ambivalence is a central component of Motivational Interviewing. Two structured tools are particularly helpful: Decisional Balance e Balance Sheet. Although similar, they serve slightly different purposes and can be used at different stages of the conversation.

1. Decisional Balance

The decisional balance is a tool used to help individuals weigh the perceived benefits and costs of maintaining the current behaviour versus changing it. Its main purpose is to clarify ambivalence in a non-judgmental way and support the person in articulating their own motivation.

It typically explores four quadrants:

1. Benefits of maintaining the current behaviour
2. Costs of maintaining the current behaviour
3. Benefits of changing the behaviour
4. Costs of changing the behaviour

This structure allows the professional and the client to map the internal conflict that often characterizes ambivalence. By hearing themselves articulate the advantages of change (and disadvantages of staying the same), clients begin to generate change talk, a key component of movement toward action.

Example prompts:

- *"What do you enjoy about using right now?"*
- *"What are some things you're not so happy about?"*
- *"If you imagined making a change, what positive things might come from that?"*
- *"What concerns would you have about changing?"*
-

This tool highlights the internal tensions, helping the person understand the broader impact of their choices—not by persuasion, but through guided self-exploration.

2. Balance Sheet

A balance sheet is a more focused version of decisional balance. Instead of comparing two behavioural options (maintain vs. change), it helps the person identify the specific perceived benefits and costs associated with a single behaviour.
This tool works well when the person is still exploring, understanding, or clarifying their relationship with one particular behaviour - for example, drug use, drinking, gambling, or avoiding healthcare.

The balance sheet typically includes two elements:

- Perceived benefits of the behaviour (e.g., pleasure, stress relief, social connection).
- Perceived costs of the behaviour (e.g., health problems, financial difficulties, relationship strain).

Because it focuses on one behaviour at a time, the balance sheet is especially useful early in the process, when the professional is trying to understand what the behaviour does for the person and why it might be difficult to change.

Example prompts:

- *"What does this behaviour give you? What needs does it meet?"*
- *"What are some of the downsides or problems this behaviour causes for you?"*

This tool respects the person's subjective experience while helping clarify the complex emotional and practical reasons behind behavioural patterns.

Important Aspects That Facilitate Change

- **Righting reflex:** the natural tendency to "fix" what seems wrong. Although well-intentioned, this can lead individuals to argue against change. Therefore, it is important to suppress this reflex so that the person explores ambivalence freely and voices their own motivations.

- **Motivation within a supportive relationship:** motivation grows when the individual - not the professional - voices arguments for change. Professionals should guide the conversation in a gentle, responsive, and creative way that encourages the person to "talk themselves into change."

- **Developing discrepancy:** a crucial component of change, rooted in highlighting the difference between what is happening now and what the person values for their future.

- **Change talk:** individuals express their own reasons for change. Change talk generally falls into four categories:

    1. disadvantages of the status quo
    2. advantages of change
    3. optimism about change
    4. intention to change

Complementarity of Models

It should be noted that the Stages of Change, Relapse Prevention, and Motivational Interviewing models are complementary when working with people who use drugs. Their application should be adapted to the individual's stage, needs, and circumstances (IDT, 2009).

Integrative Harm Reduction Psychotherapy (IHRP)

Author: Andrew Tatarsky
Objective: is based on the idea that behaviours - particularly potentially risky behaviours such as substance use - are best understood by considering the whole person and their relationship with their sociocultural context. This approach seeks to identify the psychological, biological, and social factors that contribute to the process of addiction, to clarify the multiple meanings and functions that substance use may have in a person's life, and to tailor the psychotherapeutic process to each client's unique needs (Tatarsky & Kellogg, 2010; Tatarsky, 2013).

IHRP is grounded in the core principles of good psychotherapeutic practice, with a strong emphasis on the therapeutic relationship as a catalyst for change. It integrates elements from psychodynamic approaches and cognitive-behavioural models and applies a biopsychosocial lens to understand substance use. Rather than imposing abstinence, it supports a collaborative exploration of behaviours, motivations, goals, and safer options - respecting the individual's readiness for change and valuing incremental progress.

Trust and a strong therapeutic alliance are foundational elements of Integrative Harm Reduction Psychotherapy. Therefore, therapy should focus on the client's own definition of the problem and their treatment goals. The work is collaborative, grounded in respect and empathy, and aims to establish treatment goals and a plan to achieve them - whether the goal is moderation, safer use, or abstinence - while prioritizing what is most urgent for the client.

Key Tools and Principles:

- *Teaching self-observation skills*, enabling the client to develop a clearer understanding of the role that substance use plays in their life - its situational triggers, associated thoughts and feelings, and its positive and negative consequences.
- *Developing an "ideal plan" for substance use,* which aims to maximize the positive value that substance use may hold for the client while minimizing its negative impact. This plan serves as a realistic, person-centred guide for behaviour change.
- *Exploring the multiple meanings and functions of* substance use to identify vulnerabilities and develop more adaptive and effective solutions for each of these factors.

These elements are operationalized through **seven therapeutic tasks**, which guide the intervention process:

1. Managing the therapeutic alliance: building a secure, collaborative, non-judgmental relationship that supports exploration and change.
2. Using the therapeutic relationship as a source of healing: recognizing that relational experiences within therapy can model safety, trust, and new interpersonal possibilities.
3. *Strengthening self-management skills for successful positive change:* supporting the development of practical and emotional regulation skills that enhance autonomy and reduce harm.
4. *Evaluation as treatment:* using ongoing assessment as a therapeutic tool that increases insight into patterns, motivations, risks, and opportunities for change.
5. *Embracing ambivalence:* viewing ambivalence as a natural part of the change process, and working with both sides of the internal conflict rather than pushing for a specific outcome.
6. *Establishing harm reduction goals:* collaboratively setting person-centred goals aligned with the client's readiness, needs, and priorities, which may include safer use, reduced use, moderation, or abstinence.
7. *Active strategies for positive change*, which may include:

- Harm Reduction education
- An experimental and non-judgmental attitude toward behaviour change
- Urge surfing and other urge-management techniques
- Identifying event-thought-urge-thought-choice-action sequences
- "Thinking through the urge" and developing awareness of early warning signs
- Decisional balance and internal dialogue with both sides of ambivalence
- Reflecting on personal reasons for desired change
- Identifying, managing, or resolving triggering factors
- Creating a list of 18 alternative responses to typical triggers
- Developing a game plan to implement desired changes in contexts where previous behaviours occurred

Active Listening, Reflective Listening and Communication Techniques in a Support Intervention Context

Author: Various – Canadian AIDS Treatment Information Exchange (CATIE); Carl Rogers and Richard Farson; Cynthia Osborn, Sherry Cormier and Paula Nurius

Objective: Clear and precise communication is essential in a helping relationship, as it prevents misunderstandings and promotes meaningful social change. This is particularly important in the care of people experiencing homelessness, where the goal is to support individuals in a comprehensive and person-centred manner. Elements such as empathy, open and respectful dialogue, horizontality in the relationship, acceptance of people as they are, and the provision of services in a non-judgmental manner with minimal barriers are fully aligned with a Harm Reduction approach.

Communication involves multiple dimensions that require attention. The aim of this section is to describe key aspects considered central to support and helping interventions with people experiencing homelessness. For further detail, extended information is provided in **Appendix 1**, which may also be distributed to trainees before or after the training session.

Supportive Practices (CATIE, 2022)

CATIE (2022) lists several supportive practices for service providers working with people who use drugs, such as:

- **Maintaining open and welcoming body language**
  Example: sitting at eye level, keeping arms uncrossed, maintaining soft eye contact.

- **Creating a safe and inclusive environment**
  Example: ensuring a warm, private space; offering water or a seat immediately; avoiding jargon; posting harm reduction-friendly signage.

- **Protecting confidentiality**
  Example: avoiding discussions about clients in public areas; explaining clearly how personal information is stored and who has access.

- **Ensuring consistency in policies and procedures**
  Example: maintaining consistent schedules; having clear rules about onsite substance use; making sure all staff apply the same approach.

- **Taking time for difficult conversations**
  Example: slowing down, allowing silence, offering breaks, acknowledging emotions without rushing the client.

- **Assessing personal biases**
  Example: noticing your own internal reactions ("Am I assuming this person is not motivated?") and adjusting behaviour accordingly.

Active Listening

Active Listening is a sensitive form of listening where the listener tries to capture both factual and emotional content (Rogers, 1961).

Examples:

- *"It sounds like the last few days have been really exhausting for you."*
- *Nodding, saying "I hear you" or "Take your time".*
- *Allowing silence without pressuring the person to speak.*
- *"I notice you became quieter when you mentioned your family."*

Reflective Listening

Reflective Listening is described as accurate empathy, conveyed through statements that reflect the person's meaning (Rogers; Miller & Rollnick, 2002).

Examples:

- **Simple reflection:**
  Client: *"I only use because it helps me get through the day."*
  Worker: *"Using helps you cope with everything you're dealing with."*

- **Amplified reflection:**
  Client: *"It's not really a problem; I'm in control."*
  Worker: *"So you feel there is absolutely no risk for you right now."*

- **Reflection of feelings:**
  "You seem frustrated and tired of dealing with this situation."

- **Double-sided reflection:**
  "On one hand, using helps you manage stress… and on the other hand, you're noticing consequences you don't want."

Listening Responses

Listening responses keep the focus on the client's frame of reference (Cormier, Nurius & Osborn, 2017).

- **Clarification**
  "When you say things 'went wrong,' can you tell me more about what happened?"

- **Paraphrasing**
  "So what I'm hearing is that you want to cut back, but it's difficult when you're on your own."

- **Reflection**
  "You're worried about your health but not sure if you can change right now."

- **Summarization**
  "We talked about the stress of street life, using as a coping strategy, and your interest in reducing harm. It seems all of this matters a lot to you."

Influencing Responses

Influencing responses gently help the person consider options for change or new perspectives (Egan; Cormier et al., 2017).

Questions

- *"What has helped you the most in the past when you tried to reduce your use?"*

Providing information

- *"Some people find it helpful to use sterile equipment to reduce infections. I can show you where to get it if you'd like."*

Appropriate self-disclosure (used in later stages of the helping relationship)

- *"I've supported others who felt torn like you do, and together we found small steps that felt manageable."*

Immediacy

- *"I notice that when we touched on your family, you seemed more distant. What was happening for you then?"*

Interpretation

- *"It sounds like when you feel rejected, using increases as a way to cope."*

Constructive confrontation / challenge (always delivered with empathy and respect)

- *"You've said you want to reduce risks, but you're still using alone. How do you make sense of that?" (Always delivered with empathy and respect.)*

Section 3 - Showcase of Practical Communication Tools

"Mirror Yourself"

This card game is designed to be played collaboratively by clients and social professionals. Each card presents a personal characteristic, and the game can be used in various ways to help identify individual strengths, challenges, and areas for growth.

The tool promotes self-discovery and strengthens the connection between clients and professionals, supporting a horizontal, non-hierarchical relationship. It encourages meaningful conversations - whether brief or in-depth - about the insights that emerge during the game. This makes it a simple yet effective tool for initiating engagement, fostering trust, and facilitating reflective discussions.

Image X - Mirror Yourself

Battery

This tool functions as a mini prevention plan for both clients and professionals. It provides a visual aid that helps identify when situations are going well, slightly off track, or going wrong.

It also supports conversations about the type of assistance the professional can offer, making planning more immediate and accessible. Compared to traditional long-term intervention plans, this tool simplifies the process and allows for quick, collaborative adjustments based on the client's current state and needs.

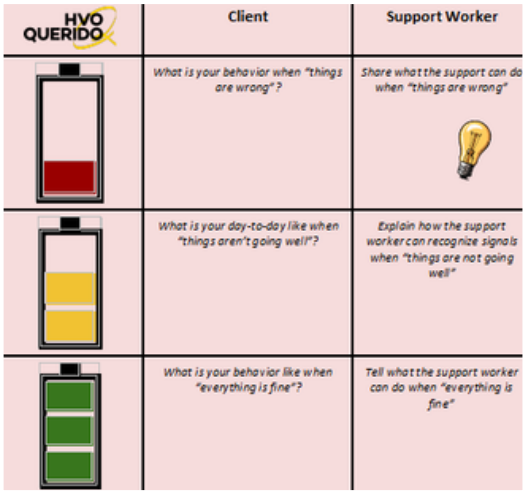

Image X - Battery

What If?!

This tool is designed for both clients and professionals as a preventive resource to help identify early signs of imbalance.
It includes a brochure with questions about potential future situations, making it especially useful after a tenant moves into their home within a Housing First program. These questions can be explored gradually during each consultation, in alignment with the Housing First principle of "*engaging in activity without coercion.*"
Topics addressed may include identifying people to notify in case of death, planning for pet care during hospital stays, and other practical matters that support stability and preparedness.

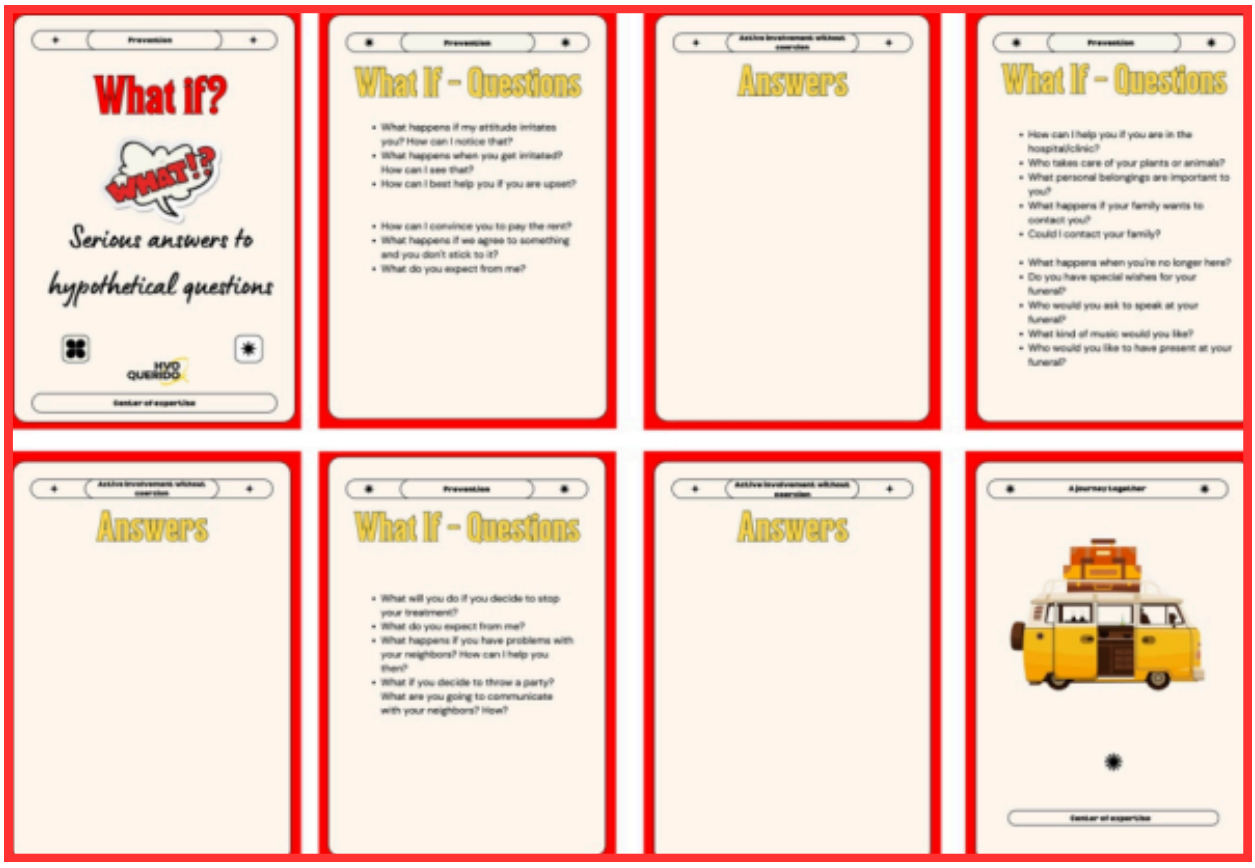

Image X - What if?!

Unit 3 | Good Practices on Homelessness, Substance Use and Trauma

Section 1 | Peer Work Perspective Definitions
Section 2 | Basic Living Conditions: Self-Care, Housing, Employment, Access to Healthcare
Section 3 | Psychoactive Substance Use

Unit 3 | Good Practices on Homelessness, Substance Use and Trauma

Section 1 | Peer Work Perspective

A peer work role is centered on providing empathetic lived experience-based support and practical assistance. Peer workers support those facing similar challenges, drawing from their own experiences to foster trust and create meaningful relationships.

1. One-On-One Support

Peer workers meet regularly with individuals to provide emotional support, empathetic encouragement, and non-judgemental clarification. They use a horizontal approach to people and an informal register of language (slang) and communication. They may or may not share their own stories and experiences to illustrate their points of view.

Example: *A peer worker helps a person understand the recovery process, offering insight into strategies that worked for them, and providing support during relapse*.

2. Collaboration With Other Service Providers

Peer workers often collaborate with other professionals, such as case managers, social workers, and healthcare providers, to ensure holistic support. Peer workers develop trustful and non-judgemental relationships with the people they work with and are facilitators in promoting healthy relationships between people and other professionals and services.Peer workers also guarantee that people's subjective experiences and backgrounds are acknowledged in case discussions or multi-disciplinary meetings.

Example: *A peer worker participates in case discussions or multi-disciplinary meetings to provide feedback on a client's progress, expose difficulties experienced by the client, and ensure that care is coordinated.*

3. Resource Navigation

Helping clients access necessary resources, such as housing, medical care, mental health services, addiction treatment, documentation, financial and legal support, etc. Peer workers know by experience how the system and the services work: they have experienced judgment, bureaucracy, and lack of adequate support. In this role, peer workers advocate hand in hand with the client ensuring healthcare providers, social services, or legal systems hear their voices. They have an empathic attitude and understand the resistance people eventually present.

Example: *A peer worker helps an individual apply for housing assistance, guides them through the paperwork, and accompanies them to appointments for support. They also respect people's will and self-determination, for example, when people say they do not want a shelter or other group response because that does not work for them.*

4. Crisis Intervention

Peers offer emotional support during times of crisis, such as relapses, housing instability, and reactions to trauma triggers. They offer a listening ear, de-escalate stressful situations, and provide practical coping strategies.

Example: *A peer worker might step in when someone is experiencing a psychotic break or emotional breakdown. They can use their lived experience to offer calming techniques or simply provide a safe presence.*

5. Life Skills Development and Access to Information

Peer workers support the development of practical life skills, such as budgeting, using public transport, cooking, and other housing cores. They also inform individuals about their rights, available community programs, and how to navigate health, social, and legal systems.

Example: *A peer worker teaches basic financial management skills to someone newly housed, helping them learn how to manage rent payments, bills, and budgeting.*

6. Group Facilitation

Peer workers can lead or co-facilitate support groups for people dealing with homelessness, substance use, and trauma, creating a safe, non-judgmental space where individuals can share their stories, challenges, and successes.

Example: *A peer worker facilitates a group meeting where people experiencing homelessness share resources, discuss necessities and support each other in navigating daily challenges.*

7. Advocacy

Peer workers advocate near healthcare providers, social and legal services, politicians, university students, and the general community about people's needs, traumatic experiences, and lack of responses. They raise awareness about the social determinants of health and the interconnection between homelessness, trauma, and substance use.

Example: *A peer worker speaks in a congress, pointing out their own experience with services and what needs to be done differently to answer people's needs.*

8. Building Self-Efficacy and Empowerment

Peer workers encourage clients to take ownership of their recovery journey, setting their individualized goals. They foster a sense of self-worth, agency, and self-determination, helping individuals feel empowered to make decisions for themselves.

Example: *A peer worker may support an individual in setting personal goals, whether that is finding a job, reconnecting with family, or getting involved in a recovery program, and celebrating their achievements along the way.*

Section 2 | Basic Living Conditions: Self-Care, Housing, Employment, Access to Healthcare

Homelessness takes many forms, which means there is no single solution for providing sustainable pathways out of it.
While all people experiencing homelessness need adequate, sustainable, and affordable housing, the level and type of additional support required can vary greatly from person to person.

Self-Care

The self-care component should not rely on an idealized or mainstream notion of "taking care of oneself," but rather focus on practical, realistic, low-threshold strategies that are coherent with principles of Harm Reduction, person-centered work, and autonomy. For people experiencing homelessness - many of whom live with trauma, poverty, mental health challenges, and active substance use - self-care must be understood within the person's real context, not as a list of expectations.

1. Self-care as survival:

- Acknowledge that people experiencing homelessness already practice self-care in multiple ways simply to survive.
- Examples: protecting documents, managing belongings, finding safer places to sleep, rationing substances, or maintaining small routines.
- Avoid moralistic messages such as “you should take better care of yourself”; focus on what is possible, not on what is ideal.

2. Realistic hygiene and personal care:

- Access to showers, toilets, laundry services, hygiene and menstrual hygiene kits.
- Discussion of common barriers: safety concerns, restrictive schedules, stigma or embarrassment
- Low-threshold strategies:
  - Small hygiene kits for quick cleaning.
  - Identifying safe spaces for washing or changing clothes.
  - Outreach support to provide essential items.

Many women, nonbinary people, and trans men experiencing homelessness face significant barriers in managing menstruation safely and comfortably. Limited access to bathrooms, showers, clean underwear, or menstrual products can result in infections, shame, and restricted daily activities.

A menstrual hygiene kit may include:

- Sanitary pads or tampons;
- Reusable pads or menstrual cups (only when safe to use and with proper facilities);
- Wet wipes for cleaning when water is not available;
- Disposable bags for safe product disposal;
- Clean underwear;
- A small pouch for discreet storage.

Why they matter:

- Promote menstrual dignity and reduce stigma;
- Prevent infections caused by prolonged use of a single product;
- Allow individuals to move freely without fear of leakage;
- Support autonomy and reduce dependence on unpredictable donation cycles.

Using Kits to Build Connection

Distributing hygiene supplies can be a meaningful entry point for relationship building. Professionals can use the moment to:

- Check in: *"Do you have what you need this week?"*
- Explore barriers: *"Is there a place where you feel safe to wash or clean up?"*
- Offer support: *"Would you like us to help you access a shower, laundry, or health service?"*

These interactions often open doors to deeper conversations about health, housing, safety, or substance use.

3. Managing physical and mental health (from a harm reduction perspective):

- Encouraging awareness of basic signs of physical discomfort or deterioration.
- Self-care when substance use is ongoing:
  - Hydration, basic nutrition.
  - Recognizing overdose risks and simple preventive steps.
  - Finding safer sleeping arrangements when possible.

- Emotional self-awareness:
  - Recognizing signs of stress, exhaustion, sadness, or irritability.
  - Simple grounding or regulation strategies offered by staff.

4. Safer use as self-care:

- Avoiding using alone.
- Testing substances when possible.
- Not sharing equipment.
- Starting with smaller doses.
- Being mindful of polysubstance use.
- Keeping naloxone accessible where available.

5. Minimal daily structure and organization:

- Small routines can provide stability and reduce chaos:
  - Regular times for eating or resting.
  - Keeping important belongings in safer places.
  - Establishing simple, predictable patterns.
- Practical tools:
  - Brief checklists.
  - Daily “traffic light” self-assessment cards.
  - Mini prevention or safety plans.

6. Relationships and social support:

- Identifying safe and unsafe relationships.
- Encouraging connection with supportive individuals: friends or acquaintances who provide encouragement; peer workers with lived experience; outreach or case workers; community volunteers; members of faith-based or cultural groups (when relevant and chosen by the person), etc.
- Small strategies for reaching out when help is needed: identifying one or two trusted people to contact during stressful moments; creating a small “help plan”: Who can I call? What can I say? Where can I go if I don’t feel safe?; using text messages when speaking feels too difficult; setting reminders to check in with outreach workers; carrying a list of emergency contacts and support services, etc.
- Promoting informal support networks.
- Invite people to participate in association events and be part of the community: invite service users to open community events; encourage them to join workshops, coffee mornings, creative activities, sports groups, or peer-support circles; offer to accompany them the first time if anxiety or mistrust is a barrier; provide transportation support when needed, etc.

7. Autonomy and self-determination

- Self-care is a choice, not an obligation.
- Professionals should avoid imposing routines, and instead:
  - Explore what the person already does;
  - Reinforce existing strengths;
  - Co-create small, achievable goals.
- Support individuals in defining what self-care means for them, in their context.

In summary, within a relational approach to self-care, staff should not “prescribe” self-care. Instead, they should:

- Explore the person’s existing practices, routines, and coping strategies.
- Validate the strategies the individual is already using to stay safe, stable, or well.
- Identify protective behaviours the person may not recognise as self-care (e.g., setting boundaries, choosing safer use practices, seeking quiet spaces).
- Co-create realistic, feasible self-care strategies that respect the person’s lived experience, priorities, and current capacity.

Housing

1 - Housing First

Model developed by Sam Tsemberis (2010), creator of the first Pathways Housing First program.

Key features include:

- Scattered-site housing in independent, community-based apartments.
- Housing combined with supportive services delivered by a multidisciplinary team, including peer workers.
- Long-term commitment: the team supports clients for as long as needed, without time limits.
- Two basic requirements:
  - Weekly home visit from program staff
  - Compliance with the lease and rental payment agreement (typically 30% of the participant’s income toward rent)
- Consumer choice and self-determination as core principles.

Evidence of effectiveness: research consistently shows that Housing First is highly effective in ending homelessness—helping approximately 8 out of 10 people achieve long-term housing stability—and is more cost-effective than emergency shelters or treatment-first models (Tsemberis, 2010; Polvere et al., 2014)

Participants also tend to show significant improvements in multiple areas of life, such as:

- Reduced substance use
- Improved adherence to treatment
- Reconnection with family members
- Strengthened social support networks

2 - Rapid Re-Housing

- Personalized, time-limited package of support (usually six months), which can include financial assistance for rent and moving expenses, help with finding housing, and other services tailored to the specific needs of each family.
- Case management accompanies housing stabilization and helps connect with resources that improve well-being, safety, health, social services, and employment opportunities.
- It allows clients to sustain their housing payments after financial assistance.
- Works as a form of secondary prevention to prevent individuals and families from entering difficult social cycles and mitigating the negative effects of long-term homelessness.

3 - Diversion

- Designed to quickly help individuals and families who have recently become homeless, preventing them from entering the social emergency system.
- Client-focused and intensive approach immediately seeks alternative housing solutions to shelters, offering services to stabilize housing or facilitate the transition to permanent housing.
- The aim is to prevent or delay entry into emergency shelters by identifying safe alternatives based on the resources available to individuals and families, rather than relying on homelessness response systems. It is a collaborative service, provided by skilled workers who use creative and flexible solutions, including financial assistance, to facilitate the transition to safe housing.

Employment

1 - Low Threshold Employment

Low-threshold employment opportunities allow individuals to choose their own level of engagement on a weekly—or even daily—basis. Service users can decide how many hours or days they feel able to commit to an activity and, step by step, increase their involvement according to their wishes, motivation, and capacity. Some projects and organizations even offer full training pathways that qualify participants for specific professions.

A key characteristic of low-threshold services is the approach adopted by support workers. Staff are expected to maintain a respectful, non-judgmental, and strengths-based attitude, which helps build trusting and empowering relationships with service users.

Employment integration projects can have a strong positive impact on participants' self-esteem, sense of purpose, and overall well-being, even when individuals do not transition directly into regular employment or require multiple intermediate steps, such as further training or supported employment. For many people with experiences of homelessness, poverty, and social exclusion, the opportunity to contribute, learn, and engage in meaningful daily activities represents an important turning point.

However, today's labour markets are highly competitive, and it is increasingly difficult for less qualified or less "labour-fit" individuals to obtain and maintain stable employment. As a result, employment interventions that focus primarily on labour market insertion may fail, as their success is heavily dependent on external economic conditions.

People who have experienced homelessness or used drugs face particular barriers to employment, including:

- Discontinuous life trajectories, with long periods of unemployment and CV gaps
- Lower resilience to work-related stress, often linked to trauma, health conditions, or long-term exclusion
- Stigma and prejudice from employers related to past homelessness or substance use

For many service users, full labour market integration may therefore be an unrealistic or unachievable goal. Organizations should be cautious about defining labour market integration as the main - or only - objective of their interventions, as doing so may unintentionally set up many participants for failure.

Access to Healthcare

1 - Decentralization of Care

Decentralization of care in harm reduction refers to shifting away from single-model interventions—such as clinics that offer only one type of treatment—toward a network of interconnected services that are flexible, accessible, and adapted to the daily environments of people who use drugs, particularly those experiencing homelessness.

Instead of expecting individuals to navigate rigid, complex, or abstinence-oriented health and social care systems, decentralization brings services directly to them, removing traditional barriers and expanding opportunities for engagement. These services can include harm reduction supports integrated with treatment, education, employment services, emergency and temporary accommodation, or long-term housing solutions, all functioning as an interlinked continuum of care.

Examples of decentralized and integrated harm reduction services include:

- Mobile harm reduction units, delivering supplies, brief interventions, and support in various locations
- Street outreach teams that engage people in their own environments with flexibility and consistency
- Low-threshold drop-in centers offering basic needs support, counselling, and connection to services
- Supervised consumption sites providing safer use environments and health monitoring
- Harm reduction integrated within housing or shelter services, supporting stability while reducing risks (EUDA, 2023)

This approach recognizes that traditional, centralized, or abstinence-based models often exclude people experiencing homelessness due to bureaucratic requirements, stigma, or preconditions such as mandatory sobriety. By contrast, decentralized harm reduction reduces barriers, increases engagement, and broadens access to essential care.

Aspect	Centralized Care	Decentralized Care
Service location	Delivered in a single, fixed site (e.g., clinic, hospital)	Delivered across multiple locations, including streets, shelters, housing sites, and mobile units
Accessibility	Often limited; clients must travel to the service and meet program requirements	High accessibility; services reach clients in their own environments
Approach	Standardized, one-size-fits-all	Flexible, person-centred, adapted to individual needs and contexts
Entry requirements	May require appointments, documentation, or abstinence	Low-threshold; minimal or no requirements, no abstinence needed
Suitability for people experiencing homelessness	Often poor due to bureaucratic barriers and inflexible structures	Strong; meets people where they are and adapts to instability or lack of routine
Types of services offered	Usually a single model (e.g., medical treatment only)	Multiple interconnected services (harm reduction, housing, outreach, medical, social support)
Engagement	Lower for marginalized people due to stigma or rigid rules	Higher due to respect, choice, and absence of punitive conditions
Relationship style	May feel hierarchical or clinical	Collaborative, horizontal, and trust-building
Responsiveness to crisis	Limited; clients must seek help	Highly responsive; services proactively respond in real time
Integration with community	Less integrated;services operate separately	
Outcomes for people who use drugs	May miss those at highest risk	Better reach, improved continuity of care, reduced harms

Activity 1.4 | Video Forum with Examples of Good Practices in Self-Care, Housing, Employment, Access to Healthcare

Objective

To expose trainees to real-life examples of homelessness interventions and harm reduction programs - such as Housing First, low-threshold employment initiatives, and social integration strategies - while encouraging critical reflection on diverse approaches. The goal is to strengthen their understanding of effective, person-centred responses and to inspire the adaptation and application of these approaches within their own professional contexts.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | Psychoactive Substance Use

Substance use can lead to both chronic and acute health problems, which may be aggravated by factors such as the pharmacological properties of the substances, the route of administration, individual vulnerabilities, and the social context in which drugs are consumed. To reduce harms related to substance use, a wide range of accessible, flexible, and low-threshold responses is required.

Historically, harm reduction efforts focused primarily on expanding access to opioid agonist treatment and needle and syringe programmes, largely as a response to high-risk heroin use and the HIV/AIDS epidemic. However, over the past three decades, harm reduction has evolved to incorporate a broader range of interventions (EUDA, 2024), such as:

- **Opioid Agonist Treatment (OAT):** includes methadone, buprenorphine, or slow-release oral morphine to stabilize opioid use and reduce withdrawal, overdose, and infectious disease transmission.
- **Needle and Syringe Exchange Programmes (NSP):** provision of sterile injecting equipment and safe disposal options to prevent HIV, hepatitis B/C, and other injection-related harms.
- **Safer Smoking and Inhalation Kits:** equipment to reduce risks associated with inhaled or smoked substances (e.g., preventing burns, infections, and transmission of respiratory diseases).

- **Safer Snorting Kits:** materials that reduce nasal damage and the transmission of infections such as hepatitis C.
- **Supervised Drug Consumption Rooms (DCRs) / Safe Consumption Sites:** hygienic, supervised spaces where people can use pre-obtained drugs under the supervision of trained staff, reducing overdose deaths and infections.
- **Take-Home Naloxone Programmes:** distribution of naloxone kits and training to reverse opioid overdoses in community settings.
- **Drug Checking / Testing Services:** allowing users to test substances for dangerous adulterants, dosage variability, and contaminants, reducing poisoning and overdose risk.
- **Mobile Harm Reduction Units:** vans or outreach teams providing harm reduction supplies, wound care, brief interventions, and referrals directly in the community.
- **Low-Threshold Drop-In Centres:** spaces offering basic services such as meals, showers, rest areas, counselling, crisis support, and referrals without requiring abstinence.
- **Overdose Prevention Education:** training on safer use practices (e.g., avoiding mixing depressants, using smaller test doses, not using alone).
- **Integration of Harm Reduction in Housing and Shelter Services:** supporting people who continue to use substances when housed, following Housing First and non-eviction principles.
- **Peer Involvement and Peer-Led Outreach:** people with lived experience providing education, supplies, support, and bridging trust with services.
- **Wound Care and Basic Health Interventions:** addressing injection-related wounds, skin infections, and other acute health issues on-site.
- **Trauma-Informed Harm Reduction Approaches:** recognizing the role of trauma in substance use patterns and ensuring services are safe, empowering, and non-coercive.
- **Sexualised drug use (e.g., chemsex settings):** providing information, supplies, and support for safer drug use within sexual contexts

Needle Exchange Programs

- Needle exchange programs aim to prevent the transmission of infectious diseases related to intravenous drug use by promoting aseptic practices.

- They increase access to sterile injecting materials, including:
  - clean needles and syringes
  - alcohol wipes
  - distilled water
  - citric acid
  - other appropriate injecting equipment

- Programs should also include an educational component, offering:
  - information on safer and lower-risk injecting practices
  - opportunities for people to reflect on their consumption habits
  - space to discuss concerns with harm reduction workers

- Needle exchange programs can be implemented in various harm reduction settings, such as:
  - mobile units
  - street outreach teams
  - drug consumption rooms
  - low-threshold drop-in centres

- These programs serve as a bridge to health and social services, offering opportunities for mediation and referral.

Low-Threshold Opioid Substitution Programs

- Low-threshold opioid substitution programs offer support to people who do not want to stop or are unable to stop using heroin at a given moment in their lives.

- These programs aim to improve quality of life across health, social, and economic dimensions.

- The intervention is based on the administration of Methadone Hydrochloride, prescribed and supervised by medical professionals.

- Methadone helps by:
  - preventing withdrawal symptoms
  - reducing cravings
  - providing a long half-life (≥ 24 hours), which supports psychological stabilization
  - enabling individuals to better organize daily life
  - facilitating improved interpersonal relationships and social reintegration

- When taken daily, methadone reaches a steady state after approximately five days.

- Benefits extend beyond the individual, including:
  - improved physical and mental well-being for the person and their family
  - reduced public health costs
  - reduced costs within the justice system

- Low-threshold opioid substitution programs can be delivered through:
  - fixed clinical structures
  - mobile units adapted specifically for this purpose (IDT, 2009).

Drug Consumption Rooms

- DCRs are professionally supervised healthcare facilities where people can use drugs in safer, hygienic conditions without fear of arrest or legal consequences.

- Their main objectives include:
  - providing a safe and supervised environment
  - offering medical oversight
  - ensuring access to sterile equipment
  - reducing risks such as overdose, infectious disease transmission, and unsafe consumption practices

- DCRs primarily serve highly marginalized populations who face significant barriers to accessing health and social services.

- They often act as gateways to additional support, such as healthcare, social services, housing assistance, or treatment programs.

- These facilities are typically located near open drug scenes, where public drug use is common.

- By offering a designated space for consumption, DCRs aim to:
  - reduce public drug use
  - decrease improper disposal of syringes and other drug-related waste
  - improve public amenities and community well-being
  - address public order and safety concerns

- As accessible, low-threshold services, DCRs help combat stigma by:
  - treating people who use drugs with dignity and respect
  - supporting social integration pathways, including housing and employment

- DCRs also play a key role in early detection of emerging drug use patterns, as they are often the first services to observe new substances or modes of consumption among high-risk groups (EUDA, 2024).

Alcohol Management Programs (MAPs)

- Alcohol Management Programs (MAPs)

- MAPs are designed for individuals with severe alcohol use disorder who also face significant barriers such as homelessness, poverty, stigma in healthcare, and past trauma.

- MAPs aim to reduce health, social, and structural harms associated with problematic alcohol use.

- For many participants, traditional healthcare and abstinence-based treatment are not feasible or accessible options.

- MAPs offer an alternative to abstinence, focusing on goals aligned with the person's needs and circumstances.

- These programs are low-threshold, allowing people to access support even while continuing to drink.

- MAPs are often integrated into low-barrier housing settings, where participants can also access:
  - basic needs (food, shelter, hygiene)
  - medical care
  - mental health support
  - social and case management services

- The program includes psychosocial support and regular assessments for intoxication, health risks, and well-being.

- Participants receive a measured amount of alcohol, dispensed at timed intervals throughout the day. This structure helps:
  - reduce overall alcohol consumption
  - prevent life-threatening alcohol withdrawal
  - reduce reliance on non-beverage alcohol (e.g., mouthwash, hand sanitizer)
  - stabilize daily functioning and routines

- By creating safety and stability, MAPs help individuals engage more effectively with services, improve their health, and enhance their overall quality of life (Help With Drinking, 2025).

Drug Checking Services

- Drug checking services are a key harm reduction intervention that allow people who use drugs to have their substances chemically analysed.

- These services provide information about:
  - the contents and composition of the drug sample
  - the potency of substances
  - the presence of adulterants, unknown chemicals, or dangerous contaminants
  - harm reduction advice and warnings about current drug trends

- Drug checking can take place in different settings, including:
  - Fixed laboratories, where individuals or organizations can submit samples and receive results within days
  - Mobile laboratories, often located at festivals, nightlife venues, or clubs, providing near-immediate results

- Drug checking services help reduce harm by:
  - identifying substances that contain unexpected or dangerous components
  - enabling early public health alerts about contaminated or high-risk batches
  - helping prevent overdoses through potency information

- These services are effective at engaging young recreational drug users, many of whom do not access traditional health or social services.

- As synthetic drugs, including high-potency synthetic opioids, become increasingly common in Europe, drug checking services have become an essential response for public health and harm reduction.

Naloxone Administration and Training

- Naloxone is a medication - commonly available as a nasal spray - used to reverse opioid overdoses by counteracting life-threatening depression of the central nervous and respiratory systems, enabling the person to breathe normally again.

- When administered promptly, naloxone can be life-saving, providing critical time while waiting for emergency medical assistance.

- Naloxone is non-addictive, has no effect if opioids are not present in the body, and is safe to use (Correlation, 2024).

- Effective naloxone interventions go beyond distribution and include:
  - training harm reduction workers, clients, and community members to recognize signs of overdose
  - teaching step-by-step overdose response, including safe positioning, calling emergency services, and administering naloxone
  - encouraging the presence of naloxone among people who use opioids, peers, family, outreach teams, and others likely to witness an overdose

- Wider availability of naloxone—both for personal and professional use—can significantly reduce drug-related deaths, especially when those most likely to be first on the scene have easy access to it.

- While naloxone alone is not a complete solution to drug-related mortality, it is a key component of a broader harm-reduction and treatment continuum.

- Naloxone is safe, cost-effective, and most importantly, saves lives (Homelessness Link, 2020).

Activity 1.5 | Video Forum With Examples of Good Practices in Harm Reduction of Drug Use

Objective

To expose trainees to real-life examples of homelessness intervention and harm reduction programs - particularly those addressing substance use - so they can deepen their understanding of effective, person-centered responses and gain inspiration for applying context-appropriate strategies within their own practice.

All the instructions and materials for the activity are available on the Toolkit.

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Appendix

Appendix

This appendix presents key models, methods, and practical tools for working with people experiencing substance use or other high-risk behaviours. It combines theoretical foundations - such as the Person-Centered/Humanistic Approach, the Transtheoretical Model, Relapse Prevention, and Integrative Harm Reduction Psychotherapy - with practical strategies for real-world application. The focus is on using these approaches to build therapeutic relationships, address ambivalence, manage relapse, set client-centred goals, and apply active and reflective listening. Together, these components offer practitioners a clear and adaptable framework to support individuals while respecting their unique needs, histories, and motivations.

Models of Intervention

The Person-Centered and Humanistic Approach

Applying a person-centered and humanistic approach requires professionals to understand who people are, what they have lived through, and what holds meaning for them.

At the core of this approach is the belief that **people are the experts on their own lives**. They exist within unique ecosystems composed of their personal histories, relationships, identities, values, coping strategies, and aspirations. They know what has happened to them and what matters most. Our task as professionals is to recognise and honour this individuality.

Carl Rogers developed this humanistic perspective, emphasising the role of the **helping relationship** as the primary vehicle for personal growth and change (Rogers, 1961). According to Rogers, this relationship must be built upon three fundamental conditions:

- **Genuineness and authenticity** – The professional strives to be real, transparent, and congruent, which creates a safe and trusting environment that allows the person to explore and express their true feelings.

- **Unconditional positive regard** – The professional accepts the person fully, including their behaviours, emotions, contradictions, and struggles, while recognising their inherent worth. This fosters a sense of safety, warmth, and non-judgment.

- **Deep empathic understanding** – The professional seeks to understand the person's internal world, from their own perspective, listening to both conscious and unconscious feelings without imposing judgments, diagnoses, or interpretations.

Rogers believed that every individual carries an **innate capacity for growth**, even when it is not immediately visible. Through a supportive and trusting relationship, people can reorganise their self-perception and engage with life in more adaptive and meaningful ways.

This type of therapeutic relationship, as emphasised by Rogers, is a powerful facilitator of change and personal development. Research widely supports the effectiveness of this approach, and its principles extend beyond formal psychotherapy, applying to many types of interpersonal helping relationships where trust, acceptance, and empathy are central.

The Transtheoretical Model - Stages of Change

The Transtheoretical Model of Behavioural Change was developed by James Prochaska (1979) after conducting a comparative analysis of over 29 theories and models that focus on the process of change, including cognitive-behavioural, existential/humanistic, psychoanalytic, and experiential/gestalt approaches.

Its central assumption is that **successful self-change depends on using the right strategies at the right time**. The model emphasises **individual decision-making** rather than sociobiological influences, proposing that behavioural change is a dynamic process in which people move through distinct **levels of motivation for change**.

According to Prochaska, DiClemente, and Norcross (1994), the stages of change correspond to the implicit or explicit activities that people engage in when modifying affect, thoughts, behaviours, or interpersonal patterns related to a problem behaviour. Although the model outlines five core stages, people often **cycle through these stages multiple times** before achieving long-lasting change.

The 5 Stages of Change

1. Pre-Contemplation

- The person is not considering change and may lack information or motivation.
- Individuals may be unaware of problematic behaviour or reluctant to change because the perceived benefits outweigh the costs (IDT, 2009; OPP, 2016).
- Common attitudes: denial, defensiveness, minimisation, or lack of insight.

2. Contemplation

- The person **recognises the problem behaviour** and can identify reasons for changing it.
- **Ambivalence dominates** this stage: motivation fluctuates, and feelings of anxiety or doubt can inhibit commitment.
- The person is “thinking about change” but has not yet decided to act.

3. Preparation

- The person is **seriously considering change** and may begin to plan concrete steps.
- Small behavioural changes may occur, although some ambivalence may still be present.
- Focus shifts toward **problem-solving** and planning for the future.

4. Action

- The person **implements new behaviours** and takes clear, observable steps toward change.
- This stage involves both **internal commitment** and **external action.**
- The person is more aware of the problem and follows a **structured plan** for behaviour change.

5. Maintenance

- Efforts focus on **sustaining the new behaviour** and preventing relapse.
- This stage is challenging, requiring continuous effort and vigilance.
- Strategies include developing new habits, reinforcing progress, and building resilience.

Lapse / Relapse

- A lapse is a brief return to old behaviour.
- A relapse is a more sustained return, such as using drugs again after abstinence, or shifting back to injecting after a period of smoking only.
- Relapse is considered normal and expected in long-term behaviour change (Miller & Rollnick, 2001).
- When relapse occurs, the key tasks are to:
  - identify contributing factors
  - understand what stage of change the person has returned to
  - re-engage with appropriate strategies for that stage

The process of change **is not linear**; individuals move between stages in different sequences depending on their circumstances, supports, and challenges.

Matching Interventions to Stages

- **Stages 1–4 (Pre-Contemplation → Action):**
  Motivational Interviewing is especially effective for increasing readiness, reducing ambivalence, and supporting commitment to change.

- **Stages 5–6 (Maintenance → Lapse/Relapse):**
  Relapse Prevention strategies become essential to strengthening coping skills, identifying high-risk situations, and supporting long-term behaviour maintenance.

Relapse Prevention Model

The Relapse Prevention Model, developed by **Marlatt** and **Gordon**, proposes that relapse is influenced by two major factors:

- Immediate determinants (e.g., high-risk situations), and
- Covert antecedents (e.g., cravings, urges, lifestyle imbalance).

Both sets of factors can interact to increase the likelihood of relapse (Larimer, Palmer & Marlatt, 1999). The model includes both **specific** and **broad** intervention strategies designed to help clients understand, anticipate, and effectively manage the relapse process.

This approach applies to:

- Relapses during abstinence-oriented treatment,
- Relapses in risky behaviours, and
- Harm reduction contexts (IDT, 2009; Larimer, Palmer & Marlatt, 1999; Marlatt & Donovan, 2009).

Relapse Prevention aims to reduce the occurrence of lapses, prevent lapses from progressing into relapse, maintain abstinence or reduced use, and support harm reduction goals.

A first step often involves giving the client a clear and simple explanation of the relapse process and the framework behind Relapse Prevention.

Core Components of Relapse Prevention

1. Identifying and Coping With High-Risk Situations

Clients work to identify situations that may trigger increased desire to use or reduced ability to cope. Assessment methods may include:

- Exploration of past lapses, relapses, dreams, and fantasies
- Self-report questionnaires (e.g., Annis & Davis, 1988; Annis, 1982a)
- Self-monitoring of substance use patterns

Once high-risk situations are identified, two main interventions are used:

1. Teaching early warning signs so clients can leave or avoid the situation.
2. Skill-building: assessing the client's motivation and coping abilities, then teaching specific coping strategies for high-risk or broad problem situations.
   - Role plays, modelling, and developing personalized coping plans help increase the likelihood the client will use these skills.

2. Enhancing Self-Efficacy

The goal is to increase the client's sense of competence in managing difficult situations without lapsing.

Strategies include:

- Emphasizing a **collaborative, horizontal relationship** where the client becomes an observer and learner of their own behaviour. Change is reframed as a **skills acquisition process**, not a test of willpower.
- Breaking down behaviour change into **smaller, manageable subtasks** (Bandura, 1977).
- Providing **positive feedback** on the client's performance— even in tasks unrelated to substance use—helps build confidence, motivation, and readiness to use new skills.

3. Eliminating Myths and Placebo Effects

- Clients' expectations about substance use often rely on myths or placebo effects. Work involves:
- Eliciting positive expectancies (e.g., "It helps me relax").
- Using **cognitive restructuring,** psychoeducation, and the client's own experiences to challenge these beliefs.
- Exploring both **immediate** and **delayed** consequences to help the client reassess expectancies and develop a more realistic understanding of their behaviour.

4. Lapse Management

Lapse management focuses on **stopping the lapse from progressing into a relapse.**
This includes:

- Preparing a clear plan for what to do if a lapse occurs
- Strategies for stopping use quickly and safely exiting the situation
- Agreeing to limit the extent of use during a lapse
- Encouraging early contact with a support person
- Identifying triggering factors immediately afterward

The aim is to minimize harm, reduce guilt and shame, and return the client to their previous stage of change.

5. Cognitive Restructuring

This helps clients reinterpret lapses not as failures but as **learning opportunities**.
Clients learn to:

- Reframe lapses as mistakes or feedback, not evidence of inability
- Understand that a lapse signals the need for better planning
- Reduce the "abstinence violation effect," which can turn shame into a self-fulfilling prophecy of relapse

Viewing lapses this way increases resilience and supports long-term change.

6. Global Lifestyle Self-Control Strategies

These strategies address covert, long-term factors contributing to relapse risk.

Key elements include:

Balanced Lifestyle & Positive Addiction

- Assessing stress, lifestyle imbalance, and daily activities
- Distinguishing between activities that feel like a **"want," "should," or both**
- Encouraging engagement in **pleasurable, meaningful activities** that may have been replaced by substance use
- Teaching skills such as relaxation, stress management, and time management
- Supporting the development of "positive addictions"—healthy behaviours that improve mood, health, and coping

A more balanced lifestyle reduces vulnerability to urges and cravings.

7. Stimulus-Control Techniques

These aim to reduce craving triggered by conditioned cues.

Strategies include:

- Removing substances and paraphernalia from the client's environment
- Remporarily avoiding subtle cues (music, objects, routines) associated with use
- Changing patterns around social events, places, or people linked to substance use
- Developing avoidance strategies to prevent exposure to high-risk cues

Stimulus control can significantly reduce craving intensity and frequency.

8.Urge-Management Techniques

The goal is to help clients anticipate, understand, and tolerate cravings without acting on them.

Key technique:

Urge Surfing

- Cravings are reframed as normal emotional or physiological reactions to previous cues
- Clients learn that cravings rise, peak, and fade—they do not grow indefinitely
- Using imagery, clients imagine "riding the wave" of the urge rather than fighting it or giving in

This technique increases psychological flexibility and decreases the likelihood of acting on cravings.

9. Relapse Road Maps

Relapse road maps are cognitive-behavioural analyses that:

- Identify high-risk situations
- Map out the choices available at each point
- Highlight the likely consequences of each choice

This helps clients visualize the chain of decisions leading to or away from relapse and strengthens informed decision-making.

Methodologies and Tools of Intervention

1. Motivational Interviewing (MI)

MI is a **person-centered counseling approach** developed by Miller & Rollnick. It helps individuals explore and strengthen their own internal motivation for positive change. MI is grounded in the belief that **every person has the capacity for change**, and that the role of the professional is to create the conditions that support this process - not to impose goals or solutions.

MI is extensively researched and provides practitioners with a structured set of principles, strategies, and tools. It also highlights common **ineffective practices**, such as:

- **The expert trap** – assuming the professional knows best and lecturing the client.
- **The righting reflex** – the urge to fix the client's problems or tell them what to do.

Instead, MI emphasizes **client strengths**, collaboration, and respect for autonomy. Ambivalence is seen not as resistance or pathology, but as a **normal part of the change process**. When treated with empathy and curiosity, ambivalence becomes the gateway to growth rather than an obstacle.

The Four Core Principles of MI (Miller & Rollnick, 2002; IDT, 2009)

1. **Express empathy** through active and reflective listening.
2. **Develop discrepancy** between the person's current behavior and their values or goals.
3. **Roll with resistance** rather than confronting it. Resistance is information, not defiance.
4. **Support self-efficacy,** reinforcing the client's belief in their ability to change.

Ambivalence is a particularly central concept. What is often labeled as "lack of motivation" is more accurately unresolved ambivalence. MI directly targets this internal conflict, helping clients become "unstuck."

Types of Ambivalence (Miller & Rollnick, 2002)

Understanding ambivalence helps practitioners tailor interventions:

- **Approach-Approach Conflict** - choosing between two attractive options.
- **Avoidance-Avoidance Conflict** - choosing between two undesirable options.
- **Approach-Avoidance Conflict** - a single option has both appealing and unpleasant aspects; often leads to oscillation and stress.
- **Double Approach-Avoidance Conflict** - two options each have both strong positive and negative aspects; movement toward one makes the negatives more apparent, and the alternative more appealing. This circular dynamic can keep people stuck for long periods.

Tools for Exploring Ambivalence

Decisional Balance

Ambivalence can be illustrated as a **balance** or **seesaw**, weighing the pros and cons of:

- changing versus maintaining the status quo, and
- maintaining the status quo versus changing.

This helps clients recognize competing motivations clearly.

Balance Sheet

A structured list of the perceived **advantages** and **disadvantages** of each option. Caveats include:

- The personal value of each item may shift over time.
- Items influence one another; change in one can affect the rest.
- People may not be consciously aware of their internal weighing process.

Balance sheets are tools for exploration, not rational persuasion.

Important Concepts to Facilitate Change

The Righting Reflex

The natural human tendency to try to fix what is wrong. In MI, this reflex backfires: the more the practitioner argues for change, the more the client argues against it. This enacts the ambivalence rather than resolving it.

Motivation as an Interpersonal Process

MI views motivation not as a static trait but as something that emerges within a supportive relationship. The goal is to elicit the person's own arguments for change—known as Change Talk.

Developing Discrepancy

A core facilitator of change. By increasing awareness of the discrepancy between values and current behaviors, practitioners help clients resolve ambivalence in favor of change.

As discrepancy grows, ambivalence intensifies; as ambivalence resolves, motivation increases.

Common Traps to Avoid in MI

- **Question-Answer Trap**
  Practitioner asks; client gives short answers.
  Avoid by: using open-ended questions and reflective statements.
- **Trap of Taking Sides**
  When the practitioner argues for change, the client argues for staying the same.
- **Expert Trap**
  Acting as though the practitioner has all the answers; the client becomes passive.
- **Labeling Trap**
  Push to define the person with a label ("addict," "alcoholic"). Labels can be stigmatizing and distracting. Only address labels if the client brings them up.
- **Premature Focus Trap**
  The practitioner focuses too quickly on what they believe is the problem; meanwhile, the client has other pressing concerns. Start where the client is.
- **Blaming Trap**
  Concerns about fault or blame can derail early engagement. MI reframes blame as irrelevant to the work at hand.

Five Essential MI Skills (OARS + Change Talk)

- **Asking Open Questions**
  Encourages fuller expression, builds trust, and allows clients to articulate their own concerns and motivations.
- **Reflective Listening**
  The cornerstone of MI. Practitioners listen carefully, form a reasonable hypothesis about meaning, and reflect it back. This deepens understanding and reduces defensiveness.
- **Affirming**
  Recognizing and reinforcing client strengths, efforts, and positive intentions. Helps build hope and autonomy.
- **Summarizing**
  Summaries help integrate themes, reinforce change talk, and ensure shared understanding.
  Types include:
  - Collecting summaries – during exploration.
  - Linking summaries – connecting different pieces of information.
  - Transitional summaries – signaling a shift in focus or moving toward closure.

- **Eliciting Change Talk**
  The most directive MI skill. Practitioners help clients articulate their own:
  - disadvantages of the current behavior
  - advantages of change
  - optimism about change
  - intention or commitment to change

  Strategies for evoking change talk include:
  - evocative questions
  - importance rulers
  - decisional balance
  - elaboration
  - querying extremes
  - exploring values, goals, past successes, and future visions

When clients hear themselves advocating for change, they naturally strengthen their motivation.

Integration With Other Models

Motivational Interviewing, the Stages of Change Model, and Relapse Prevention are highly complementary approaches. Each is applicable at different phases of a person's relationship with substance use and must be adapted to their specific circumstances (IDT, 2009).

2. Integrative Harm Reduction Psychotherapy (IHRP)

Integrative Harm Reduction Psychotherapy (IHRP) is grounded in the understanding that behaviors - particularly risky ones such as substance use - are best understood by considering the **whole person** within their sociocultural context. IHRP seeks to identify the **psychological, biological, and social contributors** to the addiction process, clarify the multiple meanings and functions of substance use, and shape the therapeutic process according to the **unique needs, goals, and lived experiences** of each client (Tatarsky & Kellog, 2010; Tatarsky, 2013).

Harm Reduction is an innovative paradigm that challenges traditional abstinence-only models of substance use treatment. In contrast to approaches that view addiction strictly as a disease with abstinence as the sole acceptable outcome, Harm Reduction sees substance use along a **continuum of potential harm**, acknowledging non-harmful or normative use as well (Tatarsky, 2013). This enables **individualized, flexible, person-centered** intervention that emphasizes strengths, respects autonomy, and values even small steps toward positive change.

In Harm Reduction, practitioners meet clients **where they are**, supporting the goals that the client identifies as meaningful and urgent. This approach fosters a more horizontal and collaborative relationship, enhancing engagement, motivation, and empowerment.

Theoretical Foundations of IHRP

Harm reduction therapy emerged from the tension between disease models and adaptive models of addiction (Denning, 2012). While its principles are more consistent with adaptive models, IHRP expands beyond both, offering a broader, more nuanced understanding of substance use and its role in people's lives.

IHRP integrates:

- **Psychodynamic models** – offering depth understanding of the individual and the emotional, relational, and symbolic functions of substance use.
  Substance use may serve adaptive functions when people lack alternative strategies (e.g., self-medication, emotion regulation, coping with trauma or grief, addressing self-esteem or relational needs).
- **Cognitive-Behavioral models** – providing practical, active strategies for behavior change.
  Biopsychosocial perspectives – acknowledging the interaction of biological, psychological, and sociocultural factors.

From an IHRP perspective, people use substances because **they work** - at least initially - for addressing specific psychological, social, or biological needs. Problems arise when the behavior begins to compromise other essential needs or personal values. Effective Harm Reduction treatment therefore tailors interventions to the **specific reasons** substance use is attractive or reinforcing for each client.

The Centrality of the Therapeutic Relationship

Across all theoretical components, IHRP emphasizes the therapeutic relationship as a primary driver of change (Tatarsky, 2013; Tatarsky & Kellog, 2010). Therapy focuses on the client's **own definition** of the problem and **self-determined goals**, working collaboratively with respect and empathy. Treatment aims - whether moderation or abstinence - are guided by what the client identifies as most urgent and meaningful.

Self-Observation as a Core Strategy

Clients are taught a self-observation practice that promotes moment-to-moment awareness of the role substance use plays in their lives. This includes:

- recognizing triggers
- identifying thoughts, emotions, sensations, and expectations
- observing consequences (both positive and negative)
- describing experiences with precision and without judgment

Over time, this enables clients to identify the internal and situational precursors to substance use and build insight into patterns and functions.

From Insight to Action: Treatment Planning

As patterns become clearer, therapist and client collaboratively develop goals and a **realistic, individualized plan** for substance use. Tatarsky (2003, cit. in Tatarsky 2013) describes the creation of an "ideal plan," which seeks to:

- **maximize** the positive functions or meanings that substance use provides
- **minimize** the negative consequences

This plan addresses substances used, methods of intake, doses, frequency, and contextual factors. As the client works to implement the plan, **microanalysis** helps identify psychological and situational themes underlying lapses or difficulties. These insights guide the development of alternative coping strategies (e.g., relaxation, anger management, assertiveness, emotional identification and expression).

By widening the therapeutic focus beyond abstinence and centering the relationship, IHRP enables collaborative exploration of the **multiple layers** of meaning behind problematic substance use and the development of targeted, effective alternatives.

The Seven Therapeutic Tasks of IHRP (Tatarsky & Kellog, 2010; Tatarsky, 2013)

1. Managing the Therapeutic Alliance

The alliance is foundational throughout treatment. Harm Reduction's principles - meeting clients where they are and supporting their goals - directly reinforce alliance building.
Research consistently shows that therapeutic alliance strongly predicts positive outcomes in substance use treatment (Dearing et al., cit. in Tatarsky & Kellog, 2010, cit. in Tatarsky 2013).

Key skills include:

- active listening
- collaborative questioning
- empathy
- reflective skillfulness
- awareness and management of countertransference

2. The Therapeutic Relationship as a Promoter of Healing

A strong therapeutic relationship creates safety, reduces anxiety, and invites self-reflection. Within this space, clients can consider less harmful ways of using substances and explore healthier avenues for addressing needs previously met through use.

The relationship also provides a context where interpersonal challenges can surface and be repaired, offering corrective emotional experiences and strengthening relational capacities.

3. Strengthening Self-Management Skills for Positive Change

Many addictive or self-destructive behaviors stem from deficits in self-regulation. Treatment aims to activate the client's motivated, growth-oriented self and build:

- curiosity
- self-reflective awareness
- affect tolerance

Self-regulatory skills are developed through methods such as:

- mindfulness training (Witkiewitz, Marlatt, & Walker, 2005)
- relaxation training (Benson, 1975)
- positive self-talk (Burns, 1999)

4. Evaluation as Treatment

Evaluation is both an initial and ongoing therapeutic task. Through collaborative inquiry, clients deepen their awareness of patterns, meanings, and consequences. This process facilitates:

- development of harm-reduction goals
- increased self-reflection
- strengthened insight into discrepancies between behavior and values

Tools include:

- behavior monitoring logs
- trigger and consequence mapping
- microanalysis of use episodes

Simply receiving feedback can itself promote motivation by making conflicts between actions and personal values more visible.

5. Embracing Ambivalence

Ambivalence is central to problematic substance use and is often mistaken for resistance. Addressing ambivalence enhances motivation for change. Strategies include:

- empathizing with both sides of the ambivalence
- decisional balance
- experiential methods like chairwork (Kellogg) or voice dialogue (Stone & Winkelman; Tatarsky)

These techniques help clients access conflicting internal voices and move toward integrated, reflective decision-making.

6. Establishing Harm Reduction Goals

Harm Reduction values acceptance and autonomy while also supporting growth toward health and wellbeing. Goals emerge from the client's reasons for seeking therapy and their exploration of ambivalence. The approach supports change across the continuum—from reducing harm within ongoing use to achieving non-problematic use or abstinence.

This **gradualist** orientation (Kellogg) integrates any strategy—harm-reduction or abstinence-oriented—that is effective and aligned with the client's goals.

7. Active Strategies for Positive Change

Once clients have clarified the problematic aspects of their substance use, specific strategies can be chosen to address each factor of vulnerability. Evidence-based cognitive and behavioral options include:

- **Psychoeducation on Harm Reduction** and the biopsychosocial meaning of substance use
- **An experimental mindset**, viewing change as ongoing trial and error
- **Urge Surfing** (Marlatt & Kristeller)
- Identifying **event–thought–urge–choice–action** sequences
- "Thinking through the urge" to visualize consequences
- Repeatedly revisiting **decisional balance**
- Clarifying internal motivations through reflective dialogues
- **Trigger identification** and management
- Relaxation training, assertiveness skills, and other alternative coping strategies
- Creating a list of **18 alternative responses** to common triggers
- Designing a **game plan**, anticipating high-risk situations and preparing adaptive responses

These strategies help interrupt automatic patterns, build awareness, and support behavioral experimentation aligned with the client's values and goals.

3. Active Listening, Reflective Listening and Communication Techniques in a Support Intervention Context

As explored in previous units, clear and precise communication is essential in any helping relationship, particularly in work aimed at promoting social change and supporting people experiencing homelessness. Effective communication helps ensure needs are addressed in a comprehensive, person-centered way. Core principles such as empathy, open and respectful communication, horizontality, acceptance, non-judgment, and low-threshold service provision are aligned with a Harm Reduction approach.

The Canadian AIDS Treatment Information Exchange (CATIE, 2022) highlights several supportive communication practices for professionals working with people who use drugs, including:

- maintaining open body language
- creating a welcoming and non-stigmatizing environment
- protecting confidentiality
- ensuring consistency in policies and procedures
- taking time for difficult or complex conversations
- examining personal biases related to race, gender, sexual orientation, mental health, disability, and substance use

Communication involves many interconnected skills and components. This unit focuses on aspects considered central in support and helping interventions with people experiencing homelessness.

3.1 The Role of Listening in a Helping Relationship

In supportive helping contexts, **listening** is the foundation of all other communication responses and strategies.

Three elements are fundamental to effective listening:

1. Listening to and understanding verbal messages
2. Observing and interpreting non-verbal communication
3. Understanding the person's context, focusing on the person more than the facts

Cormier, Nurius & Osborn (2017) describe listening as involving three steps:

1. Receiving the message (covert)

This step requires silence, presence, and focus. Reception errors occur when the listener becomes distracted or stops hearing. Creating space—for both listener and speaker—is essential.

2. Processing the message (covert)

Processing includes internal cognitions, self-talk, and mental preparation for responding. Because this involves interpreting possible meanings, it requires openness, awareness of alternative interpretations, and recognition of one's biases or blind spots that may distort what is being heard.

3. Sending the message (covert)

Processing shapes the verbal and non-verbal response sent back to the speaker. At this point, the listener engages in a **relational** aspect of listening and begins forming empathic or reflective responses.

Processing the message is closely linked to **Reflective Listening**, as the helper is listening not only to the other but also inwardly, generating empathic and reflective statements.

3.2 Active Listening and Reflective Listening

Two core concepts addressed previously are especially relevant in helping contexts: **Active Listening** and **Reflective Listening.**

Active Listening

Active Listening involves listening with sensitivity and intention, attending to both **factual** and **emotional** components of the speaker's message (Rogers, 1961). It helps the other person clarify their thoughts, feelings, and problems, and can initiate change.
In Active Listening, meaning is given to both verbal and non-verbal messages. What communicates "I am listening" is not simply repeating content but conveying **emotional presence.**

Lindhal (cit. in Cormier, Nurius & Osborn, 2017) describes true listening as involving one's "whole being," similar to the Chinese ideogram for "listen," composed of symbols for **ear, eye, undivided attention, and heart**. Listening is more than hearing words—it is holistic.

Rogers & Farson (1961) emphasize that Active Listening involves:

- listening for **total meaning** (content + feeling)
- responding to feelings
- attending to all cues (verbal and non-verbal) to understand the speaker's full message

Reflective Listening

Reflective Listening, described by Rogers (Miller & Rollnick, 2002), expresses accurate empathy and an attitude of acceptance. It involves listening respectfully and seeking to understand the speaker's feelings and perspectives without judgment or criticism.

In Reflective Listening, the listener makes an informed guess about the meaning behind the speaker's words or non-verbal expressions and responds with a **statement**, not a question (Cormier, Nurius & Osborn, 2017).

Research in Motivational Interviewing shows that reflective statements - more than affirmations or other techniques - tend to generate **change talk** (Moyers et al., cit. in Cormier, Nurius & Osborn, 2017).

3.3 Listening Responses and Influencing Responses

Cormier, Nurius & Osborn (2017) describe two broad categories of helper responses:

- **Listening responses** – grounded in the client's perspective and frame of reference
- **Influencing responses** – more active responses that bring in the helper's observations, ideas, or hypotheses, intended to promote insight, action, or change

Influencing responses should be used only when appropriate, typically later in the helping process once trust has been established.

Listening Responses (*Cormier, Nurius & Osborn, 2017*)

- **Clarification**
  Encourages client elaboration, verifies accuracy, and clarifies vague or confusing messages. It typically begins with a question followed by a paraphrase.
- **Paraphrasing**
  Rephrasing the content of the message to help the client focus on or explore the factual elements. Useful when focusing on feelings might be premature.
- **Reflection**
  Rephrasing the feeling component of the message. Helps clients become aware of dominant emotions, discriminate among feelings, regulate them, and feel understood.
- **Summarization**
  Links together multiple elements of messages. Useful for identifying themes or patterns, reviewing progress, slowing or redirecting the conversation, or containing excessive rambling.

Influencing Responses (*Cormier, Nurius & Osborn, 2017*)

- **Questions**
  Open or closed inquiries to elicit elaboration or information. Best used purposefully and sparingly
- **Information Giving**
  Providing factual information or data about events, options, or resources.
  Helps dispel myths, motivate exploration of avoided issues, and structure transitions.
- **Self-Disclosure**
  Sharing personal experiences or information to build rapport, convey authenticity, model openness, expand the client's perspectives, or instill hope.
- **Immediacy**
  Offering feedback about what is happening "in the here and now" within the therapeutic interaction. Useful for exploring unspoken feelings or relational dynamics.
- **Interpretation**
  Making implicit meanings explicit by identifying patterns, themes, or underlying feelings. Helps clients see their behavior from a different angle and deepen self-understanding.
- **Confrontation / Challenge**
  Pointing out discrepancies or inconsistencies in the client's communication or behavior. Used to explore alternative perspectives and promote action.

The last three - **immediacy, interpretation, and confrontation** - are more advanced skills, requiring sensitivity, timing, and a strong therapeutic relationship. They are typically used later in the helping process, especially when the goal is to foster insight or deeper exploration.

Home4Health Training Program

Module 2

Trauma-Informed Care Approach

Home4Health Training Program - Module 2: Trauma-Informed Care Approach

Module Overview:

Coordinated by: In partnership with:

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a) Learning objectives and outcomes

- Define complex trauma and its holistic impact on individuals
- Explain behavioural and neurobiological responses associated with trauma
- Identify intersections between trauma, homelessness, drug use, and adverse childhood experiences
- Apply trauma-informed and peer support approaches to foster recovery, post-traumatic growth, and mitigate secondary trauma in caregivers.

b) Competencies addressed

- **Cultural Competence:** Understanding the impact of trauma and the intersectionality between trauma, drug use, and homelessness, and recognising how diverse experiences shape responses and needs.
- **Analytical Skills:** Analysing patterns of behaviour and responses related to trauma among individuals and populations.
- **Critical Thinking:** Evaluating the effectiveness of trauma-informed approaches, including post-traumatic growth and peer support, and considering context-specific strategies to support healing.
- **Communication Skills:** Effectively communicating insights and applying knowledge, skills, and attitudes to provide trauma-informed care and services that promote recovery.

c) Methodology

- Lecture and presentations
- Group discussions
- Case studies
- Short videos
- Activities

d) Materials

- Articles, books
- Statistics
- Presentation slides
- Flip chart, board
- Paper, pen

e) Infrastructure

A suitable room with access to a projector and sufficient seating and space for a group of a maximum of 25.

Unit 1 | Understanding Complex Trauma

Section 1 | Introduction to the course and participant's introduction
Section 2 | Definitions
Section 3 | Trauma Awareness and Different Types of Trauma
Section 4 | Behavioural and Neurological Impacts of Trauma on the Individual
Section 5 | Peer Support

Unit 1 | Understanding Complex Trauma

Section 1 | Introduction to the course and participant's introduction

Activity 2.1 | Icebreaker "Two truths and one lie" (20 minutes)

Objective:
To help participants get to know each other in a light way. Allow each participant time to actively listen to each other, observe body language and have fun. Encourage people to be as creative as they like.
All the instructions and materials for the activity are available on the Toolkit.

Section 2 | Definitions

The World Health Organization (WHO) defines trauma as a "delayed or protracted response to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or long lasting nature, which is likely to cause pervasive distress in almost anyone".

What is trauma?
There are many different types of trauma which have far reaching diverse impacts which can affect one's body, sensory world and health. Trauma is situations or events we find traumatic and how we are affected by our experiences *(https://www.who.int)*.
Trauma can happen at any age, can cause long term harm, everyone has different reactions to trauma, and you might notice effects quickly or a long time afterwards. Adversity is a term commonly used to describe the range of challenging life experiences.Trauma does not occur within a vacuum.It is influenced by multiple systemic, relational, cultural, political and wider elements. Adversity might include social exclusions, social dislocation, discrimination, poverty, addiction abuse and so on.

Trauma can mean different things to different people. The impact and consequences of trauma vary; they can be broad, complex and multilayered.

Whether an event is traumatic depends not just on the nature of the event itself but on our experience and meaning making of the trauma as well as a range of other wider factors

Some of the interplaying factors which can influence the impact of trauma:

- Previous life events, history, traumas and stressors.
- The severity, nature and type of the trauma.
- The frequency, timing and duration of the traumas.
- The location of the traumas.
- The relationship with the person carrying out that abuse.
- The response of others around the abuse.
- How it was managed and whether it was believed, validated etc.
- The sense of making meaning around the trauma.
- Expectations, assumptions, beliefs and attributions made about oneself, others, the world and the traumas.
- The associated losses and violations.
- The social, emotional, developmental and analytical decisions major depression.
- The presence and or absence of protective factors.
- Social support and community support.
- Access to resources and support.
- The wider cultural, socio-political, economic and environmental context.
- The type of milieu, family scripts, emotional world and parenting models that the person has been shaped, soaked and marinated in. Including the intergenerational transmission of trauma and attachment styles.
- The person's temperament and unique attributes including biological identity and genetic factors.

It is important to highlight how pervasive and widespread trauma and adversity can be. This is one of the key reasons why services and systems need to be more adversity, culturally and trauma informed and responsive and why it is important to be mindful of an advocate for a universal approach.

Activity 2. 2 | “If trauma could talk, what would it say, show or tell us”

Objective:

To facilitate a collective exploration of how trauma manifests and communicates in people’s lives, enabling participants to share perspectives, articulate experiences, and co-construct understanding in a supportive group setting, thereby fostering awareness, empathy, and a foundation for deeper learning.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | Trauma Awareness and Different Types of Trauma

Trauma awareness is the understanding that past adverse childhood experiences can significantly impact individuals, reactions, and overall well-being. It involves recognizing that individuals may be sensitive to triggers and react in a way that appears unrelated to the current situation. A trauma aware approach acknowledges the prevalence of trauma, seeks to understand its potential impact, and aims to create supportive and safe environments that minimise the risk of re-traumatization. (working definition of trauma-informed practice - *https://www.gov.uk*, 2022)

Key aspects of trauma awareness:

- Understanding the Impact of trauma awareness: Recognizing that trauma can affect individuals' physical and mental health, behaviour, and relationships.
- Recognizing signs and symptoms: Being able to identify potential signs and symptoms of trauma in individuals, including behavioural changes, emotional distress, and physical manifestations.
- Awareness of triggers: Understanding that certain situations, environments, or stimuli can trigger traumatic memories or reactions.
- Promoting safety and trust: Creating environments and interactions that prioritize physical and emotional safety, fostering trust and reducing the risk of re-traumatization.
- Adopting trauma-informed practices: Implementing strategies and approaches that are sensitive to the impact of trauma, such as offering choices, promoting collaboration, and empowering individuals.
- Preventing re-traumatization: Avoiding actions or situations that could re-trigger past traumatic experiences and actively work to create a safe and supportive environment.
- Seeking professional support: Recognising when professional help is needed and encouraging individuals to seek support from therapists or other qualified professionals.
- Why is trauma awareness Important?
- It improves the understanding of trauma and its impact on the individual.
- It enhances support.
- It helps to reduce stigma.
- It promotes healing.
- It improves people's outcomes.

Different types of trauma:

Trauma can be broadly categorized into acute, chronic, and complex types, each with distinct characteristics and impacts. Acute trauma stems from a single stressful event, while chronic trauma involves prolonged exposure to stressful situations. Complex trauma arises from repeated and varied traumatic experiences. Below are examples of the different types of trauma:

- Single event – happened once.
- Developmental trauma - exposure to early life trauma.
- Intergenerational trauma - how trauma passes from generation to generation.
- Historical trauma - Institutional abuse e.g physical, sexual and emotional abuse.
- The experience of immigrants, refugees, marginalised groups and ethnic minorities.
- Secondary trauma - is a form of trauma that a person experiences not due to something that directly happened to them but rather due to indirect connection to an experience (sitting and hearing someone's story).
- Vicarious trauma - is the emotional and psychological distress experienced by individuals who are exposed to the traumatic experiences of others. It results from an empathic connection to survivors' trauma, leading to a profound shift in one's worldview and a range of symptoms including anxiety, irritability, intrusive thoughts, and change in one's core beliefs. It is a cumulative process, not an event, that can cause negative effects similar to those of direct trauma.

Early or developmental trauma happens during childhood. This happens with disruptions to a child's care, where chronic abuse, neglect, or other harsh adversity occurs. The repeated experience of abuse and adversity impacts upon the child's development (e.g. social, emotional, physical, ability to form/maintain relationships and personal development). Reminding ourselves that the trauma occurs in relationships with caregivers, or adults in authority, and this affects the sense of safety, security and trust the child needs to experience.

In other words, unresolved trauma lives on in the body and can affect a person's day-to-day life in a profound way.

Recommended watching outside of the training: Video on developmental trauma: *https://youtu.be/5xyighp2lLk?si=AHIVsrZCSMm051GS*

Post-traumatic stress disorder (PTSD)

Definition: Post traumatic stress disorder (PTSD) is a mental health condition that is caused by an extremely stressful or terrifying event either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event.

Distinction between PTSD and Complex PTSD

PTSD and Complex PTSD both stem from traumatic experiences, but Complex PTSD is specifically associated with prolonged, repeated trauma, often in interpersonal relationships, where PTSD can result from a single traumatic event.Complex PTSD includes all the symptoms of PTSD, along with additional challenges in emotional regulation, identity, and relationships. Most people who go through traumatic events may have a hard time adjusting and coping for a short time but with time and by taking good care of themselves they usually get better. If the symptoms get worse last for months or years and affect their ability to function daily they may have PTSD. Getting treatment after PTSD symptoms arise can be very important to ease symptoms and help people function better.

Symptoms

Post traumatic stress disorder symptoms may start within the first three months after a traumatic event. But sometimes symptoms may not appear until years after the event. These symptoms last more than one wants and can cause major problems in social or work situations and how well you get along with others. They can also affect your ability to do your usual daily tasks.

Generally, PTSD symptoms are grouped into four types: intrusive memories, avoidance, negative changes in thinking and mood, and changes in physical and emotional reactions. Symptoms can vary from person to person.

1. Intrusive memories

Symptoms of intrusive memories may include:

- Unwanted, distressing memories of a traumatic event that come back over and over again.
- Reliving a traumatic event as if it was happening again, also known as flashbacks.
- Upsetting dreams or nightmares about a traumatic event.
- Severe emotional distress or physical reactions to something that reminds you of a traumatic event.

2. Avoidance

Symptoms of avoidance may include:

- Trying not to think or talk about a traumatic event.
- Staying away from places, activities or people that remind of a traumatic event.

3. Negative changes in thinking and mood

Symptoms of negative changes and thinking may include:

- Negative thoughts about yourself, other people or the world.
- Ongoing negative emotions of fear, blame, guilt, anger or shame.
- Memory problems, including not remembering important aspects of a traumatic event.
- Feeling detached from family and friends.
- Having a hard time feeling positive emotions.
- Feeling emotionally numb.

4. Changes in physical and emotional reactions

Symptoms of change in physical and emotional reactions, also called arousal symptoms, may include:

- Being easily startled or frightened.
- Always being on guard for danger.
- Self-destructive behavior, such as drinking too much or driving too fast.
- Trouble sleeping.
- Trouble concentrating.
- Irritability, angry outbursts or aggressive behavior.
- Physical reactions, such as sweating, rapid breathing, fast heart beat or shaking.

For **children six years old and younger** symptoms may include:

- Reenacting a traumatic event or aspect of a traumatic event through play.
- Frightening dreams that may or may not include aspects of the traumatic event.

Intensity of symptoms

Over time, PTSD symptoms can vary in how severe they are. You may have more PTSD symptoms when you are generally stressed or when you come across reminders of what you went through, including the same time of year when a past traumatic event happened. For example, you may hear a car backfire and relive combat experiences. Similarly, you may see a report on the news about a sexual assault and feel overcome by memories of your assault.

Recommended watching outside of the training: Video on recognizing trauma by Professor Van der Kolk *https://youtu.be/rbqeGOXonUA?si=UJ-j4KgAx70QeAt5*

Trauma-Informed Care (TIC)

This is an approach used in healthcare, education, and social services that recognises the widespread impact of trauma and seeks to avoid re-traumatization while supporting healing.

The Substance Abuse and Mental Health Services Administration (SAMHSA) uses a framework that outlines six core principles, which are widely used:

1. **Safety** - Ensuring people feel physically and emotionally safe. This includes having calm, predictable environments. Respectful communication and protection of boundaries and privacy.
2. **Trustworthiness and Transparency** - Build trust through clear, honest communication. This includes explaining decisions and processes. As a professional being consistent and reliable and avoiding hidden agendas.
3. **Peer Support** - Use shared experiences to promote recovery and resilience. These may include peer mentors or support groups or people with lived experience supporting others..
4. **Collaboration & Mutuality** - Recognize that healing happens in partnership. This can involve reducing power imbalances. Ensure people are involved in decision making and their voices are heard.
5. **Empowerment** Voice & Choice Focus on strengths rather than deficits. This includes encouraging autonomy and self-advocacy. Offer options and respect choices and help build skills and confidence.
6. **Cultural, Historical and Gender Awareness** - Recognise the influence of culture, identity, and historical trauma. This includes providing culturally responsive care. Addressing bias and discrimination and respecting gender identity and social context.

Trauma informed care means asking “What happened to you?” rather than “What is wrong with you?” and shaping services in ways to promote safety, empowerment, and healing.

Video on Trauma Informed Care Principles
Trauma Informed Practice - MARAM Animation Series

Trauma amongst women experiencing homelessness:

Trauma is common amongst both men and women experiencing homelessness but the type, causes, and impacts of trauma often differ by gender. Women tend to experience more interpersonal and gender based trauma.There are a number of types of trauma commonly experienced by women.

1.Childhood trauma - Many women who are experiencing homelessness report adverse childhood experiences (ACES) including:

- Sexual abuse
- Physical abuse
- Emotional neglect
- Domestic violence in the home.
- Parental substance misuse

These experiences can increase the risk of homelessness, mental health issues and other vulnerabilities.

2**. Intimate Partner Violence** - Domestic violence is one of the leading pathways into homelessness for women. This may include:

- Physical violence
- Sexual assault
- Coercive control
- Financial control
- Psychological abuse

Many women who leave unsafe relationships do not have financial resources or housing options and this can result in homelessness.

3. Sexual violence and Exploitation - Women who are experiencing homelessness can be at high risk of sexual assault, harrassment and exploitation.This can occur as women's vulnerability can increase by:

- Sleeping rough
- Staying in unsafe accommodation
- Trafficking or coercion

4**. Trauma while homeless** - Homelessness itself can be hugely traumising.Women often experience fear, loss of dignity and control, stigma and discrimination, separation from children and exposure to violence.

Women who experience homelessness have much higher rates of:

- Post traumatic stress disorder
- Anxiety disorders
- Substance use disorder
- Self harm and suicidal thoughts
- Depression

This can lead to some women who are experiencing homelessness being hypervigilant and difficulty trusting services. Women can be emotionally dysregulated and can experience dissociation.This can make it very difficult for women to access adequate services and gain adequate housing.

Section 4 | Behavioural and Neurological Impacts of trauma on the individual

Trauma can have significant behavioral impacts, leading to a range of reactions from avoidance and heightened alertness to aggression and self-harm. These reactions can manifest in various ways, impacting daily routines, relationships, and overall well-being.

What happens inside of us when we are experiencing trauma. We can be functioning in survival mode. We can feel unsafe. Relationships become confusing and a source of threat.We might alternate between hyperarousal and hypoarousal states. Others may be perceived as threatening - vocal tone, facial expression posture. We may experience uncomfortable feelings in the body due to chronic stress and have physical health issues. It affects how we understand and express emotions. Emotions become unmanageable and a source of discomfort/threat. We can have difficulty in identifying and naming emotions.We may become emotionally numb and have chronic feelings of emptiness, limited capacity to empathize with others. It can cause people to develop unhealthy coping methods such as avoidance, suppression, rumination, denial and self blame. It may affect cognitive ability. Our ability to make decisions, our judgement of situations may be compromised. It can affect our reasoning skills, planning ability, impulsivity, our retention capacity and problem solving abilities.

What do we see in people who have experienced trauma?

- Struggle with self regulation and lack impulse control.
- React defensively and aggressively.
- Difficulties in being able to take account of actions.
- Lack ability to think through consequences before acting.
- Spacey detached distant people are out of touch with reality.
- Apparent meltdowns are over actions over minor things.
- Unpredictability, oppositional, volatile and extreme reactions.
- Engage in high risk behaviors:
  - Self harm
  - Unsafe sexual practices
  - Illegal activities
  - Alcohol and substance misuse
  - Assault
  - Running away
  - Sex work

Guidelines to remember when working with people who have trauma:

1. REALIZE what trauma is.
2. Be able to RECOGNIZE trauma in your clients.
3. As much as possible, make sure your own cup is full.
4. RESPOND with compassion and co-regulation.

Responding to trauma in service users:

- Be consistent in your actions and language.
- Listen to the person.
- Learn the person's triggers.
- Respect the person's privacy.
- Help the person to find support.
- Look after your own mental health.
- Look after their own mental health.
- Link in with colleagues for support.

Avoid:

- Judgement.
- Taking over the situation.
- Engaging in a power struggle.
- Removing unhealthy coping mechanisms without replacing them with empty ones.

Activity 2.3 | What trauma responses can you see in your clients?

Objective:

To identify trauma responses in our clients. To be able to relate to clients in a more trauma aware way regardless of behaviour and be able to recognise and respond to trauma. To work together as professionals to recognise and respond to trauma and gain a greater understanding of the impact of trauma.To recognise the emotional impact for professionals and how we can manage this.

All the instructions and materials for the activity are available on the toolkit.

Neurological Impacts

PTSD and the brain

PTSD significantly impacts the brain, altering structure and function in key areas. Changes are often observed in the hippocampus, amygdala, and prefrontal cortex, which are crucial for emotional processing, memory, and regulating responses to stress. These changes can lead to symptoms like flashbacks, nightmares, hypervigilance, and difficulty regulating emotions.

Specific brain areas and their roles

- Hippocampus: Smaller in individuals with PTSD, impacting memory and emotional processing, potentially contributing to flashbacks and nightmares.
- Amygdala: Overactive in individuals with PTSD leading to heightened anxiety, fear responses and difficulty regulating emotional reactions.
- Prefrontal cortex: May be less active or have reduced connectivity, impacting emotional regulation, decision making, and executive functions.
- Anterior cingulate cortex (ACC): Reduced volume and activity in this area, which is involved in attention, decision making, and emotional regulation, may also be seen in PTSD.

PTSD can be seen in brain imaging like PET scans. It can reveal distinct patterns of activity, including increased activity in the amygdala and reduced activity in the prefrontal cortex. These findings provide valuable insights into the neurobiological basis of PTSD and can help develop targeted treatments.

A polyvagal theory

A core component of the parasympathetic nervous system, the vagus nerve is responsible for visceral sensation, stimulating the muscles of the digestive tract and decreasing heart rate. It helps to modulate the body's once responses such as chronic stress, fear, and trauma.

Traumatic experiences can contribute to an overactive vagus nerve, leading to anxiety, mood changes, nausea, and pain. High levels of stress and anxiety can also trigger the vagus nerve when overstimulated, it can cause symptoms such as vomiting, dizziness and abdominal pain.
Traumatic events push the nervous system outside its ability to regulate itself. For some, the system gets stuck in the “on” position, and the person is over-stimulated and unable to calm. Anxiety, anger, restlessness, panic, and hyperactivity can all remain when you stay in this ready-to-react mode.

Encourage all participants to watch this in their own time to understand the polyvagal perspective.

Video on Trauma and the Nervous System: A Polyvagal Perspective
https://youtu.be/ZdIQRxwT1I0?si=U2ImpdEnEIauZozt

Sources of hope:

- **Brain plasticity:** The brain continues all our lives to rewire in response to experience.
- **Resilience:** Every trauma survivor is resilient to how they have endured and survived.

Post-traumatic growth

- **Somatic healing:** A body living in survival mode - nervous system regulation.
- **Relational repair:** Attachment styles can change from insecure to secure in later healthy relationships.

Section 5 | Peer Support

Support from peers is unique and benefits trauma survivors in terms of providing them with various types of support, practical advice for post -injury life and hope for the future. It also helps trauma survivors feel like they are not alone in their journey.

Why is peer support important in trauma informed care?

Peer support is crucial in trauma-informed care because it fosters a sense of safety, connection, and empowerment for individuals recovering from trauma. By sharing lived experiences and offering mutual support, peer supporters canhelp break down feelings of isolation, build trust, and promote healing and recovery. *(www.dess.virginia.gov)*

Important considerations:

- A peer support specialist should have personal experience with mental health conditions, substance use, homelessness or other significant challenges.
- They should be actively in recovery or have a demonstrated history of overcoming these obstacles for a period of at least one year.
- The candidate needs to be comfortable sharing their personal experiences and navigating the system they've experienced as a service recipient.
- Peer specialists must be able to build trusting relationships based on mutual respect, empathy, and non-judgmental.
- Listening, after engagement, and their communications are essential.
- Maintaining a positive outlook and inspiring hope and others is vital.
- They should be able to advocate for themselves and others, understand their rights, and the application systems effectively.
- They should feel in a healthy place in their own recovery journey, able to manage their own well-being while supporting others.
- Be able to assess the level of support needed and be able to refer clients to appropriate resources when necessary.
- They need appropriate training and on-going supervision.

What is the peer support role?

Peer support plays a crucial role in promoting recovery and well-being. By sharing experiences, peers can break down feelings of isolation and stigma, which are often barriers to seeking help. It offers practical advice, empathy and encouragement, reminding individuals they're not alone in their journey.

Peer support is any interaction between people who share these similar experiences such as one- to -one visitation or peer support groups.

This utilizes a strength based framework that emphasizes physical, psychological, and emotional safety and these opportunities for survivors to rebuild a sense of control and empowerment.

SAMHSA, an agency within the US Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation, defines peer support as “a system where individuals with livid experience of mental health conditions, substance use disorders, or both, provide supportto others navigating similar challenges”. (SAMHSA, 2024).

What are the four tasks of peer support?

- Build connections
- Helping each other understand how we come to know what we know (world view)
- Redefining health as equal learning and growing process (mutuality)
- Anything to worry about we want, rather than away from what we don't want. (Continued development in the module on Peer Work).

How do you facilitate peer support?

- Be available
- Provide the person with a safe zone to express their thoughts
- Listen attentively, openly and nonjudgmentally, and encourage discussion
- Be kind, empathic and understanding, and share your experience with the person who doesn't feel alone

Different types of peer support

- Online and telephone support
- One-to-one support
- Informal group support
- Formal group support

Reflection questions:

- How would you define trauma in your own words?
- What factors influence whether an experience becomes traumatic for someone?
- How might childhood trauma impact development differently than trauma experienced in adulthood?
- How does PTSD affect a person’s daily life, relationships, or work?
- Why is understanding the neurological impact of trauma important for professional and peers?
- Why might trauma responses sometimes be misinterpreted as “problem behaviour”?
- What are the core principles of trauma-informed care?
- What role can peer support play in trauma recovery?
- What assumptions about trauma might you need to challenge?

Unit 2 | Intersectionality Between Trauma, Homelessness and Drug Use

Unit 2 | Intersectionality Between Trauma, Homelessness and Drug Use

Section 1 | Trauma, Drug Use and Attachment

When we look at the relationship between trauma, homelessness and drug use we need to look at our work through an attachment lens.

John Bowlby's attachment theory offers an insightful understanding of human's biological need for attachment. Based on attachment theory, substance use can be understood as "self-medication", as an attempt to compensate for lacking attachment strategies. Attachment theory suggests a developmental pathway from insecure attachment to substance use disorders and, on the other hand, a negative impact of substance abuse on attachment security.

In infancy, a secure attachment is formed when a good enough caregiver is warm, nurturing, consistent, attuned to their child's needs. An insecure attachment style can develop when caregivers are inconsistent in responding to their child's physical and emotional needs.Beginning in infancy, early attachment with caregivers provides a template for future relationships, impacting how we relate to the world, others, and to ourselves.

How does this relate to trauma?

As human beings we have two fundamental needs: authenticity and attachment.Authenticity is our connection to ourselves and attachment is our connection to others. This can be problematic when a choice is made between the two.When people do not experience a sufficient secure base, they can develop insecure patterns of attachment, including negative images of themselves and others and negative expectations with regard to relationships.
Trauma significantly alters how a person's brain and body react to stressful situations. When trauma is experienced, the flight or flight response is activated. Though this is a natural reaction that prepares the body to deal with danger, when it occurs in excess, the brain can get stuck in a state of high alert. This often leads to chronic stress, anxiety, and other mental health issues. Turning to drugs or alcohol becomes a typical way to numb the pain or manage the intense emotions that come with trauma.Over some time, this way of coping leads to substance misuse disorders. As research shows, people who experience trauma are more likely to develop addiction compared to those who have not had similar experiences. (Dr Britt Gottlich, Psy.D. 2024)

The following video can be watched for further information: Video on trauma and addiction: *https://youtube.com/shorts/DeXEOPd03ws?si=XkaifZsALhWMwfzX*

addiction compared to those who have not had similar experiences. (Dr Britt Gottlich, Psy.D. 2024)

The following video can be watched for further information: Video on trauma and addiction: https://youtube.com/shorts/DeXEOPd03ws?si=XkaifZsALhWMwfzX

Recognizing insecure attachment in clients

Scenario 1 | Dismissive

What we see, when someone is dismissive: high self-reliance, reluctance to express needs or support, social distancing.

Client perspective:

- High desire for autonomy
- Mistrustful of others
- Reluctant to express needs or seek support
- May externalize frustration and anger towards staff

Staff perspective:

- Rejected support attempts can elicit insecurity and staff
- Lack of feedback can feel dismissive
- Clients' needs may be downplayed as long as they remain unexpressed

Scenario 2 | Preoccupied

Compulsively self-reliant, distant in relationships, downplays the importance of intimate relationships.

Client perspective:

- High desire for emotional closeness and proximity
- Seeks approval and validation from others
- Fears abandonment

Staff perspective:

- Elicits gentleness, and compassion
- Consistent and patient responding highly attentively to needs. New line challenging to balance dependency, with encouraging autonomy

Scenario 3 | Disorganised

Dependent on others but avoids intimacy due to fear of rejection. Low self-esteem and high attachment anxiety.

Client perspective:

- Desire for closeness but fears it also
- Leads to approach-avoid support seeking
- Mistrustful of others - expect disappointment, rejection, criticism

Staff perspective:

- Contradictory behaviors are confusing for staff, not sure how to respond. New line Uncertainty around how to provide consistent support
- Anxiety, and exhaustion

Knowing one's own attachment style is key. By being aware of our own attachment responses, we can be more mindful when working with clients. Be mindful of how we communicate. Be attuned to nonverbal, as well as the verbal cues of clients we are supporting. Encourage clients to express their needs, encourage reconnection and healing.

Can you recognize these attachment styles in your service user? What are examples of this?

Applying an attachment lens in our responses:

- Remain interested in the relationship
- Encourage service users to verbalize their needs through a stance of ongoing support, exploration, and curiosity

Additionally for highly enmeshed attachment style:

(enmeshed attachment style – this is where boundaries are blurred, leading to over dependence and lack of individuality)

- Encourage autonomy to enhance service user's ability to cope with anxiety and uncertainty.
- Provide regular but brief contact
- Avoid offering constant reassurance

Trauma, homelessness and drug use

Trauma, homelessness, and drug use are interconnected in a complex way, often creating a vicious cycle. Traumatic experiences can significantly impact mental health leading to maladaptive behaviors like substance abuse as a coping mechanism. Homelessness can exacerbate these issues creating environmental stressors and making individuals more vulnerable to substance use. Many individuals who experience violence(such as domestic violence, sexual violence or community violence) may turn to substances as a way of coping with the distress. People may self medicate to try to numb the pain or regain a sense of control. This can increase a person's vulnerability to violence as substances can impair judgement and put people in unsafe situations.Dependence on substances may create environments where people can be exploited or abused. Alcohol and drugs can also escalate conflicts or aggression.The relationship between violence, trauma and substance use can be bidirectional. Breaking the cycle requires addressing both at the same time and not treating them separately.

Trauma and mental health

Traumatic events, like violence or abuse, can lead to mental health challenges such as post traumatic stress disorder (PTSD), depression, and anxiety. These mental health issues can make it difficult to regulate emotions leading to behaviors like substance use as a way to cope.

Trauma and homelessness

Traumatic experiences can contribute to the risk of homelessness by disrupting social connections, employment, and housing stability. For example, domestic violence can lead to individuals being forced to leave their homes, and the trauma of that experience can make it difficult to rebuild their lives.

Homelessness and drug use

Homelessness creates environmental stressors, including lack of access to resources, social isolation, and potential exposure to drugs. The social acceptance of easy access to drugs within unhoused communities can also contribute to substance use.

The cycle

Trauma can lead to mental health issues, which can then be exacerbated by the stressors of homelessness. The combination can increase the likelihood of substance use as a way to cope with the emotional pain and challenges of being homeless. Drug use, in turn, can worsen mental health, create financial difficulties, and further complicate the cycle of homelessness.

What can we do to address this cycle?

- Addressing the cycle requires a multifaceted approach that includes trauma informed care, mental health services and support for housing and employment.
- Trauma informed care acknowledges the impact of trauma on individuals and helps them develop healthy coping mechanisms.
- Mental health services can provide therapy and medication to address mental health conditions.
- Support for housing unemployment can help individuals stabilize their lives and reduce the risk of homelessness.

FEANTSA

FEANTSA, the European Federation of National Organisations Working with the Homeless, in their article on “Recognizing the link between trauma and homelessness” highlights the importance of measuring the impact of what we do, to know the methods which are most effective in which circumstances and which methods are not so effective as well as not learning from our working experience.

In their conclusion FEANTSA acknowledged that trauma informed care aligns with the goals of the homeless sector can be effective without increasing cost and organizational burden as they require a change in the way of working and the attitude towards the work rather than the deployment of significant new resources. There is an ongoing shift taking place in the homeless sector, a move away from reactions to crises such as providing shelter, food and clothes, to long term solutions with permanent housing and support around the individual's needs. Trauma related support should be part of any solution to homelessness. Their recommendations include:

- To create a physical environment that is safe.
- Develop services based on the assumption that the service user will be managing the effects of trauma.
- Minimize barriers to service low threshold and harm reduction.
- Ensure the services do not reach traumatized service users EG by being too strict authoritarian rules etc.
- Ensure a gendered approach to trauma affects men and women differently.
- Established services that offer caring, long term relationships.
- Provide training and trauma informed care and therapeutic relationships.
- Make services client driven.
- Focus on strengths not deficits.
- Support staff with emotional stress to avoid burnout.

The Adverse Childhood Experiences (ACE's) study:

ACEs, or Adverse Childhood Experiences, are traumatic events experienced before the age of 18, such as abuse, neglect, or household dysfunction. Children are particularly sensitive to trauma, as their brains are still developing. Research shows that high levels of adversity during childhood can alter brain development and affect the immune system, leading to long-term negative impacts on physical, mental, and social health. ACEs are commonly measured using a 10-question questionnaire, with each question representing a different area of potential trauma. Understanding ACEs is crucial for identifying risks and supporting children in ways that promote healthy development and resilience.

Key findings of the ACE study

The study demonstrates a strong link between the number of aces experienced and the increased risk of poor health outcomes in adulthood. ACEs are relatively common, even among middle class populations. The study has identified numerous health problems associated with ACEs, including risk of heart disease, diabetes, obesity, depression, and substance use. The study highlights that the effects of ACEs can persist into adulthood, impacting physical and mental health..

ACE scores

ACE scores range from 0 to 10, with each yes answer on the questionnaire contributing to the score. A high score indicates a greater exposure to childhood adversity. In essence, the ACE study provides crucial consequences of childhood trauma and its impact on adult health and well-being. Adverse Childhood Experiences include:

- Physical abuse
- Physical neglect
- Household members who suffer from mental health issues
- Sexual abuse
- Loss of a parent due to death, divorce, or abandonment.
- Emotional abuse
- Emotional neglect
- Household members addicted to legal drugs and/or alcohol
- Household member who was incarcerated
- Witnessing domestic violence against mother

Adverse childhood experiences have been also linked to risky health behaviors, chronic health conditions, low life potential or even early death. ACEs are very common: 67% of the population have at least 1 ACE. However high ACE scores of four or more have been associated with increased risk to persons health and well-being.

A 2017 study in the Cork Simon community called “Moving towards trauma informed care - a research and practice” by Dr. Sharon Lambert and Graham Gill Emerson examined the level of trauma amongst Cork Simon service users and how our services could better respond to people who have experienced trauma. (Cork Simon Community, 2017). Trauma among Cork Simon service users was measured through the administration of the ACE questionnaire to 50 people supported by the adult homeless integrated team (AHIT) A Health Service Executive funded multidisciplinary team operating from Cork Simon’s emergency shelter among other homelessness services in the city. Significant levels of childhood trauma were reported levels notably higher than those experienced by the general population in the original Ace study. The 50 people who took part in the ACE study had an average age of 31, with ages ranging from 20 to 45 years. Most participants were men (77.6%), while women represented 20.4% of the group. Half of the participants had been homeless for less than five years, 30% for between five and nine years, and 20% had experienced homelessness for a decade or more. Their current living situations varied, including rough sleeping, emergency accommodation, unstable housing, and more stable forms of accommodation.

100% of Cork Simon service users who completed the questionnaire had experienced one or more ACE’s. Over 77% experience four or more aces. A score of four or more aces is known to put an individual at a significantly increased risk of poor health and well-being. By comparison, 67% of the general public from the original ACE study had experienced one or more aces and only 12.5% scored four or more. The three highest scoring ACEs were:

- Verbal abuse - 75% experienced a rate 10 times higher than the general public in the original study.
- Substance misuse by your family member: 71% had experienced this, 2.6 times higher than the general public in the original ACE study.
- Physical abuse experienced by 67% was 2.4 times higher than the general public in the original ACE study.

The results show that a significant majority of Cork Simon service users suffered verbal and physical abuse at home during their childhood. More than 1 in 3 participants suffered sexual abuse during their childhood. A quarter experienced physical neglect and two thirds endured emotional neglect. Over 70% lived with someone with an addiction issue, more than half lived with someone with mental health difficulties, half grew up in one parent families and close to a third grew up in households where a family member was in prison. Four in 10 witnessed domestic violence towards their mother.

There were some differences in the extent of which men and women have experienced ACEs. When ACEs are higher amongst women, they are generally significantly higher.

Overall, a higher proportion of men reported ACE scores between 4 and 10, indicating a high level of adverse childhood experiences. However, women were more likely to report the most severe scores, with a higher proportion scoring between 7 and 10. Certain types of adverse experiences were reported more frequently by women, particularly sexual abuse (60% of women compared with 30% of men), emotional neglect (reported by all women in the sample compared with 59% of men), and the loss of a parent during childhood (60% of women compared with 43% of men). In contrast, two adverse childhood experiences were more commonly reported by men: verbal abuse (78% of men compared with 70% of women) and substance abuse within the family environment (76% of men compared with 60% of women). Together, these patterns suggest that while both men and women in the sample experienced high levels of childhood adversity, the types and intensity of these experiences differed by gender.

ACEs and homelessness

ACEs have been found to be strong predictors of adult homelessness. Effectively reducing child abuse and neglect may ultimately help prevent critical social problems including homelessness. We see the interplay of aces and homelessness in our results. Some 100% of service users experienced at least one ACE (a rate 1.5 times higher than the general public in the original ACE study) and 77% experienced four or more ACEs (a rate six times higher than the general public in the original ACE study).

They also see a general correlation between service user ACE scores and the length of time they have been homeless; the higher a service user's ACE score, the longer they're likely to be homeless.

The impact of higher scores (four or more aces) can be seen. High scores of four or more have been associated with increased risk to a person's health and well-being. Across a range of health and well-being factors 81% of the time Cork Simon users wit a score of four or more reported worse outcomes than those with a score of less than four. They also reported poorer mental health and more than twice as likely to have suffered critical illness and domestic violence.

The associated consequences of high scores include:

- Difficulty reading facial and social cues
- Heightened startle responses
- Avoidance
- Memory problems
- Poor decision-making skills
- Aggression

These responses may be understood as normal trauma responses but importantly these are factors that prevent individuals from appropriately engaging with mainstream services.

Section 2 | Survival Adaptations

Trauma survivors often adopt various adaptations, both healthy and unhealthy, to cope with the effects of trauma. These adaptations can involve emotional suppression, avoidance, or changes in behavior and thinking. Seeking professional support, LED therapy, can help identify and re-evaluate these adaptations, more healthy coping mechanisms and promote healing.

Healthy adaptations may include developing self-compassion and mindfulness.Recognising and validating emotions, practicing self-compassion, and engaging in mindfulness can help individuals process trauma and reduce its negative impact.

Building a strong support system is also important. Connecting with trusted individuals and engaging in a supportive social network can provide a sense of safety and validation.

Seeking professional support can be beneficial. Therapy, especially trauma-focused therapies like EMDR and CBT, can help individuals process traumatic memories, develop coping strategies, and rebuild a sense of safety.

Practicing self-care can be helpful. Engaging in activities that bring joy and promote well-being, like exercise, healthy eating, and relaxing hobbies, can help manage stress and promote emotional regulation.

Setting realistic goals and focusing on strengths can help when identifying and focusing on personal strengths and setting achievable goals can foster a sense of hope and empowerment.

Another important aspect is developing healthy coping skills. Learning and practicing healthy coping strategies, such as journaling, art therapy or creative expression can help individuals manage difficult emotions and reduce stress.

Exploring trauma informed yoga and movement practices can be advantageous.These practices can help individuals reconnect with their bodies, regulate their nervous systems, and process trauma through physical movement.

There are a number of unhealthy adaptations that can be unhelpful. Emotional suppression and avoidance can be unhelpful. Silencing emotions, avoiding triggers, and suppressing feelings can lead to prolonged distress and hinder healing.

There can be changes in behavior. Individuals may exhibit changes in behavior, such as increased aggression, social withdrawal, or substance use, as a way to cope with trauma.
This may also include changes in thinking patterns. Trauma can lead to negative thought patterns, such as self-blame, distorted perceptions of reality, and difficulty trusting others. Physical symptoms can also be experienced. Trauma can manifest in physical symptoms, such as chronic pain, fatigue, or digestive issues.

It is important to understand and address different adaptations. Self-reflection can help. Taking time to reflect on one's behavior, thinking patterns, and emotional responses can help identify potential survival adaptations. Seeking professional guidance can also promote healthy adaptations. A therapist can help individuals understand their adaptations, distinguish between healthy and unhealthy coping mechanisms, and develop more adaptive strategies. It can help to focus on self-compassion and mindfulness.

Practicing self-compassion and mindfulness can help individuals recognize and validate their emotions, reduce the need to suppress or avoid. It is important to build a strong support system. Connecting with trusted individuals and engaging in a supportive social network can provide a sense of safety and validation. Another way is engaging in self-care. Prioritizing self-care activities that promote well-being, such as exercise, healthy things, and relaxing hobbies can help manage stress and promote emotional regulation.

By understanding the various survival adaptations that can arise after trauma, individuals can take proactive steps to foster healthy coping mechanisms and promote healthy healing and recovery.

The following video can be watched for further information: *https://youtu.be/BVg2bfqblGI?si=i80BY_ZkYZlxXh8p*

Activity 2.4 | Case Clinic (30 minutes)

Objective:

To assess and draw on the wisdom and experience of participants in responding to real-world challenges. This activity trains participants to address immediate and important issues in innovative ways while analysing behavioural patterns related to trauma, clarifying trauma history, and identifying appropriate support strategies.

All the instructions and materials for the activity are available on the Toolkit.

Reflection Questions:

- What behaviours or habits helped me survive difficult situations in the past?
- What situation or environment might have shaped the survival response?
- What strengths does this survival strategy reveal about me?
- What new coping strategies could support me now?
- How can substance use function both as a coping mechanism and a contributing factor to homelessness?
- Why is it important to view homelessness, mental health, and substance use as interconnected rather than separate issues?
- How might childhood trauma shape a person's coping strategies in adulthood?
- How might stigma toward homelessness, mental illness, or substance use discourage people from seeking help?
- How might learning about ACEs change the way you view people experiencing homelessness?

Unit 3 | Post-Traumatic Growth

Unit 3 | Post-Traumatic Growth

Section 1 | Definition

Post-traumatic growth

Post-traumatic growth (PTG) refers to the positive psychological changes that can occur after experiencing a traumatic event. It's the idea that adversity can lead to personal strength and deeper appreciation for life and altered beliefs or understanding of the self, others and the world. While trauma can cause significant distress PTG suggests that individuals can also find meaning and transform in a way that leads to positive change.

Key aspects of post-traumatic growth

PTG can encourage positive psychological change. PTG promotes positive aspects of resilience, meaning making, and finding strength in the face of adversity. PTG doesn't diminish the pain and distress caused by trauma, but rather acknowledges the possibility of growth along the entitlement process.Personal transformation can lead to new insights into oneself, others and the world, as well as changes in values, relationships, and overall world view. This can manifest as increased personal strength, a greater appreciation for life, spiritual changes, improved relationships, and a sense of new possibilities.

Tedeschi et al defined PTG as ‘a positive psychological change experience as a result of the struggle of trauma or highly challenging situations.’ (Tedeschi et al, 2018)

Although post-traumatic growth often happens naturally, without psychotherapy or other formal interventions, it can be facilitated in five ways: Education, emotional regulation, disclosure, narrative development, and service.

Survivors can simply work to process the experience and curb its influence on daily life. Effective therapies for PTSD include prolonged exposure therapy and cognitive processing therapy, and medication can address difficult symptoms.

Section 2 | The Window of Tolerance

This concept both halves to describe the optimal range of emotional and psychological arousal where a person can function effectively and regulate their emotions. When a person is within their window of tolerance, they can think clearly, manage emotion, and respond to challenges appropriately.

Outside of this window, a person may become hyper-aroused (overwhelmed, anxious, angry), or experience hypoarousal (numb, withdrawn).

Importance of the Window of Tolerance

There are a number of reasons why the window of tolerance is so important:

- Emotional regulation: Understanding and maintaining the window of tolerance is crucial for emotional regulation and managing stress
- Trauma recovery: For individuals who have experienced trauma, the window of tolerance may be narrower, and they need to develop strategies to expand it and stay within it
- Tyou herapeutic interventions: Understanding the window of covenant is essential for therapists working with clients who may experience disassociation or trauma

There are a number of strategies to maintain our window of tolerance.These include:

- Please Myou indfulness and body awareness: Practices like deep breathing, grounding exercises, and connecting with the body can help regulate the nervous system and expand the window of tolerance.
- Emotion regulation skills: Learning to identify and manage emotions can help a person stay within their window.
- Trauma-informed approaches: Practitioners who are trauma informed understand the impact of trauma on the nervous system and can provide support and guidance to expand the window of tolerance.

The window of tolerance is a framework for understanding how we respond to stress and how we regulate our emotions to function effectively in daily life.

How to explain the window of tolerance to clients

Introducing the concept:
Explain that everyone has a 'window of tolerance' which is the optimal range of arousal where they can feel calm and alert, manage emotions, and function effectively.

Explain the zones:
Within the window: Clients feel grounded, present, and can handle everyday stressors. They can think clearly, make decisions, and take care of themselves.

- Hyperarousal (outside the window): Clients feel overwhelmed, anxious, or reactive, often in a "fight or flight state". They might experience high energy anger, panic, or hypervigilance.
- Hypoarousal: (outside the window): Clients feel numb, detached, or withdrawn, they might experience shutting down, depression, or disconnection.
- Relate it to their experiences: Discuss how their personal experiences, such as trauma, chronic stress, or other mental health challenges, can impact their window of tolerance.
- Emphasize the importance of expanding the window: Explain that while some people have naturally wider windows, It's possible to learn and expand the window of tolerance through various techniques, introducing self-awareness, mindfulness practices, and behavioral interventions.

Provide examples of techniques:

Offer practical tips for clients to help them to stay within their window, such as:

- Self-awareness: Identifying triggers and signs of dysregulation
- Mindfulness: practicing deep breathing or grounding exercises
- Physical sensations: Using techniques like applying pressure to the body to feel more grounded

Offer support and resources:

Reassure clients that it's a process and offer supports and resources to help them navigate their emotional journey.

How can we help our clients self-regulate

There are a number of ways in which we can help our clients to self-regulate which can be helpful:

- Establish routines: Maintaining consistency routines for meals, appointments, exercise, and sleep can provide structure and a sense of stability.
- Self-care: Engaging in activities like hobbies, mindfulness, physical exercise, and healthy eating can help manage stress and promote well-being.
- Mindfulness and grounding: Practices like deep breathing, body scanning, and sensory awareness can help individuals connect with the present moment and regulate emotional responses.
- Emotional regulation techniques: Learning to identify and discriminate emotions, and developing coping strategies for managing triggers and flashbacks, can be empowering.
- Social support: Connecting with trusted friends, family, support or community groups can provide a sense of belonging and reduced feelings of isolation.
- Trauma therapy: Seeking professional help from a trauma informed therapist can help survivors gain a more balanced perspective and reduce distress.
- Exercise: Regular physical activity can help reduce stress, anxiety, and promote emotional release.
- Learn triggers: Identifying potential triggers and learning strategies to manage them can help prevent flashbacks and other distressing experiences.

You can watch the following video for further information: Video on ‘Window of Tolerance’: *https://youtu.be/K1ovJu2GNVo?si=1AxA1V3jTb--NLuB*

It is important to set realistic goals and focus on strengths. We can do this by identifying and focusing on personal strengths and setting achievable goals can foster a sense of hope and empowerment. We can also focus on Developing healthy coping skills.We can promote learning and practicing healthy coping strategies, such as journaling, art therapy or creative expression can help individuals manage difficult emotions and reduce stress. Another option is exploring trauma informed yoga and movement practices. These practices can help individuals reconnect with their bodies, regulate their nervous systems, and process trauma through physical movement.

A person can develop unhealthy adaptations. These can include emotional suppression and avoidance. Silencing emotions, avoiding triggers, and suppressing feelings can lead to prolonged distress and hinder healing. There can be changes in behavior. Individuals may exhibit changes in behavior, such as increased aggression, social withdrawal, or substance use, as a way to cope with trauma.

A person can experience changes in thinking patterns. Trauma can lead to negative thought patterns, such as self-blame, distorted perceptions of reality, and difficulty trusting others. People can experience physical symptoms. Trauma can manifest in physical symptoms, such as chronic pain, fatigue, or digestive issues. It is important to understand and address adaptations. Self-reflection can help with this. Taking time to reflect on one's behavior, thinking patterns, and emotional responses can help identify potential survival adaptations. A person may seek professional guidance. A therapist can help individuals understand their adaptations, distinguish between healthy and unhealthy coping mechanisms, and develop more adaptive strategies. It is important to focus on self-compassion and mindfulness.Practicing self-compassion and mindfulness can help individuals recognize and validate their emotions, reduce the need to suppress or avoid. It is important to build a strong support system. Connecting with trusted individuals and engaging in a supportive social network can provide a sense of safety and validation.

Engaging in self-care can be beneficial. Prioritizing self-care activities that promote well-being, such as exercise, healthy things, and relaxing hobbies can help manage stress and promote emotional regulation. By understanding the various survival adaptations that can arise after trauma, individuals can take proactive steps to foster healthy coping mechanisms and promote healthy healing and recovery.

Practical examples of strategies that can be used to promote post-traumatic growth:

Deliberate reflection:

Unstructured overthinking keeps you stuck.Post-traumatic growth comes from intentional processing.

How to do it:

- Set a timer (10 to 20 mins)
- Ask yourself:

What do I need to re-evaluate?

What matters more or less to me know?

- Write your answers down.
- The goal is to make meaning rather than just constantly replaying the event.

2. Rebuild your own narrative

Trauma can massively impact your own sense of identity.Growth can come from rewriting your own story which includes strength.

Exercise:

- *Who was I before?*
- *What happened to me?*
- *What have I changed?*

Focus on

- Resiliance
- New positive skills gained
- What I value now.

3. Strengths

Identify specific strengths that you demonstrated.

- I asked for support
- I kept going despite things being hard
- I didn’t stop going.

Then ask:

Where else can I apply this strength in my daily life?

4. New priorities

Many people report a shift in what matters.

Try this:

- List 5 priorities before the trauma.
- List 5 priorities now.
- Compare
- Make one small change

5. Strengthen relationships

Post-traumatic growth may help to deepen a connection.

Focus on:

- People who actively listen and don’t judge
- Those who can be honest.

Avoid

- People who are dismissive and do not validate your feelings.

Activity 2.5 | Promoting post-traumatic growth strategies (30 minutes)

Objective

To recognize potential growth without minimising trauma. Apply post traumatic growth principles in complex, ongoing trauma environments. Balance immediate needs with longer term needs.
All the instructions and materials for the activity are available on the Toolkit.

Reflection questions:

- What happened and how did it physically affect me?
- Has the experience changed how I view the world?
- What assumptions about life were challenged?
- What matters more to me now than before?
- What does “growth” look like to me personally?
- What support do I need right now?
- What is one small step I can take towards healing and growth?
- What does my body feel like when I am within my window of tolerance.
- What helps me to be regulated?

Unit 4 | Vicarious Trauma

Unit 4 | Vicarious Trauma

Section 1 | Definition

What is vicarious trauma?

Vicarious trauma refers to significant, indirect experiences of distress resulting from empathic engagement with clients who experienced trauma (World Health Organization, 2013). This exposure can be direct or indirect, and can lead to a wide range of negative effects on mental health, including intrusive thoughts, anxiety, sleep disturbances, and difficulty concentrating.

When you identify with the pain of people who have endured terrible things, you bring their fear, grief, anger and despair into your own awareness. Your commitment and sense of responsibility can lead to high expectations and eventually contribute to you feeling burdened, overwhelmed, even hopeless. Vicarious trauma, like experiencing trauma directly, can deeply impact the way you see the world, and your deepest sense of meaning and hope.

Key aspects of vicarious trauma

Vicarious trauma can happen in a number of ways. Indirect exposure results from hearing about, seeing, or learning about the traumatic experiences of others, rather than experiencing the trauma directly. It can be an on-going process. It is a cumulative process that unfolds over time as individuals continue to engage with the trauma of others. It impacts on mental health. It can lead to various mental health symptoms, including anxiety, depression, sleep disturbances, and difficulty concentrating.

It is distinct from compassion fatigue. While related, vicarious trauma differs from compassion fatigue, which is the physical, emotional, and spiritual exhaustion experienced in working with traumatized individuals. It is important to focus on self care. Recognizing the signs and symptoms of vicarious trauma and practicing self-care strategies is crucial for mitigating its negative impact. Anyone who empathizes with individuals who have experienced trauma, including family members, friends, and community members, can be affected.

The model originated in the 1990's and was first introduced by Laurie Anne Pearlman and Karen W. Saakvitne. Their work was centred around the theory of Constructivist Self Development (CSDT). They argue that exposure to traumatic material can affect a professional in a number of ways. Trauma can reshape a person's cognitive framework about themselves and the world.It can include their beliefs around safety, sense of trust, feeling of control, intimacy and their own meaning and identity.

Key components of the Vicarious trauma model :

1. **Exposure to Trauma** - Therapy sessions, keyworking sessions, case conferences, media reports
2. **Cognitive Schema Changes** - Professionals may change their beliefs on certain things including their beliefs about safety, trust, control, esteem and have difficulty connecting with others..
3. **Emotional and Psychological effects** - Intrusive thoughts about the client's trauma, emotional numbness, increased anxiety, sleep problems
4. **Factors that influence Vicarious trauma** - Personal factors may include personal trauma history, coping skills and level of empathy. Professional factors include caseload, lack of supervision and not taking breaks.Organisational factors include no work place support, sufficient training in trauma informed care and access to debriefing.

Vicarious trauma differs from other related concepts. It has deep cognitive changes from exposure to others trauma exposure. The exposure creates cognitive and emotional strain.

Strategies for reducing risk of vicarious trauma include:

- Increasing your self-observation.
- Recognizing characteristic signs of stress, vicarious trauma and burnout.
- Taking care of yourself emotionally.
- Engaging in relaxing and soothing activities, nature self-care.
- Looking after your physical and mental well-being.
- Balance your caseload. Use peer support and opportunities to debrief.
- Take up training opportunities.
- Taking regular breaks and time off when needed.
- Regular Supervision and debriefing
- Personal therapy

Our role at work is demanding. Our role requires significant mental and physical energy. We come to care for those who support and develop relationships. Regularly, we are affected by the significant difficulties people experience and the barriers they face in this. You're feeling the work is hard because the work is hard, while at the same time recognizing there are steps we can take to support ourselves and our role. We can empower ourselves in the work that we can ask ourselves why we do the work? Many of us choose and want to work in the area because it gives us purpose and meaning often, we are drawn to the helper role and we are trained to see ourselves in these roles. We use our strengths and qualities in our work.

How can we empower ourselves in the work that we do?

What qualities do we bring to the work? Empathic, non judgmental, caring, understanding, and encouraging. Being patient, attentive, dedicated, passionate and resilient. (Ask the group if there are any more they can think of).

There are a number of reactions to vicarious trauma. These can be physical: feeling “on edge”, difficulty sleeping, getting sick easily. They can be emotional. Feeling sad, anxious, angry, irritable, unsupportive, unsafe or having difficulty managing your emotions. They can be cognitive. Having difficulty concentrating or making decisions, memory problems, disturbing imagery, nightmares, ‘zoning out’.

Sometimes various traumas can be seen in relationships. Expecting the worst of others, becoming judgmental, relationship problems, loss of friendship (withdrawal, increased interpersonal conflict, avoiding intimacy). It can affect a person’s spirituality. People can feel discouraged, lack of faith, a ‘why bother’ attitude. Feeling vulnerable, worrying excessively about potential dangers in the world or others' safety.

Secondary Trauma:

Secondary trauma and vicarious trauma are closely linked but they are not exactly the same. Secondary trauma often refers to the immediate stress like symptoms that arise from indirect exposure to someone else’s traumatic experience. It usually has a sudden onset and can have similar symptoms to PTSD. It can cause emotional and psychological distress.Vicarious on the other hand usually happens gradually but can have a long term effect. This can cause a significant cognitive effect on the person.

Vicarious resilience

Vicarious resilience (VR) is “the positive psychological and emotional effects, such as strength, growth, and empowerment, that helping professionals experience when witnessing the resilience of their clients in the face of adversity” *(AlOtaibi NG, 2024)*

This is an emerging area of research. When we see clients face adversity and struggles, at the same time we can see resilience and overcoming the many obstacles in their way.

There are a number of examples of what this resilience looks like. Some of these include coping skills, problem solving, resourcefulness and courage.

Section 2 | Burnout

What is burnout?

The World Health Organization describes occupational burnout as a work-related phenomenon resulting from chronic workplace stress that has not been successfully managed.
Burnout can be defined as a state of emotional, mental,and physical exhaustion caused by prolonged stress without enough rest or support.

Factors that contribute to work stress, and can lead to burnout:

- Doing work-related reading etc at home.
- Working after hours with clients in hospitals and then not being able to take lieu-time.
- Not taking proper breaks.
- Taking calls when on break.
- Dealing with critical or potentially critical incidents.
- Lack of control – not having a say in how you do your job, such as schedule, assignments, workload.
- Not having what you need to do your job.
- Lack of clarity about what is expected of you – not sure what your boss or others want from you.
- Conflict with others.
- Too much or too little.
- Lack of support.
- Problems with work-life balance.

No time to:

- Complete work tasks when due.
- Attend team meetings and other events like training.
- Manage administration.
- Follow up care plans.
- Write up incidents properly.

Signs of burnout:

- Feeling drained.
- Not feeling able to cope.
- Not being able to sleep.
- Feeling of helplessness.
- Cynicism.
- Being sad, angry, irritable or not caring.
- Using more alcohol or other substances.
- Getting heart disease, high blood pressure or type 2 diabetes.
- More likely to get sick.
- Loss of motivation.
- Feeling irritable or frustrated.
- Feeling detached or numb.
- Having trouble concentrating.

Handling job burnout:

- Look at your options – speak to your boss about your concerns.
- Work together to make changes or solve problems.
- Set realistic goals. If nothing can be changed, you may need to look at other job options.
- Seek support – Speak to coworkers, friends, loved ones. Look at what services your employer provides.
- Activity: Try a relaxing activity. Look at activities that can help with stress like yoga or Tai Chi.
- Exercise: Regular exercise will help you cope with stress.
- Sleep: Sleep restores well-being and helps protect your health.
- Practice mindfulness.

A good practice that can be very effective for practitioners is using the traffic light system.

Trauma and the traffic light system:

The trauma traffic light system is a simple way of representing our responses to trauma.It can be used by practitioners to check in with their own physiological state on any given day.

The traffic light system in trauma-informed practice is a framework that uses the colours green, yellow and red to represent different states of the nervous system and how they impact an individual's response to trauma. It's a way to understand and respond to trauma by recognizing that behaviours are often the manifestation of the body's reaction to perceived threats or safety. It uses a colour coded system to represent physiological states.

- **Green**: Represents a state of safety, calm, and social engagement. In this state, individuals are able to connect with others, think clearly, and feel relaxed. This is the desired state for optimal functioning and well-being.
- **Yellow**: This is the “fight or flight” state, where the body is activated and alert due to perceived threat. Individuals may feel anxious, hypervigilant, or agitated. This is a normal response to stress but can be overwhelming if prolonged.
- **Red**: Indicates a state of shutdown or disconnection, often experienced when feeling overwhelmed or helpless. This can manifest as feeling numb, frozen, or disconnected from one’s body or emotions.

Burnout and vicarious trauma are related but have different responses to prolonged stress. Burnout occurs to the professional when they are overwhelmed and depleted from stress.Vicarious trauma on the other hand, is where the professional internalises others’ trauma through empathic engagement.

Section 3 | Self Care

Self-care is a necessity, not a luxury.
Self-care is the act of engaging in activities that promote overall well-being and health, including physical, mental, emotional, and social aspects of taking conscious steps to nurture oneself, often through practices that reduce stress, improve mood, and enhance overall quality of life.

Self care means intentionally doing things that protect or improve your physical, mental, and emotional well-being. It is doing the small things that keep you balanced and healthy.

There are a number of key aspects to self-care. Some of these include:

- **Physical health**: This includes practices like exercise, proper nutrition, sufficiently, maintaining good hygiene, and regular medical checkups.
- **Mental and emotional well-being**: Engaging in activities that promote mental clarity, reduce stress, and improve emotional resilience, such as mindfulness, meditation, journaling, or spending time in nature.
- **Social well-being**: Nurturing relationships with loved ones, participating in social activities and seeking support when needed.
- **Spiritual well-being**: Finding meaning and purpose in life practicing spirituality or engaging in activities that connect with a higher power.

Self-care is important because it reduces stress, improves mental health, strengthens physical health, increases resilience, and promotes a sense of purpose.

What

Self-compassion is treating yourself with the same kindness, understanding, and support that you would offer to a good friend during difficult times. It involves:

- **Mindfulness**: Being aware of your suffering and struggles without exaggerating or suppressing them.
- **Self-kindness**: Responding to yourself with care and understanding rather than harsh self-criticism

Questions to ask yourself on self-care at work:

- *Can you adapt your work schedule and day to your level of stress and tolerance?*
- *Are you taking your lunch break?*
- *What in the workplace is within your control?*
- *Can you make peace with what is not?*
- *Are you turning off your phone on breaks and after work?*
- *Are you making use of support available?*

Effective self-care through activating the vagus nerve:

- Cold exposure
- Deep slow breathing
- Chanting, singing, humming and speaking.
- Meditation
- Exercise
- Socializing and laughing.
- Massage
- Balancing the gut microbiome/probiotics/omega-3
- Devices that stimulate the vagus nerve.

Sensory integration strategies

Sight:

- Reduce harsh lighting.
- Use blue light glasses
- Going for a short walk, enjoy a change of scenery or a scenic stop.

Smell:

- Essential oils
- Scented moisturizer
- Spray your perfume

Touch:

- Wearing clothing textures that you find comfortable.
- Having a scarf or a throw on your chair in the office.
- Harsh water bottle or cooling gel.

Taste:

- Small sweets.
- Enjoy a nice lunch.
- Chewing gum.
- Getting a nice coffee.

Vestibular (this is your sense of balance):

- Yoga
- Cycling
- Dancing
- Jumping on the trampoline

Sound:

- Adding a sound you like such as music or white noise
- Reducing noise (eg noise cancelling headphones or finding a quieter space).

Proprioception (this is your sense of movement and body awareness):

- Going for a short walk
- Gentle stretching

Self care strategies for professionals:

Self care strategies for professionals:

Professionals are regularly under pressure to meet deadlines and have heavy workloads. Self care is essential to maintain health, productivity and having a long term satisfying career. Below are a number of ways of doing this:

1. Physical Care:Taking care of your body directly improve your health, concentration and energy levels.Are you:

- Getting enough sleep (7 to 9 hours a night)
- Exercising regularly (20 to 30 mins a day)
- Take regular movement breaks.
- Eayou ting balanced meals
- Drinking sufficient water
- Please Watching caffeine and alcohol intake

2. Mental and Emotional Care: Professionals often deal with cognitive overload and emotional stress. Strategies that will help include:

- Mindfulness or meditation daily.
- Journaling.
- Setting clear boundaries between work and personal life.
- Focus on single tasks instead of multi tasks.
- Seek professional support

3. Workplace self-care: This can prevent burnout and improve productivity

- Use time management methods
- Schedule short breaks between tasks.
- Delegate where possible
- Communicate workload concerns.
- Take regular annual leave.

4. Social self care. Healthy relationships can protect us against stress and burnout.Strategies include:

- Maintain regular contact with family and friends
- Build support relationships with colleagues.

- Avoid work place isolation
- Engage in social activities you enjoy.

5. Personal growth Self-Care: Engage in continuous learning and growth.

- Set goals.
- Please Learn new skills or take up a new hobby.
- Attend work trainings.
- Reflect on achievements and goals.

Example of a quick daily self care routine:

- Morning: 10 minute mindfulness, which could include some gentle stretching.
- Workday: Plan day.Work in 60 blocks and take 5-10 minute breaks. Ensure adequate lunch break.
- Evening: Cook a nutritious meal. Go for a walk. Have a digital free evening.
- Night: Get sufficient sleep.

A practical tool to creating your own self-care plan:

A self care plan is a structured way to take care of your physical, mental, and emotional well-being. Having one can make a big difference in how you handle stress and maintain overall health.

You can create two types of plans:

- Emergency/reactive to self-care plan
- Preventative self-care plan

Emergency self-care plan[1]

Answer the following:

- Things that ground me when I am heightened or distressed.
- Activities that lift me when I'm feeling drained or low.
- People to connect with when I need support?
- Affirmations: Positive things to remind myself.
- My warning signs that I am getting worn out or stressed.
- What to avoid when I am worn out or stressed.

Preventative care plan

Everyday self-care - list some of the actions that can be taken in everyday life:

- What are your non-negotiables?
- What activities filled my cup?
- Nourish my body?
- Nourish my mind?

Grounding and calming techniques:

These can help you feel more present and reduce pain or distress. The following are examples you can use:

- 5-4-3-2-1 grounding: Name 5 things you see, 4 things you feel, 3 things you hear, 2 things you smell, 1 thing you taste.
- Deep breathing: Inhale for 4 counts, hold for 4 counts, Exhale for 6 to 8 counts. Repeat 3-5 times
- Muscle relaxation: Tense a muscle group for 5 seconds, release slowly. Move from toes to head.
- Cold or warm sensation: Splash cold water on your face or hold a warm drink to bring attention to your body.
- Grounding with movement: Press your feet into the floor and feel the support. Stretch your arms, roll your shoulders, or shake out your hands. Walk slowly and notice each step.
- Mental grounding: Name all the animals, flowers, countries etc you can think out to shift your attention from anxious thoughts or recite a favourite poem, song etc.
-

The following video can be presented in order to provide examples of de-stress videos: *https://youtu.be/wE292vsJcBY?si=*.

Activity 2.6 | Create your own Emergency care plan and preventative care plan.

Objective:

To work creatively on putting together your own plan of things that help to fill your cup and nourish you. This will help to prioritise your own self care and can remind you of what helps you when life gets difficult.

All instructions and materials for the activity are explained in the toolkit.

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Home4Health Training Program

Module 3
Mental Health

Home4Health Training Program | Module 3: Mental Health

Module Overview: (6h)

Coordinated by: ABD Welfare and Development Association
In partnership with: CPES CER, HVO QUERIDO, Caritas Slovenia
Co-funded by the European Union
2023-1-ES01-KA220-VET-000158754

a) Learning objectives and outcomes

- Explain the bidirectional relationship between homelessness and mental health, including how substance use, trauma, and social determinants contribute to this interaction.
- Identify and critically assess structural, systemic, and individual-level barriers to accessing mental health care, as well as the impact of stigma, discrimination, and service fragmentation.
- Apply the Self-Medication Theory, harm reduction principles, and evidence-informed care models to support people experiencing homelessness with co-occurring substance use and mental health conditions.
- Analyse how cultural, diversity, and intersectional factors shape mental health needs, help-seeking behaviours, and the effectiveness of care systems for people experiencing homelessness.

b) Methodology

Lectures and presentations, group discussions, case studies and real-world scenarios, interactive activities, multimedia resources (video, documentaries, etc.)

c) Materials

Textbooks, Reports and Academic Articles; Statistical Information; Case Study Materials; Multimedia Resources; Presentation Slides; Basic Writing Materials (Paper and Pens).

d) Competencies addressed

Knowledge Development: collecting, integrating, and interpreting multidisciplinary information (clinical, psychosocial, environmental) to support informed and context-appropriate interventions with people experiencing homelessness.

Analytical Skills: Identifying, analysing, and interpreting behavioural, cognitive, and emotional patterns associated with mental health problems, substance use, trauma responses, and dual diagnosis in homeless populations.

Critical Thinking: evaluating the relevance, strengths, and limitations of harm reduction strategies, therapeutic models, and evidence-informed interventions, adapting them to complex and unstable life contexts.

Communication Skills: Effectively communicating clinical insights, assessments, and intervention strategies clearly and empathetically to individuals, multidisciplinary teams, and stakeholders, while maintaining trauma-informed, non-judgmental, and culturally sensitive approaches.

Gender Competence: Recognising how gender, gender identity, and gender-based experiences influence mental health, substance use patterns, risks, service access, and care outcomes, incorporating this understanding into assessment and intervention planning.

e) Infrastructure

A suitable classroom setting equipped with a projector, a whiteboard, and a seating arrangement that supports group work and discussions.

Unit 1 | Understanding mental health issues in the context of homelessness

Section 1

Introduction to the course and participant's introduction

Section 2

Intersection between Homelessness and Mental Health

Section 3

Barriers to access mental health care

Unit 1 | Understanding mental health issues in the context of homelessness

Section 1 | Introduction to the course and participant's introduction

Activity 3.1 | Icebreaker "The Conductor and the Detective"

Objective:
To foster active listening, clear communication, and teamwork among participants.
All the instructions and materials for the activity are available on the Toolkit.

Section 2 | Intersection between Homelessness and Mental Health

The WHO (2022) considers mental health a basic human right and defines it as a state of mental well-being that enables individuals to realise their potential, cope with life stresses, work productively, and contribute to their community. Mental health is more than the absence of mental disorders; it is a fundamental component of overall health and well-being that supports our ability to make decisions, build relationships, and shape the societies in which we live (WHO, 2022).

The WHO (2024) also recognises that biological and psychological factors can exacerbate mental health conditions and highlights housing as a key determinant of health. As such, homelessness and mental health are connected through a complex, bidirectional relationship.

The three-level social–ecological model suggests that homelessness results from a complex interplay between structural factors, system failures, and individual circumstances. For any given individual, homelessness is typically the outcome of the cumulative impact of multiple factors rather than a single cause. Individual and relational factors refer to personal circumstances that place people at risk of homelessness and may include persistent and disabling conditions. These conditions can involve mental health and substance use challenges experienced by the individual and/or family members, as well as disabilities that affect cognitive functioning, such as acquired brain injury and fetal alcohol spectrum disorder (Gaetz & Dej, 2017).

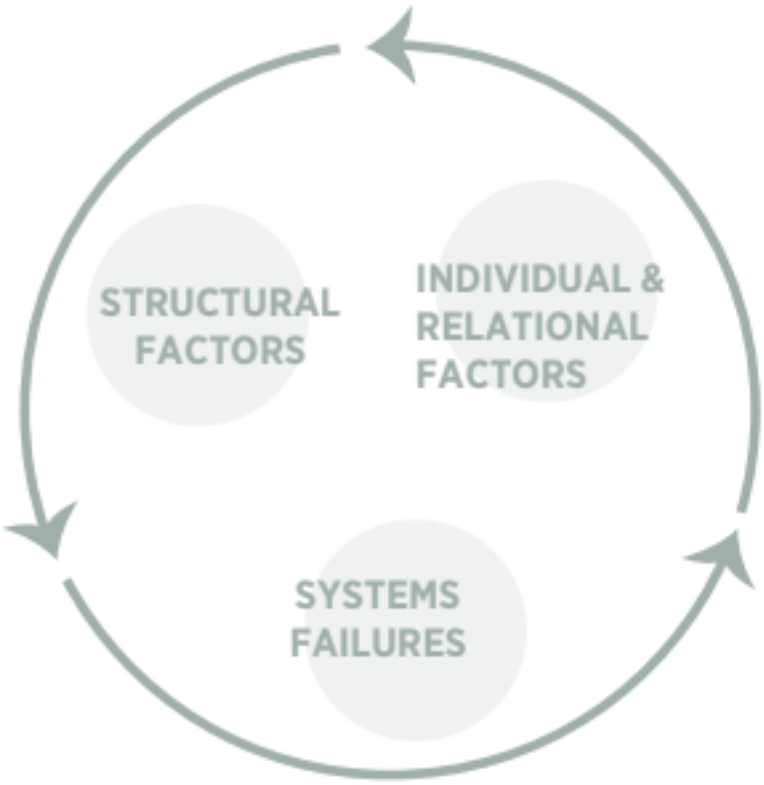

FIGURE 1 Causes of Homelessness (retrieved from Gaetz & Dej, 2017)

The three-level social–ecological model suggests that homelessness results from a complex interplay between structural factors, system failures, and individual circumstances. For any given individual, homelessness is typically the outcome of the cumulative impact of multiple factors rather than a single cause. Individual and relational factors refer to personal circumstances that place people at risk of homelessness and may include persistent and disabling conditions. These conditions can involve mental health and substance use challenges experienced by the individual and/or family members, as well as disabilities that affect cognitive functioning, such as acquired brain injury and fetal alcohol spectrum disorder (Gaetz & Dej, 2017).

Traumatic stress - commonly associated with homelessness - increases the risk of developing mental illness and has been shown to exacerbate the severity of symptoms (Spitzer, Vogel, Barnow, Freyberger, & Grabe, 2007). It plays a significant role in perpetuating mental illness, and evidence suggests that trauma often precedes the onset of mental disorders. Like the relationship between trauma and substance use disorders, this connection is bidirectional: mental illness can increase the likelihood of experiencing trauma, while trauma can heighten the risk of developing psychological symptoms and mental disorders (SAMHSA, 2014).

This dynamic creates a **vicious, self-reinforcing cycle: poor mental health increases vulnerability to housing instability and exposure to trauma, while homelessness and trauma further exacerbate psychological distress** (for more information, see Module 2: Trauma-Informed Care Approach). As Padgett (2020, p.198) states, “mental health is both a cause and a consequence of homelessness,” and interventions that fail to address both dimensions struggle to break the cycle of trauma, instability, and social exclusion. The harsh realities of homelessness - including pervasive insecurity, stigma, trauma, and lack of safety - have deeply detrimental effects on mental well-being (Padgett, 2020).

International studies cited by FEANTSA (2023a) report prevalence rates of mental illness among people experiencing homelessness ranging from 60% to 93.3%, compared to much lower rates in the general population. FEANTSA argues that these figures reinforce the need to understand homelessness as a health issue. As noted by the same report (2023a, p.2), “the importance of housing as a health determinant must be fully recognised,” emphasising that secure housing is fundamental not only for social stability but also for mental health and general well-being.

Psychological Impact of Homelessness

Mental health problems are highly prevalent among people experiencing homelessness. Evidence shows that the more severe the homelessness experience - especially in cases of long-term or recurrent homelessness - the poorer an individual’s overall mental health tends to be (EUDA, 2023). Mental health difficulties may reflect pre-existing vulnerabilities which, when combined with structural and systemic failures (Homeless Hub), increase the likelihood of homelessness. Conversely, mental health problems may also develop as a direct consequence of the homelessness experience itself.

People experiencing homelessness are repeatedly exposed to chronic and cumulative trauma, which has significant negative effects on both physical and mental health (Jayatunge, 2013). The psychological impact extends beyond the absence of stable housing and includes the daily accumulation of stress, uncertainty, and social exclusion.

Daily life in homelessness is often characterised by persistent insecurity, hunger, physical discomfort, sleep deprivation, and exposure to unpredictable or unsafe environments. This continuous struggle to meet basic needs contributes to the development or worsening of mental health conditions such as chronic anxiety, depression, and post-traumatic stress disorder (Padgett, 2020; Jayatunge, 2013).

Individuals experiencing homelessness also face an elevated risk of physical violence, sexual assault, and exploitation, both from within the homeless community and from the general public. Such experiences foster fear, mistrust, and the need for hypervigilance. Simultaneously, the loss of social status, the absence of supportive networks, and exclusion from mainstream society deepen isolation and feelings of hopelessness and worthlessness, further exacerbating existing mental health difficulties and creating additional barriers to help-seeking (Jayatunge, 2013).

Intersectional vulnerabilities - including ethnicity, gender, sexual orientation, gender identity, immigration status, and histories of substance use - can intensify the psychological impact of homelessness. These factors often increase exposure to stigma, discrimination, and multiple layers of social exclusion (FEANTSAa,b, 2023).

Limited access to stable housing and significant barriers to mental health services make it difficult for individuals to receive consistent and appropriate care. The longer a person remains unhoused without adequate support, the higher the risk of developing severe mental illness and other long-term health complications (Amore & Howden-Chapman, 2012).

Summary Box: Key Insights

- Homelessness and poor mental health are strongly interconnected, with severity and duration playing a major role.
- Trauma - often chronic and repeated - is a central feature of the homelessness experience.
- Daily stressors such as insecurity, hunger, physical discomfort, and lack of sleep contribute significantly to mental health deterioration.
- Exposure to violence and exploitation increases psychological vulnerability and mistrust.
- Social exclusion and isolation reinforce feelings of hopelessness and hinder access to support.
- Intersectional factors (e.g., gender, ethnicity, immigration status, substance use) intensify psychological harm.
- Limited access to services and prolonged homelessness heighten the risk of severe and persistent mental health problems.

Comorbidity: Mental Health and Substance Use (Dual Diagnosis)

Dual diagnosis - defined as the co-occurrence of mental illness and substance use disorder - is highly prevalent among people experiencing homelessness. Many individuals use alcohol or other drugs as a form of self-medication to cope with emotional pain, trauma, and the harshness of daily life. Although substance use may provide temporary relief, it ultimately exacerbates mental health difficulties and introduces additional barriers to recovery. High-risk drug use is particularly common among individuals experiencing long-term or recurrent homelessness (EUDA, 2023).

For many, substance use operates as a coping mechanism for unmanaged trauma; however, it simultaneously becomes a significant obstacle to treatment engagement. People experiencing homelessness routinely face discrimination, harassment, and systemic barriers that limit their access to support services. Many treatment programmes maintain an abstinence-oriented approach, meaning that individuals who continue to use substances are often excluded from appropriate care. In some systems, administrative requirements including fixed addresses or health insurance make access nearly impossible for people without stable housing.

Survival needs frequently take priority, reducing an individual's capacity or motivation to reduce or discontinue substance use. Even when motivation is present, substances are often easily accessible, and recovery without a supportive, structured environment becomes extremely difficult (National Coalition for the Homeless, 2017). Research consistently demonstrates a high overlap between substance use and mental illness among unhoused populations, along with low adherence to treatment recommendations. These findings highlight the need for low-threshold, integrated care models that can adequately respond to the needs of this target group (NPISA Lisboa, 2021).

Comorbidity between substance use disorders and other mental illnesses is well established (Mills et al., cited in AIHW, 2024). Data from the 2020–2022 National Study of Mental Health and Wellbeing in Australia show that 9% of people with anxiety or affective disorders also met criteria for a substance use disorder, whereas 46% of individuals with a substance use disorder also met criteria for at least one of these mental illnesses (ABS, cited in AIHW, 2024). Among those entering alcohol and drug treatment, between 50% and 76% meet diagnostic criteria for an additional mental health condition (AIHW, 2024).

People with co-occurring disorders experience significantly poorer outcomes, including greater functional impairment, heavier symptom burden, and markedly higher mortality rates and reduced life expectancy compared to individuals without comorbidity (Leung et al., cited in AIHW, 2024).

Housing instability and limited access to mental health and substance use services further hinder timely and effective treatment. These barriers similarly affect individuals being released from prison, contributing to cycles of homelessness and recidivism when adequate support is not available. Addressing dual diagnosis requires holistic and integrated intervention approaches, recognising stable housing as a core component of health care rather than an optional or separate issue.\

Summary Box: Key Insights

- Dual diagnosis is highly prevalent among people experiencing homelessness.
- Substance use often functions as self-medication for trauma and emotional distress but ultimately worsens mental health.
- Abstinence-based treatment models and administrative requirements often exclude unhoused individuals with mental health problems who use drugs from accessing appropriate care.
- Survival needs overshadow the capacity to engage in treatment or reduce substance use.
- High rates of comorbidity correlate with poorer health outcomes, higher mortality, and reduced life expectancy.
- Integrated, low-threshold services and access to stable housing are essential components of effective dual-diagnosis care.
- People leaving prison face compounded risks of homelessness, relapse, and recidivism when support systems are inadequate.

Activity 3.2 | Video forum

Objective:

To increase participants' awareness and understanding of how mental health issues both contribute to and are affected by homelessness.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | Barriers to access mental health care

People experiencing homelessness, including those living with mental health problems and substance use issues, face multiple barriers when trying to access health care, drug services, and social support. These barriers can be structural, service-related, and individual, often interacting to create significant obstacles to treatment and recovery.

a. Housing as a Determinant of Health

According to the World Health Organization (2024), housing is a key determinant of health. Stable, safe, and adequate housing is essential for maintaining both mental and physical well-being. For people experiencing homelessness, the absence of housing directly affects their ability to access and benefit from care:

- They lack a fixed address for registration with health services or receipt of correspondence.
- Treatment continuity is often disrupted.
- Medication cannot be safely stored.
- Exposure to violence, trauma, and environmental stressors increases.
- Opportunities for early intervention are reduced.

Thus, homelessness itself becomes a barrier to care, and discharging individuals into homelessness or providing treatment without stable housing may lead to further harm (*EUDA, 2023*). Housing instability also limits access to employment, community support, and broader health and social services (*Jayatunge, 2013*).

b. Stigma and Discrimination

Stigma is a major barrier to mental health care access. People experiencing homelessness and mental illness are among the most stigmatized groups in society, especially when substance use is also present (EUDA, 2023).

Stigma can take several forms (Mental Health Europe, 2024):

- **Public/Social Stigma:** negative stereotypes and discriminatory attitudes from the general population or service providers.
- **Self-stigma:** internalized shame that reduces help-seeking.
- **Institutional/Structural Stigma:** policies or practices that create unequal access, such as exclusionary service rules.

As a result, individuals often feel pre-judged or rejected by health professionals, leading to mistrust in institutions and reluctance to seek care (*Jayatunge, 2013*).

c. Intersectional Vulnerabilities

Certain groups face heightened stigma and inequality due to intersecting vulnerabilities such as gender, ethnicity, sexual orientation, gender identity, migration status, age, or substance use history.

These factors increase the likelihood of discrimination and exclusion from services;worsen mental health outcomes and reduce access to culturally competent care.

Women experiencing homelessness face additional barriers that intensify the impact of stigma and discrimination. They are often subject to rigid social expectations related to caregiving and family stability, which means that homelessness is perceived as a deeper “failure” when it involves women. This stigma is further magnified when mental health difficulties, substance use, or experiences of domestic and sexual violence are present - factors that are strongly interconnected in women’s pathways into homelessness. Many women also avoid services due to fear of moral judgment, shame linked to substance use, or concerns that seeking help may trigger child protection interventions, including the potential loss of custody. These fears constitute a major barrier to accessing mental health support. Gender-based violence, which is common both before and during homelessness, further contributes to distrust of institutions and reinforces avoidance behaviours. As such, gender discrimination adds an additional layer of vulnerability, requiring service responses that are gender-sensitive, trauma-informed, and attentive to women’s specific needs (FEANTSA & Fondation Abbé Pierre, 2023).

People seeking asylum, refugees, and migrants living in insecure accommodation or on the street are at high risk of developing mental health problems. Many services lack the tools and cultural competence required to respond effectively to the transcultural needs of these populations (FEANTSA & Fondation Abbé Pierre, 2023).

d. Material and Bureaucratic Barriers

People experiencing homelessness often face significant material and bureaucratic barriers that limit access to services, including:

- Lack of essential resources, such as identification documents and proof of residence.
- Absence of a secure, stable address for receiving correspondence.
- Limited access to reliable transportation or insufficient funds to travel to appointments.
- Challenges attending services without compromising basic survival activities, such as informal work, accessing food programs, or securing a safe place to sleep.

Additional systemic barriers include limited availability of free or public mental health services, long waiting lists for existing services, services that are technically available but practically inaccessible due to logistical, bureaucratic, or eligibility constraints.

These challenges, combined with bureaucratic systems and lengthy procedures, significantly limit access to services (NPISA Lisboa, 2021; Jayatunge, 2013). Due to repeated experiences of discrimination and exclusion, individuals may distance themselves from services, losing access to healthcare and other rights (FEANTSA, 2023).

Challenges Faced by Harm Reduction Professionals

Harm reduction workers frequently encounter systemic and operational barriers when trying to refer or support clients with mental health needs.

Key challenges include:

- Low accessibility of mental health services: long waiting lists for psychotherapy or psychiatric evaluations, under-resourced services, high psychiatric bed occupancy, and poor integration with wider healthcare systems.

- Limited recognition of harm reduction/community-based expertise: healthcare professionals often fail to acknowledge the specialised, practice-based knowledge held by harm reduction teams. This becomes particularly visible in complex situations such as requests for an Involuntary Psychiatric Evaluation Order or cases of dual diagnosis, where symptoms tend to be attributed exclusively to substance use rather than assessed holistically.

- Geographic and transportation barriers: services are frequently not located where people need them, and lack of transportation restricts access further.

- Insufficient low-threshold services: abstinence-based programmes or staircase housing models exclude individuals with active substance use or co-occurring mental health conditions.

- Documentation requirements: access to services often depends on ID cards, proof of address, medical records, or other documentation that people experiencing homelessness may not have.

- Client mistrust or low engagement: often rooted in previous negative or discriminatory interactions with institutions and service providers.

- Resource constraints within harm reduction teams: high caseloads, limited staff, and restricted time reduce the capacity to accompany clients, follow up referrals, or advocate effectively.

- Bureaucratic complexity: administrative procedures and rigid eligibility criteria rarely align with the urgent, fluctuating, and high-vulnerability needs of people experiencing homelessness.

Solutions to Overcome Barriers

To effectively respond to the needs of people experiencing homelessness, services must shift from expecting individuals to adapt to rigid structures toward creating flexible, inclusive, and person-centred systems. These systems should acknowledge trauma, structural disadvantage, and the importance of self-defined recovery goals.

a. Integrated and Low-Threshold Services

- Transition from single-model clinics to integrated networks that connect housing, mental health care, drug treatment, and social support (EUDA, 2023).
- Provide walk-in options and flexible intake criteria.
- Remove barriers such as abstinence requirements, documentation demands, or the need for a fixed address.

b. Outreach and Mobile Services (Decentralisation)

- Deliver services directly to individuals through mobile or outreach teams.
- Improve early intervention, reduce crisis-driven care, and increase continuity of support.

c. Support and transition services

- Medical respite programs, also known as recuperative care, offer short-term shelter with medical and social services for those recovering from illness or injury who are too ill for a shelter but don't require a hospital stay.
- Critical Time Intervention (CTI): a time-limited, stepped intervention for individuals transitioning from an institution (like a hospital or prison) back to the community.
- Case management: supportive services that help coordinate care and connect individuals with resources (Hwang & Burns, 2014).

d. Reducing Stigma in Health Systems

- Provide training for health professionals to strengthen gender and cultural competence, reduce stigma, and promote inclusive practices (FEANTSA, 2023).
- Implement trauma-informed and person-centred service approaches.

e. Multidisciplinary Service Hubs

- Create service hubs that integrate a broad range of essential supports under one roof (e.g., general practitioner, psychiatrist, psychologist, counsellor, nurse, occupational therapist, dentist, sexual and reproductive health services, infectiology specialists, trauma therapists, practitioners of complementary and alternative care, and peer support workers).
- These hubs improve service coordination, reduce missed appointments, enhance continuity of care, and facilitate holistic, person-centred support.

f. Peer Involvement (Further developed in Module 5 - Peer Work)

- Employ people with lived experience within harm reduction teams.
- Improve trust, engagement, cultural relevance, and clients' ability to navigate complex service systems.

g. Addressing Root Causes

Effective interventions for homelessness should extend beyond healthcare and tackle the broader structural determinants of health, including:

- ○ Social and structural violence - implement policies and programs that reduce exposure to violence and discrimination.
- ○ Barriers to social integration - foster inclusion through community engagement, peer support networks, and programs that strengthen social connections.
- ○ Unemployment and precarious work - promote access to stable employment, vocational training, and education opportunities to improve economic security.
- ○ Housing exclusion and poverty - address housing instability through affordable housing initiatives, rental support, and policies aimed at reducing poverty.

○ Social prescribing - connect individuals to non-clinical community services, such as social support groups, educational programs, and recreational activities, to improve overall well-being and social integration.
○ Ensure health responses are embedded within broader social policy solutions.

Activity 3.3 | Facilitators

Objective:

To support harm reduction professionals in identifying their role as facilitators in real-life situations and in developing effective strategies to help individuals overcome structural, service-based, and personal barriers to accessing care and support.

All the instructions and materials for the activity are available on the Toolkit.

Unit 2 | Mental health-related problems among people experiencing homelessness

Unit 2 | Mental health-related problems among people experiencing homelessness

Mental health problems can cause distress and interfere with daily life, relationships, and overall quality of life (*OPP, 2025*). These problems usually arise from a combination of factors, including biological and genetic influences, brain chemistry, environmental stressors, social and family dynamics, personal vulnerabilities, and adverse life events. These factors often interact, increasing the likelihood of developing mental health difficulties.

People with mental health disorders are also more likely to experience homelessness due to challenges such as high housing costs, limited access to mental health care, low income, and difficulties reintegrating into society after treatment (*Barry et al., 2024*).

This unit introduces the main symptoms of several common mental health problems experienced by people who are homeless, as well as some self-harming behaviours.

Section 1 | Prevalence of Mental Health Problems Among People Experiencing Homelessness

Barry and colleagues (2024) reviewed over 7,700 research articles and included 85 studies involving more than 48,000 participants, mostly from the US, Canada, and Germany. Their findings show that mental health problems are very common among people experiencing homelessness:

- Around two out of three (67%) currently have a mental health disorder.
- More than three out of four (77%) have experienced a mental health disorder at some point in their lives.
- Mental health problems are more common among men than women.

The most frequent disorders include:

- Substance use disorders
- Antisocial personality disorder
- Major depression
- General mood disorders

People experiencing homelessness are much more likely to have mental health conditions than the general population:

Condition	People Experiencing Homelessness	General Population
Major depression	19%	5%
Psychotic disorders	14%	0.40%
Mood disorders	18%	1-10%
Bipolar disorder	8%	0.70%
Post-traumatic stress disorder	10.50%	1.10%
Substance use disorders	44%	12-15%
Antisocial personality disorder	26%	0.6-4%

TABLE 2 - Comparison between people experiencing homelessness and the general population, based on data retrieved from Barry et al. (2024)

Antisocial personality disorder may be particularly common due to shared risk factors such as poverty, social exclusion, and early life trauma. Some diagnostic criteria—like difficulties keeping a job or taking personal risks—can overlap with the challenges of homelessness, making it harder to separate the disorder from circumstances.

These findings highlight the importance of coordinated support. Effective interventions should combine mental health care, Social services, Housing support and Supportive policies.

Substance use can mask, mimic, or temporarily reduce mental health symptoms. Staff and support workers should approach this with respectful questioning and active listening, avoiding assumptions to better understand the person's experiences.

Neurodiversity and Homelessness: Focus on ADHD

Research suggests that attention deficit hyperactivity disorder (ADHD) is much more common among people experiencing homelessness than in the general population. Gallagher (2023) estimates that ADHD affects around 32% of people experiencing homelessness, compared with 5-8% in the general population - approximately four times higher.

Similar findings are reported among children and adolescents. Denis and colleagues (2025) conducted a systematic review and meta-analysis examining ADHD in homeless children and young people. Thirteen studies were included, involving 2,878 participants, with an average age of 12 years. Boys were more frequently represented than girls. When results were combined, the analysis found that around one in four (22.8%) homeless children and adolescents had ADHD. Age was an important factor: studies involving older children and adolescents (average age 12 years or older) reported much higher rates (43.1%) than studies of younger children (13.1%).

Despite differences between studies, the evidence shows that ADHD affects a substantial proportion of homeless children and adolescents. Practice experience also suggests that many adults experiencing homelessness show long-standing difficulties consistent with ADHD, including problems with organisation, concentration, time management, impulsivity, and a low tolerance for boredom. These difficulties can significantly affect education, employment, financial management, and relationships.

It is also common for adults with untreated or unrecognised ADHD to use substances in an attempt to cope with or manage their symptoms, often without understanding the underlying cause of their difficulties. This can increase vulnerability to harm and further complicate housing stability. Recognising ADHD and providing appropriate support is therefore an important part of effective homelessness prevention and intervention.

Hoarding Among People Experiencing Homelessness

Research suggests that hoarding behaviours are more common among people with a history of homelessness and housing instability than in the general population. A study examining the prevalence of hoarding behaviour among formerly homeless individuals living in supported housing used the Clutter Image Rating to assess 660 adults. The findings showed that 18.5% of residents displayed hoarding behaviour - more than three times higher than the prevalence reported in the general population (Greig, 2020). This is a significant concern, as hoarding can negatively affect both housing stability and physical and mental health.

Additional research supports these findings. Rodriguez and colleagues (2012) examined hoarding disorder among people at risk of eviction in New York City and found that hoarding behaviours were relatively common in this group. The study also identified links between hoarding and factors such as alcohol dependence, personality disorder traits, and specific adverse childhood experiences.

The researchers studied people seeking help from the Eviction Intervention Services Housing Research Center (EIS), a non-profit organisation that supports individuals facing housing problems, including eviction. A total of 115 EIS clients were screened for hoarding disorder. The results showed that 22% (clinician-rated) and 23% (self-rated) met the criteria for hoarding disorder. This rate is five to ten times higher than estimates in the general population, where hoarding affects around 2–5% of people.

Among those who met the criteria for hoarding disorder, 32% were currently facing legal eviction, 44% had a history of eviction proceedings, and 20% had been evicted at least once in the past. Despite these serious housing risks, only 48% were receiving mental health treatment at the time of the study.

Overall, nearly one in four people seeking help for housing problems through an eviction prevention service met the criteria for hoarding disorder, yet only about half were receiving mental health support. These findings suggest that hoarding disorder may play a significant role in housing instability and eviction risk. The authors highlight the need for further research to explore whether effective treatment for hoarding disorder could help reduce eviction and homelessness.

Other studies highlight strong links between hoarding, early life trauma, and adverse childhood experiences. These experiences may include the early loss of a caregiver, poverty, material deprivation, neglect, or unstable living conditions. Such experiences can contribute to difficulties with attachment, a need for control, and feelings of insecurity, which may later develop into hoarding behaviours (Landau et al., 2011; Groundswell & South London and Maudsley NHS Foundation Trust, 2024). As explained elsewhere in this manual, these types of traumatic experiences are common among people experiencing homelessness who also use substances.

Overall, these findings suggest that hoarding behaviour is an important issue to be aware of when working with people who have experienced homelessness. If not recognised and appropriately supported, hoarding can increase the risk of housing loss (for example, within Housing First programmes), eviction (such as from rented rooms), and physical or mental health complications.

Suicide and Self-Harm Among People Experiencing Homelessness

“A population-based study of 5,188,284 residents in Denmark found that 56,663 people (1.1%) experienced at least one episode of homelessness, accounting for 570,986 person-years of follow-up. The study tracked outcomes within 10 years of the first homeless shelter contact and found (*Nilsson et al., 2024)*:

- **Suicide rates:**
  - 1.3% of men and 0.9% of women had died by suicide.
- **Self-harm rates:**
  - 9.2% of men and 9.9% of women self-harmed.

Compared with people who had never been homeless, homelessness was associated with higher risks of suicide (2.2 times higher in men, 3.8 times higher in women) and self-harm (3.5 times higher in men, 3.3 times higher in women)

Current homelessness carried higher suicide risks than past homelessness, with men at 3.7 versus 2.0 times higher and women at 8.0 versus 3.4 times higher.

Additional risks:

Among men experiencing homelessness, having a psychiatric disorder greatly increased suicide risk (19.9 times higher compared with those without homelessness or psychiatric disorder), while there were too few female cases to report reliably. Self-harm also raised the risk of later suicide among people experiencing homelessness (men 7.4 times higher; women 17.7 times higher).

Key takeaways:

- People experiencing homelessness have much higher risks of self-harm and suicide, especially those who are currently homeless.
- Psychiatric disorders and episodes of self-harm are strong indicators of suicide risk in this group.
- These findings highlight the urgent need for better assessment, support, and targeted interventions to reduce self-harm and suicide among people experiencing homelessness.

Section 2 | Key Symptoms of Common Mental Health Problems and Self-Harming Behaviours

Experiencing Homelessness

This section explores the key symptoms of common mental health problems and self-harming behaviours among people experiencing homelessness. It highlights how these conditions may present in this population, providing a foundation for understanding their challenges and informing effective support and interventions.

a. Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a developmental disorder characterized by a persistent pattern of inattention, hyperactivity, and impulsivity (NIMH, 2024):

- **Inattention**: difficulty paying attention to details, staying on task, following instructions and rules, and staying organized; tendency to make mistakes, lose things, forget daily activities, and become easily distracted.
- **Hyperactivity**: excessive restlessness or activity, even at inappropriate moments; difficulty staying seated or engaging in quiet activities; excessive talking; difficulty waiting one's turn and frequently interrupting others.
- **Impulsivity**: acting without thinking, engaging in risky behaviors, and struggling with self-control.

There are three ADHD subtypes, depending on the predominant symptoms: inattentive type (more common in women), hyperactive-impulsive type (more common in men), and combined type (NIMH, 2024). Symptoms may also evolve across the lifespan:

- **Children** often show prominent hyperactivity and impulsivity; as academic and social demands increase, inattention becomes more noticeable.
- **Adolescents** usually show reduced hyperactivity, with more restlessness and fidgeting, while impulsivity and inattention generally persist.
- **Adults**, including older adults, may experience inattention, restlessness, and impulsivity, which may become less severe but remain impairing. Adults may also present irritability, low frustration tolerance, vulnerability to stress, or intense mood swings.

rAlthough widely recognized in children and adolescents, ADHD also affects adults, who may report lifelong difficulties with academic performance, work functioning, and interpersonal relationships. In children, ADHD may contribute to academic challenges, anxiety, low self-esteem, difficulties in peer relationships, or aggressive and oppositional behaviors (OPP, 2025). Children and adolescents with ADHD are also at increased risk of experimenting with psychoactive substances and experiencing depressive symptoms.

ADHD frequently co-occurs with other mental health problems. Sleep problems are especially prevalent, affecting up to 70% of adults with ADHD. While symptoms of inattention tend to persist over time, hyperactive and impulsive symptoms often decrease (NIMH, 2024).

Because ADHD is a developmental disorder, symptoms must begin in childhood: although diagnosis may occur in adulthood, symptoms must have been present before age 12 (NIMH, 2024). Many adults were not diagnosed earlier due to lack of recognition by family or teachers, mild symptom presentation, or effective coping strategies that later became insufficient as adult responsibilities increased. Differential diagnosis is essential, since stress, sleep disorders, anxiety, depression, and physical health conditions can mimic ADHD symptoms.

Importantly, despite a tendency to attribute children's behavioral or academic difficulties to ADHD, only about 5% of children meet criteria for the disorder (OPP, 2025).

b) Anxiety Disorders

Everyone feels anxious from time to time, especially when facing situations that feel threatening, stressful, unfamiliar, or challenging. Anxiety can be described as a feeling of worry, nervousness, restlessness, or fear about what may happen (OPP, 2025). These sensations may interfere with sleep, appetite, and the ability to concentrate — but in typical circumstances, anxiety decreases once the situation passes. This everyday anxiety can even be helpful, as it increases alertness and focus.

However, when anxiety becomes overwhelming, persists over long periods, or significantly interferes with daily functioning, it may become disabling. In these situations, people may feel out of control, fear dying, or feel as though they are "losing their mind." When worry becomes dominant, persistent, and makes daily functioning difficult or reduces overall wellbeing, an anxiety disorder may be present (OPP, 2025).

Anxiety disorders are among the most common mental health problems and can affect people of all ages. People experience anxiety differently, so when anxiety begins to take over, individuals may develop various anxiety-related conditions, such as:

- panic attacks occurring without an obvious trigger
- phobic avoidance (e.g., fear of leaving the house)

- withdrawal from friends and family
- obsessive thoughts or compulsive behaviours

Anxiety affects both the mind and the body:

- **Physical symptoms**: muscle tension, headaches, increased heart rate, nausea or vomiting, frequent urge to use the bathroom, or a “butterflies in the stomach” sensation.
- **Psychological symptoms**: increased fearfulness, alertness, nervousness, irritability, difficulty relaxing or focusing, and a tendency to overthink. Thoughts may become repetitive, intrusive, and negative. People may fear the worst, become pessimistic, and avoid certain places, situations, or people — often leading to reduced social contact.

People with anxiety disorders often do not fully understand what is causing their worry and fear. Symptoms can appear suddenly or gradually. Generalized Anxiety Disorder (GAD) often begins around age 30, although it can start in childhood, and is more common in women than in men (NIMH, 2022).

Common signs and symptoms of Generalized Anxiety Disorder (NIMH, 2022):

- Excessive worry about everyday things
- Difficulty controlling worries or nervousness
- Awareness that they worry more than they should
- Feeling restless or unable to relax
- Difficulty concentrating
- Being easily startled
- Trouble falling or staying asleep
- Fatigue or feeling tired all the time
- Headaches, muscle aches, stomach aches, or unexplained pain
- Difficulty swallowing
- Trembling or twitching
- Feeling irritable or “on edge”
- Sweating, lightheadedness, or shortness of breath
- Frequent need to use the bathroom

c) Cognitive Impairment (including Drug-induced Cognitive Impairment)

To better understand cognitive impairment, it is useful to clarify the concept of cognition. Cognition refers to the mental processes involved in acquiring knowledge and understanding through thought, experience, and the senses. It encompasses a wide range of high-level intellectual functions, including attention, memory, learning, decision-making, planning, reasoning, judgment, perception, comprehension, language, and visuospatial abilities (Dhakal et al., 2023).

Cognitive impairment (also referred to as a cognitive deficit) describes difficulties in one or more of these cognitive domains. It is not a disease itself but rather a symptom that may indicate an underlying condition.

Symptoms may appear in any of the domains listed above, and people typically experience (Dhakal et al., 2023):

- Trouble remembering things (e.g., repeatedly asking the same questions or retelling the same story)
- Difficulty learning new information or concentrating
- Visual problems and difficulty speaking
- Trouble recognizing people or places; new environments may feel overwhelming
- Confusion or agitation
- Mood changes
- Changes in behaviour or speech
- Difficulties performing routine daily tasks

Cognitive impairments may be present from birth or develop later due to environmental or medical factors (Dhakal et al., 2023). Increasing age is the most significant risk factor, with cognitive impairment being more common in older adults. However, causes vary across the lifespan:

- **Early life:** genetic syndromes, prenatal drug exposure, malnutrition, prematurity, trauma, child abuse
- **Childhood/adolescence:** side effects of cancer therapy, malnutrition, metabolic disorders, autism, immune conditions
- **Adulthood and older age**: stroke, delirium, dementia, depression, schizophrenia, chronic alcohol use, substance abuse, brain tumours

Certain medications - such as sedatives, tranquilizers, anticholinergics, and glucocorticoids - are also associated with cognitive deficits. Brain injury and infections of the brain or meninges can cause cognitive impairment at any age.

As noted earlier, substance use can itself cause cognitive impairment. A specific category, Drug-Induced Cognitive Impairment (DICI), refers to cognitive decline primarily caused by medications, including drugs not directly acting on the central nervous system (Reimers et al., 2024). DICI can occur across all age groups and may range in severity from subclinical symptoms to domain-specific impairments, mild cognitive impairment, or delirium.

DICI is a common cause of delirium, especially in individuals with predisposing factors such as older age, neurological disease, or dependence on psychoactive substances, and it is often mistaken for dementia (Bowen & Larson, 2012). Sedatives—particularly benzodiazepines—carry a high risk of causing cognitive impairment, and sedating antipsychotics, opioids, and certain antidepressants are also associated with increased risk.

d) Complex Trauma and Post-Traumatic Stress Responses

There is longstanding recognition of the strong relationship between exposure to traumatic events and the development of mental health problems. Post-Traumatic Stress Disorder (PTSD) was first established as a distinct diagnosis in 1980 with the publication of the DSM-III (Larsen, 2025). However, many clinicians and researchers quickly observed that this diagnosis did not fully capture the consequences of trauma for people who experienced recurrent, prolonged, or early-life interpersonal trauma, particularly trauma occurring within relationships with caregivers, intimate partners, or other close figures.

Research has consistently demonstrated that PTSD, as originally defined, does not encompass the broader patterns of psychological and functional disturbances that result from chronic interpersonal victimization. A key factor is the developmental stage at which trauma occurs, and whether the trauma takes place within relationships that should provide protection, safety, and emotional regulation (Luxenberg et al., 2000). These insights led to the conceptualisation of Complex PTSD (also called Complex Trauma) and its introduction in the DSM-IV as Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Although it did not receive status as an independent diagnosis, it was recognised as a cluster of associated features linked to PTSD (Luxenberg et al., 2000).

Although this represented an important step, debate continues regarding whether Complex Trauma should be recognised as a distinct diagnostic category. Over time, definitions have evolved: while the DSM-5 incorporates some “complex” trauma responses within the PTSD criteria, the ICD-11 goes further by defining Complex PTSD as a separate but related diagnosis (Larsen, 2025). Nevertheless, neither classification system fully captures all the criteria originally proposed for DESNOS.

Despite differences in formal diagnostic frameworks, strong clinical and research consensus indicates that Complex Trauma involves:

- interpersonal victimisation,
- multiple traumatic events, and/or
- chronic or prolonged exposure to trauma,

with particularly severe impacts when these experiences occur early in life (*Luxenberg et al., 2000; Van der Kolk, 2005*).

Complex Trauma is characterised by difficulties across six key domains of functioning (*Luxenberg et al., 2000; Van der Kolk, 2005; Blaz-Kapusta, 2008*):

1. **Regulation of affect and impulses**: includes extreme or rapidly shifting emotional reactions, self-destructive behaviours (e.g., self-harm, eating disorders, suicidal ideation), impulsive or dysregulated sexual behaviour, or difficulty controlling and expressing anger.
2. **Attention or consciousness**: includes dissociative episodes, depersonalisation, memory disturbances (amnesia or hypermnesia) related to traumatic events, or "losing time" during periods of stress.
3. **Self-perception**: includes persistent negative views of the self, feelings of helplessness, worthlessness, shame, guilt, self-blame, or a sense of being "contaminated," stigmatised, or fundamentally damaged.
4. **Relationships with others**: includes chronic distrust, difficulty forming safe attachments, patterns of revictimisation, or—in some cases—victimising others as a learned survival strategy.
5. **Somatisation**: includes chronic pain and bodily symptoms affecting digestive, circulatory, cardiopulmonary, and sexual functioning, often without identifiable medical causes.
6. **Systems of meaning**: includes loss of core beliefs, hopelessness, existential distress, and difficulty sustaining purpose, direction, or a sense of future.

e) Depressive Disorders

Depression is one of the most common mental health problems worldwide - affecting an estimated 5% of adults, with women more frequently diagnosed than men (WHO, 2023). It is recognised by the WHO as the leading cause of disability globally (OPP, 2021).

Depression involves persistent sadness, anguish, and hopelessness. These emotions can appear naturally in response to life events such as bereavement, loss, or major disappointment, and may constitute a normal, healthy, and adaptive reaction (OPP, 2025). In these situations, the emotional response is proportional to the event and tends to diminish over time. However, when such feelings persist for more than two consecutive weeks, recur frequently, or significantly interfere with daily functioning, they may indicate a clinical depressive disorder.

Depression exists on a spectrum:

- **Mild depression**: individuals maintain daily routines, though tasks may feel more difficult, overwhelming, or less meaningful.
- **Severe depression**: functioning may be markedly impaired, physical safety may be at risk due to suicidal thoughts or behaviours, and secondary psychotic symptoms such as hallucinations or delusions may arise (*NIMH, 2024*).

Depressive symptoms can affect emotions, thoughts, behaviours, and physical functioning. While each person may experience depression differently, common symptoms include (*NIMH, 2024; OPP, 2025*):

Emotional and cognitive symptoms

- Persistent sad, unhappy, irritable, anxious, or “empty” mood (lasting more than two weeks)
- Feelings of hopelessness or pessimism
- Frequent irritability, frustration, or restlessness
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in previously enjoyed activities
- Difficulty concentrating, remembering, or making decisions

Physical and behavioural symptoms

- Persistent fatigue, low energy, or feeling “slowed down”
- Sleep disturbances (difficulty falling asleep, early awakening, oversleeping, frequent awakenings, nightmares)
- Changes in appetite or unexplained weight gain/loss
- Increased use of psychoactive substances, including tobacco and alcohol
- Physical complaints such as headaches, cramps, or digestive problems without a clear medical cause

Risk-related symptoms

- Thoughts of death or suicide, or suicide attempts

Other potential changes in mood or behaviour

- Increased anger or irritability
- Feeling restless or constantly “on edge”
- Becoming withdrawn, detached, or more negative
- Engagement in high-risk or impulsive behaviours
- Increased alcohol or drug use
- Social withdrawal from family and friends
- Neglecting responsibilities or important roles
- Difficulties related to sexual desire or performance

f) Hoarding Disorder and Hoarding Behaviours

Hoarding is typically understood as a persistent pattern of acquiring and keeping almost everything. A severe hoarding problem, according to Tompkins (2015), is defined by two main factors:

1. being at risk of serious injury or even death due to the compromised living environment, and
2. exhibiting low functional capacity.

Functional capacity refers to the ability to perform necessary or desirable daily activities (Soniat et al., cited in Tompkins, 2015). It reflects the interaction between physical, psychological, and social capacity, assessed within one’s living context (Tompkins, 2014).

When discussing hoarding, it is important to distinguish between hoarding behaviours and Hoarding Disorder.

Hoarding behaviours

These may appear in the context of various **medical, genetic, or psychological** conditions, including but not limited to Hoarding Disorder (Mataix-Cols et al., cited in Tompkins, 2015). Prevalence estimates suggest that **2–5% of adults** exhibit significant hoarding behaviours (Iervolino et al., cited in Options Bytown, 2024).

Hoarding Disorder

Hoarding Disorder is understood as a **complex and multidimensional phenomenon**, involving cognitive, behavioural, and emotional processes.

Research highlights a strong link with other mental health issues:

- **92%** of individuals with Hoarding Disorder also have a co-occurring mental health condition, such as depression, anxiety, OCD, or social phobia (*Mass Housing Conference, cited in Options Bytown, 2024*).
- ADHD symptoms commonly accompany hoarding (Hartl et al., 2005, cited in Options Bytown, 2024).
- Acquiring behaviours may manifest as **compulsive buying**, considered an impulse control disorder (*McElroy et al., cited in Options Bytown, 2024*).
- Social phobia has been associated with hoarding (*Samuels et al., cited in Options Bytown, 2024*), with objects sometimes functioning as emotional safety barriers.

Because of these high comorbidity rates, **assessment must include screening for associated conditions**. This is essential for designing effective interventions and preventing relapse. Co-occurring conditions may complicate or influence a harm-reduction approach, requiring professionals to address them as part of a comprehensive plan for severe hoarding.

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Interventions

IInterventions for hoarding are often **complex, lengthy, and costly**, yet essential. Clean-outs conducted without therapeutic intervention show a **100% recidivism rate** (Options Bytown, 2024), underscoring the need for psychosocial and behavioural support.

DSM-5 Diagnostic Criteria for Hoarding Disorder (*SHIP, 2024*)

- Persistent difficulty discarding or parting with possessions, regardless of actual value, due to a perceived need to save items and distress associated with discarding.
- This difficulty leads to accumulation that **clutters active living areas**, substantially compromising their intended use.
- The hoarding causes **clinically significant distress or impairment** in social, occupational, or other areas of functioning, including maintaining a safe environment.
- The behaviour is not attributable to another medical condition.
- The behaviour is not better explained by another mental disorder.

Specifiers (SHIP, 2024)

- Excessive acquisition: difficulty discarding is accompanied by acquiring items not needed or for which there is no available space.
- Good or fair insight: the individual recognises the problem.
- Poor insight: the individual is mostly convinced behaviours are not problematic.
- Absent insight / delusional beliefs: complete conviction that behaviours are appropriate despite clear evidence otherwise.

Course and Onset

- Hoarding behaviours often **begin around age 13.**
- People typically **seek help decades later**, with an average age of treatment-seeking around 50 (*Bratiotis, Sorrentino & Steketee, cited in Options Bytown, 2024*).
- **Late-onset hoarding** (after age 50) may be triggered by major life changes (downsizing, bereavement, loss) or associated with undetected cerebrovascular events (*Anderson, Damasio & Damasio, cited in Tompkins, 2014*).

g) Personality Disorders, including Borderline Personality Disorder

Personality refers to the constellation of patterns in thinking, feeling, behaving, and relating to others and to the environment. These patterns tend to remain relatively stable across time and contribute to what makes each individual unique (Moreira, 2024). Personality develops throughout childhood and continues to evolve across the lifespan.

A personality disorder is understood as an enduring and inflexible pattern of inner experience and behaviour that causes significant distress or impairment and markedly deviates from cultural expectations (Moreira, 2024; APA, 2025). These deviations typically occur across three domains of functioning: affective, cognitive, and behavioural. According to FOCUS (2013), personality disorders are not better explained by a general medical condition, substance use, a normative developmental stage, or sociocultural context.

These long-term dysfunctional patterns must affect at least two of the following four areas (*APA, 2025*):

1. the individual's way of thinking about self and others

2. emotional responses
3. interpersonal functioning
4. impulse control and behaviour

A formal diagnosis must be made by a trained mental health professional and is rarely applied to individuals under 18, as personality is still developing (APA, 2025). The DSM-5-TR includes ten personality disorders, grouped into three clusters. Although these conditions differ in many ways, they share several core features, including markedly different ways of perceiving themselves, others, and events; emotional responses and behaviours that deviate from social expectations; and impaired impulse control, which may involve either excessive control or a lack of control.

People with personality disorders may also experience symptoms associated with other mental health conditions, due to the significant impact their persistent patterns of thinking, feeling, behaving, and relating can have on daily functioning (Moreira, 2024). Common co-occurring issues include anxiety, depression, substance use disorders, eating disorders, sexual difficulties, and interpersonal conflict.

Historically, personality disorders have been challenging to conceptualise and diagnose. For many years, individuals with these conditions were excluded from general mental health services due to the belief that they were “untreatable.” However, substantial research now supports the effectiveness of multiple treatment approaches (Macmanus, 2008). The evolution of diagnostic models and treatment expectations highlights the importance of addressing the needs of people with personality disorders, particularly since comorbidity can complicate treatment and negatively affect prognosis.

IIn the most recent revision of the DSM-5, personality disorders are conceptualised as involving impairments in personality functioning and pathological personality traits, using a multidimensional and continuum-based model (FOCUS, 2013). This “alternative model” aims to address limitations of previous diagnostic systems while maintaining continuity with current clinical practice.

Borderline Personality Disorder

Borderline Personality Disorder (BPD) affects approximately 1 in 100 people. It is a mental health condition that severely impacts a person’s ability to regulate emotions, which can increase impulsivity, affect self-image and self-perception, and negatively influence relationships with others.

Symptoms may include (*OPP, 2025; NIMH, 2022*):

- sudden mood swings and intensely distressing emotions (e.g., anxiety, deep sadness, rage), followed by feelings of emptiness, indifference, or isolation (lasting from hours to several days)
- chronic feelings of emptiness
- contradictory thoughts (e.g., feeling confident one day and despairing the next) and impulsive or reckless behaviours (e.g., overeating, overspending)
- a distorted or unstable self-image or sense of identity
- rapid changes in interests and personal values
- fears of abandonment, rejection, or being alone
- efforts to avoid real or perceived abandonment, such as entering relationships quickly — or ending them abruptly
- intense and unstable relationships with family, friends, and partners
- impulsive and potentially dangerous behaviours, such as spending sprees, unsafe sex, substance use, reckless driving, or binge eating[1]
- self-harming behaviour
- recurring thoughts of suicidal behaviour or threats
- inappropriate or intense anger, or difficulty controlling anger
- dissociative symptoms, such as feeling detached from oneself, observing oneself from outside the body, or experiencing a sense of unreality

Not everyone with BPD experiences all symptoms (NIMH, 2022). Symptom severity, frequency, and duration vary widely across individuals and over the course of the illness. Because of its symptoms, BPD can negatively impact many areas of life. Individuals may experience sudden life changes, more frequent negative events (such as losing a job, leaving school, or conflicts with the justice system), unstable relationships, and increased conflict, separation, or exposure to abusive dynamics (OPP, 2025).

BPD generates significant psychological suffering both for the individual and for those around them (OPP, 2025). People with BPD are at elevated risk of other mental health conditions — such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, eating disorders, or substance use disorders — as well as self-harm and suicidal thinking. Rates of self-harm and suicidal behaviour are significantly higher than in the general population. Because symptoms are diverse, accurate diagnosis can take time, and misdiagnosis is possible (OPP, 2025). Early diagnosis is essential to help individuals learn to manage symptoms and achieve a more stable and fulfilling life.

h) Psychotic Disorders, including Schizophrenia, Substance-Induced Psychosis, and Other Psychotic Presentations

Schizophrenia

Schizophrenia is a severe mental health disorder that affects how a person thinks, feels, behaves, and relates to others (*OPP, 2025; NIMH, 2024*). The condition involves significant distortions in the perception of reality, including:

- **Hallucinations** (e.g., hearing voices that others do not hear)
- **Delusions**, such as beliefs of being followed or believing one has special powers or identity (*OPP, 2025*)

This apparent loss of contact with reality can be highly distressing for the individual as well as for family members and others around them.

Functional Impact

As with other severe mental illnesses, schizophrenia can cause significant functional impairment (*NIMH, 2024*), including difficulties engaging in everyday activities; symptoms lasting several weeks or becoming chronic; interference with autonomy, relationships, and work; increased need for support to maintain stability.

Despite these challenges, effective treatments exist, and many people with schizophrenia live autonomous and fulfilling lives. Psychosocial rehabilitation is a key component of recovery and complements biomedical and psychopharmacological approaches (Amorim & Perestrelo, 2024; OPP, 2025).

Symptom Categories

Symptoms vary among individuals but generally fall into three groups (*NIMH, 2024*):

1. Psychotic or Positive Symptoms

- Alterations in thinking, behaviour, and perception of reality, including:
- Hallucinations
- Delusions
- Disorganised thinking or speech
- People may also struggle to distinguish what is real from what is not. These symptoms may fluctuate or remain stable over time.

2. Negative Symptoms

- Loss of motivation
- Reduced interest or pleasure in daily activities
- Social withdrawal
- Reduced emotional expression
- Difficulties performing everyday tasks

3. Cognitive Symptoms

- Attention problems
- Difficulty concentrating
- Memory impairments

Violence and Schizophrenia: Clarifying Misconceptions

People with schizophrenia are often mistakenly seen as violent. It is essential to emphasise:

- Most people with schizophrenia are not dangerous
- They are 10 times more likely to be victims of violent crime than the general population
- Only 3–5% of violent acts are committed by individuals with a mental disorder (*OPP, 2025*)

Risk increases primarily when the illness is untreated, or there is co-occurring substance misuse (NIMH, 2024).

New Psychoactive Substances (NPS) and Psychosis

New Psychoactive Substances (NPS) are synthetically produced to mimic controlled drugs while avoiding regulation (EUDA, 2025). They generally fall into six groups: synthetic cannabinoids, phenethylamines, cathinones, plant-based substances, piperazines, and ketamine (Stanley et al., 2016).

NPS use has been linked to:

- Psychiatric presentations
- First-episode psychosis
- Self-harm and suicidal ideation (Tait et al., cited in Gerra, 2025)
- High psychological distress (Champion et al., cited in Gerra, 2025)
- Social dysfunction (Matsumoto et al., cited in Gerra, 2025)

Substance-induced psychosis appears significantly more common among NPS users.

Examples:

- NPS were involved in 22.2% of adult inpatient psychiatric admissions in one Scottish ward, contributing to symptoms in 59.3% (*Stanley et al., 2016*).
- Acute symptoms included:
  - hallucinations
  - aggression
  - psychotic or bizarre behaviour
- Most symptoms were linked to synthetic cannabinoids, followed by cathinones, hallucinogens, natural NPS, and stimulants (Taflaj et al., 2024).

NPS use can also produce psychotic-like experiences even in people without psychotic disorders. However, research is complicated by underreporting, polydrug use, and changing chemical formulas (Taflaj et al., 2024; Ellila, 2023).

Other Psychotic Presentations

Psychosis refers to a cluster of symptoms affecting thinking, perception, behaviour, and emotional regulation (NDARC, 2011; NIMH, 2023).

Common symptoms (Ford, cited in SAMHSA, 2019) include delusions, hallucinations, incoherent or nonsensical speech, memory problems, difficulty thinking clearly, disrupted perceptions or beliefs, impaired reality testing, poor decision-making abilities and behaviour inappropriate to the situation. Delusions and hallucinations are typically the most recognisable symptoms. Disorganised speech and behaviour may also occur (NDARC, 2011; NIMH, 2023).

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Types of Psychotic Disorders

Psychotic disorders differ in symptom duration and severity (*NDARC, 2011*):

- **Brief Psychotic Disorder:** symptoms lasting <1 month, often stress-related
- **Schizophreniform Disorder:** symptoms for 1–6 months
- **Schizophrenia:** symptoms for ≥6 months
- **Schizoaffective Disorder:** psychosis + mood disorder symptoms
- **Delusional Disorder:** persistent false beliefs for ≥1 month

Psychotic symptoms may also occur in mood disorders (depression or bipolar disorder), or result from medical conditions such as brain tumours or head injuries.

Psychosis and Substance Use

People with psychosis have a higher risk of developing substance-related problems (NDARC, 2011).

Examples:

- Links between cannabis use and psychosis onset among some young adults (*Gonzalez-Ortega et al., cited in SAMHSA, 2019*)
- 2010 Australian National Survey:
  - 51% of adults with psychotic disorder had harmful substance use
  - 55% had a lifetime history of harmful illicit substance use - six times the rate in the general population (*Morgan et al., cited in AIHW, 2024*)

Integrated Treatment

A comprehensive review (EMCDDA, 2015, cited in EMCDDA, 2019) found that integrated treatment programmes addressing both psychosis and substance use disorder significantly reduce psychotic symptoms and substance use. By contrast, receiving separate and uncoordinated treatment for these conditions is rarely effective (SAMHSA, 2019). Research consistently supports integrated, coordinated, and concurrent treatment for co-occurring disorders.

Substance-Induced Psychosis

Drug-induced psychotic symptoms emerge during or following psychoactive substance use, either due to intoxication or withdrawal (NDARC, 2011).

More specifically, substance-induced psychosis refers to psychosis that:

- Begins during or shortly after substance use, and
- Persists even when the substance is no longer active — sometimes for days or weeks (Inchausti et al., 2022)

Individuals who have experienced substance-induced psychosis are at higher risk of recurrence with re-exposure to the substance. Although typically brief, these episodes can:

- Act as triggers for longer-lasting psychotic disorders in vulnerable individuals
- Represent transitional states preceding an independent psychotic disorder (Magidson et al.; Martín-Santos et al., as cited in EMCDDA, 2016)

ITypical Symptoms by Substance Class

While hallucinations and delusions are core features of psychosis, symptom profiles vary by substance (*American Addiction Centers, 2025*).

Stimulants (amphetamine, methamphetamine, cocaine) • Persecutory delusions • Paranoia • Auditory, visual, or tactile hallucinations • Agitation, anxiety, or manic-like states • Increased aggression or hostility • Impaired concentration and memory • Cognitive slowing	**Depressants (alcohol, benzodiazepines)** • Impaired cognition • Rapid mood swings • Aggression or disinhibition • Poor judgement • Perceptual distortions • Hallucinations (especially during withdrawal) • Delirium
Hallucinogens and Dissociatives (LSD, mescaline, psilocybin, ketamine, PCP, MDMA) • Hallucinations and major sensory distortions • Time and space distortion • Synaesthesia (“mixing of senses”) • Dissociation • Impaired reality testing • Paranoia or panic • Persistent psychosis • HPPD: visual trails, halos, afterimages	**Cannabis** • Altered time perception • Intensified sensory experiences • Panic, fear, or paranoia • Hallucinations and delusions • Depersonalisation or loss of identity

Hallucinogens may also cause “flashbacks.” A “bad trip” can occur after a single use or repeated use. Chronic use may be associated with depression or suicidal ideation.

Relevant Epidemiological Data

- Health Research Board (Ireland, 2022) reports:
- Significant increases in substance-related hospitalisations among young people
- 171% rise in cocaine-related treatment episodes (2011–2019)
- Strong links between substance use and mental health problems, including anxiety, self-harm, and suicide
- Young adults with alcohol dependence show higher rates of severe anxiety
- Cannabis users are six times more likely to report mental ill-health
- Alcohol involved in 25% of youth hospital presentations for self-harm
- 75% of individuals aged 15–24 who died by suicide had a history of alcohol and/or drug misuse

These data emphasise the need for integrated mental health and substance use interventions.

i) Self-Harm Behaviors

Self-harm refers to intentionally inflicted acts of aggression or injury toward one's own body without the intention to cause death (e.g., cutting with sharp objects, burning with cigarettes, attempting to break one's own bones) (OPP, 2025). Many people who self-harm report that physical pain feels easier to manage than overwhelming emotional pain. These behaviours often occur in secrecy.

Self-harm may function as an unhealthy coping strategy used to manage emotions that feel unbearable. For some individuals, it may serve as:

- A way to communicate distress when words fail;
- A way to "feel something" during periods of emotional numbness;
- A form of self-punishment rooted in guilt or shame;
- A method for temporarily relieving intense emotional tension.

However, this relief is brief, and the emotional difficulties that triggered the behaviour remain unresolved. Although self-harm may begin impulsively, it can become a habitual pattern over time.

Self-harm is a mental health concern frequently associated with other conditions, including depression, anxiety, borderline personality disorder, substance use disorders, childhood abuse (particularly sexual abuse), severe familial abuse, post-traumatic stress disorder (PTSD), and eating disorders (OPP, 2025; CRPSIR, 2025). While self-harm is distinct from suicidal behaviour, individuals who self-harm are at increased risk for suicide (OPP, 2016). These behaviours must always be taken seriously, as they can cause significant physical harm and may signal underlying mental health conditions.

Self-harm can occur at any age but is more prevalent among adolescents and young adults worldwide (CRPSIR, 2025).

Possible signs of self-harm behaviours include:

- Cuts, scars, burn marks, or unexplained bruises;
- Implausible or repeated explanations for injuries;
- Wearing long sleeves or trousers in hot weather;
- Avoiding swimming pools or other situations requiring changing clothes;
- Changes in sleep or appetite;
- Secretive behaviour;
- Social withdrawal or isolation.

j) Suicidal Thoughts and Behaviours

Suicide is a serious public health problem with profound impacts on individuals, families, communities, and society. It is a global phenomenon, occurring in every region of the world, not only in high-income countries. In 2021, 73% of global suicides occurred in low- and middle-income countries (WHO, 2025). Suicide is the third leading cause of death among 15–29-year-olds, though it can occur at any age.

The reasons behind suicide are diverse, influenced by social, cultural, biological, psychological, and environmental factors across the lifespan. A previous suicide attempt is one of the most significant risk factors for death by suicide in the general population.

Understanding Suicidal Thoughts

Death is naturally a topic that can provoke anxiety, anguish, or fear (OPP, 2025). Thinking occasionally about our own death or the death of loved ones is normal. However, in certain situations—whether the cause is identifiable or not—people may feel that there is no solution to their problems or that they are powerless to change their lives. In these moments, the idea of dying may seem to offer comfort or control over their circumstances. This experience is known as suicidal ideation or suicidal thoughts (OPP, 2025).

Having suicidal thoughts does not necessarily mean a person wants to die. Many people experience such thoughts without ever acting on them. Yet, when an individual cannot see any purpose in continuing to live, and suicidal ideation becomes recurrent, these thoughts and feelings can become overwhelming and frightening.

Emotional Experiences Linked to Suicidal Ideation

Individuals may feel:

- Worthlessness, shame, or guilt
- Anger or rage
- Rejection, loneliness, or being misunderstood
- Indifference or confusion about wanting to live or die

For some, death may seem like the only escape from a problem or unbearable emotional pain. Suicide can be either planned or impulsive, occurring during moments of acute despair.

Warning signs of suicide can appear in different ways and may develop gradually or suddenly. A person might talk about suicide, death, or express a desire to “go away.” They may begin making plans, such as writing farewell letters or posting goodbye messages online. Some individuals give away personal belongings or mention that they will no longer need certain things. Emotionally, they may express deep feelings of despair, guilt, or hopelessness.

Behavioral changes are also common. Someone may withdraw from friends and family, lose interest in leaving the house, or stop engaging in activities and hobbies they once enjoyed. They might have difficulty concentrating or thinking clearly, and noticeable changes in eating or sleeping patterns can occur. Their mood may shift, showing signs of irritability, persistent sadness, or anxiety.

In some cases, individuals may engage in self-destructive behaviours, such as substance misuse or self-harm. A sudden sense of calmness or happiness after a long period of sadness can also be a warning sign, as it may indicate they have made a decision about suicide.

Risk Factors

- Mental disorders, particularly depression, substance use disorders, and previous suicide attempts
- Impulsive crises triggered by events such as financial problems, relationship conflicts, chronic pain, or illness (WHO, 2025)
- Experiences of conflict, disaster, violence, abuse, loss, or social isolation
- Higher risk among groups facing discrimination, including refugees and migrants, Indigenous peoples, LGBTI persons, and people in prison (WHO, 2025)

Prevention

A first step in preventing suicide is talking openly about it. Open conversations can help reduce anxiety, negative feelings, and distressing thoughts (OPP, 2025).

In the Netherlands, Ireland, and Portugal, Suicide Prevention helplines offer immediate support for anyone feeling overwhelmed or at risk. Trained counsellors are available 24/7 to listen and help people stay safe. Reaching out is an important step toward relief and support.

In Ireland, a national suicide prevention strategy was established in 2015, which includes the Connecting for Life programme. More information is available at: *https://www.hse.ie/eng/services/list/4/Mental_Health_Services/connecting-for-life/*

Recognising warning signs, providing emotional support, and helping people access professional care are critical components of suicide prevention.

Activity 3.4 | Information stations

Objective:

To promote knowledge of basic aspects of mental health problems, focusing on: main symptoms, common risk factors / causes, how the condition may present in homelessness, links with trauma and substance use, and practical intervention tips.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | The Self-Medication Theory

A considerable amount of research and theoretical reflection has explored why and how people develop addiction, and why they continue substance use despite the suffering and negative consequences it causes (Achalu, no date). Various models and theories have been proposed, highlighting different factors, including:

- Sociocultural and biogenetic influences
- Environmental, contextual, or psychological factors
- Neurobiological mechanisms of addiction
- Individual traits and personal history

In this section, we focus on the Self-Medication Theory (SMT), which addresses the emotional and psychological dimensions relevant to the etiology of substance-related disorders, complementing other explanatory perspectives (Khantzian, 1997).

Key Versions of the Self-Medication Theory

Two main versions of this theoretical hypothesis exist, and both approaches are primarily based on clinical observations of individuals struggling with addiction. The psychoanalytic perspective, developed by Edward J. Khantzian and his colleagues, focuses on underlying emotional and psychological factors. In contrast, the behavioristic perspective, developed by David F. Duncan, emphasizes learned behaviors and external influences in the development of addiction.

Central Premises (Khantzian, 1985; 1997)

- Individuals may be predisposed to addiction due to psychological vulnerabilities, disturbances, and painful affective states.
- The substance of choice is not random. While individuals may experiment with multiple substances, most develop a preferred substance.

Addiction as a Self-Regulation Disorder

The theory proposes that addiction develops in the context of self-regulation vulnerabilities. Addiction is viewed as a disorder of affect regulation, involving difficulties in managing emotions, maintaining self-esteem, self-care and anticipating harm and maintaining relationships. Substances become powerfully reinforcing when they relieve unbearable feelings or enable the individual to experience or regulate emotions, acting as a self-regulation mechanism.

The specific psychotropic effect of a substance interacts with psychiatric disturbances and painful affective states, making it compelling for predisposed individuals. The short-term effects help them cope with distressing internal states and external reality perceived as overwhelming. Khantzian (1997) calls this process “self-selection”, influenced by the main effect of the substance, the individual personality traits and organisation and the inner psychological suffering. Self-selection may also lead to aversion to certain substances. Over time, adverse effects of one substance can drive the individual to switch to another that counteracts those effects.

Examples of Substance Selection (Khantzian, 1997)

- **Opiates** – calming and “normalizing” effect; reduce rage, violent affect, internal fragmentation, and interpersonal disruption.
- **Depressants** – temporarily reduce feelings of isolation, emptiness, tension, and anxiety; mask fears of closeness and dependency.
- **Stimulants** – amplify energy in hypomanic or high-energy individuals; counteract depression or boredom; paradoxically reduce hyperactivity and inattention in ADHD; manage emotional lability.

Duncan’s Behavioristic Perspective

Duncan emphasizes the distinction between substance use and substance abuse. Only a minority of users lose control, leading to abuse or addiction (Achalu, no date). Substance use is maintained by positive reinforcement (pleasurable effects) and substance addiction is maintained by negative reinforcement (removal of unpleasant emotional states).

Addiction involves avoidance/escape behavior, where substances provide temporary relief from ongoing distress caused by mental disorder, stress, or aversive experiences. These behaviors are resistant to extinction and may recur even after seeming cessation.

The SMT has been criticized for a lack of consistent, robust scientific evidence (Lembke, 2012; 2013), an overemphasis on subjective, individual factors that neglects context, environmental influences, and biological aspects, and for potentially leading to misleading treatment approaches if applied in isolation. However, Khantzian positions SMT as complementary to other addiction theories rather than as a replacement.

Self-Medication and Psychiatric Disorders

Although substance use is strongly associated with psychiatric disorders, there is variation in causality: substance use may be a cause or consequence of psychopathology (Khantzian, 1997). SMT focuses less on specific psychiatric disorders and more on subjective symptoms and states of distress, whether or not they are formally diagnosed. Individuals struggling with addiction may:

- Be at higher risk for substance use and comorbid addiction (EMCDDA, 2016)
- Experience long-term substance problems, which may improve when the underlying mental health condition is managed (Bizzarri et al.; Leeies et al.; Smith & Randall, cited in EMCDDA, 2016)
- Continue substance use even after psychiatric conditions remit (Moeller et al., cited in EMCDDA, 2016)

Epidemiological Evidence

National surveys indicate that individuals with mental health problems are more likely than those without such conditions to engage in risky substance use. Data from the National Drug Strategy Household Survey (2022–2023), cited by the Australian Institute of Health and Welfare (2024), shows that 37% of people with mental health conditions consume alcohol at risky levels, compared to 32% of those without. Daily smoking is also more common, affecting 15% of individuals with mental health problems versus 7.4% of those without. Additionally, 29% of people with mental health conditions report using any illicit drug, compared to 16% of those without such conditions.

A general practice study also found moderate-to-heavy drinking among patients with severe or long-term mental illness was 4.7%, more than double that of the general population (2.2%) (Belcher et al., 2021).

Unit 3 | Harm reduction strategies and evidence-informed practices

Unit 3 - Harm reduction strategies and evidence-informed practices

When people are primarily focused on meeting basic survival needs - such as finding a safe place to sleep, obtaining their next meal, or protecting themselves from weather, hunger, or violence - it becomes extremely difficult to concentrate on health-related tasks, including organising medications or scheduling and attending medical appointments (NHCHC, 2024). These challenges are often intensified when mental health issues and substance use are also present.

Harm reduction workers do not need to diagnose mental health conditions, but they play a crucial role in recognising distress early, reducing harm, and facilitating access to appropriate care. Their contribution relies on consistent presence, trust-building, and low-threshold support.

It is important to keep in mind that formal diagnoses can take time, which often leaves many people experiencing homelessness without an official diagnosis. Therefore, interventions should focus on identifying behaviours that cause distress, increase vulnerability, or lead to social exclusion, rather than waiting for a formal diagnosis.

From this starting point, harm reduction workers can work perseveringly to support engagement in behaviours - such as treatment adherence, medication management, safe substance use practices, or social prescriptions - that enhance quality of life, autonomy, and social inclusion. Research highlights that interventions grounded in trust, consistency, low-threshold access, and client-centred approaches are associated with improved outcomes, including reduced hospitalisations, improved mental health, and increased uptake of health and social services (Gontijo et al., 2025; Lauchaud et al., 2021).

Additionally, adopting a strengths-based perspective - focusing on skills, resilience, and existing coping strategies - can empower individuals to make incremental changes and maintain engagement with support services, even in the absence of a formal psychiatric or substance use diagnosis (SAMHSA, 2014).

Section 1 | Harm reduction strategies supporting people experiencing homelessness with mental health concerns

In this section, we will focus on key harm reduction strategies that are useful when supporting people experiencing homelessness who have mental health concerns (NHCHC, 2024; SAMHSA, 2020; Hwang & Burns, 2014; Hopper et al., 2010; WHO, 2021; Padgett et al., 2016).

These strategies are intended for use by professionals and frontline staff who may not have formal mental health training, but who work with people who have already been diagnosed with, or identified as experiencing, a specific mental health condition.

The harm reduction strategies are presented below:

1. Noticing early signs

Harm reduction professionals are often among the first to observe changes in behaviour, appearance, or mood. Early signs - such as increased agitation, withdrawal, confusion, changes in sleep or appetite, or unusual beliefs - can indicate emerging mental health deterioration. Identifying these signs early allows workers to intervene sooner, prevent crises, and support timely referral.

2. Providing a safe space to talk

Many people experiencing homelessness face discrimination, stigma, and repeated traumatic experiences that undermine trust. By offering a consistent and non-judgemental space, harm reduction workers create the psychological safety needed for individuals to express concerns, fears, experiences of victimisation, and symptoms they might not feel able to share with formal services.

3. Validating feelings without judgment

Validation helps reduce shame and defensiveness, especially for individuals with trauma histories or co-occurring substance use. Acknowledging emotions (e.g., “It makes sense you’re feeling overwhelmed”) strengthens rapport, decreases distress, and increases readiness to seek support.

It is also important to consider that people’s behaviours often make sense in context: behaviours that might appear paranoid or unusual in other settings may serve as survival strategies on the street. Contextualizing and validating feelings is essential for understanding behaviours accurately.

4. Assessing immediate safety

Harm reduction workers are well-positioned to identify acute risks, including self-harm, suicidal ideation, psychosis, overdose risk, or exposure to violence. While they do not diagnose, they can recognise when a situation is unsafe and activate crisis protocols, emergency services, or mobile mental health teams.

5. Supporting access to mental health services

Navigating mental health systems can be extremely challenging for someone experiencing homelessness. Workers can help by explaining available services, assisting with referrals, contacting providers, accompanying clients to appointments when possible, and supporting them in overcoming practical barriers such as transportation, documentation, scheduling, and access to prescribed medication. Peer workers are particularly important in these tasks due to their lived experience with services and their ability to navigate stigma and judgment within the system.

6. Keeping regular contact when possible

Continuity is a core element of effective support. Frequent but low-threshold contact—brief check-ins, street-based outreach, or drop-in interactions—helps maintain follow-up, sustain engagement, monitor changes, and prevent people from falling out of the care pathway. This requires persistence and commitment from teams to meet people where they are and to use community-based strategies - for example, identifying informal peers within the community - to help keep individuals connected to care.

7. Coordinating with mobile or crisis teams

Harm reduction workers often act as connectors between clients and specialised services. Their real-time knowledge of a person's context and history can guide mobile psychiatric units, crisis teams, or emergency responders, improving intervention quality and reducing unnecessary hospitalisations or police involvement.

8. Supporting provision of medication

Medication continuity is often disrupted by homelessness, and workers can help by supporting clients to understand their prescriptions, assisting with pick-up or delivery, storing medication safely when possible, reminding clients of dosing times, and identifying side effects early. Stable medication routines can significantly reduce symptom intensity and crisis frequency.

9. Promoting health literacy and understanding prescribed medications

People experiencing homelessness may have limited access to reliable health information. Harm reduction professionals can explain how mental health conditions develop, how treatments work, what side effects may occur, and why treatment adherence matters. Clear and accessible explanations strengthen autonomy and support informed decision-making.

Workers can also help clients understand interactions between prescribed medications and the substances they use, supporting them in developing strategies to reduce risks - for example, avoiding the combination of other central nervous system depressants, such as benzodiazepines, with alcohol due to the increased risk of overdose and respiratory depression.

10. Compensating for difficulties with physical or cognitive skills

Some individuals struggle with executive functioning, memory, or motor skills due to mental illness, trauma, neurodiversity, substance use, and/or ageing. Workers may assist with organising medication boxes; keeping track of appointments; filling forms; breaking down complex tasks into manageable steps. This type of practical support reduces treatment dropout.

11. Supporting communication with healthcare professionals

Clients may find it difficult to explain their symptoms, treatment experiences, or side effects. Harm reduction workers can help clients prepare what they want to communicate, accompany them when possible, or follow up afterwards. Clear communication ensures that care providers receive accurate information and that clients feel heard.

12. Reducing isolation and risk through consistent care

Even small, repeated moments of connection - such as brief conversations, outreach visits, or remembering someone's name and personal history - can significantly reduce feelings of invisibility and distrust. For people living with severe mental health problems, trauma, or chronic homelessness, this kind of relational consistency provides stability, reduces isolation, and can lower the risk of crisis or harmful behaviours.

Different activities can support this approach, such as therapeutic groups, structured social activities, or other consistent engagement opportunities that foster trust and connection.

13. Supporting basic needs as an entry point to mental health care

Before any psychological intervention is possible, many people need their basic needs to be stabilised: food, water, hygiene, safety, and rest. Creating minimal conditions of stability increases a person's capacity to engage in mental health care and reduces the cognitive load associated with survival. In some programmes, practical supports or small financial incentives (for example, transportation vouchers, meal tokens, or participation stipends) have been shown to improve engagement and adherence when used ethically and within structured frameworks.

14. Structuring routines and predictability

People experiencing complex trauma, psychosis, or problematic substance use often live in both internal and external chaos. Establishing simple, predictable routines — such as consistent schedules, regular meeting points, and practical reminders — can help reduce disorganisation, lower anxiety, and prevent crisis episodes. Predictability also increases a person's sense of safety and control, which is fundamental for engagement and stabilisation.

15. Advocating for clients within systems

Services do not always give credibility to the experiences of people who use drugs or who are experiencing homelessness, and harm reduction professionals play a critical advocacy role by challenging unfair barriers, negotiating exceptions (such as lack of a fixed address or ID), requesting priority assessments in urgent situations, and ensuring that symptoms are not dismissed or attributed solely to substance use (diagnostic overshadowing).

16. Strengthening motivation and readiness for care

Using motivational interviewing principles, professionals can help individuals identify personal goals, explore ambivalence, understand and reduce resistance, and increase self-efficacy. This approach is particularly valuable when formal treatment is not yet possible, as it supports engagement, enhances autonomy, and prepares the person for future therapeutic steps.

17. Crisis de-escalation and emotional regulation support

Harm reduction workers are often present during moments of emotional dysregulation. Basic grounding techniques, breathing support, a calm relational presence, and orienting the person toward safety can reduce risks of harm and compulsive substance use.

Services can plan ahead by creating safe rooms or low-stimulation spaces for individuals experiencing acute distress - for example, during a substance-induced psychotic episode involving delusions (false, fixed beliefs) or hallucinations (perceiving things that are not present). Teams can also prepare clear procedures or “safety plans” to guide staff responses in these situations, ensuring that everyone - including administrative personnel, support staff, and technical teams - understands their role and how to act in a coordinated, trauma-informed manner.

18. Recognising and responding to trauma triggers

Most people experiencing homelessness have a history of severe trauma. Noticing signs of activation, avoiding intrusive practices, and working in a calm and predictable manner helps prevent retraumatisation. Above all, staff should maintain a trauma-informed lens throughout their interventions, avoiding simplistic or moralising interpretations of behaviour. Instead, workers are encouraged to move beyond surface reactions and cultivate curiosity guided by trauma-informed principles — asking “What happened to this person?” or “Why are they reacting this way?” rather than “What is wrong with this person?” or “This behaviour is unacceptable.” This perspective improves understanding, reduces stigma, and supports more compassionate and effective responses.

Adopting this stance also helps staff avoid personalising the behaviour or becoming reactive rather than understanding. This does not mean ignoring one’s own boundaries or triggers; maintaining personal safety and emotional limits is essential for sustainable, trauma-informed practice.

19. Documenting observations and information safely

When possible, recording observations, concerns, contact attempts, and changes over time helps to monitor risks more effectively; support continuity of care across different teams and provide fuller, clearer, and more accurate referrals.

Confidentiality and informed consent remain essential. Documentation should be factual, neutral, and focused on observable behaviours rather than interpretations or assumptions. Sensitive information must be handled according to ethical and legal standards to protect the person's privacy and safety.

20. Collaborating across sectors

The complexity of people's needs requires coordinated action across multiple systems, including:

- Mental health services
- Addiction services
- Housing providers
- Social services
- Justice and probation systems,
- Hospitals and emergency departments,
- Street outreach teams,
- NGOs and community organisations.

Strengthening these connections improves service continuity, reduces fragmentation, and leads to significantly better outcomes. Harm reduction workers often act as the bridge between systems, ensuring that information flows appropriately, barriers are identified early, and the person remains at the centre of the intervention.

Section 2 | Evidence-informed actions

In this section, we focus on evidence-informed actions that harm reduction workers can implement to support people experiencing homelessness who have mental health concerns (*NHCHC, 2024; SAMHSA, 2020; Hwang & Burns, 2014; Hopper et al., 2010; WHO, 2021; Padgett et al., 2016; Tolin, Meunier, Frost & Steketee, 2010; NIMH, 2008*).

For each mental health condition or related behaviour, this section is organized into four key areas:

1. **Practical Screening Considerations** – Guidance on recognizing early signs in a simple, accessible way, adapted for street-based or low-threshold contexts, without requiring formal clinical tools.
2. **Key Warning Signs That Require Special Attention** – Indicators suggesting the situation needs closer monitoring, additional support, or professional follow-up.
3. **Red Flags for Urgent Intervention** – Signs of immediate risk of physical or psychological harm, including potential risk of death, requiring rapid medical or psychiatric response.
4. **Practical Daily Interventions** – Concrete strategies and actions that workers can implement daily to support the individual, including communication techniques, safety measures, structuring routines, orientation, documentation, and assistance with decision-making.

Attention-Deficit/Hyperactivity Disorder (ADHD)

1. Practical Screening Considerations

- Observe difficulties with attention, focus, and following instructions in daily tasks (e.g., forgetting appointments, losing belongings, missing steps in routines, frequently changing topics in conversations, or being unable to keep track of what has been agreed).
- Notice impulsive or hyperactive behaviours (e.g., acting without planning, fidgeting, talking excessively, or having difficulty staying seated or remaining in one place during a conversation).
- Look for emotional dysregulation: frustration, irritability, or sudden mood changes.
- Take into account that people with ADHD may react differently to substances compared with others - for example, some may feel calmer or more focused after taking stimulants such as amphetamines, rather than experiencing the usual stimulating effects.
- Use simple, non-clinical questions:
  - *“Do you find it hard to keep track of things or remember appointments?”*
  - *“Do you get restless or feel the need to move a lot even when you shouldn’t?”*
  - *“Are you finding it difficult to focus on one thing at a time?”*

2. Key Warning Signs That Require Special Attention

- Frequent difficulty completing essential tasks or attending appointments.
- Impulsive behaviours that create safety concerns (e.g., running into traffic, taking unnecessary risks).
- Extreme frustration or anger outbursts affecting social interactions or service engagement.
- Difficulty following instructions or understanding safety information, leading to repeated errors or risky situations.
- Frequent abandonment of activities, responsibilities, or work as an impulsive reaction to others' behaviour.

3. Red Flags for Urgent Intervention

- Severe impulsivity resulting in imminent danger to self or others.
- Acute emotional outbursts with risk of harm (e.g., aggressive behaviour, self-injury).
- Signs of co-occurring conditions escalating (e.g., severe anxiety, psychosis, substance overdose).
- Inability to maintain basic functioning despite support, putting the person at immediate risk of harm.

4. Practical Daily Interventions

- Use clear, concise communication and break tasks into small, manageable steps.
- Support organization with reminders, checklists, or visual aids.
- Establish predictable routines and consistent meeting points to reduce chaos and confusion.
- Help the person organize the meeting or interaction by collaboratively listing the topics to cover (e.g., "Shall we list the topics we need to address today so I can help us stay focused on these goals?"), write them down, and check off the themes as they are discussed, supporting attention and structure.
- Anticipate the end of meetings or interactions by giving a clear verbal cue (e.g., "We're getting to the end of our meeting. Is there anything specific you want to discuss in the last 10 minutes?"), helping the person with ADHD transition smoothly and maintain focus until the conclusion.
- Help individuals understand how ADHD affects their behaviour, attention, and decision-making, highlighting patterns in daily life (e.g., impulsivity, difficulty following instructions, forgetfulness) in a non-judgmental, supportive way.
- Offer emotional support and validation: acknowledge the challenges and frustrations caused by ADHD.
- Monitor safety and provide guidance for impulsive behaviours (e.g., planning safe spaces, supervising high-risk activities).
- Support low-threshold pharmacological interventions, for example, working with the person to implement agreed-upon strategies for reducing benzodiazepine use through controlled dispensing, while respecting their autonomy and safety.

- Document observations and progress to help coordinate with other services and support continuity of care.

Anxiety Disorders

Anxiety disorders can profoundly affect a person's ability to manage daily tasks, engage with services, make decisions, and adopt safer-use strategies. For people experiencing homelessness, trauma, or substance use, anxiety often presents in fluctuating, masked, or intensified forms due to chronic stress, unsafe environments, or withdrawal effects.

Understanding anxiety in these contexts helps workers to:

- Approach the person with patience and sensitivity
- Adapt expectations around engagement or follow-through
- Reduce escalation and panic during interactions
- Support grounding and emotional regulation
- Identify when anxiety may signal additional risks (e.g., psychosis, overdose, withdrawal, or medical issues)

1. Practical Screening Considerations

- Use simple, non-clinical, conversational questions:
  - "Have you been feeling very tense or on edge lately?"
  - "Do you get moments when your body feels like it's in danger, even if nothing is happening?"
  - "Are worry or fear making your day harder to manage?"
  - "Do you notice your heart racing, trouble breathing, or sudden panic?"

2. Focus on functional impacts rather than labels:

- Difficulty waiting in lines or crowded spaces
- Avoiding services or appointments
- Trouble organizing belongings or tasks
- Difficulty staying asleep due to worry or intrusive thoughts

3. Observe interplay with substance use:

- Stimulants (cocaine, methamphetamine): agitation, paranoia, panic
- Cannabis: may reduce anxiety or trigger panic depending on dose and individual
- Alcohol or benzodiazepines: short-term relief, rebound anxiety during withdrawal
- Opioids: reduce physical tension but may mask underlying anxiety or trauma

4. Consider environmental triggers:

- Unstable, noisy, or unsafe spaces can increase baseline anxiety
- "Aggressive," "irritable," or "uncooperative" behaviour may reflect panic or overwhelm

2. Key Warning Signs That Require Special Attention

Verbal Indicators:
- Reporting constant worry or inability to “shut their mind off”
- Expressing fear of losing control, “going crazy,” or dying
- Describing panic attacks with physical symptoms
- Avoiding places, staff, or services due to fear
- Catastrophic thinking (e.g., “Everything will go wrong,” “I can’t cope with anything”)

Behavioural Indicators:
- Restlessness, pacing, scanning environment constantly
- Avoidance of crowded or unfamiliar places
- Difficulty staying long enough to complete a task or appointment
- Sudden withdrawal from services or supports
- Increased substance use to self-medicate
- Seeming “on edge,” easily startled, jumpy, or hypervigilant

Physical & Emotional Indicators:
- Rapid heartbeat, sweating, trembling, dizziness
- Shortness of breath or chest tightness (common in panic attacks)
- Gastrointestinal distress, nausea, “butterflies in stomach”
- Muscle tension, headaches, chronic pain
- Irritability, difficulty relaxing, emotional exhaustion
- Sleep disturbance due to excessive worry or fear

3. Red Flags for Urgent Intervention

Signs suggesting severe anxiety, panic disorder, medical emergencies, or imminent risk of harm:
- Frequent or prolonged panic attacks, sometimes misinterpreted as heart attacks
- Hyperventilation with risk of fainting
- Severe dissociation or inability to orient to time, place, or surroundings
- Anxiety with hallucinations or paranoid delusions (possible psychosis or stimulant effect)
- Anxiety during withdrawal from alcohol, benzodiazepines, or opioids

Statements such as:
- “I can’t breathe, I’m going to die.”
- “My mind won’t stop, I’m losing control.”
- “I can’t go on like this.”

In street or homelessness contexts, these symptoms can escalate quickly and require immediate medical or psychiatric intervention.

4. Practical Daily Interventions

- Communication: Use calm, patient, non-judgmental language; validate feelings
- Grounding & Emotional Regulation: Support breathing exercises, sensory grounding, or brief mindfulness techniques
- Safety: Ensure safe environment; reduce triggers and overstimulation
- Routine & Predictability: Maintain consistent schedules and meeting points to reduce anxiety
- Orientation & Reminders: Provide simple instructions, reminders, or visual cues
- Record-Keeping: Note observations, triggers, and changes in anxiety levels for continuity of care
- Substance Use Support: Monitor for self-medication attempts; provide harm reduction guidance
- Referral & Collaboration: Engage mobile or crisis teams, accompany clients to appointments when possible

Cognitive Impairment, including Drug-Induced Cognitive Impairment

1. Practical Screening Considerations

Observe the following functional and behavioural indicators:

Memory & Attention:

- Repeating questions or stories
- Losing track of conversations
- Difficulty following instructions
- Struggling to learn new information
- Missing appointments frequently

Orientation & Recognition:

- Confusing places or people
- Getting lost easily
- Difficulty using public transport and navigating the city
- Feeling overwhelmed in new environments

Communication:

- Difficulty finding words
- Slowed or disorganised speech
- Trouble understanding complex explanations

Behaviour & Emotions:

- Sudden agitation or confusion
- Mood changes or irritability
- Appearing withdrawn or apathetic
- Changes in walking patterns (which could indicate difficulties in motor planning or spatial orientation)

Possible Drug-Related Signs:

- Strong sedation or “foggy” thinking
- Poor coordination
- Disorientation after using benzodiazepines, opioids, synthetic cannabinoids, methadone, pregabalin, alcohol, or antipsychotics
- Periods of delirium, especially with mixed substance use

2. Key Warning Signs That Require Special Attention

- Repeated inability to complete daily tasks or follow routines
- Frequent confusion interfering with communication or decision-making
- Sudden mood or behaviour changes not explained by context
- Signs of intoxication or adverse reactions affecting safety
- Noticeable decline in attention, memory, or learning

3. Red Flags for Urgent Intervention

- Acute confusion or delirium (fluctuating consciousness, disorientation, hallucinations, sudden behaviour change)
- Person unable to keep themselves safe (wandering into unsafe areas, leaving stoves/heat sources on, forgetting essentials)
- Major decline in functioning (unable to perform basic previously manageable tasks)
- New confusion associated with:
  - Head injury
  - Fever or infection
  - Intoxication with sedatives or multiple substances
  - Withdrawal from alcohol, benzodiazepines, or GHB
  - Strong suspicion of overdose or adverse medication interactions

4. Practical Daily Interventions

- **Communication Strategies:**
  - Use short, concrete sentences
  - Give instructions one step at a time
  - Repeat information calmly without showing frustration
  - Check understanding (“Can you tell me in your own words what we just agreed?”)
  - Avoid abstract or complex explanations

- **Environmental Support:**
  - Reduce noise and stimulation when the person is overwhelmed
  - Create predictable routines (consistent meeting place and time)
  - Offer reminders (texts, calls, written notes)
  - Provide orientation cues (location, time/day, ongoing activities)
  - Do tasks together when needed (e.g., support with using public transport, cooking, or bathing)
  - Introduce physical supports (e.g., bath rails, toilet supports) in house-based environments to enhance safety, independence, and reduce risk of falls or accidents.

- **Support Decision-Making:**
  - Break choices into simple options
  - Allow time to process information
  - Use visual aids to support understanding and decision-making (e.g., written steps, diagrams, checklists)
  - Check for memory gaps before expecting follow-through.
  - Avoid expecting independent appointment adherence without support

- **Safety Measures:**
  - Monitor for intoxication that increases confusion (benzodiazepines, alcohol, opioids, pregabalin)
  - If delirium suspected, avoid confrontation, keep the person calm, and seek medical assessment
  - Note patterns: time of day, triggers, substances used
  - Avoid using gas-based equipment in house-based interventions
  - Ensure an emergency contact number is easily accessible
  - Make home address easy to identify and visible
  - Keep keys, access cards, or essential items attached to the body or in a consistent, easy-to-reach location

- **Documentation:**
  - Record changes over time in memory, attention, and functioning
  - Identify triggers or substances linked with worsening confusion
  - Share relevant observations with clinical teams, respecting consent

Complex Trauma and Post-Traumatic Stress Responses

People experiencing homelessness have extremely high rates of Complex Trauma due to repeated exposure to violence, abandonment, institutionalization, childhood adversity, exploitation, or unsafe living conditions. Complex Trauma profoundly shapes emotional regulation, trust, ability to maintain routines, and engagement with services. Understanding these patterns helps professionals respond with empathy, avoid escalating distress, recognize trauma-driven behaviors, prevent retraumatization, and increase safety through trust-building and grounding strategies.

1. Practical Screening Considerations

- Use simple, non-intrusive questions to explore effects of trauma rather than specific events, e.g.:
  - *"What kinds of situations make things feel overwhelming for you?"*
  - *"What helps you feel safer when you're stressed?"*
  - *"Are there things that make it harder to trust people or services?"*
  - *"What do you need from us when you're feeling activated or upset?"*

- Pay attention to bodily and emotional cues: sudden withdrawal, fast shifts from calm to agitation, spacing out, intense reactions to proximity or authority, overwhelming guilt or shame.

- Consider environmental triggers: unsafe or unstable living conditions can exacerbate hypervigilance, emotional dysregulation, or trauma-mimicking behaviors.

2. Key Warning Signs That Require Special Attention

Emotional & Behavioral:

- intense reactions to small triggers
- difficulty calming
- rapid shifts in emotions
- sudden attachment or avoidance
- constant scanning of the environment
- repetition of unsafe or maladaptive behaviors without anticipating negative consequences (e.g., returning to abusive situations, engaging in risky interactions, or recreating patterns of victimization).

Dissociation & Consciousness Changes: • freezing • blank staring • spacing out • losing track of time • feeling detached • inconsistent recall	**Somatic & Physical:** • chronic unexplained pain • gastrointestinal or cardiopulmonary symptoms • fatigue • headaches • sexual dysfunction

3. Red Flags for Urgent Intervention:

- Severe dissociation with unawareness of danger.
- Uncontrollable panic, rage, or terror.
- Suicidal thoughts, self-harm, or sudden hopelessness.
- Trauma-linked hallucinations or hearing voices.
- Signs of recent assault or exploitation.
- Escalating substance use directly triggered by trauma reminders.
- Presence in an unsafe environment with a known abuser.

4. Practical Daily Interventions:

- Prioritize safety, predictability, and calmness: approach slowly, explain actions, use consistent routines.
- Grounding and regulation techniques: slow breathing, orienting to the present, sensory grounding, low-stimulation spaces.
- Maintain a trauma-informed relational stance: curiosity instead of judgement, validation, collaboration, respect pace, avoid personalizing reactions.
- Respect boundaries and choice: ask permission, offer options, never force disclosure, accept slow trust-building.
- Reduce retraumatization in services: avoid punitive approaches, minimize intrusive procedures, ensure privacy, monitor staff tone.
- Embrace the harm reduction principle of accountability without termination, which recognizes that individuals are responsible for their own choices and health decisions, while ensuring that services are not discontinued if specific goals are unmet or rules are not followed.
- Identify triggers and create safety plans: collaboratively explore triggers, early signs, coping strategies, supportive contacts, environments to avoid.
- Strengthen protective factors: stable routines, peer support, reinforcing small achievements, connecting to health services, safer use practices when relevant.
- Collaborate across sectors: mental health, primary care, domestic violence services, addiction services, shelters/housing, justice system, community organizations.

Depression

Depression can significantly affect an individual's ability to engage with services, follow treatment plans, maintain motivation for change, or adopt harm reduction strategies.

Understanding depression in the context of homelessness helps professionals:

- approach individuals with greater empathy,
- adjust expectations around engagement,
- identify early signs of risk (especially suicide risk),
- and tailor interventions to the person's reality and capacity at the moment.

Early recognition of depressive symptoms is essential for preventing deterioration, improving engagement, and reducing suicide risk. In homelessness settings, symptoms may appear differently due to chronic stress, environmental insecurity, and co-occurring substance use.

1. Practical screening considerations

- Use simple, conversational, open, empathetic questions such as:
  - *"How have you been feeling lately?"*
  - *"What has been hardest for you recently?"*
  - *"Have you been feeling down, hopeless, or without energy?"*

- Focus on functional changes - people may not describe "sadness" directly. Look for:
  - reduced motivation
  - difficulty organizing daily tasks
  - withdrawal from usual routines or supports
  - more time spent isolated

- Consider the impact of environment

Sleeping outdoors or in unsafe shelters can cause exhaustion and irritability, which may mask or mimic depressive symptoms. A holistic view is essential.

2. Key warning signs that require special attention

- **Verbal indicators**
  - Expressing hopelessness (“There’s no point anymore”).
  - Talking about death, not wanting to wake up, or feeling like a burden.
  - Mentioning giving up on goals, relationships, or health.
- **Behavioural indicators**
  - Marked withdrawal from peers or support services.
  - Sudden increase or decrease in substance use.
  - Decline in self-care or inability to manage basic needs.
  - High-risk behaviors (unsafe substance use, unsafe sex, risky environments).
- **Physical and emotional indicators**
  - Persistent fatigue, slowed movements, agitation, or restlessness.
  - Noticeable weight loss or gain, or appetite changes.
  - Chronic pain complaints without clear medical cause.
  - Irritability, anger outbursts, or emotional numbness.

3. Red flags for urgent intervention

- Talking about wanting to die or harm oneself.
- Planning or seeking means for suicide.
- Hearing voices encouraging self-harm (possible psychotic features).
- Severe hopelessness or “no way out” statements.
- Recent traumatic events (e.g., assault, loss, eviction).
- Co-occurring heavy alcohol or drug intoxication.
- Being alone and disconnected from support networks.

4. Practical interventions

- **Build safety and stabilization first**
  - Create a calm, predictable, non-judgmental interaction.
  - Prioritize immediate needs (food, rest, shelter, medical care) - unmet basic needs can worsen depressive symptoms and block engagement.
  - Use grounding strategies if the person appears overwhelmed (e.g., slow breathing, focusing on the present moment).

- **Support emotional expression**
  - Normalize talking about feelings, especially hopelessness or exhaustion: “Many people who go through difficult situations feel this way. I’d like to understand how I can support you.”
  - Validate instead of minimizing: “What you’re feeling makes sense, given the circumstances.”
- **Promote small, achievable steps - depression reduces motivation and executive function; aim for micro-goals:**
  - encourage getting out of bed, eating something, taking a shower when possible
  - break tasks into small steps
  - focus on “one thing today” rather than multiple expectations
- **Increase support and frequency of contact**
  - Offer more frequent check-ins (presence is therapeutic).
  - Short, consistent interactions can prevent deterioration.
  - Select one or two staff members to maintain close and consistent contact with the person.
  - Bridge between services (healthcare, psychiatry, harm reduction, social care).
- **Facilitate access to clinical evaluation when appropriate and with consent:**
  - accompany or arrange mental health assessments
  - support adherence by offering reminders, transportation help, or attending appointments
  - advocate for low-threshold psychiatric care (e.g., street psychiatry, mobile teams)
- **Integrate harm reduction into mood support**
  - Explore how substance use is linked to self-medication without judgment.
  - Watch for patterns: withdrawal increasing depressive symptoms, intoxication masking risk.
  - Help the person identify safer use strategies when abstinence is not possible.
- **Use behavioural activation approaches - simple, low-pressure activities can counter depressive inertia:**
  - walking together
  - having a coffee
  - doing a task together
  - connecting with meaningful people or routines
- **Strengthen connection and belonging - depression in homelessness is strongly associated with isolation.**
  - Facilitate social reconnection when possible, even minimally.
  - Encourage participation in community meals, group activities, peer groups.
- **Safety planning when suicide risk is present**
  - Explore the level of risk calmly and directly.
  - Create a brief, meaningful safety plan:
    - who to call (list more than one option)
    - where to go to feel safe
    - what helps them calm down

- Ensure emergency contacts are known and accessible.
- Coordinate with crisis teams or emergency services when necessary.

- **Adopt a patient, long-term perspective**
  - Depression in homelessness is often chronic and tied to life circumstances.
  - Progress is nonlinear — expect fluctuations.
  - Maintain a stance of "I'm here, even when things get worse."
  - Do not interpret withdrawal or missed appointments as lack of interest.

Hoarding Disorder and Hoarding Behaviours

People who hoard often experience significant safety risks, impaired functioning, and co-occurring mental health conditions such as depression, anxiety, obsessive-compulsive disorder (OCD), ADHD, trauma histories, or social isolation. Hoarding behaviours may appear in street settings, shelters, transitional housing, or Housing First programs.

However, it is important to highlight that, in many cases, the accumulation and sale of items serve as an informal source of income, necessary for survival among people experiencing homelessness. Understanding the context and discussing with the person the functional role of hoarding behaviour is essential, as it allows the development of individualized strategies adapted to the life and well-being of each person.

1. Practical Screening Considerations

Use non-judgmental, curious, and practical questions; avoid moralising language ("messy," "dirty," "lazy").

- **Observational indicators:**
  - Large amounts of possessions around sleeping areas (tents, shelters).
  - Items blocking exits, ventilation, beds, or walkways.
  - Difficulty allowing staff to remove trash or items.
  - Strong emotional distress when objects are moved or touched.
  - Repeated collecting of free items (clothing, food containers, donated objects).
  - Avoidance of home visits or inspections in supported housing (may indicate shame or stigma).
  - Living space not used for its intended purpose (e.g., bed buried under belongings, kitchen or bathroom unusable).
  - Observe defensiveness, assertions of self-determination, rationalizations, or positive re-appraisals of collecting behavior.

- **Simple conversational screening questions:**
  - *"Do you feel comfortable in your living space right now?"*
  - *"Are the items around you helpful, or are they making daily tasks harder?"*
  - *"Is it stressful to think about sorting or throwing things away?"*
  - *"Has anyone ever expressed concern about safety in your house/room/tent?"*
  - *"Do you find yourself collecting more things than you have space for?"*
- **Probe gently for co-occurring issues:**
  - ADHD symptoms (disorganisation, distractibility, procrastination in getting rid of items).
  - Trauma history (objects used as emotional security).
  - Anxiety or social isolation linked with hoarding.
  - Compulsive buying or acquiring behaviour.

2. Key Warning Signs That Require Special Attention

- Distress, anger, or panic when discussing belongings.
- Difficulty allowing staff to remove items due to high emotional distress
- Strong defensiveness, avoidance, or reluctance to engage with support services.
- Avoidance of home-based support services.
- Living space unusable for daily tasks (safe movement, sleeping, cooking, hygiene).
- Repeated collecting that interferes with daily functioning.
- Rationalizations or minimizations that prevent acknowledgment of safety risks.
- Frequent evictions or complaints due to clutter.
- Co-occurring mental health issues likely worsening hoarding (e.g., depression, OCD, substance use).

3. Red Flags for Urgent Intervention

- Items blocking exits, ventilation, or walkways (fire and safety hazards).
- Living space poses immediate health or sanitation risks (e.g., kitchen or bathroom unusable, structural hazards, vermin, mould).
- Extreme distress or inability to ensure basic needs are met due to clutter.
- Structural overload (floor bowing, dangerous weight accumulation).
- Hoarding combined with severe self-neglect (not eating, poor hygiene, medical concerns).
- Threat of eviction, municipal orders, or loss of housing.
- Elderly individuals living alone in extreme clutter.
- Hoarding following a major loss, trauma, or cognitive decline.

4. Practical Daily Interventions

- **Build trust and reduce shame:**
  - Approach in a non-judgmental, curious, and supportive manner; avoid shaming language ("possessions" instead of "junk"). Take into account that the person may have experienced repeated shaming from family, neighbors, and society. Approach with empathy, avoid moralizing language, and normalize the challenges associated with hoarding to reduce stigma and build trust.
  - Collaborate with the person to understand the functional role of items (e.g., survival, income, emotional security).
  - Normalize distress and highlight collaboration.
  - Avoid touching belongings without permission.
  - Validate the emotional attachment to items.
- **Break tasks into small, manageable goals:**
  - Identify one safe area to clear (e.g., exit path, heater area).
  - Support "harm reduction decluttering" - focus on safety, not full clean-outs.
  - Not full clean-outs.
  - Encourage use of containers, bags, or shelves to reduce hazards.
  - Use visual aids (checklists, simple floor plans of a safe room layout).
- **Address co-occurring mental health needs:**
  - Provide calm support for anxiety or distress when sorting items.
  - Screen for depression, trauma, or cognitive impairment contributing to hoarding.
  - Refer for mental health evaluation and support, when possible.
- **Prevent crisis and eviction:**
  - Be consistent with the intervention - maintain predictable schedules for appointments or visits. This could mean increasing frequency but keeping interactions brief, or spacing them appropriately, depending on what supports engagement and reduces stress for the person.
  - Liaise with housing providers, mental health, and social services for coordinated support.
  - Offer support by describing engagement and progress - highlight what has been achieved, especially in interactions with landlords, housing providers, or the community, to reinforce autonomy, build trust, and demonstrate positive involvement.
  - Attend inspections with the client when appropriate.
  - Help prioritize immediate safety hazards to satisfy landlords/inspectors.
- **Support meaningful goals:**
  - Ask what the person wants: privacy? a safe room? fewer inspections?
  - Reinforce autonomy and choice.
  - Celebrate micro-progress (one bag removed, 10 minutes of sorting).
- **Collaborate across services:**
  - Occupational therapy, mental health teams, fire prevention, social housing workers.
  - Avoid punitive or forced interventions unless life-threatening risk is present.
  - If a clean-out is unavoidable, provide comprehensive, wraparound support to minimize trauma, noting that without ongoing intervention, recidivism is almost certain.

Personality Disorders

People with personality disorders may exhibit long-standing patterns of thinking, feeling, and behaving that challenge relationships, engagement with services, and emotional regulation. Among people experiencing homelessness, these patterns can be intensified by trauma, chronic stress, and substance use. Understanding these patterns helps workers to:

- Maintain consistent and predictable interactions;
- Avoid escalation or breakdowns in engagement;
- Recognize that “difficult” behaviours often have an adaptive function;
- Increase safety and engagement through clear boundaries and collaboration.

1. Practical Screening Considerations

- Observe relationship patterns: difficulty trusting, alternating between closeness and withdrawal, intense reactions to perceived rejection.
- Note extreme emotional responses or rapid mood changes.
- Identify protective behaviours: isolation, service avoidance, manipulation, threats of abandonment.
- Look for difficulty with rules, limits, or frustration with delays and setbacks.
- Ask open, non-judgmental questions about relationships and past experiences:
  - “What helps you trust people?”
  - “How do you prefer we handle conflicts or misunderstandings?”
- Observe patterns of substance use that may modulate emotions or impulsivity.

2. Key Warning Signs That Require Special Attention

- Extreme reactions to perceived rejection or criticism.
- Threats of self-harm, self-punishment, or abandoning services in response to conflict.
- Manipulative behaviours to reduce discomfort, risk, or frustration.
- Difficulty keeping commitments, leading to repeated breakdowns in care plans.
- Risk-taking behaviours directed at self or others, even if subtle or indirect.

3. Red Flags for Urgent Intervention

- Imminent threat of serious self-harm or suicide.
- Aggressive behaviour with risk of harming others.
- Loss of contact with reality (psychosis, severe dissociation).
- Extreme substance use combined with impulsivity, increasing risk of overdose or accidents.
- Situations in which the person is in immediate danger without capacity to protect themselves or follow safety instructions.

4. Practical Daily Interventions

- Establish clear and consistent boundaries: define rules firmly but without punishment; explain consequences predictably.
- Be predictable and consistent: maintain stable schedules, appointments, and responses.
- Validate feelings without reinforcing harmful behaviours: “I understand you feel frustrated, and we’ll try to find a safe solution together.”
- Use clear, direct communication: avoid ambiguity; repeat information as needed.
- Maintain small, achievable goals: gradual support for service engagement and emotional regulation.
- Offer choices whenever possible: increases sense of control and reduces resistance.
- Strengthen support networks: connect with mental health services, trusted peers, and key workers.
- Plan for crises in advance: co-create de-escalation strategies and emergency contacts for high-risk situations.
- Apply harm reduction principles: focus on reducing harm, not eliminating behaviours; support autonomy and safe decision-making.
- People with borderline personality disorder often engage in self-harm to regulate emotions, relieve distress, or distract themselves from internal pain. Because self-harm can provide immediate relief, it can be very difficult to stop. Developing skills to manage emotions, tolerate distress, stay present in the moment, and improve relationships is helpful. It is also important to recognize that both their own behaviors and the behaviors of others arise from internal mental states, such as thoughts, feelings, and desires.

Psychosis

Schizophrenia and Other Psychoses

1. Practical Screening Considerations

- **Conversational questions:**
  - “*Have you noticed anything unusual in the way you see or hear things?”*
  - *“Do you sometimes feel like people are watching you or trying to harm you?”*
  - *“Do you find it hard to focus, or do your thoughts feel jumbled or racing?”*
  - *“Are there times you feel confused about where you are or what’s happening?”*

- **Observational Indicators:**
  - Disorganized speech or thought patterns (jumping between topics, incoherence)
  - Paranoia or suspiciousness
  - Auditory or visual hallucinations
  - Social withdrawal or isolation
  - Unusual behaviours (repetitive movements, odd postures, catatonia - a state where a person has unusual or very reduced movement, speech, or responsiveness)
  - Neglect of personal care or basic needs
  - Rapid or extreme mood changes unrelated to context
  - Poor sleep, agitation, or anxiety accompanying unusual thoughts
- **Functional Changes to Notice:**
  - Difficulty keeping appointments or following instructions
  - Problems managing daily tasks (shopping, cooking, paying bills)
  - Trouble sustaining attention during conversations or group activities

2. Key Warning Signs That Require Special Attention

- Intensifying hallucinations or delusions
- Sudden withdrawal from people or services
- Inability to manage self-care or daily tasks
- Rapid decline in social, occupational, or functional abilities
- Unusual or dangerous behaviours that could harm self or others
- Increased agitation, aggression, or emotional lability
- Difficulty distinguishing reality from internal experiences

3. Red Flags for Urgent Intervention

- Active hallucinations or delusions driving behaviour (command hallucinations)
- Severe agitation or aggression unresponsive to de-escalation
- Suicidal ideation, self-harm, or risk of harming others
- Acute disorientation to time, place, or identity
- Psychotic episode accompanied by fever, dehydration, or medical emergencies
- Rapid deterioration in functioning over hours or days
- Sudden onset or worsening of psychotic symptoms (possible medical, substance, or neurological cause)

4. Practical Daily Interventions

- **Communication & Interaction:**
  - Use calm, clear, and simple language; short sentences
  - Avoid arguing about delusions or hallucinations; validate feelings instead
  - Offer choices to increase sense of control
  - Give repeated orientation cues: place, date, safe environment
- **Environmental Adjustments:**
  - Reduce sensory overload: minimize noise, bright lights, or crowded spaces
  - Ensure safe, low-stimulation environment whenever possible
  - Maintain predictable routines and meeting points
- **Support for Daily Functioning:**
  - Help with tasks requiring organization or planning
  - Encourage attendance at appointments with reminders or accompaniment
  - Break tasks into manageable steps; use visual cues if needed
  - Monitor sleep, nutrition, and hydration
- **Harm Reduction & Substance Awareness:**
  - Monitor for substance use that may worsen psychosis (stimulants, alcohol, synthetic cannabinoids)
  - Educate about triggers and safer-use strategies if applicable
  - Support engagement with mental health or peer support services
- **Crisis & Follow-Up:**
  - Document observations and triggers, share with clinical teams (with consent)
  - Establish a safety plan for times of acute psychosis
  - Coordinate with mental health professionals for evaluation, treatment, and ongoing support
  - Maintain patience and consistency; progress is often gradual
- **Collaborate across services/community:**
  - Coordinate with occupational therapy, mental health teams, social workers, and other relevant professionals to support the person holistically.
  - Avoid punitive or forced interventions unless there is an immediate life-threatening risk.
  - If a housing intervention (or relocation to a safer environment) is unavoidable, provide comprehensive wraparound support to minimize distress, emphasizing that without ongoing support, relapse or deterioration is highly likely.
  - Work with the community to promote understanding of psychosis rather than judgement.
  - Advocate for safe, low-stigma environments that support engagement and reduce social isolation.
  - Encourage peers, neighbors, and service providers to respond with empathy and practical support instead of punitive measures.

Substance-Induced Psychosis

1. Practical Screening Considerations

- **Conversational / Non-clinical Questions:**
  - *"Have you noticed anything recently that feels strange or confusing?"*
  - *"Have you heard or seen things that others might not notice?"*
  - *"Have you felt unsafe, watched, or that someone might want to harm you?"*
  - *"What substances have you used recently? Anything new or different?"*
  - *"Do these experiences usually happen after using certain substances?"*
  - *"Are you sleeping okay?"*
  - *"Has this ever happened before?"*
  - *"Does anyone in your family have mental health issues or psychosis?"*
- **Observational Indicators:**
  - Paranoia, grandiosity, or ideas of reference
  - Auditory or visual hallucinations
  - Heightened sensitivity to noise or light
  - Sudden agitation, fear, or disorganized behaviour
  - Rapid speech or flight of ideas
  - Talking to oneself or responding to internal stimuli
  - Neglecting basic needs
  - Signs of recent stimulant, cannabis, synthetic cannabinoid, ketamine, hallucinogen, alcohol withdrawal, or benzodiazepine withdrawal use
  - Confusion, disorientation, or memory gaps

2. Key Warning Signs That Require Special Attention

- Strong persecutory beliefs or paranoia
- Recurrent psychotic episodes linked to substance use
- Extreme agitation, irritability, or unpredictable behaviour
- Disorientation to place, time, or situation
- Rapid deterioration in self-care or basic functioning
- Sleep deprivation of 48–72 hours or more
- Intense distress during intoxication, withdrawal, or after hallucinogenic experiences

3. Red Flags for Urgent Intervention

- Command hallucinations instructing self-harm or harm to others
- Severe agitation or aggression unresponsive to de-escalation

- Persistent psychosis beyond the expected duration of intoxication
- Severe confusion, convulsions, collapse, or high fever
- Psychosis combined with polysubstance use
- Suicidal thoughts or self-harming behaviour
- Inability to keep self safe
- Dangerously impaired reality testing ("I'm being watched," "They're coming for me")
- Signs of stimulant toxicity, serotonin syndrome, or synthetic cannabinoid complications

4. Practical Daily Interventions

- **Immediate Approach / On the Street:**
  - Prioritize safety: calm environment, minimal stimulation, maintain personal space
  - Grounding and orientation: *"You're here with me, you're safe right now."*
  - Speak clearly with short sentences; avoid arguing about delusions
  - Offer choices to increase control: *"Do you want to sit here or outside?"*
  - Encourage hydration, rest, and basic needs support
- **Short-Term Support (Hours–Days):**
  - Monitor for worsening symptoms
  - Support sleep, hydration, and nutrition
  - Help avoid triggers (substances, unsafe spaces)
  - Encourage medical or psychiatric evaluation if receptive
  - Document observations safely and accurately
- **Longer-Term Harm Reduction:**
  - Educate about substance-specific psychosis risks (stimulants, synthetic cannabinoids, high-THC cannabis, hallucinogens)
  - Identify early warning signs and personal triggers
  - Support gradual reduction or safer use strategies
  - Encourage use with trusted peers and avoid using alone
  - Facilitate connection with peer support or mental health services
  - Accompany to appointments if needed and coordinate with multidisciplinary teams
  - Develop safety plans for recurrent episodes

Self-Harm Behaviours

1. Practical Screening Considerations

- **Observational Indicators:**
  - Fresh cuts, scars, burn marks, or unexplained injuries
  - Bandages or improvised dressings
  - Wearing long sleeves/pants even in hot weather
  - Sudden withdrawal or mood changes
  - Avoidance of showers, changing rooms, or medical car

- **Gentle Conversational Screening:**
  - *"How have you been coping with stress lately?"*
  - *"When you're feeling overwhelmed, what helps you get through it?"*
  - *"Have you had moments recently where you hurt yourself to cope?"*
  - *"Is there anything happening that has made things feel more intense than usual?"*
  - *"Would you feel comfortable telling me if you were using self-harm to cope?"*
- **Contextual Questions:**
  - Current stressors, loss, conflict, trauma triggers
  - Substance use patterns (especially stimulants, alcohol, or withdrawal)
  - Social isolation or lack of support
  - History of abuse or mental illness

2. Key Warning Signs That Require Special Attention

- Talking about wanting to escape feelings or "numb out"
- Statements like "I can't handle this anymore"
- Giving vague explanations for injuries
- Increased alcohol or stimulant use to cope
- Risk-taking behaviours, chaotic relationships, emotional volatility
- Decline in self-care or functioning
- Significant shame, secrecy, or avoidance of support

3. Red Flags for Urgent Intervention

- Self-harm accompanied by suicidal thoughts or plans
- Severe injuries, infections, or wounds needing medical attention
- Escalating frequency or severity of self-harm
- Hallucinations or psychosis directing self-injury
- People under influence of depressants expressing hopelessness
- Youth or young adults with repeated self-harm episodes
- Individuals with a history of self-harm who are currently experiencing recent stressors such as trauma, relationship breakup, eviction, loss, or assault
- Individuals isolated with no support network

4. Practical Interventions

- **Creating a Safe Space:**
  - Validate emotional pain: "You're doing your best to cope."
  - Avoid moralising or panic; stay grounded
  - Show empathy and curiosity about what the behaviour means

- **Reducing Harm from Self-Injury:**
  - ○ Encourage safer wound care (sterile supplies if policy allows)
  - ○ Provide dressings, antiseptic wipes, aftercare advice
  - ○ Anatomy awareness: encourage the person to avoid high-risk areas of the body (e.g., veins, arteries, genitals – areas with high risk of severe blood loss or infection) while discussing openly and providing practical information about anatomy and safer practices whenever possible.
  - ○ Discuss alternative coping strategies - with or without associated pain - such as using ice cubes, snapping an elastic band on the wrist, engaging in grounding or sensory techniques, or other strategies that help regulate distress without causing significant harm.
  - ○ Support reduction of triggers where possible
- **Emotional Regulation and Coping:**
  - ○ Grounding strategies (deep breathing, sensory grounding)
  - ○ Identify early warning signs of urges
  - ○ Use an adapted version of "Surf the Urge" strategy (*Marlatt & Gordon, 1985*), helping the person notice the urge to self-harm, observe how it rises and falls like a wave, and stay with the feeling without acting on it. Keep the steps simple and brief, focusing on breathing, grounding, and reminding the person that urges are temporary and will pass.
  - ○ Develop coping plans (music, walking, contacting support)
  - ○ Reinforce protective factors (relationships, routines, goals)
- **Collaborative Safety Planning:**
  - ○ Identify trusted supports (friend, worker, helpline)
  - ○ Map out safest places to go if urges escalate
  - ○ Agree on situations requiring medical help
- **Professional Support:**
  - ○ Offer connections to mental health services, trauma therapy, etc.
  - ○ Normalize help-seeking
  - ○ Ensure that conversations about self-harm focus on safety, infection prevention, and alternative coping strategies rather
- **Medical Risk & Substance Links:**
  - ○ Respond to wounds and infection signs
  - ○ Know emergency thresholds:
    - ■ Uncontrolled bleeding
    - ■ Acute suicidal ideation (intent, plan, and/or means)
    - ■ Recent or escalating self-injury that the person cannot safely manage
    - ■ Signs of infection (redness, swelling, fever, spreading cellulitis)
  - ○ Explore links with substance use
  - ○ Provide harm-reduction tools when relevant (e.g., naloxone, wound-care supplies)

○ Explore links with substance use
○ Provide harm-reduction tools when relevant (e.g., naloxone, wound-care supplies)

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- **Worker Well-being:**
  - Stay calm and consistent
  - Seek supervision after difficult disclosures
  - Follow agency protocols for risk

Suicidal Ideation & Suicide Risk

1. Practical Screening Considerations

- **Direct but Gentle Questions:**
  - *"Sometimes people feel overwhelmed or hopeless. Has this been happening for you?"*
  - *"Have you had thoughts about not wanting to live or hurting yourself?"*
  - *"Do you feel you're at risk of acting on those thoughts?"*
  - *"What helps you get through moments like this?"*
- **Functional & Situational Screening:**
  - Recent conflict, eviction, assault, breakup, legal problems
  - Chronic pain, severe withdrawal, unmanaged mental health symptoms
  - Feelings of being a burden or unwanted
  - Concomitant presence of intoxication and feelings of despair
  - Past suicide attempts or self-harm
- **Observation:**
  - Affect and behaviour (shut down, hopeless, reflective after intoxication)
  - Presence/absence of future-oriented speech

2. Key Warning Signs That Require Special Attention

- Talking about suicide, death, "not being here tomorrow"
- Saying they are a burden or others are "better off without me"
- Farewell messages, giving away personal items
- Sudden calmness after prolonged distress
- Extreme guilt, shame, hopelessness, despair
- Looking for means (rope, pills, high places)
- Recent self-harm or escalating self-destructive behaviour
- Concomitant alcohol or stimulant intoxication and emotional collapse
- Serious isolation, withdrawal from services
- Previous suicide attempts, depression, PTSD, psychosis, substance dependence
- Recent loss, violence, trauma, chronic illness

3. Red Flags for Urgent Intervention

- Intent, plan, and access to lethal means
- Severe injuries or self-harm
- Hallucinations or psychosis directing self-harm
- Severe disorganization or inability to guarantee safety
- Intoxication with suicidal intent
- Emergency-level risk situations (imminent threat to life)

4. Practical Interventions

- **Immediate Frontline Actions:**
  - Stay calm, present, non-judgemental
  - Validate feelings (*"It sounds like you're in a lot of pain. I'm here with you."*)
  - Ask directly about suicidal thoughts/plans
  - Reduce immediate risk (check access to means, move to safer space)
  - Slow the situation (breathing, water, seating, reduce stimulation)
  - Create a temporary safety plan (*"Who can we call right now?" "What helps you stay safe?"*)
- **Connect to Professional Help:**
  - Mental health crisis lines, mobile crisis teams, emergency department
  - Out-of-hours psychiatric services
  - GP or mental health clinic follow-up
  - Never leave a high-risk person alone
- **Documentation & Follow-Up:**
  - Record observations, actions, risk indicators, contacts/referrals
  - Share with team for continuity
  - Support ongoing stability (regular check-ins, reduce isolation, monitor mood, sleep, substance use)
- **Grounding & De-escalation Techniques:**
  - Offer drink/snack to regulate nervous system
  - Sensory cues: notice things you see/hear
  - Focus on slow breathing
  - Invite walking if agitated
  - Sit in calm place away from triggers
- **Worker Well-being:**
  - Debrief with colleagues/supervisors
  - Maintain boundaries, recognize personal triggers
  - Take breaks, avoid carrying burden alone

Activity 3.6 | Success stories in engagement

This activity invites participants to explore practical examples of successful interventions, demonstrating how harm reduction and mental health strategies can be applied effectively in fieldwork with people experiencing homelessness.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | Cultural Diversity and Mental Health: Considerations for Practice

Mental health providers and frontline workers frequently support clients from cultures different from their own. Cultural differences have a range of implications for practice, including:

- How people understand health and illness
- Treatment-seeking patterns and preferences
- The nature of the therapeutic or support relationship
- Experiences of racism, discrimination, and social marginalization

It is important to bear in mind that modern psychiatric and mental health frameworks have been largely developed within the Global North, grounded in Western biomedical, individualistic, and positivist epistemologies that prioritize symptom classification, diagnosis, and standardized treatment models. These frameworks - codified through instruments such as the DSM and ICD - have historically been presented as universal, despite being shaped by specific socio-cultural, economic, and historical contexts of the Northern Hemisphere (Kirmayer, 2007; Mills, 2014). As a result, they often inadequately account for cultural variations in how distress is experienced, interpreted, and expressed, particularly in non-Western or marginalized communities.

Research consistently demonstrates that perceptions of health and illness are culturally constructed, influencing explanatory models of etiology that may emphasize spiritual imbalance, social disharmony, moral disruption, or structural adversity rather than individual pathology (Kleinman, 1980; Kirmayer & Minas, 2000). These culturally embedded understandings directly shape help-seeking behaviors, coping strategies, and engagement with care, including reliance on community networks, traditional healers, rituals, or collective forms of support. When dominant mental health models fail to recognize these differences, they risk misdiagnosis, pathologization of culturally normative responses to adversity, and the marginalization of adaptive survival strategies developed in contexts of poverty, displacement, or structural violence. From a critical and decolonial perspective, this raises important questions about epistemic dominance in mental health knowledge production and underscores the need for culturally responsive, context-sensitive, and participatory approaches that move beyond colonial assumptions of universality (Fernando, 2017; Summerfield, 2012).

Building on Gopalkrishnan's analysis of cultural perceptions of health, illness, and etiology , research consistently shows that understandings of health and illness differ across cultures, and that these cultural meanings have direct and tangible consequences for mental health practice. Perceptions of the causes of disease (etiology) can also vary widely: what one culture attributes to biological factors, another may interpret as spiritual imbalance, social disharmony, or emotional disruption. These beliefs influence:

- **Help-seeking behavior:** consulting medical professionals, traditional healers, or community/spiritual supports
- **Coping strategies:** rituals, herbal remedies, prayer, or family-based interventions
- Engagement with treatment: beliefs affect willingness to adhere to clinical interventions
- **Interpretation of symptoms:** cultural frameworks shape how distress or impairment is expressed and understood

This perspective means that mental health workers should explore clients' views on the causes of their distress or illness, avoid assumptions based on their own cultural framework, and tailor interventions in ways that respect these perspectives.

Hechanova & Waelde (2017) identify five cultural components with major implications for mental health practice. These factors shape how clients manage stress, engage with services, and relate to practitioners.

Emotional Expression

Some cultures view imbalance in emotional expression as a risk factor for illness. Individuals may avoid discussing painful issues for fear it will intensify distress.
Implication: talking therapies may need adaptation, integrating non-verbal or experiential approaches.

Shame

Shame can significantly delay help-seeking, especially in cultures where family reputation and social harmony are central.
Implication: trust-building, privacy, and normalization of help-seeking are essential.

Power Distance

In cultures with strong hierarchical norms, the therapist or worker may be viewed as an unquestioned authority.
Implication: emphasize collaboration and shared decision-making to enhance agency and autonomy.

Collectivism Vs Individualism

Collectivist cultures emphasize interdependence and family/community support.
Implication: involving social networks can strengthen engagement, coping, and resilience.

Spirituality and Religion

Beliefs about mental suffering are often tied to spiritual or religious frameworks.
Implication: recognizing these explanatory models can support culturally appropriate assessment and intervention.

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

Working with clients from diverse cultural backgrounds requires sustained awareness of how culture shapes mental health perceptions, experiences, and responses (Gopalkrishnan, 2018):

1. Treatment-Seeking, Stigma, and Historical Context

Cultures vary in how they access mainstream health systems. Migrant and minority groups often present later and with more severe symptoms. Several factors contribute:

- **Stigma**

Stigma is widely defined as a "mark of shame or disapproval" leading to rejection and exclusion. It can cause individuals to hide distress, avoid services, or fear being labelled.

- **Historical trauma and discrimination**

Historical trauma and discrimination have profound effects on many immigrants in Europe, particularly those whose communities have been shaped by centuries of colonialism and systemic oppression in Africa, South America and the Middle East. These experiences, both historical and ongoing, contribute to heightened levels of stress, mistrust of institutions, and reluctance to engage with health and social services. Structural inequalities, racialization, and everyday discrimination in host countries can bring the legacy of intergenerational trauma, affecting mental health, coping strategies, and help-seeking behaviors. Recognizing these historical and social contexts is essential for designing culturally informed interventions that are both responsive and respectful of the lived experiences of these populations.

- **Racism and systemic barriers**

Modern racism often operates through implicit cultural hierarchies rather than biological narratives. Health systems may inadvertently perpetuate stereotyping and bias. For example, the overdiagnosis of schizophrenia among African Americans illustrates systemic distortions in assessment.

- **Cultural mismatch**

Talking therapies may feel unacceptable or unsafe for some groups, which highlights the need for flexible, culturally responsive approaches - alternatives such as movement-based, expressive, or online therapeutic formats.

2. Coping and Resilience

Coping styles are culturally shaped strategies for managing stress, including collective problem-solving, spiritual practices, family support, or somatisation. Family support can be protective, although cultural norms may also create risk (e.g., stigma, marital expectations, taboos).

Resilience refers to the ability to thrive despite adversity and is influenced by cultural norms. Collectivist cultures may emphasize interdependence, with resilience emerging from cultural identity, community, spirituality, and collective action.

Implication: Practitioners should support culturally grounded strengths and protective factors.

3. Cultural Factors in the Therapeutic Relationship

The therapeutic relationship is shaped by the cultural contexts of both client and practitioner. Differences may appear in:

- language, communication style and norms of emotional expression
- norms around authority, autonomy, and disclosure
- the role of family and community
- expectations about privacy, boundaries, or professional distance

Without linguistic, conceptual, and cultural equivalence, assessments can be inaccurate, leading to misdiagnosis or inappropriate interventions. The consistent underuse of interpreters in high-income countries remains a major barrier to equitable mental health care.

Working with culturally diverse populations in situations of homelessness and/or drug use

When working with people experiencing homelessness who also use drugs, culturally sensitive practice is essential because experiences of distress, substance use, and pathways into homelessness are shaped not only by individual circumstances but also by cultural meaning systems, social structures, and historical contexts. Drawing on transcultural mental health scholarship, it is clear that **culturally embedded beliefs about health, substance use, and coping influence how people understand their own experiences and interact with services.** For example, research on social determinants of health notes that marginalized groups — including migrants and racialised communities — often confront dual stigma related to both substance use and non-normative cultural identities, which can delay help-seeking or lead to avoidance of mainstream healthcare altogether (Corrigan, Druss & Perlick, 2014). Similarly, ethnographic research on homelessness demonstrates that individuals from different cultural backgrounds construct meaning around substance use not simply as pathology but in relation to social survival strategies, community norms, and structural exclusion (Herring, 2019).

Cultural beliefs also shape explanatory models of substance use and distress. In some cultural traditions, substance use may be interpreted through relational, spiritual, or collective frameworks rather than purely biomedical ones. For instance, qualitative research with Indigenous and migrant populations shows that understandings of addiction can be tied to historical trauma, forced displacement, and community disenfranchisement, rather than individual moral failure (Gone, 2013; Whitbeck et al., 2004). These culturally grounded interpretations influence whether individuals seek support from formal healthcare providers, community elders, traditional healers, or peer support groups. They also affect coping strategies — from collective food sharing and communal ceremonies to embodied practices that integrate cultural norms into recovery.

Another critical dimension is **how culture intersects with service engagement and system trust.** Studies have documented that people from culturally diverse backgrounds often face institutional mistrust, rooted in experiences of discrimination, systemic racism, or exclusion within healthcare and social services (Snowden & Yamada, 2005). This mistrust is compounded for people experiencing homelessness who use substances, as their contact with services is frequently shaped by coercive, punitive, or surveillance-oriented practices rather than supportive, culturally affirming care. In this context, culturally responsive approaches must address not only language and communication differences but also structural barriers — such as undocumented migration status, lack of culturally competent providers, and inflexible treatment models — that hinder equitable access to care.

Besides, **cultural norms influence therapeutic relationships and symptom expression**. Research in transcultural psychiatry emphasizes that distress and coping are expressed through culturally patterned idioms of distress, which may not align with standardized diagnostic categories, leading to misdiagnosis or inappropriate intervention (Kirmayer, 2007). In homelessness settings, for example, what a clinician might interpret as “resistance” could be a culturally acceptable expression of autonomy or survival instinct shaped by historical marginalisation. Here, culturally adapted assessment tools, interpreter use, and reflective practice become essential components of competent care.

Finally, culturally grounded strengths — including family networks, community elders, spiritual practices, and informal peer support — offer critical avenues for engagement and resilience. As Anthony Marsella and colleagues have argued, culturally informed interventions that build on community values and social capital not only improve individual outcomes but also reinvigorate collective coping systems that have been eroded through colonization, urban marginalisation, and socio-economic exclusion (Marsella, 2009). Therefore, practitioners working with culturally diverse populations experiencing homelessness and substance use should adopt an integrative approach that validates cultural explanatory models, addresses systemic inequities, and partners with community resources to support meaningful, sustainable recovery.

Overall Directions in Cultural Diversity & Mental Health

a. Systems must recognise diversity, not only add tools

The DSM-5 Cultural Formulation Interview represents an important step forward, but it remains insufficient on its own. Professionals need to be able to adapt interviews, scales, and other assessment tools to the specific realities of people experiencing homelessness and active substance use. This ensures that the questions are relevant and meaningful, taking into account not only the individual’s cultural background and potential experiences of cultural shock, but also the current challenges of living in inadequate housing or using substances, which may affect perceptions, capacities, and decision-making.

b. Move toward holistic and integrated care

Moving toward holistic and integrated care is essential when working with people experiencing homelessness and substance use. Biopsychosocial and recovery-oriented models should provide a framework that supports cultural relevance, recognizing the interplay between social, psychological, and biological factors in shaping health outcomes. Integrating these services into primary care settings can reduce stigma and improve accessibility, particularly for individuals who may avoid specialized addiction or mental health services due to fear of discrimination or past negative experiences.

Additionally, acknowledging medical pluralism—the coexistence of Western, traditional, and community-based healing systems—can create space for culturally informed interventions that respect clients' beliefs and practices, fostering trust and engagement in care.

c. Strengthen community-based and traditional supports

Many culturally diverse people experiencing homelessness, including migrants and refugees, may prefer to seek guidance and support from elders, traditional healers, or religious leaders rather than formal healthcare systems. Evidence demonstrates that collaboration with these community-based resources can enhance engagement and effectiveness, as seen in contexts such as Indian healing temples or Indigenous ceremonial practices. For populations navigating both unstable housing and substance use, incorporating culturally familiar sources of support can help build trust, validate lived experiences, and complement clinical interventions.

d. Address the limits of cultural competencePlease

It is important to recognize the limits of cultural competence. Cultural competence is not value-neutral: effective practice requires critically examining issues of power, historical trauma, and systemic racism that shape individuals' experiences. For people experiencing homelessness and substance use, these factors often intersect, influencing access to services, exposure to discrimination, and vulnerability to social exclusion. Addressing these structural dimensions alongside cultural considerations ensures that interventions do not merely adapt to surface differences but actively respond to the broader contexts that affect health, well-being, and engagement in care.

Not value-neutral; must include analysis of power, historical trauma, and racism.

e. Build cultural partnerships

Building cultural partnerships is a key strategy for effective support of people experiencing homelessness and substance use. This involves sharing power with community members, co-designing programs with those who have lived experience,including peers, and ensuring that staffing reflects the cultural backgrounds of the populations served. Collaboration between mental health and substance use services and cultural communities helps to create interventions that are not only culturally appropriate but also trusted and accessible, fostering engagement, continuity of care, and more effective outcomes.

f. Promote interdependence, not hierarchy

Promoting interdependence rather than hierarchy is essential in working with people experiencing homelessness and substance use. Mental health care should integrate existing support networks, cultural identity, spiritual practices, and local knowledge as core components of intervention. Recognizing and building on these resources not only strengthens resilience and coping strategies but also ensures that care is grounded in the lived realities and strengths of the individuals and communities being served.

Finally, the broader societal context also plays a significant role: structural issues such as racism, rapid social change, migration, globalization, and loss of traditional support systems can exacerbate mental distress, especially in populations who are already exposed to the hardships of living in poor housing conditions or being homeless. Scholars argue that mental health professionals working across cultures must sometimes act as social advocates, addressing systemic inequities that shape clients' well-being.

Practical Considerations for culturally competent interventions with populations experiencing homelessness and with active substance use.

- **Be culturally aware**
  - Acknowledge variations in distress expression and coping.
- **Adapt communication**
  - Use interpreters.
  - Ask open, culturally sensitive questions:
    - *"How does your community understand what you're experiencing?"*
    - *"Who do you usually turn to when you are stressed?"*
    - *"Are there traditions or practices that help you cope?"*
- **Be attentive to risks**
  - Cultural misunderstandings that increase distress.
  - Isolation from culturally safe supports.
  - Conflicts between cultural norms and service expectations.
  - Compounded vulnerabilities (migration, gender, disability, sexuality).
  - Cultural or racial trauma.
  - Barriers to expressing urgency or danger due to language or norms.
  - Risks from systemic forces (eviction, police involvement, threat of detention).
- **Good practices include**
  - Creating culturally safe environments.
  - Validating cultural experiences and avoiding moralizing.
  - Collaborating with communities, cultural leaders, and peers.
  - Adapting harm reduction strategies to align with cultural values.
  - Supporting navigation of systems shaped by inequality.
  - Continuous learning, reflection on biases, and supervision.

Activity 3.6 - Roundtable

Objective:

Help participants understand how cultural background, trauma experiences, and harm reduction intersect, and support them in applying strategies respectfully and effectively through reflection, sharing real-world experiences, and identifying practical approaches for culturally sensitive, trauma-informed care.

All the instructions and materials for the activity are available on the Toolkit.

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Home4Health Training Program

Module 4

Psychoactive Substance Use

Home4Health Training Program | Module 4: Psychoactive Substance Use

Module Overview: (6h)

Coordinated by: ABD Welfare and Development Association
In partnership with: CPES CER, HVO QUERIDO, Cork Simon Community
Co-funded by the European Union
2023-1-ES01-KA220-VET-000158754

a) Learning objectives and outcomes

- Identify categories of psychoactive substances and explain their neurobiological effects
- Identify Harm Reduction strategies specific to substance use cases
- Analyse intersectional factors such as homelessness, gender, sex work, and trauma in substance use
- Explain the functional use of substances in different contexts to inform supportive interventions

b) Competencies addressed

Cultural Competence: Understanding the legal and sociocultural context that shapes substance use across different countries and cultures.

Analytical Skills: Analysing patterns of substance use and recognising its role in a person's life, considering their history and circumstances.

Critical Thinking: Evaluating the effectiveness of Harm Reduction strategies for different types of substance use, considering context-specific solutions.

Communication Skills: Effectively communicating findings and insights about substance use among people experiencing homelessness to diverse audiences.

c) Methodology

- Lectures and Presentations;
- Group Discussions;
- Case Studies and real-world scenarios;
- Interactive Activities;
- Multimedia Resources (Video documentaries, etc).

d) Materials

Textbooks, reports and Articles; Statistic information; Case Study Materials; Multimedia Resources; Presentation Slides; Paper and pens.

e) Infrastructure

A suitable classroom setting equipped with a projector, whiteboard, and seating arrangement conducive to group work and discussions.

Unit 1 | Psychoactive Substance Use

Section 1 | Introduction to the course and participant's introduction
Section 2 | Harm Reduction Strategies for Psychoactive Substance Use
Section 3 | Harm Reduction Strategies Aimed at People Experiencing Homelessness

Unit 1 | Psychoactive Substances

Section 1 | Introduction to the course and participant's introduction

Activity 4.1 Icebreaker "Factsheets: Truth or False?

Objective:
To help participants reflect on the effects of legal and illegal psychoactive substances, challenge common misconceptions, and encourage cooperative reasoning. By engaging in an interactive true/false exercise, they activate prior knowledge and build a foundation for deeper discussion.
All the instructions and materials for the activity are available on the Toolkit.

Section 2 | Psychoactive Substances

Definition of Psychoactive Substances and Neurobiological Interaction

A psychoactive substance is any chemical compound that, when introduced into the body, alters brain function and produces changes in perception, mood, consciousness, cognition, or behavior. This definition is based on a neurobiological framework, which is the dominant paradigm in most European health and drug policy systems. It emphasizes the interaction of substances with the central nervous system (CNS), particularly the modulation of neurotransmitters such as dopamine, serotonin, GABA, glutamate, and norepinephrine.

These neurochemical effects can lead to short-term outcomes (e.g., euphoria, alertness, sedation, hallucinations) as well as long-term consequences such as tolerance, dependence, and neuroadaptation. This perspective has shaped much of the scientific literature and clinical practice around substance use.

However, it is important to recognize that this biomedical approach is only one of many possible frameworks for understanding psychoactive substance use. Other traditions, especially Indigenous, community-based, and anthropological approaches, offer equally valid perspectives that emphasize meaning, ritual, spirituality, and social context over isolated biological mechanisms.

As Norman Zinberg (1984) stated “the effect of a drug is never the same twice, because it always depends on who is taking it, under what circumstances, and with what expectations.” This means that the same substance may produce very different effects depending on individual factors (such as mental state, physical condition, hormonal fluctuations, the phase of the menstrual cycle, sleep, nutrition), social factors (peer group, setting, stigma), and the meaning the substance holds for the user.

Furthermore, social and legal frameworks also shape substance use. As Antonio Escohotado (2004) explains “what we call a drug is not just a molecule with effects, but a cultural product shaped by fear, desire and power.” Substances are often categorized by their neurobiological action (e.g., depressants, stimulants, hallucinogens), but also by their legal status, which varies greatly across countries and historical periods.

Many of the substances that are currently prohibited or criminalized under international drug control conventions have long histories of ritual, medicinal or spiritual use in Indigenous and ancestral cultures. For example, ayahuasca in the Amazon, peyote among Native American peoples, coca leaves in the Andes, or psilocybin mushrooms in Mesoamerican traditions. Global prohibitionist policies have often erased or persecuted these practices, imposing a biomedical and punitive model that disregards non-Western epistemologies.

In a globalized world marked by high levels of mobility and migration, it is particularly important to understand that the meanings, uses and perceived risks or benefits of psychoactive substances vary significantly across cultures. What is considered therapeutic, spiritual or acceptable in one community may be seen as pathological or deviant in another. A transcultural perspective reminds us that our categories and frameworks are not neutral nor universal (Kirmayer, 2006), and that effective support requires cultural humility and contextual understanding.

It is also important to highlight that the international scheduling of substances has not always been based on scientific or public health evidence. The classification of substances under international conventions has often reflected political, colonial and commercial interests, rather than objective assessments of harm (UNODC, 2017; Nutt et al., 2010). For example, alcohol and tobacco, despite causing extensive harm, remain legal in most countries, while other substances with lower personal and social harm remain strictly prohibited.

Moreover, it is essential to recognize that substance use is not exclusively linked to harm, pathology, or suffering. For many people, using psychoactive substances is also connected to pleasure, curiosity, connection, self-exploration, creativity or even care (Duff, 2008; Moore, 2008; Pienaar & Dilkes-Frayne, 2017). Whether in celebratory, ritual, therapeutic, sexual, or everyday contexts, the pursuit of altered states is a deeply human experience. A one-sided focus on risks may obscure the reasons why people use substances in the first place and hinder our capacity to accompany them with empathy and effectiveness.

Finally, throughout this module we will not use the term "drug", due to the high degree of stigma, moral judgment, and generalization it carries. The term is often used indiscriminately to group together very different substances, uses and contexts, ranging from heroin injection to cannabis tea or antidepressant medication, thus reinforcing negative stereotypes and supporting punitive policies (Friedman et al., 2007; Keane, 2002). As several publications point out, language plays a crucial role in shaping public attitudes and institutional responses to substance use. Choosing precise, respectful and context-sensitive terms is an ethical and political decision (Room, 2005).

Understanding psychoactive substances, therefore, requires not only a biological lens, but also a historical, cultural and political perspective.

Categorization of Psychoactive Substances

The international control of psychoactive substances is based on a system of multilateral treaties developed throughout the 20th century, mainly in response to public health concerns, addiction, and the regulation of international trade. However, these conventions have also been deeply influenced by colonial, racial and geopolitical agendas, shaping which substances are considered dangerous and which populations are targeted (Bewley-Taylor, 2001; Mills, 2003). Two main United Nations treaties structure the current classification system.

The 1961 Single Convention on Narcotic Drugs

This treaty consolidated and replaced earlier drug control treaties. It primarily targets plant-based substances such as opium, coca leaf, and cannabis. The treaty aimed to eliminate non-medical use while preserving medical and scientific access (United Nations, 1961). It created four Schedules, with Schedule I and IV being the most restrictive:

Schedule	Description	Examples
Schedule I	High abuse potential, limited therapeutic value	Cannabis, cannabis resin, cocaine, morphine, opium
Schedule II	Substances with similar use to Schedule I but slightly less strict control	Codeine, ethylmorphine
Schedule III	Preparations with lower risk due to dilution or combination	Certain codeine-based medicines
Schedule IV	Substances already in Schedule I but considered especially dangerous (most restricted)	Heroin, previously cannabis and cannabis resin (until 2020)

Table 1: Schedules of the 1961 Single Convention

In December 2020, the UN Commission on Narcotic Drugs voted to remove cannabis and its resin from Schedule IV, acknowledging its medical potential. However, it remains in Schedule I (UNODC, 2020).

The 1971 Convention on Psychotropic Substances

This treaty was introduced to regulate the growing use of synthetic psychoactive substances—such as amphetamines, LSD, benzodiazepines and other drugs not covered by the 1961 Convention. Its goal was to ensure control while allowing for medical and scientific research (United Nations, 1971). It established four Schedules based on the substance's abuse potential and therapeutic value:

Schedule	Description	Examples
Schedule I	High abuse potential, no recognized medical use	LSD, MDMA, mescaline, psilocybin

Schedule II	High abuse potential, some medical use	Amphetamine, methamphetamine, methylphenidate, PCP
Schedule III	Moderate abuse potential, accepted medical use	Buprenorphine, cathine, pentobarbital
Schedule IV	Low abuse potential, widely used medically	Diazepam, alprazolam, clonazepam, zolpidem

Table 2: Schedules of the 1971 Convention on Psychotropic Substances

Video for further insight: What is the Drug War? With Jay-Z & Molly Crabapple

National Interpretations and Legal Diversity

While these international schedules serve as guidance, their application is not uniform across countries. Each nation implements the conventions through national laws, taking into account cultural, legal and political considerations (Room et al., 2010).

For example, in Spain, recreational cannabis is decriminalized for personal use in private spaces, although it remains illegal to grow, sell or consume in public. A legal grey zone has led to the proliferation of cannabis social clubs, which operate under associative and non-profit models, though their status remains ambiguous and subject to judicial interpretation (González-Rábago et al., 2020). A regulated framework for medical cannabis is currently under development, following recommendations issued by the Spanish Congress in 2022.

The regulation of cannabis in the Netherlands is characterized by a unique policy of tolerance, commonly referred to as 'gedoogbeleid'. Although the production and sale of cannabis are technically illegal, the government permits the sale of small quantities (up to 5 grams) in licensed coffee shops under strict conditions. These establishments are required to avoid causing public disturbances, must not sell to minors, and are prohibited from advertising drugs. Despite this front-door tolerance, the cultivation and wholesale supply to coffee shops remain illegal, creating what is known as the "backdoor problem." This legal inconsistency has led to debates about full legalization and regulation. To address these issues, recent pilot programs have been introduced to explore legal cannabis cultivation, aiming to ensure product quality and reduce criminal involvement (Government of the Netherlands, 2024[1]).

[1] Government of the Netherlands. (2024). "Toleration policy regarding soft drugs". [https://www.government.nl/topics/drugs/toleration-policy-regarding-soft-drugs] (https://www.government.nl/topics/drugs/toleration-policy-regarding-soft-drugs)

In Portugal, the acquisition and possession of drugs for personal use have been decriminalized since 2001 under Law No. 30/2000, of 29 November, which established the legal framework governing the use of narcotic drugs and psychotropic substances. Under this regime, possession of substances up to the quantity corresponding to the average individual consumption for a period of up to 10 days does not constitute a criminal offence. Consequently, criminal sanctions do not apply in such cases.

In 2025, Law No. 23/2025, of 7 March, amended the previous legal framework governing drug control, including amendments to Decree-Law No. 15/93, of 22 January. This reform expanded and clarified the legal definition of controlled substances, incorporating additional psychoactive substances and updating the regulatory approach to new psychoactive substances within the broader drug control system. While these substances may now be explicitly addressed within the legal definition of drugs, the decriminalization regime for possession for personal use under Law No. 30/2000 remains applicable within the established quantitative limits.

Nevertheless, administrative measures may still apply in cases of possession for personal use. These measures may include the imposition of an administrative fine and/or referral to the Commission for the Dissuasion of Drug Addiction (Comissões para a Dissuasão da Toxicodependência), where appropriate. These commissions assess the circumstances of use and may determine educational, health-related, or other therapeutic follow-up measures.

When possession exceeds the legally defined threshold corresponding to 10 days of average consumption, the situation may be assessed as potential drug trafficking, which remains a criminal offence under the applicable drug control legislation. If it is determined that the substance was intended for personal use despite exceeding the indicative threshold, the case may still be referred to the competent Commission for the Dissuasion of Drug Addiction for assessment and possible administrative follow-up.

Medical cannabis has been legal in Portugal since 2018 under Law No. 33/2018, of 18 July, and is regulated by Decree-Law No. 8/2019, of 15 January. This framework permits medical prescription of cannabis-based products for conditions such as chronic pain, epilepsy, and other pathologies when conventional therapies have proven ineffective or inadequate. The prescription is subject to medical assessment and compliance with regulatory criteria.

Dispensation of cannabis-based medicinal products is carried out exclusively through pharmacies, and only products authorized and approved by the National Authority of Medicines and Health Products (INFARMED, I.P.) may be placed on the market and dispensed.

The production and cultivation of cannabis for medicinal or scientific purposes are likewise subject to licensing and supervision by the competent national authorities.

Products containing cannabidiol (CBD) may be lawfully marketed when compliant with applicable legislation. CBD is a non-psychoactive cannabinoid present in the cannabis plant and does not automatically fall under the same control regime as narcotic substances, provided that such products comply with legal limits concerning tetrahydrocannabinol (THC) content and meet applicable requirements relating to market authorization, product classification, and consumer safety.

In Ireland, drug legislation is governed by (1) the Misuse of Drugs Act 1977, which regulates the control, possession, and distribution of controlled substances and (2) the Criminal Justice (Psychoactive Substances) Act 2010. Under the Misuse of Drugs Act. Anyone found in possession of Cannabis or Cannabis resin is considered guilty of an offence. From 2020, Cannabis possession may be treated under the Adult Cautioning Scheme. This permits the possession of Cannabis or Cannabis resin to be treated with a simple caution under the Adult Cautioning Scheme rather than an offense.

It is important to note that it still remains an offense to possess controlled drugs without a prescription; individuals may face more severe charges if they are found with a quantity of drugs deemed to be for sale or supply, regardless of whether a sale has occurred or not. Currently the problem of drug misuse in Ireland is tackled in a coordinated and integrated strategy welcome development, 2017-2025: Reducing Harm, Supporting Recovery. This is a national, health-led response to drug and alcohol use in Ireland that was developed following a broad and open public process of consultation across the country.

In 2019 Ireland also introduced legislation that led to the establishment of the Medical Cannabis Access programme for a trial basis for 5 years. This programme permitted doctors to prescribe cannabis treatment for certain medical conditions. This follows strict rules for prescribing Cannabis based products safely for eligible patients. In 2023 additional cannabis based products for medical use were permitted under the Misuse of Drugs (Prescription and Control of Supply of Cannabis for Medical Use)(Amendment)(No. 2) Regulations 2023.

Classification by Neurobiological Mechanism of Action

Category	Examples	Main Effects
Depressants (CNS depressants)	Alcohol, benzodiazepines, opioids	Sedation, muscle relaxation, pain relief, reduced anxiety, impaired cognition
Stimulants	Cocaine, amphetamines, nicotine, caffeine	Increased alertness, euphoria, energy, reduced appetite
Hallucinogens (classical psychedelics)	LSD, psilocybin, mescaline	Altered perception, hallucinations, synesthesia, emotional shifts
Dissociatives	Ketamine, PCP	Detachment from self and environment, analgesia, derealization
Cannabinoids	THC (from cannabis)	Euphoria, altered time perception, relaxation, anxiety (in some users)
Empathogens / Entactogens	MDMA (ecstasy)	Emotional openness, increased empathy, sociability, sensory enhancement

Table 3: Neurobiological Classicification of Psychoactive Substances

Another widely used system for categorizing psychoactive substances focuses on their effects on the central nervous system (CNS) and the neurotransmitter systems they modulate. This classification is common in clinical and educational contexts and helps to understand pharmacological risks, interactions, and subjective experiences.It is important to note that psychoactive substances do not always produce the same effects in all people or in all contexts. While categorizing them into depressants, stimulants, hallucinogens, etc., is useful for pedagogical purposes, these classifications can become reductive if not critically examined. Many substances produce a range of effects that can shift depending on dosage, individual physiology, and social or emotional context.

For example, alcohol is pharmacologically classified as a central nervous system depressant. However, at low doses and in stimulating environments (e.g., parties), it often produces disinhibition, talkativeness and a temporary sense of euphoria, which can mimic the effects of a stimulant. As blood alcohol levels rise, sedation and motor impairment become more evident, and the depressant effects dominate. This biphasic effect is not exclusive to alcohol; many substances exhibit dose-dependent reversals or amplifications of their effects.

Furthermore, under multiple drug addiction (policonsumption), substances may mask, enhance, or unpredictably interact with one another. A person combining a stimulant (e.g., cocaine) with a depressant (e.g., alcohol) may feel “balanced,” yet the physiological stress on the body is significant and can be dangerous (e.g., formation of cocaethylene in the liver). These interactions challenge the idea of fixed, stable categories and highlight the need for nuanced knowledge in harm reduction.

Finally, the effect of any psychoactive substance is co-produced by multiple factors, including:

- The substance itself (chemical composition, purity, dose),
- The person (tolerance, neurobiology, mental health, hormonal cycle),
- The context (physical environment, emotional state, expectations, social dynamics).

This interplay is often described using the ‘drug, set and setting’ model (Zinberg, 1984), which remains a foundational framework in understanding psychoactive experiences. In this sense, it is important to emphasize that the aim of this training is not only to present the characteristics of psychoactive substances themselves, but also to explore the relationship that people establish with them, which frames both the relevance and the intention of this professional and educational work.

New Psychoactive Substances (NPS)

A separate and evolving category includes what are known as New Psychoactive Substances (NPS). These are synthetic or semi-synthetic substances that are not listed under the 1961 or 1971 UN Conventions but may pose public health risks and are often marketed as “legal highs,” “research chemicals,” or “designer drugs.”

According to the United Nations Office on Drugs and Crime (UNODC): “a new psychoactive substance is any substance in pure form or in preparation that is not included in the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances but that may pose a threat to public health.”. (UNODC, 2013)

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines NPS similarly in Council Decision 2005/387/JHA: "'new psychoactive substance' means a new narcotic drug or a new psychotropic drug in pure form or in a preparation […] that has not been scheduled under the 1961 United Nations Single Convention on Narcotic Drugs, and that may pose a threat to public health comparable to substances listed in Schedule I, II or IV."

The EMCDDA and UNODC identify six main families of emerging substances (EMCDDA, 2011; 2013): Phenethylamines, Tryptamines, Piperazines, Synthetic cathinones, Synthetic cannabinoids and Other substances (e.g., designer benzodiazepines, novel opioids, dissociatives). These substances vary widely in effect and risk profile. Their rapid proliferation and lack of long-term studies make them a key challenge for harm reduction and policy.

NPS present a growing challenge in the Netherlands due to their rapid development and legal ambiguity. These substances are designed to mimic the effects of traditional drugs like MDMA or cannabis but are often chemically distinct enough to avoid immediate classification under existing drug laws. As a result, they can be legally sold until they are specifically banned. The Dutch government has adopted a reactive approach, adding harmful NPS to the Opium Act once they are identified and evaluated. (The Opium Act is the Dutch national drug law that regulates the possession, production, and trade of controlled substances.)

However, this process often lags behind the appearance of new substances on the market, raising concerns about public health and safety. To improve control, the Netherlands is considering a generic ban approach and works closely with the EU Early Warning System to monitor emerging NPS trends (Trimbos Institute, 2023).

Understanding Use Through Function: When Substances Help to Survive

TTo fully grasp psychoactive substance use, especially from a harm reduction and social care perspective, it is essential to move beyond asking "What is being used?" or "What category does it belong to?" and begin asking "What function does this substance serve in this person's life?"

As Zinberg (1984) already established in his model of drug, set and setting, the effects of substances cannot be separated from the person's internal state and surrounding environment. However, beyond understanding effects, it is equally important to analyze why someone uses a given substance, at a given time, and for what purpose. Substance use is rarely arbitrary, it often responds to unmet needs, systemic failures, or the search for bodily or emotional regulation (Duff, 2014).

In the case of people experiencing homelessness or housing exclusion, psychoactive substances often fulfill pragmatic, affective or survival functions. As evidenced by research in multiple contexts (*Fountain & Howes, 2002; Pauly, 2011*), substances are used to:

- Stay awake and alert in unsafe environments,
- *F*all asleep in harsh outdoor conditions,
- Cope with physical pain, cold or hunger,
- Manage trauma, loss or hypervigilance,
- Sustain a sense of routine, connection or temporary relief.

In this sense, homelessness is not just a “context” but a structural condition that transforms the meaning and function of use (*Bourgois & Schonberg, 2009*). This transformation is not necessarily a “pathology,” but rather a rational adaptation to structural violence.

As Duff (2007) proposes, we must see drug use as a social practice embedded in assemblages of meaning, space and survival, rather than an isolated behavior. Interventions rooted in harm reduction and social justice must therefore:

- Understand the logic of survival behind some uses,
- Avoid moral or diagnostic readings of consumption,
- Focus on modifying the conditions of life, not just the substance itself.

This is especially urgent when housing, health and care systems fail to provide protection or continuity. As the Latin American Network of People Who Use Drugs (LANPUD) puts it: “the use of substances in contexts of structural vulnerability is often the only possible way to stay alive. Condemning that use without changing the structures that generate it is profoundly violent.” (LANPUD, 2022)

Substances may be used to increase stamina, disinhibit, block fear or emotional distress, or even create boundaries between the worker's body and the transaction (Fung, 2020; Benoit et al., 2017). For some, they serve to sustain night work, for others to cope with humiliation, repetitive acts or threats. In each case, what is consumed is tightly linked to what the working context demands.

In practice, understanding the function of substance use allows professionals to better interpret behaviours and respond appropriately. For example, a person experiencing homelessness may use stimulants to stay awake while sleeping on the street, where remaining alert can be a matter of safety; in this case, the role of the professional is not to immediately discourage use, but to acknowledge its survival function and explore safer alternatives or support options. Similarly, a person may use alcohol daily as a way to cope with trauma or emotional distress; here, the substance plays a role in emotional regulation, and interventions should focus on building trust, reducing harm, and offering support without imposing abstinence. In other situations, a person may combine substances such as cocaine and benzodiazepines to balance stimulation and anxiety; this pattern reflects an attempt at self-regulation, but also carries significant risks due to unpredictable interactions, which professionals can address through information, safer use strategies and a non-judgemental approach.

Activity 4.2. "Fortune Wheel" on Psychoactive Substances / Interaction

Objective:

To support participants in integrating basic knowledge about the effects and legal classification of various psychoactive substances, while beginning to reflect on the function they may serve in people's lives. This activity combines factual learning with social and ethical analysis.

All the instructions and materials for the activity are available on the Toolkit.

Unit 2 | Harm Reduction Strategies for Psychoactive Substance Use

Unit 2 | Harm Reduction Strategies for Psychoactive Substance Use

Section 1 | Types of Aministration Routes of Psychoactive Substances

Harm reduction (HR) is a public health approach that aims to minimize the negative health and social consequences of psychoactive substance use without requiring abstinence. In the European context, it has evolved as a pragmatic response to complex realities, emphasizing dignity, inclusion, and evidence-based interventions (EMCDDA, 2024; Correlation Network, 2023). The route by which a substance is consumed plays a crucial role in shaping both the risks involved and the type of harm reduction response needed (UNODC, 2023).

Patterns of psychoactive substance use across Europe are shifting. While injection was historically the main concern, other routes such as smoking, snorting, and oral ingestion are increasingly common in diverse contexts (EMCDDA, 2023). These shifts are influenced not only by personal preference or cultural factors, but also by the chemical form in which substances are available. For example, cocaine hydrochloride is typically snorted, whereas crack cocaine is smoked. An important distinction, as the physical properties of each substance determine the route of administration and thereby influence harm profiles and access to harm reduction tools (HRI, 2021).

Gender, migration status and social context may influence access to harm reduction services and should be considered in practice.

Injecting route

Injecting substances intravenously remains one of the most high-risk routes of administration, associated with a greater incidence of infectious diseases such as HIV and hepatitis C, as well as overdoses, vein damage, and social exclusion. Harm reduction responses across Europe have historically focused on this route, developing a robust set of interventions that remain essential today.

1. Needle and syringe programs (NSP)

Are the cornerstone of harm reduction for people who inject substances. These programs distribute sterile injection equipment (needles, syringes, cookers, filters, water ampoules, and disinfectants) aiming to reduce the transmission of blood-borne viruses. As of 2023, all EU countries and Norway have some form of NSP, but only seven meet the WHO-recommended level of 200 sterile needles per person who injects substances per year, revealing important gaps in coverage (EMCDDA, 2023). Access is also geographically uneven: availability is higher in major urban centres than in rural areas. In prisons, access is even more restricted; only Spain, Luxembourg and one women's facility in Germany provide NSPs (EMCDDA, 2023).

Despite the overall success in reducing HIV rates among people who inject substances in Europe, challenges remain. Outbreaks of HIV linked to injection of stimulants (e.g., methamphetamine or cocaine) have occurred in at least seven cities across six countries in the last decade (HRI, 2021). These cases highlight the need to adapt NSP delivery to patterns of high-frequency injection and to ensure unrestricted access to materials (e.g., by avoiding 'one-for-one' exchange limits)

2. Opioid agonist therapy (OAT)

Such as methadone or buprenorphine is a second pillar of harm reduction for people who inject opioids. OAT reduces the need to inject, stabilizes individuals, and helps prevent overdose. All EU countries provide some form of OAT, but coverage varies widely, especially in Eastern Europe, where bureaucratic, geographic or political barriers persist (HRI, 2021). In prisons, OAT is often unavailable or interrupted, which undermines treatment continuity and increases risk upon release. WHO and ECDC guidelines recommend offering OAT and NSPs simultaneously, both in the community and in custodial settings, to maximize effectiveness (EMCDDA & ECDC, 2022).

3. Drug consumption rooms (DCRs)

Provide hygienic and supervised environments where people can inject substances using sterile materials, with trained staff present to respond in case of emergency. DCRs aim to prevent fatal overdoses and reduce disease transmission while offering pathways to social and health services. As of 2024, 13 EU countries and Norway host DCRs, with 12 in Spain, 25 in Germany, and growing implementation in Portugal and Greece. While initially focused on injection, many now include inhalation spaces and offer on-site drug checking (EMCDDA, 2023). Evidence shows that DCRs do not increase local crime or use, and they improve survival and service engagement among marginalized populations (HRI, 2021).

In the Netherlands, the NGO De Regenboog Groep has recently launched a mobile users' bus ("gebruikersbus") near Amsterdam's Oosterpark, providing a low-threshold harm reduction service for people using drugs and experiencing homelessness. Operating daily from 11:00 to 17:00, the bus, supervised by trained professionals, accommodates up to six individuals at a time, offering coffee, tea, soup, wash facilities, hygienic spaces for safe syringe disposal, and referrals to addiction care, shelters, or overseas repatriation services. Although it does not distribute drugs, this pilot initiative—running through the end of 2025—helps reduce public drug use and street-level nuisance and supports engagement with care services, aligning with harm reduction principles promoted by the European Harm Reduction Network.

4. Overdose prevention and naloxone distribution

Have become a priority in Europe, especially with the increasing presence of potent synthetic opioids. Naloxone is an opioid antagonist that reverses respiratory depression in overdose situations. Community-based take-home naloxone programs exist in at least seven countries (Germany, Estonia, Ireland, France, Italy, Lithuania, Norway), with others running local pilots (EMCDDA, 2023). Several countries (France, Italy, Sweden, Denmark) allow over-the-counter sales of naloxone. Yet access remains inconsistent, and training of peers and frontline workers is not always widespread. Responding to synthetic opioids like fentanyl may require multiple doses and ventilatory support. For instance, in Portugal, grassroots activism and harm reduction organizations have since 2019 enabled regular access to naloxone through outreach teams in Lisbon and O'Porto. These teams distribute naloxone directly to people who use drugs and to local community actors, usually with brief street-based training and periodic refreshers, or through more extensive training events (e.g. annually on 31 August, Overdose Awareness Day). Although not yet formally regulated, this initiative is consolidated in practice, and steps are being taken with governmental health and addiction authorities to integrate it into the forthcoming national drug strategy.

Moreover, access to harm reduction in prisons is still extremely limited in most countries, despite the high prevalence of injecting use in these settings.

Finally, gender and migration are crucial dimensions often overlooked in injecting-related harm reduction. Women who inject may face stigma, gender-based violence, and structural invisibility in male-dominated services (EHRA, 2020). Migrants may lack documents, fear law enforcement, or not speak the local language, all of which hinder access to sterile materials and care. Tailoring interventions to their realities (through gender-responsive, low-threshold, peer-led outreach) remains essential to reduce inequalities in health.

Inhaled route

Inhaling psychoactive substances (through smoking or vaporizing) is becoming more common in many parts of Europe. This route includes the use of crack cocaine, heroin ("chasing the dragon"[1]), methamphetamine, catinones, cannabis, or synthetic cannabinoids. While traditionally considered less risky than injection in terms of blood-borne infections, the inhaling psychoactive substances carries its own health harms: pulmonary damage, burns, tuberculosis transmission, and overdoses, especially in the context of stimulant use or adulterated substances. This is currently in the dutch prison system a growing problem. Especially problematic because of difficulties with dosage (when its impregnated on paper).

Harm reduction services have documented a significant increase in the number of people who smoke crack or heroin, especially among people experiencing homelessness or social exclusion. In response, many European cities have begun to implement safer smoking kits that include heat-resistant pipes, foil, personal mouthpieces, disinfecting wipes, lip balm, and educational materials. These kits aim to reduce injuries (cuts, burns), prevent transmission of infections via shared equipment, and promote non-injecting practices among people who may otherwise be forced to inject due to lack of alternatives (HRI, 2021).

1. Safer Smoking Kits

Safer smoking kits aim to reduce the health risks associated with improvised or shared smoking tools. These kits may include heat-resistant glass or metal pipes, personal mouthpieces, aluminum foil for heroin inhalation, lip balm, disinfectant wipes, filters, and educational leaflets. By offering safer and cleaner materials, these kits help prevent oral injuries, reduce the risk of infection (such as HCV or TB), and promote non-injecting use when possible (HRI, 2021). They are also essential for supporting people who prefer not to inject or who have deteriorated veins due to chronic injection use.

Despite their effectiveness, the provision of safer smoking materials remains limited. At least ten countries in Western Europe, including Spain, Germany, France, Portugal, and the Netherlands, provide such kits to varying degrees. However, legal restrictions on paraphernalia and the absence of stable public funding are common obstacles (HRI, 2021). For example, in the United Kingdom, only aluminum foil is legally permitted for distribution by harm reduction services. Nevertheless, pilot projects in several areas are working with local authorities to distribute crack pipes discreetly and document outcomes.

It is also essential to recognize that the objects associated with each route of administration carry distinct symbolic and cultural meanings. A syringe is widely understood as a medical instrument, often distributed and accepted as such by people who inject substances. In contrast, the pipe used for inhalation is typically a domestic or improvised tool, and its meaning varies widely depending on the person's context, experience, and history. Simply distributing sterile pipes does not guarantee their use. The transition from homemade to hygienic equipment must be accompanied by respectful, comprehensive, peer-informed education that validates users' knowledge. Pipes are not just tools. They are part of people's identity and carry embedded practices and survival strategies. Harm reduction must honour these narratives and avoid homogenizing diverse user experiences under a one-size-fits-all approach.

The structure and design of a pipe can vary greatly depending on the substance being consumed, the cultural background of the person, and the materials available in their environment. Pipes are made from a wide range of objects (glass, metal, plastic, ceramics) and are often shaped by necessity, creativity, and resourcefulness. It is crucial not to impose a biomedical standard without dialogue. Instead, materials for safer smoking should be co-created with users, drawing on both lived experience and academic or professional knowledge. Even when sterile pipes are distributed, they should not take away from the fact that the user still has the ability to make their own choice's and decide whether they engage in the practice of smoking.. In fact, crafting one's own pipe can itself be a harm reduction strategy: slowing down the act of consumption, encouraging attention to the condition of the material, and creating moments of self-regulation. Recognizing this process as meaningful is key to building effective and respectful harm reduction practices.

2. Drug ConsumptionRoom (DCRs) for Inhalation

Several cities in Europe have adapted their supervised consumption rooms to include ventilated spaces for inhalation. These spaces are particularly relevant for people who smoke crack, heroin, or methamphetamine and who are often excluded from traditional injecting-focused services. Facilities in Barcelona, Lisbon, and Paris have incorporated inhalation rooms, helping to prevent public use, reduce exposure to violence or criminalization, and increase access to health and social support (EMCDDA, 2023). In some centers, drug checking is also available on-site.

3. Preventing the Transition to Injecting

One of the key benefits of harm reduction for the inhaled route is its potential to prevent the transition to injecting. People may shift to injection due to reasons such as tolerance, economic pressure (greater efficiency), vein access, or social influence. Providing safer smoking materials and dedicated spaces can delay or avoid this transition, especially when people are at early stages of use or concerned about injection-related stigma or risks. Studies have shown that when services distribute smoking kits and educate people on safer inhalation, the likelihood of initiating injecting decreases significantly (HRI, 2021; EMCDDA, 2023).

Across several European contexts, frontline professionals and community organizations have observed a clear shift in visibility and consumption patterns related to the inhaled route. Unlike injecting, smoking substances often occurs in less visible, less publicly alarming ways (such as the use of aluminum foil or small, improvised pipes) which can lead to a false perception of reduced risk both socially and institutionally. This invisibility poses challenges for outreach, data collection, and the design of responsive services. When indicators like discarded syringes are no longer reliable, programs must adapt their methods for identifying needs and engaging with users (Aranda, 2023).

Many harm reduction services were originally designed for injecting use and may not fully address the needs of people who smoke substances, requiring adaptation of tools and interventions.

Crucially, failing to recognize and respond to this shift can result in unintended harms. For instance, in contexts where safer smoking materials are not available or where the inhaled route is culturally or economically inaccessible, some people may turn to injection despite perceiving it as more dangerous.

Sniffing Route

The sniffing or snorting route of administration is frequently used for substances such as cocaine hydrochloride, ketamine, amphetamines, synthetic cathinones, and crushed prescription medications (e.g., benzodiazepines or opioids). It offers a rapid onset of effects due to high vascularization of the nasal mucosa, but also poses specific health risks: mucosal damage, perforation of the nasal septum, chronic sinusitis, and—especially when sharing equipment—the transmission of infections like hepatitis C (EMCDDA, 2023; CATIE, 2022).

1. Safer Sniffing Kits

Several harm reduction initiatives have begun distributing safer sniffing kits to reduce injury and infection. These typically include individual straws (plastic, glass, or cardboard), small clean cards to crush powder, saline solution or seawater spray for rinsing nasal passages, tissues, and educational materials. The aim is to reduce nasal trauma and discourage sharing of equipment—particularly important given the documented presence of blood microparticles in shared sniffing implements (CATIE, 2022). These kits are still limited in availability, often provided only by grassroots organizations or pilot programs.

The shape and material of sniffing devices vary greatly depending on culture, setting, and substance. In many places, users craft their own devices from familiar or improvised objects. As with pipes, these tools can carry meaning, identity, and autonomy. Simply distributing sterile straws is not enough, especially when these materials don't match people's established habits or make them feel infantilized or surveilled. As with smoking equipment, co-design processes between users and services are recommended, respecting experiential knowledge and fostering ownership.

2. Nasal Hygiene and Education

User education is essential to minimize nasal harm. Harm reduction services advise people to finely crush powders to reduce abrasion, alternate nostrils during sessions, and avoid use when there are visible nasal wounds or bleeding. Cleaning the nose with saline after consumption can reduce infections and inflammation. Moisturizing the nasal mucosa can also prevent cracks and ulcers. These recommendations are often shared informally, but formalized, peer-led interventions could significantly reduce cumulative nasal damage.

3. Avoiding Risky Combinations and Dosing Practices

The rapid effect of many snorted substances can lead to repeated dosing and intense binge patterns. This is particularly true for stimulants like cocaine or methamphetamine, which may be combined with depressants (e.g., alcohol or benzodiazepines) to manage the comedown. However, these combinations can mask symptoms of overdose and increase toxic load, such as the production of cocaethylene when alcohol and cocaine are mixed. Harm reduction messaging should address these dynamics, encouraging safer pacing, dosing awareness, and the use of drug checking when possible.

Oral Route

The oral route is one of the most common and socially accepted forms of substance use. It involves the ingestion of pills, capsules, liquids, edibles, and homemade preparations, and can be applied to nearly all types of psychoactive substances (including opioids, stimulants, depressants, psychedelics, alcohol, and newer synthetic compounds) (UNAD, 2022; Merkinaite et al., 2010).

Absorption through the gastrointestinal tract is significantly slower compared to other routes, but the effects tend to be longer-lasting and sometimes more intense. This slow onset may lead to premature re-dosing, especially among less experienced users, increasing the risk of overdose —particularly with substances such as MDMA, LSD, GHB/GBL, or synthetic opioids (Curto et al., 2020).

In recent years, the oral route has become increasingly visible in harm reduction services—not only due to alcohol use, but also because of the growing presence of GHB/GBL, cannabis edibles, and the non-medical use of psychopharmaceuticals, including diverted prescriptions and illicit market products. These patterns may be more common in contexts of vulnerability and should be considered in intervention.

In addition, some culturally specific substances consumed through the oral route require tailored harm reduction responses. Khat (qat) and N20, whose fresh leaves are chewed for their stimulant effects, is commonly used in East African and Arabian Peninsula communities. Its use can produce increased alertness and reduced appetite, but prolonged consumption may lead to insomnia, gastrointestinal problems, dental damage, and psychological distress. Because it is often used in long social sessions, sometimes combined with tobacco or sugary drinks, harm reduction strategies should include promoting hydration, oral hygiene, and awareness of extended use patterns, while approaching its use with cultural sensitivity.

1. Dosing Awareness and Onset Delays

One of the most frequent risks of oral consumption is unintentional overdose due to delayed onset. Substances taken orally may take between 30 and 90 minutes to produce psychoactive effects. In this window, users may take additional doses believing the initial dose was ineffective. Educational campaigns emphasize the importance of patience, body awareness, and waiting times (Merkinaite et al., 2010).

2. Encapsulating Doses for Safer Ingestion

A recommended harm reduction strategy for powdered substances is the use of gelatin capsules to dose individual quantities in a precise and hygienic manner. This avoids the risks associated with directly ingesting from a bag or using makeshift wrappers like cigarette rolling paper (bombetas), which can lead to uneven absorption and accidental overdose (UNAD, 2022).

3. Use of Droppers or Liquid Dosers

For substances that are liquid at room temperature—such as GHB or GBL—accurate dosing is essential due to their potency and the small volume required to produce effects. Droppers, oral syringes, or measured caps are recommended tools to avoid overdose. Measuring doses by "capfuls" or guessing by eye increases the risk of severe intoxication. This is particularly relevant in chemsex contexts, where GHB/GBL is common (Curto et al., 2020).

4. Safe Preparation and Measurement of Edibles and Natural Substances

The oral route also includes homemade or natural preparations such as cannabis edibles (cookies, brownies, teas) and psychedelic mushrooms. In the case of edibles, the effects are delayed and can last up to 8 hours or more, making them particularly prone to accidental overconsumption. Harm reduction programs should promote awareness of how to cook and dose cannabis properly, and provide access to accurate scales for weighing mushrooms or truffles, as the dosage threshold can be narrow (Parés & Bouso, 2015).

5. Hydration, Temperature and Environmental Safety

Substances like MDMA or methamphetamine, often used in nightlife contexts, can lead to dehydration, overheating, and electrolyte imbalance. Harm reduction strategies should include guidance on hydration, cooling, and recognition of serotonin syndrome symptoms, especially in festival or club settings (UNAD, 2022).

6. Monitoring Interactions and Polyconsumption

Oral use is frequently combined with other substances, increasing the complexity and risks. Common combinations include alcohol with benzodiazepines, stimulants with antidepressants, or opioids with pregabalin. These interactions can result in sedation, respiratory depression, or hepatic toxicity (Carrasco-Garrido et al., 2021). In addition, intoxication may also occur through the oral route when substances are consumed in higher doses than prescribed, as in the case of methadone, where excessive intake can result in a fatal overdose."

7. Cultural Patterns and Shifts in Use

In some contexts, users may shift from illegal to legal substances (e.g., alcohol or prescription drugs) due to stigma, cost, or accessibility. These transitions are not necessarily safer and may entail risks of dependence or organ damage. Harm reduction must respond with culturally sensitive and non-punitive approaches (Pleace & Lloyd, 2022).

8. Gender, Autonomy and Invisibility

Women, gender-diverse people, and others in vulnerable situations may favor the oral route as a discreet and socially acceptable way of consuming substances. However, this can lead to institutional neglect if programs are not adapted. Gender-sensitive harm reduction must include peer-led support and reproductive health integration (Meroño, 2019; Sales & Guijarro, 2017).

Activity 4.3: Video Forum and material for safer consumption showcase

Objective:

To deepen participants' understanding of practical harm reduction strategies for different routes of administration, build empathy by engaging with real-life experiences of people who use substances, and familiarise them with safer use materials and their functions through direct interaction.

All the instructions and materials for the activity are available on the Toolkit.

Section 2 | More Harm Reduction Strategies

Drug Checking

Drug checking is a harm reduction intervention that allows people who use drugs to analyze the content and composition of substances they intend to consume. It includes qualitative and, in some cases, quantitative testing, offering critical information about the presence of active substances, adulterants, unexpected compounds, and potency. While drug checking has long been associated with recreational settings—such as festivals or nightclubs—it is increasingly recognized as a vital strategy for populations in vulnerable situations, particularly in urban contexts where street-based consumption and polyuse are common (Measham, 2020; EMCDDA, 2021).

For people using drugs in conditions of exclusion (homelessness, mental health distress, or structural violence), drug checking plays a particularly protective role. Contrary to common assumptions, these populations are not necessarily in direct contact with drug dealers. In many cases, users on the street cannot choose who they buy from and are far less likely to question or challenge sellers about substance composition (Aranda-Rodriguez, 2022). This dynamic makes it even more urgent to provide accessible, anonymous, and non-punitive testing services that empower users with knowledge, not blame. Whereas in nightlife contexts some dealers may feel socially or reputationally constrained by the presence of drug checking services, this pressure does not exist in the same way in street markets—leaving users more exposed to unpredictable substances, unknown cuts, and extreme potency variations (Vidal Giné et al., 2021).

The emergence of Novel Psychoactive Substances (NPS) has made drug checking not just helpful, but life-saving. NPS are often sold as more common substances (e.g., MDMA, cocaine, benzodiazepines) and may appear in powders, pills, or liquids with no visible difference to the user. Many NPS are highly potent and poorly understood, with unpredictable pharmacological effects and narrow safety margins (EMCDDA, 2021; Brunt et al., 2017). Identifying these substances before use allows for informed decision-making, dosage control, and the potential to avoid highly dangerous compounds. Equally important is the detection of adulterants, such as levamisole in cocaine (linked to immune suppression and tissue damage), caffeine in MDMA (which can amplify cardiovascular stress), or synthetic cannabinoids in herbal products (with severe neuropsychiatric risks) (Tanner-Smith, 2006; Brunt et al., 2017). Recent alerts in the Netherlands, for example, have reported counterfeit oxycodone tablets containing highly dangerous nitazenes still circulating on the market, further underlining the critical role of drug checking in preventing fatalities (Trimbos Institute, 2024).

For drug checking to successfully work as a true harm reduction strategy, communicating the results clearly and respectfully to users is essential. This means not only reporting the presence or absence of expected substances but also engaging users in meaningful dialogue about what those results imply. A high-quality feedback process should include explanations of health risks, potential interactions, and tailored advice about safer use or avoidance (Martins et al., 2017). When services take the time to explain results in an accessible, non-judgmental way, they build trust and support users' capacity for self-protection.

In recent years, the development of rapid test strips for fentanyl and nitazenes has expanded the scope and urgency of drug checking. These strips allow users and outreach teams to detect the presence of these highly potent synthetic opioids—often invisible to the naked eye—in powders, pills or even crack or meth samples. The spread of fentanyl and nitazenes into non-opioid markets (e.g. counterfeit benzodiazepines or stimulants) has led to fatal overdoses among unsuspecting users (CDC, 2023; D'Anci et al., 2023).

Test strips, used on residue or dissolved samples, offer a low-cost, fast and scalable way to intervene. In community settings, especially among people who inject drugs or use in public spaces, distributing and training on these strips is now seen as a frontline overdose prevention measure (Harm Reduction International, 2023).

Take-Home Naloxone

Take-home naloxone (THN) programs are one of the most effective and widely implemented harm reduction interventions for preventing opioid overdose deaths. Naloxone is an opioid antagonist that rapidly reverses the effects of opioids, especially respiratory depression, which is the primary cause of death from overdosing. When administered intramuscularly or intranasally, naloxone can restore normal breathing within minutes, buying critical time for emergency services to arrive. THN programs aim to place this lifesaving tool in the hands of people who are most likely to witness an overdose: people who use opioids, their peers, family members, and frontline workers.

The logic of THN is simple and powerful: deaths from opioid overdose are preventable, and many occur in the presence of others who could intervene if they had access to naloxone and knew how to use it (WHO, 2014). Unlike traditional emergency responses, THN decentralizes the intervention and builds community capacity to act before it's too late. Studies from multiple countries have shown that THN programs significantly reduce mortality and increase the likelihood that overdoses are responded to quickly and effectively (McDonald & Strang, 2016).

In Catalonia, the Programa de Provisión de Naloxona (Naloxone Distribution Program), coordinated by the Agència de Salut Pública de Catalunya, is a longstanding and internationally recognized example of successful THN implementation. It began in 2009 with the goal of integrating naloxone provision into low-threshold services, including harm reduction centers (centres de reducció de danys), drug treatment facilities, and mobile outreach units. Since its inception, thousands of naloxone kits have been distributed, accompanied by brief training sessions on overdose recognition, response, and intramuscular administration.

What distinguishes the Catalan program from others is its public health integration and continuous evaluation. Naloxone is prescribed and dispensed within a public health framework, and data is systematically collected on its distribution, use, and outcomes. Training materials are adapted to various populations, including people who use heroin, methadone patients, and families. The program emphasizes non-judgmental dialogue, practical simulations, and trust-building, which has helped overcome initial reluctance among some users and professionals (Ventura et al., 2018).

Another strength of the Catalan model is its peer-based approach. Many of the overdose reversals reported have been performed by people who use drugs themselves, demonstrating the program's reach and the importance of treating users as agents of care rather than passive recipients of services. This challenges stigma and empowers communities to protect one another. The Catalan case also illustrates that overdose prevention does not depend on abstinence: many people who carry and use naloxone are still active users, and their engagement in carrying naloxone is central to harm reduction success.

In recent years, the Catalan program has also included training on fentanyl overdose, recognizing the growing presence of synthetic opioids in European markets. While fentanyl is still rare in street heroin in Spain, preventive education and preparation are essential given the devastating impact fentanyl has had in other contexts (e.g., North America). In the United States, for instance, fentanyl and its analogues have become the main driver of the opioid crisis, contributing to more than 70,000 overdose deaths annually. Its high potency, frequent adulteration of heroin and counterfeit pills, and rapid spread across drug markets have made fentanyl a central public health emergency."[1]

[1] Trainers are advised to review the most recent data on fentanyl and other synthetic opioids in Europe before delivering this session, as the situation may evolve rapidly.

Managed Alcohol Programs (MAPs)

Managed Alcohol Programs (MAPs) are harm reduction interventions designed to support people with severe alcohol dependence, particularly those experiencing homelessness or extreme marginalization. Alcohol is often the most common substance associated with long-term homelessness. Instead of requiring abstinence, MAPs provide measured doses of beverage alcohol (usually wine or beer) at regular intervals throughout the day in a controlled and supervised setting. These programs aim to stabilize consumption patterns, prevent harmful withdrawal, reduce binge use and non-beverage alcohol consumption, and engage participants with broader health and social services.

MAPs originated in Canada in the early 2000s and are now gaining attention internationally. A growing body of evidence shows that MAPs reduce hospitalizations, emergency service use, alcohol poisoning, criminal justice contact, and consumption of toxic alternatives like hand sanitizer or cleaning products (Pauly et al., 2018). Participants report improved quality of life, housing stability, mental health, and social reintegration (Stockwell et al., 2017).

In recent years, countries in Europe have begun piloting MAPs adapted to their local contexts. A noteworthy example is Ireland, where in 2021–2022, Dublin launched the country's first Managed Alcohol Programme as a collaborative effort between the Health Service Executive (HSE), the Peter McVerry Trust (a housing and homeless organization), and Dublin Region Homeless Executive. The pilot targeted individuals in emergency accommodation with severe alcohol dependence who had not been successful in abstinence-based services and were at high risk of harm from their drinking patterns (HSE, 2022).

The Irish MAP offered private rooms within a supported housing facility, where participants received controlled doses of alcohol every 90 minutes under the supervision of trained staff, along with access to medical care, psychosocial support, meals, and case management. Evaluation of the pilot indicated significant improvements: participants reduced overall alcohol intake, experienced fewer emergency hospital admissions, had better medication adherence, and reported improved sleep and well-being. Importantly, none of the participants returned to rough sleeping during the program. The project was guided by the principle of housing first, with harm reduction embedded as a core philosophy (HSE, 2022).

Critics sometimes argue that MAPs "enable" alcohol use, but this critique ignores the complex realities of structural vulnerability, trauma, and exclusion. For many participants, abstinence is neither realistic nor safe in the short term. In such cases, chaotic and unsupervised use leads to repeated overdoses, police encounters, and deteriorating health. By contrast, MAPs provide structure, trust, and opportunities to reconnect with care systems. As the Irish pilot demonstrated, MAPs can act as a gateway to stability, not a resignation to long-term drinking.

Psychoeducation and Emotional Support for Psychedelic Use

Psychedelics such as LSD, psilocybin, mescaline or 2C-B are typically not associated with physical toxicity or dependence. However, they can provoke intense psychological effects—euphoria, altered perception, emotional release, or existential anxiety—that are highly sensitive to "set and setting". Harm reduction for psychedelics therefore focuses not only on pharmacological information, but also on psychoeducation and emotional accompaniment: preparing people before the experience and supporting them during or after if needed.

This educational and therapeutic approach aims to reduce the likelihood of distressing experiences (commonly called "bad trips") and to foster integration afterwards. Key messages include understanding the substance's duration and intensity, using in safe environments with trusted people, and avoiding use when emotionally unstable or in unsafe surroundings (Bedi et al., 2022). Psychoeducation also includes warning against mixing psychedelics with other substances, especially alcohol or stimulants, and it encourages grounding strategies such as hydration, breathwork, and having a sober "sitter" present.

An international reference in this field is Kosmicare, a pioneering harm reduction project launched in Portugal in 2002. Originally created by a group of psychologists, therapists and harm reduction professionals, Kosmicare began as an on-site intervention service at Boom Festival, one of Europe's largest psychedelic music events. It has since developed into a broader model of crisis intervention and emotional care in drug use settings, blending harm reduction with psychological containment and trauma-informed care (Martins et al., 2017).

At Boom Festival, Kosmicare sets up a dedicated space near the medical tent where people experiencing difficult psychedelic journeys can come voluntarily (or be brought by friends or security). The service is non-medical and non-coercive: its primary tools are empathetic listening, reassurance, physical safety, and human presence. Trained volunteers and professionals offer emotional support during acute psychological distress, helping individuals return to a manageable state without the use of sedatives or restraint unless absolutely necessary.

The approach is inspired by principles from psychedelic therapy research—such as acceptance, non-directivity, and containment, and emphasizes the value of staying with the person throughout the experience. Many users later describe these interventions as transformative, and the Kosmicare team has developed post-event integration tools, including referrals and community support (Kosmicare, 2023).

Kosmicare also contributes to psychoeducation before consumption, offering materials on dosage, drug combinations, and safer use, and participates in drug checking in collaboration with other organizations. Its model has since been replicated at other festivals and club events across Europe, showing how emotional support can be a powerful harm reduction tool in both nightlife and broader drug use contexts.

Responding to Stimulant-Induced Psychosis

Stimulant use—especially high doses or prolonged use of substances like methamphetamine, cocaine or synthetic cathinones, can lead to acute psychiatric symptoms including paranoia, delusions, hallucinations, agitation, and severe anxiety. While these episodes may be transient, in some cases they evolve into full stimulant-induced psychosis, a condition that resembles schizophrenia but is directly linked to the effects of the drug. For people using in contexts of vulnerability, such as homelessness, trauma, or polysubstance use, these episodes are often exacerbated by environmental stressors, lack of rest or nutrition, and isolation (Darke et al., 2008).

Traditional mental health services often struggle to respond appropriately to stimulant-induced psychosis. The person may be agitated, incoherent, or afraid of healthcare workers. When no immediate containment is available, responses can escalate—leading to police intervention, mechanical restraint, or involuntary hospitalization. From a harm reduction perspective, these responses often worsen the person's fear and reinforce distrust in public services.

A more grounded, compassionate model is found in frontline harm reduction centers that integrate psycho-social accompaniment in real time. A leading example is CAS Baluard, the harm reduction facility operated by ABD (Asociación Bienestar y Desarrollo) in Barcelona's Raval neighborhood. Since 2022, professionals at CAS Baluard have reported a significant increase in episodes of stimulant-induced psychosis related to methamphetamine use, especially among people living in the street and in extreme social exclusion. Many of these individuals use meth in an attempt to stay awake, protect themselves from violence, or cope with underlying trauma; often entering into cycles of days without sleep, with little access to calm or safety (ABD, 2023).

At CAS Baluard, the team has developed non-pathologizing, low-threshold strategies to respond to this phenomenon. Instead of focusing on psychiatric labeling or immediate containment, staff prioritize presence, containment and calming strategies. This includes offering safe shelter during crisis episodes, maintaining visual contact, using simple and respectful language, reducing environmental stimuli, and (when needed) activating emergency services with prior emotional preparation of the person. The goal is not just crisis resolution, but preserving the therapeutic alliance, even when hospital transfer becomes necessary.

It collaborates with other harm reduction and housing programs to develop continuity of care. For example, when a person is stabilized after a psychotic episode, the team may accompany them to follow-up services, offer brief psychological support, or facilitate access to low-demand housing that reduces exposure to triggering environments. Peer workers and outreach professionals play a key role in identifying early signs of stimulant-related distress and in defusing paranoia through trust and proximity.

This model reflects a broader harm reduction principle: even when mental health symptoms are intense, the person remains the protagonist of their process. Psychosis does not eliminate agency, it demands adaptation and care that are grounded in dignity, slowness, and safety.

Cannabis Social Clubs

Cannabis Social Clubs (CSCs) are non-profit associations formed by adult cannabis users to collectively cultivate, distribute and consume cannabis within a closed, regulated network. Their purpose is to avoid the harms of prohibition and unregulated markets—such as contact with criminal networks, uncontrolled potency, or contaminated products—while offering a safer, transparent, and health-oriented alternative. The model, first consolidated in Spain, has expanded across Europe (Malta, Germany, Switzerland) as a form of bottom-up regulation, combining community autonomy with harm reduction principles (Decorte, 2015).

CSCs operate on a set of ethical guidelines: only members may access cannabis; production is limited to personal, non-commercial use; transparency and accountability are central; and public health (not profit) is the priority. Many CSCs also offer education on responsible use, alternatives to smoking, and support for members experiencing problematic consumption.

A unique example of regulated cannabis supply informed by CSC principles is the Amsterdam cannabis supply pilot, part of the Dutch government's “closed coffee shop chain” experiment. While the Netherlands has long tolerated cannabis sale in licensed coffee shops, cultivation and supply remained illegal—creating a paradox where cannabis is legally sold but illegally sourced. To address this contradiction, Amsterdam joined a national pilot (launched in 2023–2024) that allows selected municipalities to legally grow and distribute cannabis under controlled conditions, thereby closing the grey area of “backdoor supply” (WODC, 2023).

Although Amsterdam's model differs structurally from Spain’s CSCs, it shares key principles:

- Controlled production under public oversight.
- Limited, local distribution to known users.
- Cannabis grown without harmful pesticides, with consistent THC/CBD levels and lab testing.
- Educational outreach on responsible use and health risks.
- Avoidance of criminal markets by ensuring traceability from seed to sale.

This pilot allows for up to ten licensed producers to supply designated coffee shops in participating cities (including Breda and Tilburg, with Amsterdam now joining partially). The goal is to evaluate the impact on public health, user experience, and organized crime, with the possibility of informing broader reform across the Netherlands (Government of the Netherlands, 2023).

From a harm reduction perspective, these initiatives reduce exposure to unpredictable black-market cannabis, enable clear labeling of THC/CBD content, and open space for user education, including non-smoking alternatives, dosage awareness and the importance of avoiding use during adolescence or in vulnerable mental health states.

Section 3 | Peer Work Perspective

The integration of peer work into harm reduction is not a complementary add-on—it is a multilevel strategy that enhances effectiveness, reach and equity. Peer workers, understood as people with lived experience of substance use, are uniquely positioned to operate across individual, community, service and policy levels. Their contributions are not merely supportive: they are transformative, especially when applied to the substance-specific strategies outlined in Section 2.

Individual Level: Building Trust and Supporting Safer Practices

Peers are often the first point of contact for people who use drugs. They create an atmosphere of non-judgment and mutual recognition, which is essential when introducing strategies such as:

- **Take-home naloxone:** Peers distribute naloxone and explain its use through lived examples of overdose reversal, demystifying the process and reinforcing the message that people who use drugs can save lives—including their own.
- **Safer use education**: Peers share practical tips on dose management, hydration, pacing and sleep—especially relevant in stimulant use or chemsex contexts—based on first-hand knowledge of bodily effects, risk moments and coping strategies.
- **Pyou sychedelic support:** Peers trained in emotional accompaniment (e.g. in the Kosmicare model) guide users through intense experiences, offering presence and reassurance, especially in altered states of consciousness.

Community Level: Cultural Mediation and Early Risk Detection

Peer workers act as cultural translators and relational anchors. They detect new patterns of use (e.g. adulterated batches, new substances like nitazenes), and help integrate strategies into community routines:

- **Drug checking:** Peers play a key role in interpreting test results in accessible language, discussing adulterants (e.g. levamisole, synthetic cannabinoids), and facilitating decisions about consumption. They also help identify when people feel too ashamed or afraid to engage with testing.
- **Smoking and sniffing kits:** Peers explain how to use pipes, foil or snorting straws safely, validate improvisations made by users, and promote hygiene without moralizing. Their role is key in reducing transitions to injecting and preventing infection.

- **Polydrug education:** Peers share insight on how certain combinations feel, how to avoid masking effects (e.g. alcohol + cocaine = cocaethylene), and how to plan recovery time after a binge.
- **MAPs and community alcohol care:** Peers normalize managed use, reduce stigma toward those who do not want to stop drinking, and encourage engagement with daily routines that improve stability.

Organisational Level: Service Design, Accessibility and Continuity

Inside services, peers support low-threshold, person-centred interventions. Their input ensures that programs are realistic, culturally safe and respectful:

- **Drug Consumption Rooms (DCRs):** Peers greet and orient new users, explain house rules, and help prevent conflict. Their presence reduces anxiety and supports smoother referrals to housing, mental health, or detox services.
- **Inhalation rooms:** In facilities that include crack or meth smoking spaces, peers help users understand ventilation, mouthpiece hygiene, and overdose risks. They may also provide grounding after high-dose use.
- **Encapsulated dosing and oral strategies:** Peers advise on how to measure and time doses, especially with substances like MDMA, GHB or mushrooms. They explain the effects of delayed onset and how to avoid re-dosing mistakes.
- **Sniffing hygiene:** Peers share techniques to reduce nasal damage (e.g. crushing well, alternating nostrils), and encourage use of saline sprays or personal straws.

In all these settings, peer workers increase continuity, following up with users across contexts and helping them return to services after interruptions or crises.

Policy and Systems Level: Advocacy, Evaluation and Redistribution of Power

Peers are essential in making harm reduction accountable to the communities it serves. Their participation in system-level actions includes:

- **Designing policy pilots:** Peer input has shaped safer smoking kit rollouts, legal cannabis experiments, and fentanyl test strip distribution strategies across Europe.
- **Monitoring and alerts:** Peers contribute to early warning systems by reporting new substances or dangerous shifts in market supply (e.g. presence of xylazine, novel benzos).
- **Training and capacity-building:** Peers train professionals and other users, helping services overcome stigma, adapt language, and embrace harm reduction in practice—not just discourse.
- **Advocacy:** Networks like EuroNPUD or LANPUD advocate for decriminalization, housing rights, and legal protections for people who use drugs, ensuring that harm reduction includes social justice, not just health.

Unit 3 | Harm Reduction Strategies Aimed at People Experiencing Homelessness

Unit 3 | Harm Reduction Strategies Aimed at People Experiencing Homelessness

Section 1 | Introduction to Situations of Homelessness

In recent years, the number of people experiencing homelessness has been steadily increasing across Western countries (*FEANTSA, 2023*). This is not an isolated trend, but the result of intersecting structural crises: the deepening housing crisis (*Baptista & Marlier, 2019*), increasingly restrictive migration policies, and the expanding precarity generated by decades of neoliberal reforms that have eroded social protection systems (*Wacquant, 2009*). These factors are further compounded by the growing impact of climate change, which disproportionately affects those without access to shelter: exposing them to heatwaves, floods, and extreme weather with little to no protection (*Parsell et al., 2020*).

In this context, psychoactive substance use must be understood not as a moral or individual failure, but often as a strategy of survival in the face of structural abandonment and unlivable conditions (*Fountain & Howes, 2002; Bourgois & Schonberg, 2009*). Harm reduction with this population cannot rely solely on biomedical models or on behavior-change approaches detached from people's lived realities. Instead, it must respond to the material conditions of life on the street: instability, violence, hunger, trauma, exposure, and social isolation.

For many people living without housing, substance use serves a functional and adaptive role: staying awake to avoid assault, numbing pain or cold, coping with trauma, or establishing a sense of routine in an unpredictable world (Duff, 2014; Pauly, 2011). As one rough sleeper described, it can be at once a necessity for survival, a coping mechanism, and a means of escapism. Over time, this use can become part of a self-perpetuating cycle: people use to survive, but are then further excluded, criminalized, or denied access to services because they use. This vicious circle reinforces both homelessness and risk. For this reason, it is essential to dedicate a specific chapter to harm reduction in contexts of homelessness, not as a side issue, but as a central front in the struggle for health equity and human dignity.

Section 2 | Harm Reduction in Cases of Homelessness

Key Characteristics of Harm Reduction in Homeless Contexts

Harm reduction in homelessness settings requires tailored strategies that address the structural violence, instability and constant exposure experienced by people living without safe or stable shelter. Unlike traditional clinical settings, where interventions occur in controlled environments, harm reduction in this context must be mobile, flexible, relational and survival-oriented. It also needs to be adaptable and responsive to the unique situation of each individual, meeting them where they are in their homelessness, mental health and/or substance use journey

Outreach Teams

Mobile and outreach-based harm reduction constitutes a foundational pillar in responding to the needs of people who use drugs and are experiencing homelessness. These interventions are delivered directly in public or semi-private spaces where people live and use substances: under bridges, in alleyways, in parks, abandoned buildings, squats, or on the streets themselves. For many, these services are not complementary, but their only point of contact with healthcare, emotional support, or social accompaniment (Fountain & Howes, 2002; Pauly, 2011). Outreach work combines the distribution of harm reduction materials—such as sterile syringes, foil, naloxone or safer smoking kits—w[1] ith emotional containment, informal advocacy, overdose response, and pedagogical work with the wider community. It is, fundamentally, a form of care rooted in presence, repetition, and relational trust.

One of the core contributions of outreach lies in its capacity to reduce stigma through an empathetic understanding, presence and action. Teams collect discarded syringes, respond to overdoses in public spaces, mediate with neighbors, and provide calm, respectful engagement with users who are often perceived as threatening or disruptive. Through this sustained visibility, harm reduction is re-signified—not as a source of disorder, but as an intervention that protects both public health and human dignity (Bourgois & Schonberg, 2009). At the same time, outreach workers must negotiate a constant tension between being recognizable as care professionals and, in certain contexts, remaining discreet to protect users from criminalization. This dual strategy—being identifiable and invisible at once—is part of what makes street work such a delicate and context-sensitive craft.

Crucially, outreach teams operate on the frontlines of NIMBY (Not In My Backyard) dynamics, which frequently affect harm reduction and homelessness services. These reactions, often fueled by fear, misinformation or classist and racialized anxieties, tend to resist the presence of people who use drugs in public space. Outreach workers act as a buffer, absorbing community complaints, mediating tensions, and defending the right to exist for people in extreme exclusion.

A particularly complex and sensitive part of this mediation involves interactions with law enforcement. Police presence in public drug scenes can escalate tension, lead to rushed consumption, or deter users from accessing services. Outreach teams often mediate directly between police officers and users, helping de-escalate confrontations, advocating for harm reduction-informed responses, and defending people's right to access care without harassment. While this role is rarely formalized, it is essential: outreach workers can explain what naloxone is, defuse assumptions of danger, and even build pragmatic alliances with individual officers to reduce harm in daily interactions (Vitale, 2017). In contexts where criminalization remains a dominant framework, these micro-mediation efforts can mean the difference between life and death, or between trust and rupture.

An illustrative example comes from Cork, where the Local Authority is recruiting Community Safety Wardens to improve public safety and the urban environment. This partnership between Cork City Council, the Cork Business Association, and An Garda Síochána will deploy wardens in designated areas to provide assistance and report issues. Cork Simon has been invited to contribute to their training, ensuring that wardens' presence can foster positive engagement with homeless people and related issues such as drug use. This initiative is hoped to become a constructive step forward for the city.

Outreach work is particularly vital for reaching structurally excluded populations such as women, trans people, undocumented migrants, and people with untreated mental illness or histories of institutional violence. For many of them, the outreach team may be the only visible and trustworthy structure in the city. It is often in these interactions—quiet, patient, non-demanding—where new forms of safety and engagement become possible (EHRA, 2020; Meroño, 2019). These teams detect early signs of psychosis, respond to wounds and overdoses, offer shelter referrals, or simply accompany a person to the hospital—bridging the gap between street life and inaccessible institutions.

Working in open consumption scenes, abandoned buildings, rooftops, or train stations requires knowledge that is rarely part of formal training. Outreach is learned in practice: knowing how to navigate conflict, hold space without rushing, or connect through a casual conversation about football, family, or the weather. It demands emotional intelligence, deep cultural competence, and the capacity to act without imposing. It is a pedagogy of the street—slow, situated, dialogical. And it is often this pedagogy that keeps people alive in contexts where every other system has failed them.

Outreach teams operate daily in environments that are unstable, unpredictable, and often hostile, both for the people who use them and for the professionals themselves. Unlike clinical or institutional settings, these are spaces with no doors to close, no panic buttons, and no formal authority. The intervention happens in real time and in public view, often in a haze of noise, weather, onlookers, or active consumption. These contexts require teams to constantly adapt—not only logístically, but emotionally and relationally. Teams must decide whether to approach or hold back, whether to intervene in a conflict or observe discreetly, whether to engage in dialogue or simply offer presence. This ability to read the micro-dynamics of space and group behavior is part of the embodied knowledge that outreach work builds over time.

In this sense, adaptation also means being able to navigate spaces of heightened surveillance and contestation. Open consumption scenes are often heavily policed and politically instrumentalized. Outreach teams must learn how to work within these pressures—sometimes negotiating informal agreements with law enforcement, other times stepping in to de-escalate tensions before punitive actions are taken. In abandoned buildings or squats, where people may be asleep, under the influence, or experiencing psychotic episodes, the outreach approach is slow, respectful and attuned to risk. It also means recognizing that not all spaces are equally accessible: gendered and racialized dynamics shape who feels safe where. Outreach teams that are diverse, trauma-informed and culturally competent are better equipped to adapt to these environments without reproducing harm, ensuring that their presence does not become another layer of control, but rather a vector of protection.

Shelter Inclusion and Low-Threshold Housing Models

Access to shelter remains one of the most urgent and structurally neglected issues in harm reduction and homelessness response across Europe. Despite the growing evidence that stable housing significantly reduces the harms associated with substance use, many cities still operate under abstinence-based or punitive housing models (Pleace & Lloyd, 2022). In these systems, substance use is grounds for exclusion or expulsion, forcing people to choose between safety and survival strategies[1] . The result is a paradoxical and often cruel reality: people are denied housing because they use substances, while continuing to use substances because they are denied housing. This situation is aggravated by deeply inadequate public housing policies, especially in countries where neoliberal reforms, gentrification, and speculative markets have eroded the right to housing into a competitive, inaccessible commodity (Rolnik, 2019; FEANTSA & Fondation Abbé Pierre, 2023).

In many European cities, another structural barrier affects people with irregular administrative status: access to shelters is limited to emergency beds only, usually at night and without continuity. This restriction (based on administrative status) reproduces exclusion and weakens the possibility of long-term accompaniment. For people who use substances and are also migrants in irregular situations, this model prevents access to stable routines, psychosocial care, or meaningful harm reduction. It disregards the weight of trauma, the pain of the migratory journey, and the need for relational security (Wirth & Leclerc, 2022). Moreover, the impossibility of storing belongings, resting during the day, or accessing basic hygiene further entrenches instability and invisibility. Leaving people in a cycle of exhaustion, exposure, and stigmatization.
Many shelters across Europe still fail to offer low-threshold, user-adapted services, and this failure is particularly acute for women and gender-diverse people who use drugs. These shelters are rarely designed with the safety needs of women in mind—especially those who are survivors of violence, engage in sex work, or use substances as a form of coping. The risk of being judged, pathologized or even sexually harassed by staff or other residents is real. For people involved in chemsex or using stimulants in sexualized or nocturnal settings, most shelters offer no structural support or adapted routines. Instead of providing rest and care, they impose rigid schedules, moral surveillance, and decontextualized rules, alienating many who would otherwise engage (Meroño, 2019).

In this context, the CRI Galena in Barcelona (Catalonia) stands out as a good practice. This harm reduction center includes a housing support specifically designed for people who use substances and are living in street-based exclusion. It allows entry without abstinence requirements, offers supervised consumption rooms, emotional support, smoking kits, MAP and staff trained in mental health and trauma-informed approaches. The center is especially attentive to the needs of women, trans and non-binary users, and its design was informed by community participation and long-term street outreach work. Galena provides not only a place to sleep, but a relational and structural bridge between street life and more stable forms of care, avoiding institutional coercion and focusing on continuity.

A more long-term approach is found in Housing First models that do not condition access to housing on abstinence, treatment or behavior change. These programs offer independent housing from day one and provide voluntary, wraparound support. A particularly powerful example is CRESCER's housing first project. In 2013, CRESCER implemented É UMA CASA, Lisboa Housing First program, targeting people who experience homelessness and use psychoactive substances. Following the Housing First model founded in 1992 by Sam Tsemberis, this project rests on Housing First methodology and is based on Harm Reduction approach. It aims to eradicate chronic homelessness through effective community inclusion, recognizing that the main problem of a person experiencing homelessness is not having a home. After this basic human right is guaranteed and basic needs are assured, people find it easy to manage other life problems.

For this reason, it offers people who experience homelessness a place of their own without preconditions like compliance to psychiatric treatment or sobriety, no restrictions like having no documentation or Portuguese nationality, being in an irregular situation, having had time in prison; there is no need for people to prove housing readiness or that they deserve access to housing.

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É UMA CASA, Lisboa Housing First provides immediate access to independent, time-unlimited, and scattered houses (to promote social inclusion) in Lisbon Municipality, combined with the off-site support of a specialized team (24/7) and community-based services. The client-staff interaction is based on respect, warmth, and compassion from the first contact on the street. Housing is independent of services, conceptually and physically, guaranteeing that the frequency of clinical services does not influence housing stability. Support and treatment services must be provided by existing responses in the community. Furthermore, Housing First believes that people are capable of defining their own goals and promotes people's self-determination. It has a recovery orientation, being recovery defined by each person and beginning with choice and self-determination. Finally, Housing First uses a harm-reduction approach: the team meets people where they are – usually on the street – and starts the support process from that point, helping people gradually gain control over harmful behaviors and, at the same time, encouraging the use of addiction treatment, mental health, and other services. In this line, if the client does not yet consider his/her consumption of psychoactive substance to be a problem, the focus is not placed on stopping but instead on reducing the negative consequences of this behavior.

É UMA CASA, Lisboa Housing First uses specific harm reduction strategies focusing on psychoactive substances use are implemented in our daily practice:

- Promotion of healthier sleeping, eating, and hygiene patterns.
- Work with people to start using in their own houses, reducing situations of intoxication on the street, exposure to violent contacts, injuries, and problems with the police.
- Promotion of health education sessions.
- Home access to HCV and HIV tests and treatment are also provided in cases where tenants are more resistant to linkage to care.
- Staff home-delivered aseptic material to injected and smoked psychoactive substance use (kits, syringes, aluminum foils, pipes).

- Strategies to prevent life-threatening situations are discussed and implemented (e.g., naloxone supply – medication which reverses OD situations – to be used in cases of OD, alcohol withdrawal prevention)
- Low-threshold pharmacological treatments are implemented when needed (e.g., benzodiazepine or alcohol management) – CRESCER psychiatrist starts a low-threshold pharmacological treatment, which could include benzodiazepine reduction using the same substance that people previously used to use in an addictive way, daily or weekly provided by the team/community resource. Normally, after a period people adhere to community services (e.g., treatment team).

A notable example of age-specific harm reduction housing in the Netherlands is Woodstock, a residential facility in The Hague for older people with long-term substance use histories. Opened in 2008, Woodstock provides 24-hour supported housing for individuals over the age of 45 who have experienced chronic addiction and homelessness. Unlike traditional care homes, drug use is tolerated within limits, and residents are not required to abstain. Instead, the focus is on stabilizing daily life, providing medical care and methadone treatment if needed, and promoting dignity and social connection in later life. The project has been credited with improving residents' quality of life while reducing public nuisance and petty crime in the surrounding neighborhood. Woodstock illustrates a compassionate, realistic approach to aging in marginalization and continues to operate today under the Parnassia Group's care framework (Taipei Times, 2012).

However, it is important to acknowledge that group-based housing models, such as shelters or shared apartments, are not without challenges. Placing people together solely on the basis that they have lived on the street or use substances is often insufficient to ensure compatibility or well-being. The absence of common goals, interests or rhythms can lead to relational tension, conflict, or retraumatization. Expecting individuals to adapt rapidly to shared living under conditions of accumulated trauma and social suffering is, in many cases, an unrealistic demand. Support teams must anticipate this complexity and offer mediation, individualized follow-up, and exit options when needed.

24/7 Service Coverage

For people living in street-based conditions, time is not divided into office hours and rest—it is continuous, unstable, and often shaped by survival imperatives. Traditional health and social services, constrained by limited operating schedules, are often misaligned with the real rhythms and urgent needs of people experiencing homelessness and substance use. The absence of night and weekend services becomes a structural barrier in itself, leading to avoidable harms, unmet needs, and missed opportunities for intervention.

hImplementing 24/7 service coverage—whether through mobile outreach, night shelters, crisis response units, or low-threshold centers open around the clock—is a key harm reduction strategy. It acknowledges that overdoses happen at night, that crises do not follow business hours, and that many people who use drugs avoid daytime spaces due to stigma, anxiety, or incompatible routines. For women, trans people, or individuals recently released from prison, the night may be when they feel most vulnerable, but also when they are most willing to seek help—provided there is someone there to receive them.

An essential component of this 24/7 framework is the round-the-clock availability of safer use materials—syringes, foil, smoking kits, naloxone, filters. When people cannot access these materials at the time they need them, they may reuse or share equipment, resort to high-risk strategies, or lose the capacity to delay or modify use. Ensuring constant access through dispensing machines, drop-in centers, or outreach distribution saves lives and protects public health. It also sends a message of consistency and respect: harm reduction is not conditional on time, location, or social status.

Equally important is the existence of safe, identifiable places where people can go when experiencing unwanted effects of substances. Whether due to overdose risk, stimulant-induced agitation, or emotional distress, people must know where they can be received without judgment, coercion or punishment. The availability of supervised consumption spaces operating 24/7 provides this safety net. These spaces allow people to use substances with sterile equipment, trained staff, and immediate emergency response if needed. Beyond safety, they offer something more: human presence, relational containment, and the reduction of avoidable trauma.

For women and LGTBIQ+ people who use drugs, the impact of 24/7 services is particularly significant. Many have experienced gender-based violence, transphobia, or sexual assault, often intensified by homelessness and drug use. Being able to access harm reduction spaces at night, when vulnerability increases, reduces exposure to unsafe environments and creates islands of safety in otherwise hostile urban territories. These services not only meet material needs—they recognize the political and emotional dimensions of safety, inclusion, and dignity.
Moreover, 24/7 harm reduction allows for continuity of care: it reduces disconnection between street-based support and institutional systems, facilitates follow-up after emergencies, and enables a more flexible and relational approach, as staff have time to adapt to people's rhythms rather than forcing engagement into rigid formats. It also offers points of calm and refuge, where people can rest, hydrate, warm up, talk, or simply exist without being asked to move along.

In many European cities, the lack of 24/7 harm reduction and low-threshold infrastructure reflects a deeper issue: a prioritization of efficiency over equity. Funding tends to support 9-to-5 models even when evidence shows that the most vulnerable populations operate outside these limits. For people sleeping rough, closing time can mean returning to unsafe environments, losing access to naloxone, or being left alone during psychosis, withdrawal or emotional breakdowns.

Managed Alcohol Programs (MAPs)

MAPS are harm reduction interventions designed to support people experiencing severe alcohol dependence, particularly those who are unhoused or living in chronic exclusion. Unlike abstinence-based models, MAPs provide measured doses of beverage alcohol (typically wine or beer) at regular intervals throughout the day, in a supervised, structured and supportive environment, often integrated into a housing facility.
When embedded within housing resources, MAPs offer more than symptom management—they provide stability, dignity and reconnection for individuals whose alcohol use has made them ineligible or unable to remain in traditional shelters. These programs aim to:

- Prevent dangerous alcohol withdrawal, which can be life-threatening in heavy drinkers.
- Reduce non-beverage alcohol consumption (e.g. mouthwash, hand sanitizer).
- Limit binge drinking and high-risk use in public space.
- Increase engagement with health and social care systems
- Promote daily structure and trust-building.

Housing-integrated MAPs operate within residential units, where participants are offered private rooms and access to additional services such as nursing care, social work, meals, mental health support and peer accompaniment. Alcohol is usually administered at set intervals (e.g. every 90 minutes or 2 hours), according to an individualized plan based on participants' needs and consumption patterns.

One of the key strengths of housing-based MAPs is their recognition that alcohol use, for many, plays a functional role in daily survival: coping with trauma, regulating emotions, dealing with loneliness or staying alert while living on the street. These programs remove the chaos and criminalization associated with unsanctioned use, offering a contained space where people can gradually reduce harm, re-establish routines, and explore change without pressure.

Evidence from Ireland's national pilot MAP (implemented between 2021 and 2022) shows promising outcomes. According to a qualitative study by McCann et al. (2024), participants experienced improved health, reduced reliance on emergency services, increased food intake, better medication adherence and enhanced sleep quality. Staff also reported that the model fostered more meaningful engagement, with residents feeling safer and more respected. The study highlighted that MAPs can be a key component of trauma-informed care, and that housing and harm reduction are not mutually exclusive, but mutually reinforcing.

In Barcelona, a pilot MAP implemented by ABD and the public health system has shown similar benefits, particularly in terms of reduced emergency health use, improved emotional well-being, and user engagement with health professionals. According to the evaluation by Filomena-Velandia et al. (2024), participants valued the balance between structure and flexibility, and the program was found to be cost-effective. The study adds valuable evidence from the Southern European context, where such programs are still rare and often contested.

From a harm reduction and housing rights perspective, MAPs challenge the moralizing and exclusionary logic of abstinence-based shelters. They affirm that everyone deserves housing, even if they continue to use substances, and that care should be adapted to people—not the other way around.

Mobile Units in Dispersed and Non-Urban Areas

In many territories, particularly peri-urban, industrial, or semi-rural zones, substance use does not follow the logic of centrality. While some cities concentrate services around urban cores or known drug scenes, there are growing patterns of consumption and marginality in isolated environments (abandoned industrial areas, forest zones, road peripheries, or informal settlements) disconnected from basic infrastructure. In these settings, there are no fixed harm reduction centers, no nearby health services, and no immediate institutional visibility. What exists instead is a dangerous vacuum: people using substances far from care, far from witness, and far from help.

In this context, mobile harm reduction units are not just useful. These units (vans, outreach vehicles, or pop-up tents) provide on-site access to sterile equipment, information, emotional support, basic first aid and overdose response, often being the only visible public health resource for miles. They reach people who do not appear in official statistics, who avoid city centers due to policing, stigma or past trauma, and who are entirely disconnected from the healthcare or social protection systems.

The strategic role of mobile units is not only operational but territorial. They map the invisible, responding to sudden displacement caused by police operations or evictions, and adapting routes to local knowledge and seasonal variation. In agricultural zones, industrial peripheries, or areas with high migratory turnover, consumption can appear in waves and in places where no institutional response has been imagined. Mobile units offer flexibility, continuity and relational knowledge in these unstable terrains.

These settings also pose unique challenges. The people reached may have no phone, no documents, no health card, and no trust. The level of physical and psychological deterioration may be extreme, and many use in group dynamics where power relations, violence or silence operate in harmful ways. In such environments, establishing contact requires time, patience and presence. The mobile unit becomes a familiar face in an unfamiliar place.
Moreover, in territories where no fixed facilities exist, the mobile unit may be the only opportunity to intervene in an overdose, deliver naloxone, detect abscesses, or simply ask someone if they're okay. It may be the first and only time a person receives health-related information not linked to threat or punishment. For women, trans people and racialized communities, it may also be the only space where they are listened to without being judged or invisibilized.

Harm Reduction and Digital Rights

In the context of homelessness and drug use, access to digital technology is often overlooked, yet it plays a crucial role in harm reduction and social inclusion. For people who live in the street or in unstable housing conditions, the possibility of charging a phone, connecting to the internet, or using a digital device can be a matter of safety, emotional connection, and survival.

In many low-threshold harm reduction services, offering spaces to charge phones and access Wi-Fi is one of the few consistent ways to reduce isolation, support communication with family or networks of care, and maintain continuity in therapeutic or social processes. For people who use substances, especially those in situations of extreme exclusion, being digitally disconnected often means being institutionally invisible: unable to receive medical appointments, access housing lists, renew documentation, or follow up on legal, health or social procedures.

At the same time, the digitalization of bureaucracy imposes a new layer of violence on people who live in the street. The dominant social narrative expects them to behave like any other citizen (keeping appointments, downloading documents, answering emails, accessing apps) while ignoring the fact that they do not have the means to own or maintain a phone, let alone afford internet data or replace a stolen charger. A cracked screen, a forgotten password, or a lost SIM card becomes not just an inconvenience, but a barrier to accessing rights. In this way, the same systems that exclude people from housing or care now demand digital performance as a condition for reintegration, reproducing stigma through technological gatekeeping.

This is further compounded by stigmatizing imaginaries that surround people who use drugs and live in the street. There is a widespread assumption that if someone is consuming substances and homeless, they are also incapable of engaging with technology, or unworthy of having access to it. The presence of a phone may trigger suspicion or even hostility: people assume it must be stolen, or that the person is manipulating the system. This suspicion reflects a broader punitive logic: as if dignity and connectivity must be earned, and not something to which everyone is entitled. Such ideas deny not only people's capacity to relate to the digital world, but their right to care, presence, and connection.

Meanwhile, digital access is a powerful harm reduction tool in itself. It allows people to seek information about substances, read alerts on contaminated batches, learn safer use strategies, and locate services nearby. In a landscape where misinformation and stigma are common, reliable online content can support agency, informed decision-making, and peer education.

Beyond the functional aspect, the digital realm also serves as a source of mental and emotional regulation. For many, watching a video, listening to music, following a live stream, or playing a mobile game is a way to escape from street stress, anxiety, or cravings. Digital leisure becomes a form of self-care, offering temporary refuge and helping fill time in long, unstructured days.

For younger people, women and LGTBIQ+ users, digital access may also mean maintaining contact with chosen families or distant support networks, which are often safer than immediate physical environments. In the absence of safe housing, the phone can be a lifeline, a way to call for help, to be located, or simply to feel less alone.

Despite this, many harm reduction programs do not consider digital access as part of their intervention logic, and public institutions rarely integrate digital connectivity as a health determinant. In the meantime, people charge their phones in gas stations, public toilets or exposed sockets, often risking theft, confrontation or police interaction. Denying this access reproduces the same logics of exclusion and punishment that harm reduction seeks to challenge.

Hygiene, Privacy and Body Care

In harm reduction responses aimed at people who use drugs and live in the street, basic hygiene and access to private spaces are often treated as peripheral needs. Yet their absence has deep consequences on both physical and emotional health. The lack of access to showers, toilets, laundry facilities, menstrual hygiene supplies or spaces to rest in privacy undermines dignity, self-perception and even the ability to detect signs of illness. These are not marginal issues: they are core components of care and self-agency.

Most European cities have reduced or eliminated public infrastructure that allows for bodily hygiene: public toilets are rare, often locked or for-pay, and access to showers or laundry requires navigating charity-based systems that may impose moral judgment or abstinence requirements. For people living in unstable housing or sleeping rough, washing clothes, brushing teeth, managing body odor or keeping nails clean becomes a daily challenge. Over time, this affects not only social perception, but internal self-image. Looking in the mirror and not recognizing oneself—or avoiding mirrors altogether—is a form of disconnection that reinforces shame, isolation and mental health distress.

Among women, trans people and gender-diverse users, this invisibilized degradation is often compounded by stigma and menstrual vulnerability. The experience of menstruating while homeless and using substances is rarely spoken of, but deeply embodied. Substance use may cause amenorrhea, hormonal disruption or irregular bleeding. These changes already produce a sense of distance from one's own body cycles. If, in addition, there is no private space to change a pad, rinse blood, or even carry hygiene products safely, the result is often deep dissociation, increased risk of infections, and reduced capacity to detect symptoms of STIs or gynecological issues.

This scenario contributes to the social imaginary of the "unclean" or "irresponsible" substance user a powerful, dehumanizing stereotype that ignores how structural barriers limit any possibility of self-care. The problem is not the person's will or capacity, but the absence of conditions that make care possible. When you have no safe space to wash, change your underwear or simply be alone with your body, it becomes nearly impossible to sustain routines of hygiene, intimacy, or symptom awareness. The person is then not only socially excluded, but progressively estranged from their own body.

Access to showers, toilets, clean clothes and menstrual care supplies should not be framed as "extra services". They are essential harm reduction tools. They support skin health, infection prevention, sexual health monitoring, and psychological resilience. They also allow people to see themselves again as human beings, not just as objects of assistance or control. The act of choosing clean clothes, rinsing your face, or washing your hair is not cosmetic, it is a radical gesture of survival and self-preservation.

From a harm reduction perspective, this implies offering low-threshold, judgment-free and gender-sensitive hygiene facilities. It means incorporating toilets, menstrual products, mirrors, lighting, hot water and gender-specific safe zones into drop-in centers, shelters and outreach programs. And it means understanding that the right to dignity is not conditional on sobriety, documentation, or performance of cleanliness.

Paradoxically, many cities deliberately avoid installing public bathrooms for fear they will be used by people who live on the street to shower, use substances, or rest; thus reinforcing a cycle where their absence perpetuates the very image of “public uncleanliness” that is then used to justify further exclusion. This policy logic transforms basic hygiene infrastructure into a tool of spatial and moral control, blaming individuals for behaviors structurally produced by neglect and invisibility.
Caring for the body is not a luxury. It is a political act, a form of trauma prevention, and a necessary step in the reconnection between people, health systems, and themselves.

Layered Stigma

People who use substances and live in the street are among the most systematically stigmatized individuals in contemporary societies. Both substance use and homelessness carry intense symbolic and institutional stigma—connoting failure, irresponsibility, danger and unworthiness. When these two forms of exclusion intersect, they do not simply add up: they multiply, creating a specific condition of hyper-visibility and erasure, where the person is constantly watched, judged, and yet denied presence and protection.

This double stigma—being both a substance user and homeless—translates into daily experiences of dehumanization. Services may deny access, professionals may lower expectations, police may increase surveillance, and communities may demand expulsion from public space. In the eyes of society, this population becomes a target of pathologization and punishment, often blamed for their own condition and perceived as beyond help.

For women who use substances and are unhoused, the stigma deepens. Gendered expectations of care, cleanliness and emotional control collide violently with the figure of a woman using substances in public or visibly unwell. These women are often judged not only as “addicts” or “homeless” but as “bad women”, subject to moral contempt, sexualization, and institutional neglect. They are more likely to experience gender-based violence, exploitation, and invisibilization in both services and public narratives. Their maternal capacity is often questioned or legally attacked, and their vulnerability rarely results in protection—it often results in punishment.

When this is combined with racialization, the stigma becomes even more structural. Racialized people who use substances and live in the street are more likely to be stopped by police, excluded from shelters, denied documentation, and stereotyped as criminal or threatening. They face barriers not only in access to care, but in the very presumption of humanity and legitimacy.

A racialized woman who uses substances and is unhoused carries a triple or quadruple stigma, depending on how society reads her body: not just as deviant, but as disposable.

This interlocking stigma has profound effects. It reduces access to healthcare, weakens therapeutic alliances, increases fear of institutional contact, and isolates individuals from both formal and informal networks. It also damages the internal world of the person: self-perception, trust, the sense of deserving care, and the ability to imagine change.

From a harm reduction perspective, responding to this requires more than offering sterile equipment or a place to sleep. It requires services that are actively anti-stigmatizing, culturally competent, trauma-informed, and conscious of power dynamics. It requires listening without conditions, restoring complexity to people whose lives have been flattened by judgment, and replacing moral narratives with relational ones. Above all, it requires recognizing that what looks like disengagement is often self-protection, and that trust must be earned—not demanded.

Substance Use and Extreme Temperatures in the Context of Climate Change

The climate crisis is not a future threat, it is already here. And while its impacts are global, not all bodies are equally exposed. People who use substances and live in the street are among the most vulnerable to extreme weather events, yet they are rarely considered in climate adaptation strategies. From deadly heatwaves to freezing nights, from urban droughts to flash floods, the convergence of homelessness, substance use and environmental instability is a growing public health emergency and a critical challenge for harm reduction.

Heat and cold are not neutral. For a person using opioids, stimulants or alcohol in street conditions, the body's thermoregulation is already compromised. High doses of stimulants can raise body temperature, while opioids and alcohol can suppress awareness of cold or heat. When this is combined with exhaustion, dehydration, lack of shade or shelter, and limited clothing, the risk of fatality increases exponentially. In cities across Europe, cases of death by heat stroke or hypothermia among unhoused people who use substances are no longer exceptional, they are becoming predictable and preventable tragedies.

Climate change exacerbates this reality. Longer and more intense heatwaves, sudden cold snaps, and extreme rainfall events disproportionately affect those who live outdoors. In recent years, several cities have seen rivers overflow after torrential rains, resulting in the deaths of unhoused people whose tents were installed in informal riverside camps. In many cases, they were the only victims. These are not isolated accidents, they are a symptom of structural abandonment.

While some cities have implemented cold and heat emergency plans, these are often insufficient or poorly adapted. Cooling or heating centers may be far from areas of substance use, unknown to the population, or difficult to access due to policing, stigma, or incompatibility with active use. In many cases, people do not know where to go, or fear losing their belongings if they leave their spot. Emergency shelters opened during extreme weather may be overcrowded, lack harm reduction protocols, or impose abstinence-based conditions that exclude precisely those at highest risk.

Harm reduction strategies in the context of climate change must be concrete, material and anticipatory. In summer, this includes:

- Guaranteeing free and accessible drinking water in key urban points.
- Providing shade structures or access to air-conditioned spaces.
- Distributing sunscreen, caps, and hydration salts via outreach.
- Ensuring people can rest safely without being moved on.

In winter, it means:

- Providing warm sleeping bags and insulated ground mats.
- Identifying and communicating safe warm spaces open 24/7.
- Adapting cold shelters to low-threshold, consumption-tolerant models.
- Ensuring emergency teams have naloxone and can identify overdose symptoms, which may be confused with hypothermia.

More broadly, this means including people who use substances in municipal climate emergency planning, and designing responses that take into account the realities of street-based life and substance use trajectories. Outreach teams must be resourced not only with supplies, but with training and protocols to intervene in extreme weather conditions. Public authorities must acknowledge that structural climate vulnerability is not only about geography. It is about power, exposure, and neglect.

If a city opens its cooling centers only during business hours, hides water fountains to prevent “loitering”, or locks its public restrooms at night, it is not failing to adapt. It is choosing whose lives are considered worth protecting.

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Home4Health Training Program

Module 5
Peer work

Home4Health Training Program - Module 5: Peer work

Module Overview: (6h)

Coordinated by: ABD

In partnership with: CPES CER, HVO QUERIDO, Caritas Slovenia

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a) Learning objectives and outcomes

Define Peer Work and its relevance in service design and delivery;

Explain the knowledge, skills, and impact peers bring to teams and service users;

Apply strategies for integrating peers effectively in professional settings;

Analyse challenges and opportunities in sustaining peer roles within service structures.

b) Competencies addressed

Cultural Competence: Understanding structural, sociopolitical, and cultural factors related to homelessness in different contexts, as well as approaches to civic activism and peer participation in advocacy campaigns.

Analytical Skills: Analysing behavioural, social, and political factors affecting people experiencing homelessness and identifying key elements that support their success as peer workers.

Critical Thinking: Evaluating the effectiveness of peer integration within teams and assessing the adequacy of support provided to enable their professional development.

Communication Skills: Communicating effectively about the experiences of people facing homelessness and complex health issues, including substance use and trauma, to promote empowerment and the defence of their rights.

c) Methodology

Lectures and Presentations;

Group Discussions;

Case Studies and real-world scenarios;

Interactive Activities;

Multimedia Resources (Video documentaries, etc).

d) Materials

Textbooks, reports and Articles; Statistic information; Case Study Materials; Multimedia Resources; Presentation Slides; Paper and pens.

e) Infrastructure

A suitable classroom setting equipped with a projector, whiteboard, and seating arrangement conducive to group work and discussions.

Unit 1 | Peer work; roles and profile

Unit 1 | Peer work; roles and profile

Section 1 | Introduction to the course and participant's introduction

Activity 5.1 - Icebreaker: "Soup of Traits"

Objective:
To help participants get to know each other, explore diverse backgrounds, and appreciate the variety of experiences and skills that can be valuable in a professional context. This activity encourages networking, active listening, and curiosity in a light, engaging way.
All the instructions and materials for the activity are available on the Toolkit.

Section 2 | What is peer work?

In this section, we will explore the concept of peer work, specifically in the context of supporting individuals experiencing homelessness. To begin, we will watch a video from the peer work HUB in Australia that introduces the key elements of peer work. While the video primarily focuses on mental health, we will later discuss how peer work can be applied to various lived experiences, including homelessness.

Video: HOMELESSNESS RESPONSE: the role of peers in recovery

Understanding peer work in homelessness support

Peer work is a growing profession that originates from the lived experiences of individuals who have faced and overcome significant life challenges, such as mental health issues, substance use, homelessness, and other fields like gender-based violence and sex work.

A peer is someone who shares similar life experiences with the individuals they support. In the context of peer work, this typically means a person who has experienced – and navigated through – issues such as homelessness, complex relationship to substance use, or marginalization and now uses that lived experience to support others in similar situations. Peers are not defined by professional qualifications, but by the relevance and authenticity of their personal journeys.

Peer work refers to the practice in which individuals draw on their own recovery or life experiences to offer guidance, advocacy, and support to others. This type of support is based on mutual respect, shared understanding, and a belief in recovery and empowerment. Peer work can take place in various settings, including homelessness services, mental health care, substance use programs, and sex work support organizations. Peers can operate in different roles as outreach workers, educators, mentors, or advocates, often contributing to both individual recovery and system-level change.

In the context of homelessness, peer work refers to the process by which individuals use their personal recovery journey to support others currently facing similar challenges. This recovery process helps individuals realize that their own insights and experiential knowledge are crucial for rebuilding balance and stability in their lives after disruption.

For those supporting people experiencing homelessness, peer work offers a unique opportunity to connect with clients on a deeper, more empathetic level by leveraging lived experience. Peer workers bring valuable perspectives that can bridge the gap between professional care and the real-life experiences of those in need.

In countries like Spain, Portugal and The Netherlands, experiential knowledge is increasingly being recognized as essential within support services, including fields like sex work and gender-based violence — for example, the Amsterdam Center of Sex Work in The Netherlands. Peer workers with lived experience are involved in education, outreach, and public dialogue to share their stories and advocate for the rights and realities of (former) sex workers. These roles not only empower individuals but also provide meaningful work experience and opportunities for further employment. Their insights are a crucial bridge between policy and practice, ensuring that sex workers are actively included in conversations that affect them. Additionally, working as a peer allows individuals to collectivize and reframe periods of suffering, transforming them into tools for support, social change, and identity affirmation for those who have lived through such experiences.

The role of experiential knowledge in peer work

At the core of peer work is experiential knowledge—the insights gained through personal experiences of overcoming challenges. Individuals who have experienced homelessness themselves possess invaluable knowledge that can aid in the recovery and support of others. Peer workers use this experiential knowledge not only to assist those they support but also to enhance the understanding of other professionals and caregivers.

The role of peer workers is to share their lived experience with others, helping clients, families, communities and even other professionals gain a deeper understanding of recovery. This sharing fosters greater equality between service providers and clients, allowing both professional and experiential knowledge to complement one another and improve the overall support system.

Recognition of peer work at the European level

Peer work: also known as peer support or peer-led services - is gaining increasing recognition across Europe. It plays a vital role in areas such as mental health, substance use, homelessness, and social inclusion. Several European policies and initiatives have helped promote and strengthen the role of peer workers in these fields.

Policy support from the European Union: The European Union (EU) has acknowledged the value of peer support, particularly in mental health services. In the European Framework for Action on Mental Health and Well-being (2016), peer support is highlighted as an empowering and effective approach. The EU also includes peer work in broader social inclusion strategies, especially for people facing homelessness or social exclusion.

Funding and project support: European funding programmes, such as the European Social Fund (ESF), support projects that use peer-based approaches to help vulnerable groups reintegrate into society. These projects often include: training programmes for peer workers, peer involvement in outreach and advocacy, community-based support services
European guidelines and standards: To ensure quality and consistency, specific European guidelines and standards for peer work have been developed. One key resource is the document European Standards for Peer Work in Mental Health, created through the Erasmus+ project From peer to peer (2022). This guide outlines: core values of peer work, key competencies for peer workers, frameworks for implementation across different countries.

Access the guidelines here:
https://www.grone.de/fileadmin/Projekte/Erasmus_/2022/The_IO1_product._European_standards_.I.Mazur__002_.pdf

Legal and professional recognition of peer work in Europe

Peer work is implemented differently in each country. Some countries have well-established systems, while others are just beginning. The Housing First Hub has created an insightful webinar on peer work in Housing First. You can watch this webinar for more information:

WEBINAR - Peer Work in Housing First

Below is an overview of the situation in Portugal, Spain, Ireland, and the Netherlands, with a brief explanation and a link to more information.

In Portugal, peer work is still developing. It mainly occurs in smaller projects and within organizations focused on mental health and addiction services. Peer workers are usually volunteers or receive a small stipend. There is no official recognition of peer work as a profession yet.

- More information: European Standards for Peer Work – Portugal (Mazur, 2022) *EU standards for peer work - Portugal*

In Spain, there is growing attention for peer work, especially in mental health care. In some regions, such as Catalonia and the Basque Country, peer workers are already involved in public care services. However, at the national level, it is not yet a recognized profession.

- More information: ActivaMent – Peer Support in Catalonia; Mental Health Europe – Peer Support in Spain *ActivaMent Peer support in Catalonia*

Ireland is a frontrunner in the field of peer work. The government has developed clear job descriptions for peer workers in mental health care. Peer workers are paid and are part of care teams. There are also official training programs, including those offered by Recovery Colleges.

- More information: HSE – Peer Support Workers; Mental Health Ireland – Recovery Education *HSE Peer Support workers - Ireland*

In the Netherlands, peer work is often referred to as experiential expertise. It is increasingly recognized, especially in mental health care, addiction services, and the social domain. There are official training programs at vocational (MBO) and higher professional (HBO) levels, such as those offered by Howie the Harp or HAN. More and more organizations are offering paid positions for peer workers. However, the profession is not yet legally protected.

- More information: *Movisie* - Experiential Expertise in the Social Domain; *Howie the Harp* – Training Program; HAN – Social Work with Experiential Expertise

What makes peer work unique?

Peer workers bring a distinct and valuable perspective to care teams. Unlike traditional service providers, they draw on their own lived experiences of adversity—such as homelessness, mental health challenges, or substance use—to support others on their recovery journeys. This unique position allows them to build trust, foster hope, and offer support in ways that complement professional care.

Enhancing recovery through lived experience

Peer workers support clients not only through practical guidance but also by offering a sense of connection and understanding that comes from shared experience. Their presence can help clients feel seen and validated, which is especially important for individuals who may have felt excluded or misunderstood by traditional services.

Creating empowering environments

By sharing their experiences of stigma, survival, and personal growth, peer workers help create environments that are more inclusive and recovery-oriented. They often act as advocates for systemic change, working alongside professionals to improve service delivery and promote dignity and inclusion.

Reducing stigma across the system

Peer work plays a crucial role in addressing stigma—not just for clients, but within services and the broader community. When peer workers are integrated into care teams, they challenge stereotypes and humanize the experience of homelessness and recovery. This benefits everyone involved:

- Clients feel more accepted and hopeful.
- Services become more responsive and person-centered.
- Professionals gain deeper insight into the lived realities of those they support, leading to more empathetic and effective care.

A collaborative approach

For care professionals, working alongside peer workers offers an opportunity to enrich practice, strengthen team dynamics, and co-create more holistic support systems. Recognizing and valuing the contributions of peer workers is essential to building inclusive, recovery-focused services.

The core value: "Free space" in peer work

The concept of "free space" is central to the practice of peer work. Free space refers to the mental, emotional, and physical room that individuals need to reconnect with their inner strength, make decisions, find meaning, and discover new possibilities for their lives. This "breathing room" is essential for personal growth and recovery, and it is the role of peer workers to create and maintain this space for others.

Peer workers help clients reclaim their own "free space" - a place where they can heal, reflect, and rebuild their lives in their own unique way. This space allows individuals to regain control over their personal journey and explore new opportunities for recovery and growth.

The added value of peer work in homelessness support

Peer workers have a distinct advantage in supporting individuals experiencing homelessness. They understand how to integrate experiential knowledge into care processes, organizational practices, and broader policies. Peer workers have learned where the care system unintentionally creates barriers or reinforces trauma and where it can create space for healing and growth.

Their ability to use lived experience to identify and challenge systemic issues makes them a powerful force in improving homelessness services and support. Peer workers help create recovery-supportive environments at three levels:

- **Individual level** – Supporting clients in their unique recovery processes.
- **Organizational level** – Advising organizations on how to create more recovery-friendly services.
- **Societal level** – Advocating for policies and societal changes that foster inclusion and recovery.

The insights of peer workers—gained through their personal experiences—are crucial for improving the care and services available to those experiencing homelessness. These insights help ensure that recovery is not just a goal but a tangible process supported by meaningful, experiential knowledge.

Conclusion

Peer work is an essential approach to supporting individuals experiencing homelessness. By using their lived experiences, peer workers can provide unique support that fosters recovery, empowers individuals, and helps create a more inclusive and supportive environment for everyone involved. In this training, we hope you have gained a deeper understanding of the value of experiential knowledge and how it can be used to help those in need. The journey of recovery is not just about professional expertise but about creating space for personal stories to inform and guide the healing process.

Section 3 | The role of lived experience expertise in supporting people experiencing homelessness

As professionals working in homelessness services, it is essential to recognize that not all expertise comes from formal education or clinical training. Individuals with lived experience of homelessness bring a different, yet equally valuable, form of knowledge to the table. Their insights—shaped by personal journeys through adversity—can enhance the relevance, empathy, and impact of the support we provide. This section explores how lived experience expertise contributes to more effective, person-centered care and why integrating this perspective into your practice can lead to better outcomes for clients and teams alike.

Understanding lived experience expertise

When working with individuals who are experiencing homelessness, it is essential to recognize the value of lived experience expertise. This concept refers to the personal knowledge gained through direct experience of adversity, such as homelessness, mental health challenges, substance use, or other disruptive life circumstances. A person who has lived through such experiences often possesses unique insights that are invaluable in supporting others on their journey to recovery and stability.

Lived experience expertise goes beyond theoretical or academic knowledge. It encompasses a deep, personal understanding of the emotional, psychological, and practical challenges faced by those in crisis—insights that may not always be easily articulated but are deeply felt. The ability to empathize with someone in a similar situation, because you have been there yourself, creates a powerful bond and enhances the effectiveness of support.

Knowledge of survival strategies

One of the most critical yet often overlooked aspects of lived experience is the practical survival knowledge that peer workers carry. This includes knowing where it is relatively safe to sleep in the city, how to access informal and non-stigmatizing community support, and how services actually function on the ground—beyond what is written in policy documents. These insights are often invisible to professionals but can make a significant difference in how support is offered and received. Peer workers help bridge this gap, offering real-world strategies that are grounded in lived reality.

Blending lived and theoretical knowledge

While peer work is rooted in personal experience, its growing recognition as a professional practice also brings with it the integration of theoretical frameworks. Peer workers are increasingly trained in areas such as trauma-informed care, recovery-oriented practice, and communication strategies. This combination of lived and learned knowledge strengthens their role within multidisciplinary teams and ensures that their contributions are both emotionally resonant and professionally grounded.

For care professionals, understanding this dual foundation is key. It allows for more effective collaboration, mutual respect, and the development of services that are both evidence-informed and deeply human.

The key competencies of a peer worker

Peer workers—individuals with lived experience of homelessness—bring invaluable strengths to care teams. These competencies go beyond technical skills and include personal qualities, survival knowledge, and insights rooted in their own recovery journeys. For professionals, understanding and valuing these competencies is essential for building more responsive, inclusive, and effective support systems.

Empathy and understanding

One of the most vital aspects of peer work is the ability to deeply relate to others. Peer workers have a unique capacity to understand what clients are going through because they have faced similar challenges themselves. Their experiences with stigma, trauma, and exclusion allow them to offer support that feels authentic and trustworthy. This empathetic connection fosters a sense of belonging and safety—critical conditions for engagement and recovery.

Personal insight and growth

Lived experience is not only about understanding hardship, but also about recognizing the pathways to healing. Peer workers often have valuable insights into what supported their own recovery and can share practical strategies with others. Their familiarity with navigating complex care systems also enables them to identify service gaps and advocate for improvements that better meet the needs of people experiencing homelessness.

Survival strategies and real-world knowledge

Peer workers possess survival skills that are directly applicable to real-life situations—skills that professionals typically cannot acquire through training alone. This includes knowing where it is relatively safe to sleep, how to access informal community support without stigma, and how services actually function in practice. These insights are critical for helping clients navigate daily challenges and for informing service design that reflects real-world needs.

Breaking down barriers

Because they have experienced the same barriers—such as social isolation, lack of access to resources, and systemic discrimination—peer workers are well-positioned to help others overcome them. Whether through emotional support, practical guidance, or advocacy, they play a key role in reducing the obstacles that prevent people from accessing care and rebuilding their lives.

Advocacy and systemic change

Peer workers contribute not only at the individual level but also at the systemic level. Their lived experience gives them a powerful voice in shaping policies, services, and practices. By highlighting gaps and offering grounded recommendations, they help create systems that are more inclusive, equitable, and respectful of the people they serve.

Activity 5.2: "Peer worker competency simulation"

Objective:

To help healthcare professionals understand and practice the key competencies of a Peer Worker, including empathy, personal insight, breaking down barriers, and advocacy, through an interactive role-playing exercise.

All the instructions and materials for the activity are available on the Toolkit.

Section 4 | Best practices for integrating lived experience into peer work

Successfully integrating lived experience expertise into the support for people experiencing homelessness requires careful planning and adherence to best practices. The following principles are essential to ensuring that peer workers are supported in their roles and that their contributions are maximized:

Recognizing flexibility in peer roles

When working with peer workers, it is essential to acknowledge that individuals with lived experience may be at different stages in their recovery journey. For this reason, roles and responsibilities should remain flexible. Offering a range of roles with varying levels of responsibility allows peer workers to contribute in ways that align with their current strengths, capacities, and personal development. This flexibility supports both the well-being of the peer worker and the effectiveness of their contribution.

Benefits of peer work across all levels of an organization

Peer workers bring value not only in direct service delivery but also across the full hierarchy of an organization—from frontline practitioners to leadership and governance. Their involvement at all levels strengthens services and promotes a culture of inclusion and responsiveness. It is also highly valuable to involve peer workers as trainers and to include them in general training sessions, as their lived experience brings a different perspective to certain themes, making learning richer and more meaningful for all participants.

Improved engagement and trust

Peer workers help build stronger, more authentic relationships with service users. Their shared experiences foster trust, increase engagement, and reduce dropout rates—especially among individuals who may feel disconnected from traditional services.

Better services

Through their lived experience, peer workers offer practical insights into the design, delivery, and evaluation of programs. Their input helps ensure that services are relevant, accessible, and responsive to the real needs of people experiencing homelessness.

Empowerment and inclusive leadership

Including peer workers in leadership roles and decision-making processes—such as advisory boards, program development teams, or even the Directive Board—creates a culture where all voices are valued. This leads to more inclusive, equitable, and effective service models.

Systemic change

Peer workers are powerful advocates for change. Their lived experience allows them to identify systemic barriers and propose grounded, realistic solutions. When empowered to speak and act at all organizational levels, they can help transform systems to become more person-centered, trauma-informed, and socially just.

Supportive supervision and training

While lived experience is invaluable, it is essential that peer workers receive proper training and ongoing support to thrive in their roles. Training should be tailored to the specific demands of peer work—equipping individuals with the skills needed to engage effectively with clients, navigate complex systems, and maintain professional boundaries.

Peer workers also require regular supervision and emotional support. Working with individuals experiencing homelessness can be emotionally demanding, and structured support helps peer workers sustain their own well-being and recovery.

Across Europe, several countries have developed training pathways to support peer workers:

- Ireland offers formal education through programs like the Certificate in Peer Support Practice at Atlantic Technological University, which prepares individuals to work professionally in mental health and homelessness services
- Spain has implemented peer support training through initiatives like the PEER2PEER project, which adapted Scottish peer support methodologies to the Spanish context. This included pilot training courses and employment pathways for peer workers in mental health
- Portugal is still developing its peer support infrastructure, but has participated in European projects like PEER2PEER, helping to build foundational training and awareness.
- The Netherlands has a well-established training landscape, with programs such as Howie the Harp and HBO-level courses at HAN University of Applied Sciences, offering structured pathways into paid peer work roles.

By investing in high-quality training and supervision, organizations not only support the professional development of peer workers but also strengthen the overall quality and impact of their services.

Involvement in program design

Peer workers should be involved not only in delivering services but also in designing programs and policies. This involvement ensures that programs are better aligned with the real needs of individuals experiencing homelessness. Peer workers can offer valuable feedback on what works and what doesn't, helping shape services that are more responsive and relevant to the lived experiences of clients.

Creating an inclusive and respectful environment

For peer workers to thrive, it is essential that the work environment is inclusive, respectful, and psychologically safe. Organizations must go beyond simply hiring peer workers—they need to actively foster a culture where lived experience is genuinely valued and integrated into everyday practice.

This includes offering:

- Equitable pay that reflects the value of their contribution
- Formal employment contracts that provide job security and clarity
- Access to professional development and career progression opportunities
- Safe spaces for peer workers to share insights, raise concerns, and reflect on challenges without fear of stigma or judgment

In several countries, peer workers are formally employed under standard contracts. However, managing these contractual obligations in an inclusive and respectful way requires flexibility. Professional teams must understand that certain working conditions—such as fixed hours, rigid performance metrics, or standard leave policies—may need to be adapted to accommodate the unique needs and recovery journeys of peer workers. This flexibility is not a compromise on professionalism, but a recognition of the value of lived experience and the importance of sustaining it within the workforce.

These principles are echoed in initiatives such as The crack users project, highlighted in the Home4Health Best Practices Report (2024). This project emphasizes the importance of creating working conditions that respect the dignity, autonomy, and expertise of peer workers, and demonstrates how inclusive practices can lead to more effective and compassionate service delivery.

Conclusion

Peer workers bring essential lived experience that enhances trust, engagement, and the relevance of homelessness services. To fully benefit from their contributions, organizations must offer flexible roles, fair employment conditions, and supportive environments. When peer workers are included at all levels—from service delivery to leadership—they help create more inclusive, person-centered, and effective systems. Investing in their development is key to improving outcomes and driving meaningful change.

Activity 5.3: In their words: Voices of peer workers

Objective:

To foster empathy and deeper understanding of peer work through firsthand testimonials from peer workers.

All the instructions and materials for the activity are available on the Toolkit.

Unit 2 | Principles of peer integration

Section 1

Basic principles of peer institutional integration

Unit 2 | Principles of peer integration

Section 1 | Basic principles of peer institutional integration

In this section, we explore the unique challenges faced by peers—individuals with lived experience of homelessness—when living and working within the same environment. These challenges can create boundary issues and require careful navigation. Best practices for peer integration are outlined here, with a focus on various decision-making levels: financial supporters, direction, coordination, and team collaboration.

Critical professional situations and tensions

Peer workers (often referred to as "experts by experience") frequently encounter situations that require a nuanced approach, where a clear-cut answer is not easily found. These are moments when multiple interests and perspectives collide, demanding careful consideration and decision-making. These situations can lead to tensions and conflicts. Every time such a challenge arises, peer workers must decide on the approach or method that best fits the context, which requires professional competence.

Below, we explore key themes that often arise when integrating peer workers into support roles, and how these issues can be addressed in supervision and peer-to-peer reflection.

1. Closeness vs. distance

Managing the balance between proximity and distance is a common tension for both peer workers and other professionals. A defining characteristic of a peer worker is their ability to be close to the client and share personal experiences. Building a trusting relationship requires being present while maintaining a professional boundary that is comfortable for both parties. This boundary is fluid and may vary from situation to situation. Peer workers must learn to assert their own limits while inviting clients to express their needs and boundaries as well. Handling one's emotions—and the emotions of others—becomes a crucial skill. Peer workers are often open to the emotions of clients and may, in turn, trigger strong emotional responses. The key is to stay emotionally present without becoming overwhelmed by the client's emotions. Recognizing and validating emotions is important, so is maintaining the ability to step back and avoid becoming entangled in emotional dynamics. Tensions may arise when personal boundaries are tested, especially in interactions with former peers or friends.

We recommend explicitly addressing the risk of vicarious trauma and the potential reactivation or resonance with one's own traumatic experiences. Too often, it is assumed that peer workers already possess the skills to recognize what is happening to them emotionally. Including structured reflection on these risks during training and supervision helps reduce the emotional burden. Tools such as Transforming the Pain (Saakvitne & Pearlman, 1996) can offer valuable frameworks for this.

Boundaries are essential for defining roles and guaranteeing professional support, but they can be challenging due to the relationship between professionals and users (page 6, H4H Best practices report, 2024). Clear communication is crucial to establishing these boundaries, avoiding ambiguity.

Professionals should have personal boundaries that help them distance themselves from emotionally impacting situations, recognising the difficulties that arise when working in the same community. In addition, attention must be paid to those who, by remaining in their community of drug users, may have an accumulated risk of being retraumatised or triggered (Mason, 2006). Countertransference, which refers to the transfer of feelings from the professional to the client, must be managed to strengthen the therapeutic alliance (Tatarsky & Kellog, 2010).
Society often treats substance users in a stigmatising way, which can affect professionals and lead to negative reactions. This approach is harmful and underlines the importance of Harm Reduction as a therapeutic method that aims to destigmatize substance users and promote constructive treatment.

Good practices related to boundaries in the supporting relation, may include:

- Personal psychotherapy and/or continuous supervision, to promote one's self-knowledge and the ability to identify counter transferential reactions that may eventually be unknown;
- Developing effective communication skills (such as assertiveness, empathy, clarity);
- Provision and/or engagement in differentiated spaces and activities for distinct areas of life to be lived with fulfilment; For example access to organisation supports such as a counsellor, reflective practise group, yoga, mindfullness. (e.g. Herstelbureau at HVO-Querido and Cork Simon)
- Provision of flexible boundaries and discussion, between peer workers and at an agency level, around expectations and limits of these boundaries, as well as clear policies in the context of harm reduction and peer work (Mason, 2006).

Expectation management is essential in the relationships between service users, support workers, and professionals, including the specific circumstances of peer workers. It is important to balance flexibility in boundaries with clarity regarding existing guidelines, ensuring a healthy and effective work environment.

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2. Meaning vs. meaninglessness and tolerating pain

One of the most essential aspects of peer work is offering hope—sometimes through direct action, and sometimes simply by being present. However, feelings of hope and meaning can be undermined by the chronic nature of homelessness, mental health issues, or the side effects of psychotropic medication. Peer workers may feel the urge to help clients adopt a more optimistic perspective, but it's crucial to allow clients to discover their own meaning and interpretation of their experiences at their own pace. Peer workers must remain vigilant, ensuring their good intentions do not inadvertently cross the client's boundaries. Crisis moments can often feel like a significant step backward, bringing a sense of hopelessness and frustration. Both the peer worker and the client may feel disappointment in the face of setbacks. Navigating grief without the impulse to 'fix' can be a profound learning experience. Peer work is, in many ways, about facilitating recovery, which should be seen as a learning process. Supporting clients through setbacks, without framing them as failures, can help shift the focus from a medical or pathological model to one of learning and growth.

3. Strength vs. vulnerability

Peer workers often carry an inherent vulnerability due to their lived experiences. This vulnerability can be a source of strength, as it allows peer workers to connect with clients on a deep human level. However, this can create a tension, as vulnerability may be perceived as a risk, particularly in contexts where peers or professionals might exploit it. There is a need for balance in showing vulnerability while maintaining professional boundaries. Understanding and accepting one’s own vulnerability, and managing how it is shared with others, is a complex but important part of peer integration.

4. Pride vs. shame

Peer workers can sometimes feel conflicted about their role, especially when their lived experiences may be accompanied by feelings of shame. While many peer workers take pride in being able to use their life experiences to help others, these experiences can also be sources of stigma. Sharing personal, painful experiences can provoke feelings of shame and vulnerability. This internal conflict—feeling both pride and shame—can be difficult to navigate, but it is a common experience for many peer workers. Learning how to manage this ambiguity, without letting shame dominate, is an ongoing process for many individuals in peer roles.

5. New vs. existing cultural values

Peer workers often play a role in introducing new cultural values within healthcare and social support systems, such as promoting user autonomy and decision-making in care. This can create friction with existing organizational cultures and long-standing practices. Peer workers need to understand and empathize with both sides, maintaining a balanced perspective while also advocating for the values that come from lived experience. In some cases, peer workers may face subtle forms of disqualification and must respond wisely while maintaining clear boundaries. As change agents, peer workers sometimes need to take a critical stance on the systems they are part of. This can lead to feelings of isolation, as they may find themselves advocating alone. To do this effectively, peer workers must cultivate a strong, independent voice.

In conclusion, integrating peers into service teams involves navigating complex and often contradictory tensions. Professionals and organizations must recognize the value of lived experience while providing the support and guidance necessary to maintain professional boundaries and foster meaningful collaboration. Best practices for integration can help create environments that support both the professional growth of peer workers and the empowerment of those they serve.

Best practice example: Peer work at HVO-Querido, Amsterdam, The Netherlands- The addendum for employees with lived experience

Best practice example: Peer work at HVO-Querido, Amsterdam, The Netherlands- The addendum for employees with lived experience

At HVO-Querido, one of the most effective practices for integrating peers (employees with lived experience) into the workforce is the addendum for employees with lived experience. This formal framework outlines the competencies, training, and development opportunities for individuals who bring lived experience to their roles, allowing them to contribute meaningfully to the recovery and support of clients.

Key elements of the best practice:

The Addendum provides a clear pathway for employees to gain formal recognition of their lived experience competence, which is documented in their personnel file. This recognition is not just about acknowledging their past experiences but also about assessing and fostering their competencies to use that experience in their roles.

The process begins with a conversation between the employee (or a manager) and the team, in which the peer worker expresses their intention to further develop and apply their lived experience in their professional capacity. The Addendum is designed for both new recruits and existing employees who wish to pursue this path.

Structured phases for development

The Addendum defines clear steps for peers to develop their competencies, beginning with an orientation course, "Working with Own Experience," offered by the Recovery Bureau. This helps peers assess their readiness and develop the necessary skills to integrate their experience into professional practice. In phase two, employees are encouraged to further their training and education. They have the option to pursue several accredited courses, such as Howie the Harp (equivalent to MBO level 2) or MOED (an accredited MBO level 4 qualification), ensuring that they are adequately trained to use their lived experience in a professional, recovery-focused context.

1. Peer support and integration within teams

In this model, peers don't just work in isolation. They actively integrate into teams and help shape recovery-oriented practices. One of the key components of this practice is the integration of team-level agreements on how to maintain and support lived experience knowledge. Peer workers take on an active and influential role within teams, sharing their experiences in a way that fosters trust and mutual understanding with clients and colleagues alike. The role of the peer worker must be clear to all team members.

2. Supervision and continuous development

Peer workers are encouraged to participate in intervision sessions and a yearly training day, which are vital for their ongoing professional development. The continuous development model helps peers stay engaged and refine their approach to recovery and service delivery. This ensures that peers not only contribute to their teams but also continue to grow and adapt their skills as they evolve in their roles.

3. Outcome-Based Evaluation

Competence in lived experience is evaluated against specific result areas such as providing recovery support, identifying opportunities for group recovery, and promoting inclusivity and equal rights. The competence is formally evaluated by the line manager based on these criteria, with feedback from the Recovery Bureau as necessary. This process ensures that peers are contributing effectively to their teams while maintaining professional boundaries.

4. Organizational Support and Flexibility

A key feature of the Addendum is that it offers flexibility in how peers can balance their lived experience with their professional role. The recognition and competency development are individualized, ensuring that employees can adapt the Addendum to suit their personal growth and professional context. This system helps create an inclusive work environment that values lived experience and fosters a culture of continuous learning.

Results and Impact

This approach has resulted in a high level of professional integration of peers in the workforce at HVO-Querido. The clear framework ensures that peers are well-equipped to bring their experiences into their work in a meaningful and supportive way, without feeling overwhelmed by the emotional demands of their roles. By combining lived experience with professional training, peers are empowered to support clients effectively while maintaining personal well-being and professional integrity.

Through the Addendum, HVO-Querido has created an environment where employees with lived experience are not only valued but are also provided with the tools and support they need to thrive in their roles. This practice fosters an inclusive, empathetic, and recovery-oriented workplace, benefiting both peers and clients alike.

Best practice example at Crescer - Peer Meetings

The meetings aim to promote sharing experiences, mutual support and empowerment between colleagues who share similar challenges and needs. The goal is to create a safe, welcoming space for the participants being able to share their experiences, to receive support, guidance and working together to overcome the challenges they face. "It is a very particular and intimate space", as described by a peer colleague.

Goals of Peer Meetings

- **Mutual Support:** To create a space where participants can support each other, share experiences and offer practical advice;
- **Empowerment:** To empower participants in order they can take control of their lives and make informed choices on their health, well-being, labor conduct;
- **Harm Reduction:** To promote harm reduction practices regarding the use of psychoactive substances and managing leisure times, nights and weekends;
- **Social inclusion:** To promote relation between peers and social and community inclusion of participants, helping them to access services and resources that can ameliorate their quality of life;

What is done in Peer Meetings?

- **Share experiences:** participants share their experiences and challenges, offering support and practical advices to one another;
- **Discussion of relevant themes**; participants discuss relevant themes for their health and well-being; any theme can be discussed , always from a perspective of encouraging a critical mass;
- **Planning actions:** participants suggest actions to ameliorate their quality of life, well-being and amelioration of procedures in their workplace;
- **Emotional support:** participants offer emotional support to one another, create friendship bonds and extending a support network extra working context. Weekends programs, dinners, etc.

It is considered a Good Practice within the organization because of:

- **Integration of peer professionals:** these meetings provide a good opportunity for integrating peer professionals, who can offer support and guidance to participants, as they face distinct challenges compared to other professionals.
- **Deepened knowledge of the organization:** these meetings can enhance understanding of the organization's working philosophy, as well as its various projects, procedures, and the rights and duties within the institution.
- **To reduce prejudice and stigma:** these meetings can help reduce stigma and prejudice that sometimes exist between peer and non-peer professionals or different points of view. Since intolerance often stems from ignorance, increasing understanding of differences and others can foster a more inclusive environment.

Summing up, Peer Meetings are considered a good practice within the organization, since they promote mutual support, empowerment and personal, social, and communitarian inclusion of participants.

Activity 5.4: Sharing experiences with peer work

Objective:

To exchange experiences with working with peers in different organisations for a better understanding of the involvement of peers in the daily activities and collect examples of practices that can be applied to other organizations and settings.

All the instructions and materials for the activity are available on the Toolkit.

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Home4Health Training Program

Module 6
European Policy Perspective on Homelessness and Advocacy

Home4Health Training Program | Module 6: European Policy Perspective on Homelessness and Advocacy

a) Learning objectives and outcomes

Define homelessness and its various forms across cultures and countries, and explain the concept of advocacy in professional practice;

Identify key causes and contributing factors of homelessness globally, including economic, social, gender, and political influences;

Analyse global policies and approaches to homelessness, highlighting factors in successful and unsuccessful examples;

Apply best-practice language and terminology when addressing homelessness to understand its impact on individuals and communities;

b) Competencies addressed

Cultural Competence: Understanding and respecting the diverse experiences of homeless populations across countries and cultures, including structural, sociopolitical, and cultural factors, to design effective advocacy campaigns.
Gender Competence: Understanding and respecting the diverse experiences of homeless populations based on gender.
Analytical Skills: Analysing data, trends, and behavioural, social, and political factors related to homelessness to identify patterns, disparities, and advocacy opportunities, and to develop structured strategies.
Critical Thinking: Evaluating the effectiveness of responses to homelessness globally and considering context-specific solutions.
Communication Skills: Effectively communicating insights about homelessness to diverse audiences to promote empowerment and the defence of rights.

c) Methodology

- Lectures and Presentations;
- Group Discussions;
- Case Studies and Real-World Scenarios;
- Interactive Activities;
- Multimedia Resources (Video documentaries, etc)".

d) Materials

- Textbooks;
- Reports and articles;
- Statistic information;
- Case study materials;
- Multimedia resources;
- Presentation slides;
- Paper, post-its and pens.

e) Infrastructure

A suitable classroom setting equipped with a projector, whiteboard, and seating arrangement conducive to group work and discussions.

Unit 1 | Understanding Homelessness

Unit 1 | Understanding Homelessness

Section 1 | Introduction to the course and participant's introduction

This Module provides an in-depth exploration of homelessness and advocacy for better housing solutions. It covers definitions, types, and underlying causes of homelessness, as well as global policies and approaches. The training also highlights the role of advocacy in promoting systemic change and emphasizes the importance of appropriate language when addressing homelessness.

The course methodology combines lectures, interactive activities, group discussions, case studies, and multimedia resources to facilitate engagement and practical learning. Participants will work with real-world scenarios and evidence-based materials to analyze challenges and opportunities in advocacy and policy-making related to homelessness. Any possible doubts should be clarified by the trainer.

Activity 6.1 - Icebreaker "A Day in Someone Else's Shoes"

Objective:

To foster empathy and awareness about homelessness by exploring personal perceptions and associations with related concepts.

All the instructions and materials for the activity are available on the Toolkit.

Section 2 | Definition and Types of Homelessness

a. Basic Definitions

Homelessness is a multifaceted social phenomenon that extends beyond merely lacking a physical reality. It involves the absence of stable, safe, and adequate housing, and is often associated with economic vulnerability, social exclusion, and limited access to essential services. Although there is no single, globally agreed definition, several official institutions have provided definitions that help clarify who is considered homeless in policy, research, and service delivery.

For statistical purposes, the United Nations[1] has described homeless households as those without a shelter that would fall within the scope of living quarters, carrying their few possessions and sleeping in streets, doorways, or other places not intended for habitation. This highlights the most visible form of homelessness as experienced in many contexts worldwide

In many OECD member states, definitions encompass people who sleep rough, stay in emergency or temporary accommodation, live in institutions without permanent housing, or reside in unconventional dwellings. These variations reflect differences in policy priorities, data collection systems, and legal frameworks across contexts.

> *Across the OECD, homelessness remains a persistent challenge, with more than 2 million people estimated to be experiencing homelessness in a given year. While the measurement of homelessness continues to improve, methodological challenges complicate data collection and cross-national comparison. Furthermore, while governments at different levels have put in place homelessness strategies and introduced preventive measures and targeted support to people experiencing homelessness, much remains to be done to design, implement, evaluate, and scale-up effective homelessness policies."*
>
> ***(OECD Toolkit to Combat Homelessness)***

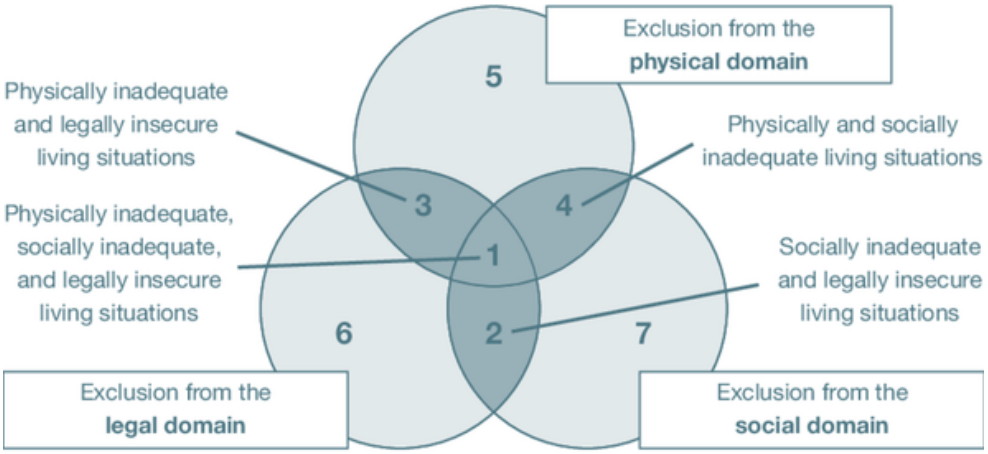
[1] *United Nations Human Settlements Programme (UN-Habitat). (2010). Adequate housing for sustainable cities: A policy-guide on financing urban shelter (Fact Sheet No. 21). United Nations Human Settlements Programme. Retrieved from: https://unhabitat.org/sites/default/files/documents/2019-05/fact_sheet_21_adequate_housing_final_2010.pdf*

b. ETHOS Conceptual Framework

TTo enable **comparability across Europe**, FEANTSA proposed ETHOS as a **conceptual framework** that goes beyond narrow definitions (such as “rough sleeping”) and captures the full spectrum of housing exclusion.

ETHOS defines homelessness in relation to the **absence of a home**, understood as lacking at least one of the following three domains:

- **The physical domain** – having an adequate dwelling (or space) in which to live.
- **The social domain** – being able to maintain privacy and enjoy social relations.
- **The legal domain** – possessing legal title (e.g., tenancy, ownership) that guarantees security of occupation.



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From these domains, ETHOS identifies **four main categories** of living situations that constitute homelessness or housing exclusion (*FEANTSA, 2005*):

- **Rooflessness:** People living rough (e.g., on the streets or in public spaces).
- **Houselessness:** People in emergency accommodation, shelters, refuges, institutions, or other temporary arrangements without a place of usual residence.
- **Insecure housing:** People living under threat of eviction, domestic violence, or lacking legal title.
- **Inadequate housing:** People living in unfit housing, in extreme overcrowding, or in non-conventional dwellings (such as caravans, temporary structures).

2 Amore, K., Baker, M., & Howden-Chapman, P. (2011, January). The ETHOS Definition and Classification of Homelessness: An Analysis. Retrieved from ResearchGate. Retrieved from: https://www.researchgate.net/figure/Model-for-defining-a-population-as-homeless-housing-excluded-or-adequately-housed_fig2_265799835

ETHOS is not intended as a **single legal definition**, but as a **tool for policy harmonization, research, and service provision.** By adopting a broad and inclusive approach, it helps policymakers acknowledge that homelessness is not only about living on the streets, but also about living in insecure or inadequate housing that prevents individuals from enjoying the basic functions of a "home." This perspective aligns with the **right to adequate housing** as recognized in international human rights instruments, such as Article 25 of the Universal Declaration of Human Rights and the UN Committee on Economic, Social and Cultural Rights (CESCR, General Comment No. 4, 1991).

Definitions of homelessness vary considerably across European countries, reflecting different legal frameworks, welfare systems, and policy priorities. This diversity complicates cross-national comparison and is one of the main reasons why FEANTSA developed the ETHOS typology, which offers a common conceptual framework.

c. Ethos Light

Recognizing that not all Member States are able to collect data across the full ETHOS typology, FEANTSA and the European Observatory on Homelessness later proposed a simplified version, **ETHOS Light**, which is used by the **European Statistical System** and by many governments in monitoring homelessness (Busch-Geertsema, 2010). ETHOS Light focuses on a smaller set of operational categories, particularly rough sleeping, emergency accommodation, shelters, institutions, and temporary arrangements.

d. Definitions Across European Countries

In **Spain**, there is no single legal definition of homelessness at the national level. The National Statistics Institute (INE) periodically surveys personas sin hogar (people without a home), focusing primarily on those who use shelters or social services. The 2015 National Strategy for the Homeless adopted a definition closer to ETHOS Light, recognizing people living rough, those in emergency accommodation, individuals staying in longer-term shelters, and those in institutions without a housing alternative. However, broader forms of housing exclusion, such as insecure or inadequate housing, are usually not included in official statistics.

In **Ireland,** homelessness is defined in law under the Housing Act of 1988. According to this legislation, a person is considered homeless if they have no accommodation available that they can reasonably occupy, if they are living in an institution, or other place because they lack accommodation, or are unable to provide accommodation from their own resources. A broader definition also includes "hidden homeless" individuals, such as those living in temporary, insecure, or overcrowded situations with friends and family, as well as rough sleepers and those in institutional settings.

tIn **Portugal**, homelessness is defined in alignment with the **ETHOS typology** of FEANTSA, but the country has gone further by institutionalizing a national framework through successive strategies. The most recent, the **National Strategy for the Integration of Homeless People 2025–2030 (ENIPSSA 2025–2030)**, was approved in 2024 and reflects a significant shift in emphasis. Rather than focusing exclusively on emergency responses, the strategy places strong emphasis on prevention and the development of a holistic, integrated approach. It also introduces an **Integrated Alert and Prevention System**, supported by a national data platform, to identify and respond to risks of homelessness early.

The strategy also expands interventions beyond shelter provision, promoting **Housing First Models**, increasing temporary and shared housing solutions, and strengthening street outreach teams, employment support, and mental health services. Importantly, ENIPSSA 2025–2030 highlights the need for tailored responses for vulnerable groups such as older people, persons with disabilities, migrants, Roma communities, LGBTI individuals, people with substance use disorders, and those with mental health issues. Nevertheless, the definition used in Portugal is seen as insufficient since a person is considered to be experiencing homelessness when they are roofless - living on the street or in a place unfit for habitation - or houseless, meaning temporarily accommodated in an emergency response or shelter for a limited period. While this definition is useful for statistical and operational purposes, it excludes other forms of severe housing vulnerability, such as:

- Victims of domestic violence who remain with the perpetrator due to a lack of housing alternatives;
- People in prison settings without an articulated release plan;
- Individuals residing in therapeutic communities or institutions, with no guaranteed access to housing upon discharge;
- Families and individuals living in conditions of extreme housing poverty, including overcrowding or substandard housing.

The exclusion of these situations from the official definition means that systemic failures remain unidentified and unaddressed, limiting the planning of preventive responses and reducing the capacity to intervene before the actual loss of housing occurs.

IIn the **Netherlands**, the official definition of homelessness used by Statistics Netherlands (CBS) historically focused on adults aged 18–65 without a permanent residence who sleep outdoors, stay in night shelters or crisis accommodation, reside in non-conventional living spaces, or temporarily stay with friends or relatives. Although this definition is aligned with elements of ETHOS Light, it excludes several categories recognised within the broader ETHOS framework, such as people leaving institutions without housing prospects, individuals facing imminent eviction, minors, older adults, and people without civil registration. As a result, CBS figures capture only a portion of the total homeless population. To address these gaps, the Netherlands introduced a nationwide ETHOS-based enumeration in 2023, conducted by the University of Applied Sciences Utrecht (HU) and Kansfonds, which applies a much broader understanding of homelessness. This new approach includes hidden homelessness—people staying temporarily with others, living in non-standard housing, or facing acute housing insecurity—and early results show that homelessness in the Netherlands is far more widespread than suggested by CBS statistics. Consequently, while policy has increasingly moved toward Housing First, the country is now shifting from a narrow, visibility-based definition toward a more comprehensive ETHOS-aligned understanding of homelessness.

Taken together, these examples illustrate how national definitions remain uneven. Ireland has a relatively broad legal definition, though its operational measurement is narrower. Spain and Portugal rely on strategy-based definitions that resemble ETHOS Light but remain focused on visible homelessness. The Netherlands has long applied a narrow, visibility-based definition as reflected in CBS statistics, but the introduction of a nationwide ETHOS-based enumeration in 2023 signals a shift toward a broader and more inclusive understanding of homelessness. None of these four countries apply the full ETHOS framework in legislation, yet ETHOS has influenced policy discourse and serves as a reference point for European-level comparability.

Activity 6.2: Video Forum With Examples of Different Types of Homelessness

Objective:

To gain direct insights into the different types of homelessness through firsthand accounts and real-life examples.

All the instructions and materials for the activity are available on the Toolkit.

Section 3 | Causes of Homelessness and main statistics

Main statistics regarding homelessness

Homelessness is not the result of a single cause; rather, it stems from a complex interplay of structural forces, systems failures, and individual or relational crises. Before addressing the main causes of homelessness, it is worth taking a deeper look into the most recent data regarding this social reality, in Europe.

Homelessness has become an increasingly visible social challenge across Europe, reflecting broader structural issues related to housing affordability, labour market precarity, and the availability of social protection systems. Recent European estimates suggest that at least 895,000 people experience homelessness on any given night across Europe, a figure roughly equivalent to the population of a medium-sized European city (FEANTSA & Fondation Abbé Pierre, 2023). However, this estimate is considered conservative because it mainly captures the most visible forms of homelessness, such as people sleeping rough or staying in emergency accommodation, while many other forms—often referred to as “hidden homelessness”—remain difficult to measure (FEANTSA & Fondation Abbé Pierre, 2023).

The number of people experiencing homelessness in Europe has increased significantly in recent decades. Estimates indicate that homelessness across the European Union has more than doubled since 2009, driven by factors such as rising housing costs, shortages of affordable housing, migration pressures, and the broader cost-of-living crisis affecting many European households (Euronews, 2024). In addition, major urban centres across Europe have become focal points of housing exclusion, where increasing rents and limited housing supply place significant pressure on vulnerable populations. These structural challenges have contributed to growing demand for emergency accommodation services and social support systems across many EU member states.

Southern European countries have experienced increasing housing pressures in recent years, partly due to rising housing costs, tourism-driven housing markets, and limited social housing supply. These structural pressures have contributed to rising homelessness levels across several Mediterranean countries, although the scale and characteristics of the phenomenon vary between national contexts.

Among these countries, France and Italy record some of the highest absolute numbers of people experiencing homelessness or living in non-standard housing situations. In France, approximately 169,538 people were recorded in the 2021 census, while Italy reported around 185,531 individuals in similar housing conditions (FEANTSA, 2024). In both countries, homelessness is strongly concentrated in large metropolitan areas—such as Paris, Rome, Milan, and Naples—where housing affordability has deteriorated significantly over the past decade and demand for emergency accommodation and temporary housing continues to grow.

Homelessness has become an increasingly visible social challenge across Europe, reflecting broader structural issues related to housing affordability, labour market precarity, and the availability of social protection systems. Recent European estimates suggest that at least 895,000 people experience homelessness on any given night across Europe, a figure roughly equivalent to the population of a medium-sized European city (FEANTSA & Fondation Abbé Pierre, 2023). However, this estimate is considered conservative because it mainly captures the most visible forms of homelessness, such as people sleeping rough or staying in emergency accommodation, while many other forms—often referred to as “hidden homelessness”—remain difficult to measure (FEANTSA & Fondation Abbé Pierre, 2023).

Main causes of Homelessness

According to HomelessHub, these three domains collectively shape the pathways into and out of homelessness.

1. Structural Factors

At the societal level, structural drivers create environments that predispose individuals and families to housing instability. Chief among these are poverty, shortages of affordable housing, and discrimination.

Poverty acts as a powerful precipitant of homelessness. Individuals living in poverty often struggle to afford basic necessities—housing, food, healthcare. As Homeless Hub notes, poverty means a person is “one illness, one accident or one paycheque away from living on the streets”

Closely linked is the **lack of safe, affordable, and stable housing**. When housing costs outpace income, families fall into what researchers call "core housing need", spending more than half their income on rent. This unsustainable financial burden increases the risk of homelessness.

Additionally, discrimination—based on race, gender, ethnicity, income, sexual orientation, or disability—limits access to housing, employment, and social services. Marginalized groups are disproportionately represented among people experiencing homelessness.

FEANTSA’s Research Digest No. 3 provides a comprehensive analysis of the socio-economic characteristics of families experiencing homelessness across Europe, highlighting the particular vulnerability of lone mothers and single-parent households. The report demonstrates that women who are raising children on their own face a disproportionately high risk of losing stable housing, due to a combination of economic, social, and policy-related factors (FEANTSA, 2025)

According to the report, three primary support needs are crucial in preventing homelessness particularly among women and mitigating its effects:

- **Access to financial resources –** Economic instability remains one of the most significant structural factors contributing to homelessness. Many lone parents have limited income, rely on low-paid or precarious employment, or face delays and inadequacies in social welfare provision. Without sufficient financial resources, families struggle to maintain housing, meet basic needs, and avoid eviction.

- **Familial and social support –** Strong social networks, including extended family, friends, and community ties, are protective factors against homelessness. FEANTSA highlights that the absence of social support increases vulnerability, particularly for lone mothers who may lack childcare options, emotional support, or informal housing assistance. Social isolation can exacerbate stress and reduce resilience when facing housing crises.

- **Social protection systems –** Effective public social protection is critical for supporting families at risk. This includes access to affordable housing, welfare benefits, childcare, and healthcare. FEANTSA notes that deficiencies in these systems—such as long waiting lists for social housing, insufficient income support, or fragmented services—heighten the risk of homelessness and reduce the capacity of families to recover once they lose stable accommodation.

2. Systems Failures

Even when individuals face manageable risks, inadequate institutional responses can tip them into homelessness. Homeless Hub emphasizes that failures in systems such as **child welfare, healthcare, mental health services,** and **corrections** serve as major contributors.

For instance, young people leaving foster care are often unprepared for independent life and receive little transitional support, increasing their vulnerability to homelessness. Similarly, when patients are discharged from hospitals, psychiatric facilities, or correctional institutions without coordinated housing plans, they frequently end up without a home.

Gaps in support for **immigrants and refugees** also highlight systemic shortcomings. The same applies for internal migrants within one same country, finding for better life conditions without having the material support needed. When individuals cannot access language, legal, or employment services, their risk of becoming in a situation of homelessness rises.

3. Personal Circumstances and Relational Problems

At the individual level, personal circumstances and relationship dynamics can trigger homelessness, especially when existing vulnerabilities are present. Several traumatic life events like job loss, death of close relatives, forced migration, family breakdown, mental health issues, and family or gender based violence as common precipitating factors.

Family violence and gender based violence, in particular, are pervasive and urgent causes of homelessness especially in women. Women and youth fleeing abuse are often compelled to leave home quickly—frequently without support or safe alternatives—placing them directly at risk of street homelessness.

Mental health challenges and substance use disorders also form a critical nexus of vulnerability. A large meta-analysis of studies among homeless populations in high-income countries found that the prevalence of any current mental disorder (including severe mental illness, mood disorders, anxiety, PTSD, etc.) is approximately 76.2%, with substance use disorders affecting 44%, major depression around 19%, and schizophrenia spectrum disorders about 7% (Gutwinski, S., Schreiter, S., Deutscher, K., & Fazel, S., 2021)

Overlapping Oppressions: Gender, Sexual Orientation and Homelessness

Research highlights how homelessness often intersects with other forms of social exclusion—such as gender inequality, migration status, health conditions, or discrimination based on sexual orientation and gender identity. These overlapping vulnerabilities can intensify housing insecurity and make it more difficult for affected individuals to access stable housing and support services.

Although men represent the majority of the homeless population, women's homelessness has been increasing and often remains less visible. According to national statistics in Spain, for example. women represent around 23% of the homeless population, a proportion that has grown in recent years (INE, 2022; FEANTSA, 2023). Women experiencing homelessness frequently face additional risks related to gender-based violence, economic dependence, and caregiving responsibilities. Research also shows that women are more likely than men to experience forms of hidden homelessness, such as staying temporarily with friends or relatives or remaining in unsafe housing situations in order to avoid sleeping rough.

In addition, women experiencing homelessness often encounter multiple intersecting disadvantages. Data from Spain's national homelessness strategy indicate that several thousand homeless women face additional vulnerabilities, including chronic illness, disability, or migrant status, illustrating how different forms of social exclusion can accumulate and reinforce each other. These overlapping risk factors can increase exposure to violence, worsen physical and mental health outcomes, and complicate access to employment and housing opportunities.

Sexual orientation and gender identity can also play an important role in pathways into homelessness. Studies on the LGBTI population in Spain indicate that over one third (36%) of LGBTI individuals report having experienced some form of homelessness during their lifetime, while 34% have faced housing instability in the previous five years. These situations often result from family rejection, discrimination, or conflict related to sexual orientation or gender identity. Trans people appear to be particularly vulnerable: more than half of trans respondents (53.2%) report having experienced situations of housing exclusion, and a small but significant proportion report having slept on the street at some point.

These patterns highlight how homelessness is not only a housing issue but also a reflection of broader social inequalities. Individuals who already experience marginalisation—such as women facing gender-based violence, LGBTI individuals experiencing family rejection, migrants, or people with disabilities—may encounter greater barriers to accessing housing and support services. Addressing homelessness therefore requires approaches that recognise these overlapping forms of exclusion and incorporate gender-sensitive and LGBTI-inclusive perspectives in housing, social protection, and support policies.

Conclusions: A Complex Web

All reports and studies emphasize that **homelessness is rarely the result of a single factor**. Instead, it emerges at the intersection of structural inequalities, weak social support, and inadequate safety nets. Poverty, discrimination, and labor market insecurity create conditions in which families are vulnerable, while gaps in social protection and limited familial support remove the safety nets that might prevent housing loss. Lone mothers, in particular, are disproportionately affected because they must navigate these challenges while also caring for children, often with limited external resources.

Notably, most individuals experiencing homelessness encounter multiple, overlapping factors—structural, systemic, and personal—in a cascading fashion. As described by researchers and supported by in-depth platform analyses, it is the cumulative weight of economic instability, inadequate infrastructure, institutional neglect, and personal trauma that frequently pushes individuals over the threshold into homelessness.

In other words, structural factors set the context—creating an environment where homelessness becomes more likely. System failures remove safety nets. And personal or relational crises are often the tipping points that finally propel individuals into housing loss.

Section 4 | Approaches to Addressing Homelessness

a. Introduction

Developing effective responses to homelessness is crucial not only to improve the well-being of individuals and families, but also to promote social cohesion and reduce public costs associated with emergency services, healthcare, and social interventions. Homelessness intersects with numerous social challenges, including unemployment, mental health issues, substance use, discrimination, and systemic inequities, making it a multidimensional problem that demands coordinated, evidence-informed solutions.

To address homelessness effectively, policymakers, service providers, and communities implement a range of approaches that operate at different levels. These approaches include:

- Preventive measures to reduce the risk of housing loss;
- Crisis interventions that respond to urgent needs;
- Temporary and transitional housing programs that provide stability and support;
- And long-term housing solutions, such as Housing First or permanent supportive housing, which aim to promote sustained stability and social integration.

Each approach plays a critical role in reducing the incidence, duration, and recurrence of homelessness, and in ensuring that support is tailored to the specific circumstances of individuals and families.

However, responding to homelessness presents **several challenges**. These include accurately identifying those at risk, coordinating across sectors, addressing complex and intersecting needs such as mental health or substance use, and ensuring that housing solutions are both affordable and accessible. A comprehensive approach to homelessness requires integrating policy, practice, and community engagement to create systems capable of meeting these challenges while supporting individuals on the path to stability and inclusion.

The Centre for Homelessness Impact developed a framework for ending homelessness, defined as preventing homelessness wherever possible and, where prevention is not possible, ensuring that it is a **rare, brief, and non-recurrent experience.** The framework also integrates a method for measuring progress towards this goal through a set of eight core indicators. These indicators capture the prevalence of specific forms of rough sleeping, such as **long-term rough sleeping and recurrent episodes of rough sleeping.**

PREVENTED	RARE	BRIEF	NON-RECURRING
P1 Number of new people sleeping rough	R1 Number of people sleeping rough	B1 Number of people experiencing long-term rough sleeping	NR1 Number of people returning to rough sleeping
P2 Number of people seen rough sleeping after being discharged from institutions	R2 Number of people sleeping rough who have moved accommodation	B2 Number of nights seen sleeping rough	NR2 Number of people sleeping rough who had previously moved into settled accommodation

Table 4 Retrieved from https://www.homelessnessimpact.org/ending-homelessness-framework-england

b. Prevention as the first approach

Peter Mackie (Cardiff University) and Suzanne Fitzpatrick (Heriot-Watt University) are the principal authors of the theoretical framework on homelessness prevention. They have developed an in-depth analysis of how public policies can prevent homelessness, distinguishing between different levels and mechanisms of prevention.

Tipology of Homelessness Prevention (*Mackie et al., 2017*)

Mackie and colleagues (2017), in the framework published by Crisis and Cardiff University, propose five levels of homelessness prevention, each aimed at addressing different stages of risk and need.

1. **Universal prevention** targets the general population and aims to reduce structural and systemic risk factors. This includes broad policies in housing, income, and health that lower the overall risk of losing a home. Examples include affordable housing policies, subsidies, and universal housing support.
2. **Targeted prevention** focuses on vulnerable or at-risk groups to prevent housing loss before a crisis occurs. Interventions are directed at identifiable groups such as young people transitioning from care, individuals leaving prison, or victims of domestic violence.
3. **Crisis prevention** addresses people experiencing a housing crisis and aims for immediate intervention to prevent rough sleeping. These responses act quickly to prevent situations like eviction or family conflict from resulting in actual homelessness.

4. **Emergency prevention** is for people already sleeping rough and focuses on rapid response and minimizing the impact of homelessness. Measures include reducing the duration of time spent without accommodation, for example through rapid rehousing programs.
5. **Recovery prevention** supports people post-homelessness, aiming to promote reintegration and prevent relapse. This level involves post-housing support such as psychosocial assistance, rent support, and community integration to ensure long-term stability.

Level	Target Group	Aim	Examples / Description
1. Universal	General population	Reduce structural and systemic risk factors	Broad housing, income, and health policies that lower the population-level risk of losing housing (e.g., affordable housing policies, subsidies, universal housing support).
2. Targeted	Vulnerable (at-risk) groups	Prevent housing loss before a crisis occurs	Interventions aimed at identifiable at-risk groups (e.g., young people transitioning from care, people leaving prison, victims of domestic violence).
3. Crisis	People experiencing housing crises	Immediate intervention to prevent rough sleeping	Immediate responses to prevent a crisis (e.g., eviction, family conflict) from resulting in actual loss of housing.
4. Emergency	People already sleeping rough	Rapid response and impact mitigation	Measures to reduce the time someone spends without accommodation, including rapid rehousing.
5. Recovery	Post-homelessness	Support reintegration and prevent relapse	Post-housing support to prevent relapse and promote stability (e.g., psychosocial support, rent assistance, community integration).

Table 5

Image 5 - Retrieved from Fitzpatrick et al., 2021

In some research articles and reports (e.g., Fitzpatrick & Bramley, 2018–2020), the five levels have been **grouped or simplified** to facilitate dialogue with national systems, such as the Welsh or Scottish models. As a result, a **four-level version** is often used, typically including: **universal, at-risk, crisis, and chronic**. In this version, the **"emergency"** and **"recovery"** levels are merged with **crisis** and **chronic**, respectively.

Primary prevention aims to stop homelessness before any risk appears by addressing broad structural factors and strengthening the overall functioning of the housing system and welfare state. This includes a wide range of strategies such as increasing the supply of social and public housing, implementing rent controls and tenant protections, and introducing policies that limit speculation and the excessive use of short-term rentals, alongside incentives for affordable construction. Primary prevention also involves poverty-reduction measures, including minimum income guarantees, access to employment programmes, child and family benefits, and targeted support for survivors of gender-based violence.

In addition, it requires ensuring universal access to essential services such as mental health and substance-use support, youth and educational services, and various forms of income assistance and social protection. Typically led by governments, primary prevention is crucial because it reduces the overall number of people who enter homelessness in the first place.

Secondary prevention focuses on intervening early when individuals or households show signs of housing instability, with the goal of preventing an imminent loss of housing. This approach relies on early detection and screening systems, such as healthcare providers identifying patients at risk, schools observing signs of instability among students, social workers detecting potential evictions, and women's services recognising survivors who may be fleeing violence. It also includes targeted support for high-risk groups, such as young people leaving foster care, individuals exiting prisons, hospitals, or other institutions, migrants and refugees facing legal or administrative barriers, and women and LGBTQ+ individuals experiencing family rejection or violence. In addition, secondary prevention involves practical, short-term assistance to help people remain housed, including support to cover rent arrears, mediation between tenants and landlords, rapid access to legal advice, and emergency financial aid or crisis grants. When effectively implemented, secondary prevention can stop evictions, stabilise families, and significantly reduce public spending.

Tertiary prevention aims to prevent the recurrence of homelessness by focusing on individuals who have already experienced it, ensuring they do not return to a cycle of housing instability. Key components include providing supportive housing, such as Housing First programs, alongside comprehensive case management and mental health support. It also encompasses income assistance and pathways to employment, long-term tenancy support, trauma-informed services, and specialized programs for survivors of domestic violence. Tertiary prevention recognizes that simply providing housing is often insufficient for people with complex needs, and that ongoing, tailored support is essential to break the cycle of homelessness and promote long-term stability.

Although this is the standard model, other authors have suggested different approaches. For example, Dej, E., Gaetz, S., & Schwan, K. (2020) in the article "Turning Off the Tap: A Typology for Homelessness Prevention" (published in The Journal of Primary Prevention)[1], propose a comprehensive framework that identifies five interrelated elements necessary for effective homelessness prevention:

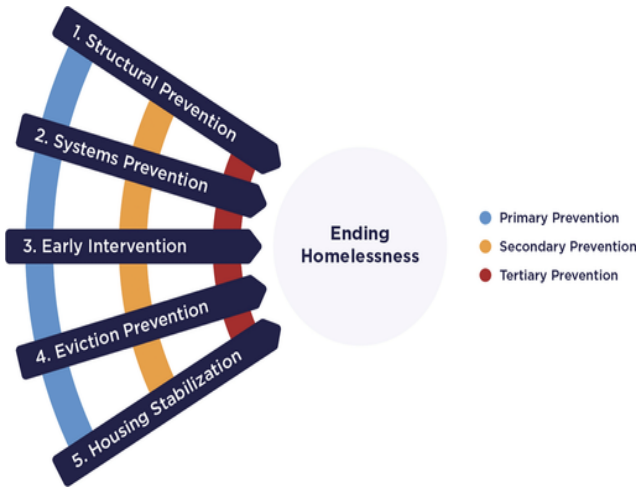

Image 6 - Retrieved from: Dej, E., Gaetz, S., & Schwan, K. (2020). Turning off the tap: A typology for homelessness prevention. Journal of Primary Prevention, 41(5), 397–412. https://doi.org/10.1007/s10935-020-00607-y

These five elements are designed to **cut across the traditional primary, secondary, and tertiary prevention categories**, recognising that different strategies can have aspects of all three types of prevention and that coordinated approaches are required to address homelessness at multiple levels. The typology emphasises that homelessness is not an isolated event but the outcome of complex social, economic, and systemic factors, and therefore prevention must be equally comprehensive. This work draws on the **public health prevention model** (which categorises interventions into primary, secondary, and tertiary levels based on risk and timing of intervention) and adapts it to homelessness policy and practice by integrating structural and systems-level factors as well as intervention-based strategies.

c. Emergency Response / Crisis Intervention

Emergency response or crisis intervention refers to immediate, short-term services designed to respond to urgent needs of people experiencing homelessness, often at the point of first contact with services. These interventions serve as a **first line of support** and aim to ensure safety, dignity, and basic needs such as shelter, food, and sanitation while longer-term solutions are pursued.

In Europe, emergency responses take many forms, including **24/7 shelters,** day centres, outreach teams, mobile support services, and emergency accommodation provided by both public authorities and civil society. Although not sufficient on their own to end homelessness, such services are crucial for **reducing the immediate harms associated with being without stable housing** and can provide entry points into additional supports and housing pathways. A comparative report on homelessness services across Europe notes that **emergency shelters, food distribution, and day centres remain among the most common forms of homelessness support across European contexts,** highlighting their continued relevance in current service systems.

While emergency services are essential, European organisations and policy networks have also emphasised the quality and **accessibility** of these responses. For example, the European Federation of National Organisations Working with the Homeless (FEANTSA) has called for **unconditional access to emergency accommodation for all people experiencing homelessness**, regardless of administrative status, and for moving beyond “night-only” shelters toward more dignified, 24-hour facilities that better meet people’s holistic needs.

Further demonstrating the importance of crisis responses in Europe, the **Lisbon Declaration on the European Platform to Combat Homelessness** (signed in June 2021 by EU Member States, the European Commission, and key civil society partners) outlines several commitments that directly relate to emergency and crisis intervention in homelessness systems. According to the Lisbon Declaration, one of the core objectives agreed by signatories is that "no one sleeps rough outdoors for lack of accessible, safe and appropriate emergency accommodation", affirming that emergency shelter must be available and accessible to all people experiencing homelessness as a fundamental right and first point of support. The Declaration also states that no one should remain in emergency or transitional accommodation longer than necessary before moving to permanent housing solutions, reflecting a clear commitment to crisis support as the entry point to longer-term pathways out of homelessness. This emphasis on emergency accommodation is part of a broader effort by the Platform to coordinate evidence, share best practices, and encourage EU Member States to align strategies and avoid gaps in immediate care while pursuing integrated responses across prevention, housing, and support services.

As an example, in Spain, the **Cruz Roja (Red Cross)** runs specialised emergency social units (Unidades Móviles de Emergencia Social) that operate particularly during crisis periods (e.g., cold weather) to provide immediate support for people experiencing homelessness. These mobile units offer food, warm beverages, blankets, hygiene products, and referrals to shelters or temporary accommodation, helping to address urgent needs and reduce harm associated with exposure to harsh conditions. In 2025, Cruz Roja **reported** having 91 emergency units operating across 35 provinces, serving more than 22,000 people experiencing homelessness and coordinating with temporary shelter spaces and day centres to ensure rapid basic support.

d. Temporary or Transitional Housing

Temporary or transitional housing provides short- to medium-term shelter and support services to people who are experiencing homelessness but are not yet ready to move into permanent housing. This category is more structured than emergency shelters and typically offers case management, life-skills support, and pathways toward stable housing.

While definitions vary across contexts, many housing systems combine what is sometimes called transitional housing with rapid re-housing programs that help people move quickly into community housing with time-limited support. Research published by the Urban Institute highlights that joint transitional and rapid-rehousing programs help move people out of unsheltered homelessness more quickly and link them to community services even after their initial stay, demonstrating the role of transitional options as bridges, not endpoints, in homelessness systems.

Transitional housing can be particularly important for people who need time to stabilise after living on the streets, access employment services, or engage with treatment before entering long-term housing. While transitional programs are not a solution on their own, they serve a vital function within a continuum that connects emergency shelter to permanent housing pathways.

For example, In Lyon, France, temporary modular housing has been used as part of the **Home Silk Road project,** where prefabricated housing units were installed to **temporarily accommodate homeless families on a redeveloped urban site**. These units provide private living space with basic amenities, and the project also integrates social, cultural, and economic support to facilitate community engagement and transition toward more stable housing.

One notable example of a temporary housing initiative in the Netherlands is Onder de Pannen, a project developed by the Regenbooggroep to address the growing issue of economic homelessness. The programme matches people who suddenly find themselves without a home, often due to job loss, relationship breakdown, or other financial pressures, with residents who have an extra room to offer. Through careful screening and support from the Regenbooggroep, these individuals are housed in private homes for up to twelve months, giving them the stability they need to regain control of their lives while continuing to look for permanent housing. The project operates in collaboration with local municipalities and housing associations and has successfully placed hundreds of economically homeless people into temporary accommodation across several Dutch cities.

e. Housing First / Permanent Supportive Housing

One of the most efficient models to address homelessness is the Housing first model.
This model was developed by Sam Tsemberis (2010), creator of the first Pathways Housing First program and is based on the understanding that **stable housing is the foundation for improving health, social inclusion, and overall well-being**. By removing the barriers and preconditions that often delay access to housing, Housing First has been shown to increase housing stability, reduce reliance on emergency services, and support long-term recovery and social reintegration.

The Housing First model is an approach to addressing homelessness that prioritizes providing people with stable, permanent housing as the first and immediate step, without requiring them to meet conditions such as sobriety, treatment, or employment. Once individuals have secure housing, they are offered tailored support services—such as mental health care, addiction treatment, or employment assistance—according to their needs and preferences.

Key features of Housing First program include:

- Scattered-site housing in independent, community-based apartments.
- Housing combined with supportive services delivered by a multidisciplinary team, including peer workers.
- Long-term commitment: the team supports clients for as long as needed, without time limits.
- Two basic requirements: Weekly home visit from program staff and compliance with the lease and rental payment agreement (typically 30% of the participant's income toward rent)
- Consumer choice and self-determination as core principles.

Housing First tends to work better than traditional "housing readiness" approaches because it prioritizes providing stable, permanent housing immediately, without requiring people to meet conditions such as sobriety, treatment, or employment.

By providing individuals with a home first, along with the support of specialized professionals, stress is reduced, as well as the health risks, and social instability associated with prolonged homelessness, creating a stable foundation from which they can address other challenges. This immediate stability increases housing retention, improves physical and mental health, and lowers reliance on emergency services and shelters.

Unlike readiness-based models, which can leave the most vulnerable trapped in cycles of homelessness while they "qualify" for housing, Housing First removes barriers, respects individual dignity and autonomy, and supports tailored services according to each person's needs. The result is not only more successful long-term housing outcomes but also greater opportunities for social reintegration, well-being, and cost-effective public resource use.

Research consistently shows that Housing First is highly effective in ending homelessness—helping approximately 8 out of 10 people achieve long-term housing stability—and is more cost-effective than emergency shelters or treatment-first models (Tsemberis, 2010; Polvere et al., 2014).

Participants also tend to show significant improvements in multiple areas of life, such as Reduced substance use, Improved adherence to treatment, reconnection with family members and strengthened social support networks

Unit 2 | Successful Public Policy and Advocacy in Solutions to Homelessness

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Section 1 | Public Policy

> *By encouraging policymakers to take action, advocacy can be extremely effective at making change. On countless occasions, legislators have stated initially that they could not take a specific step or support a specific program until advocates stepped in and worked to change their minds.*
>
> ***National Alliance to End Homelessnes***

Homelessness is not solely the result of individual circumstances; it is a complex social phenomenon shaped by economic, social, and institutional factors. Public policies—particularly those related to housing, health, and social services—play a decisive role in both preventing and alleviating homelessness.

At the high-level conference in Lisbon co-organised by the Portuguese Presidency of the Council of the EU in 2021, national ministers, together with representatives of the European Commission, the European Parliament, the Economic and Social Committee, the Committee of Regions, civil society organisations, social partners, and cities, signed the Lisbon Declaration and launched the European Platform on Combating Homelessness (EPOCH). The signatories pledged to work together under the Platform and to deliver actions within their respective competences.

Stemming from the European Platform for the Eradication of Homelessness, the European 2030 Strategy aims to ensure that by 2030, no one has to live on the streets due to lack of adequate housing, promoting the progressive eradication of homelessness across all Member States. Combating homelessness has also been established as a priority for Social Europe, with all stakeholders committing to renewed efforts in line with the European 2030 Strategy. To implement the shared principles of the Strategy, the following key objectives have been agreed upon.

- Evidence-based approaches, such as Housing First and early prevention;
- Multisectorial cooperation, involving housing, health, employment, and social protection;
- Monitoring and sharing of comparable data across countries;
- European funding oriented towards sustainable results, through instruments such as the European Social Fund+, the European Regional Development Fund (ERDF), and InvestEU.

Basic Humans Rights as the Background for Homelessness Policies

Addressing homelessness effectively requires not only well-designed policies but also a clear **understanding of the legal and rights-based foundations that underpin these policies**. Homelessness is recognized under international and European law as more than a social problem—it is a violation of fundamental human rights. The International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966)[1] explicitly establishes the right to adequate housing, stating that everyone has the right "to an adequate standard of living, including adequate housing" and that governments must take steps to progressively realize this right. Similarly, the European Social Charter and the EU Charter of Fundamental Rights reinforce obligations on member states to ensure access to social protection, housing, and non-discrimination for vulnerable populations.

These legal frameworks provide a foundation for policy development and advocacy, as they create enforceable standards that governments and local authorities must meet. They also offer tools for challenging systemic gaps and injustices, such as discriminatory access to housing or criminalization of homelessness. For example, European courts have ruled that states must prevent evictions without alternative accommodation, recognizing housing as a basic human right.

Within the EU, national legislation often incorporates these principles, although implementation varies widely. Some countries have codified homelessness prevention, housing access, and social protection in law, while others rely primarily on policy guidance without enforceable rights. Legal recognition is particularly important for vulnerable groups, including migrants, refugees, women experiencing domestic or economic abuse, and people with disabilities, who are disproportionately affected by barriers to housing and social support.

A **rights-based framework also emphasizes accountability, participation, and equality**. Policies should be co-designed with people with lived experience, ensuring that interventions reflect real needs and empower affected communities. By situating homelessness within a legal and human rights context, practitioners and policymakers are equipped not only to provide immediate support but also to advocate for systemic change, challenge discriminatory practices, and ensure that public interventions are consistent with broader social justice objectives

Homelessness and Intersectionality as a Basic Approach

It is fundamental to bear in mind that **Homelessness does not affect all populations equally and public policies must integrate an intersectional lens aimed to prevent gaps in service delivery and ensure that interventions reach those most at risk.** Public policies that address housing, health, and social services must consider the ways in which multiple social identities and structural inequalities intersect to increase vulnerability. For example, migrant and refugee women may face language barriers, precarious legal status, and discrimination that limit access to both housing and social services. Similarly, older adults experiencing homelessness often confront age-specific challenges such as limited mobility, health vulnerabilities, and social isolation.

People with disabilities or chronic health conditions may require tailored support, including accessible housing, healthcare continuity, and adaptive social services. Women experiencing Gender Based Violence face additional layers of vulnerability, where housing instability may be compounded by financial control, coercion, or the need to escape unsafe domestic environments.

This approach requires the collection of disaggregated data, coordination across sectors, and the active involvement of affected communities in policy design.

Evaluation and Accountability Mechanisms on Homelessness Policy and Advocacy

Ensuring that public policies effectively address homelessness requires more than well-intentioned programs—it requires **systematic evaluation and accountability mechanisms. Policies must be monitored to determine whether they are achieving their intended outcomes**, particularly for the most vulnerable groups identified through an intersectional lens. This involves defining clear indicators, such as reductions in rough sleeping, successful transitions to permanent housing, improvements in access to healthcare and social services, and the elimination of discriminatory barriers.

Evaluation should also capture **qualitative dimensions,** such as user experience, the perceived accessibility of services, and the responsiveness of interventions to the specific needs of marginalized populations. By combining quantitative and qualitative data, policymakers can better understand gaps in provision, identify unintended consequences, and adapt strategies to ensure inclusivity and effectiveness.

Accountability mechanisms are equally important. This includes reporting structures that allow governments, local authorities, and service providers to demonstrate progress, independent audits that validate results, and channels for civil society and community organizations to provide feedback or highlight systemic shortcomings. Advocacy plays a crucial role in this process: by using evaluation data and evidence-based research, advocates can push for policy improvements, highlight successful models, and ensure that commitments made at national or European levels are translated into meaningful change on the ground.

In this way, evaluation and accountability not only measure policy success but also create a feedback loop that strengthens interventions, supports advocacy efforts, and ultimately improves outcomes for people experiencing homelessness, particularly those facing compounded vulnerabilities.

Multi-Level Governance and Cross-Sector Collaboration

Effective public policy responses to homelessness increasingly **depend on coordination across different levels of governance — local, national, and European — alongside strong partnerships between public institutions, civil society organisations, research networks, and grassroots movements.** Multi-level governance recognises that homelessness is shaped by complex, intersecting factors that no single actor can address alone. Coordination ensures that resources, strategies, and knowledge are shared, enabling more coherent and sustainable solutions. Civil society and grassroots actors are essential partners in this process — they bring experiential knowledge, mobilise communities, and serve as watchdogs that hold public authorities accountable.

At the **European level,** networks like the Housing First Europe Hub and FEANTSA (European Federation of National Organisations Working with the Homeless) exemplify this collaborative approach. The Housing First Europe Hub was established to support the scaling up of the Housing First model across countries by connecting municipal, national, and civil society actors to share research, training, implementation experience, and advocacy for evidence-based housing solutions. Such networks help bridge local practice with EU policy debates, ensuring that innovative responses inform broader policy frameworks.

City-led initiatives also illustrate how governance at municipal and regional levels contributes to system-wide responses. For example, the URBACT ROOF network — comprising cities like Ghent and others committed to housing strategies aimed at ending homelessness — combines local experimentation with peer learning and joint policy development across European contexts, fostering collaboration among public services, NGOs, and community stakeholders.

Grassroots organisations play a crucial role in linking lived experience to policy change. In Hungary, the advocacy group The City is For All (A Város Mindenkié) works with people experiencing homelessness and housing poverty to defend housing rights, campaign against evictions, and challenge the criminalisation of homelessness through direct action, legal mobilisation, and public advocacy. Their efforts — including stopping evictions, providing legal support via affiliated groups such as Streetlawyer and From Streets to Homes, and amplifying housing justice into national political conversation — have helped bring housing issues into the foreground of public debate and influence local and national policy agendas.

In Portugal, Habita! – Associação pelo direito à habitação e à cidade advocates for the right to housing and to the city, challenging real estate speculation and pushing for legal protections and policy safeguards against evictions, particularly in the Lisbon metropolitan area. Habita! participates in broader European coalitions such as the European Action Coalition for the Right to Housing and the City, linking national struggles to transnational housing justice movements and demonstrating how local advocacy can contribute to shaping both political discourse and legislative priorities.

In the Netherlands, this broader conceptual shift is also reflected in practice-oriented initiatives such as Valente's project Cultuuromslag – NAD in je DNA. The project is led by the HVO-Querido Centre of Expertise on behalf of Valente, the national association representing organisations working in homelessness services, social care and supported housing in the Netherlands. The project aims to embed the principles of the National Action Plan on Homelessness (NAD) into the "DNA" of organisations, professionals and clients. Through a structured learning pathway combined with concrete tools, it focuses on moving from knowing the principles, to believing in them, and ultimately doing them in everyday practice.

These examples demonstrate that multi-level governance in homelessness is not only about aligning policy across institutional layers but also about creating spaces for dialogue, joint problem-solving, and shared accountability. In this context, advocacy plays a crucial role in ensuring that the **commitments made at the European level are translated into real change on the ground**. People experiencing homelessness often face barriers that go beyond a lack of housing, including discrimination, bureaucratic obstacles, and gaps in access to healthcare or social support. Effective advocacy helps to challenge these barriers, amplify the voices of those affected, and ensure that public policies are responsive to their needs.

Concrete Policies: Housing, Public Health and Social Services

Given the principles presented above, **specific housing policy** is fundamental — access to secure, affordable, and adequate housing and prevention of homelessness provides the stability necessary for individuals to address other life challenges. The European Committee of the Regions (CoR) has explicitly emphasized that local/regional governments are key implementers in the fight against homelessness. In its opinion, the CoR calls for a "housing-led" approach, especially Housing First, complemented with social support services. Strategies such as the Housing First model, which prioritises immediate access to permanent housing before addressing other needs, have proven effective across Europe. In Portugal, the ENIPSSA 2025–2030 (Estratégia Nacional de Intervenção em Pessoas Sem-Abrigo) explicitly embeds Housing First into the national homelessness strategy, recognising that without stable housing, other interventions are far less effective.

In Spain, several municipal programmes implement housing-with-support approaches integrated into public policy. For example, Barcelona's **Xarxa d'Habitatges d'Inclusió** provides inclusion housing with socio-educational support for people in situations of residential exclusion, combining accommodation with tailored social support. Additionally, Spain's **National Strategy for Social and Economic Inclusion and Poverty Eradication 2024–2030** includes measures to strengthen supported housing as a pathway to social integration.

In the Netherlands, the **Dutch National Action Plan on Homelessness: Housing First (2023-2030)** promotes integrated approaches, including Housing First pilots in cities such as Amsterdam and Utrecht. These programmes provide rapid rehousing combined with psychosocial support, case management, and links to employment and health services, preventing long-term street homelessness and reducing reliance on emergency shelters.
In Ireland, the Housing for all Plan emphasises Housing First for people with complex needs, combining permanent housing with integrated supports delivered through partnerships between local authorities, health services, and community organisations.

Housing policies also determine the **availability of emergency shelters, temporary accommodation, and inclusive housing programmes targeting vulnerable populations,** including migrants, older adults, people with disabilities, and individuals with mental health or substance use challenges. For example, Ireland's Winter Emergency Accommodation Plan provides temporary shelter during periods of extreme weather while ensuring pathways to long-term housing.

Public health policy is equally critical, given the close link between homelessness and complex health vulnerabilities. Integrated and accessible public health services help mitigate these risks, improve quality of life, and reduce long-term social and economic costs. Policies that ensure continuity of care, community mental health support, and outreach prevent service gaps that can push individuals further into housing instability.

In **Spain**, municipal health outreach teams — such as the Equipos de Atención a Personas Sin Hogar in cities like Madrid — work closely with social services to provide primary healthcare, mental health support, and referrals directly to people experiencing homelessness. In the Netherlands, multidisciplinary community care teams, inspired by neighbourhood care models, link health services with social support for precariously housed or at-risk populations, bringing services closer to those who might otherwise face barriers.

These public health policies should be developed in contexts of trust and co-construction, involving government institutions, community organisations, frontline professionals, and people with lived experience of homelessness. Horizontal collaboration ensures that housing and health interventions are responsive, equitable, and socially legitimate.

Social service policies provide the structural safety net that may help prevent people from becoming homeless. These include social protection systems, income assistance, employment programmes, and community-based networks. In Spain, municipal and regional social services offer a wide range of support — from financial assistance to family support and employment programmes — tailored to local needs. However, decentralisation means coverage and accessibility vary across autonomous communities.

In **Ireland,** instruments such as the Housing Assistance Payment (HAP) and the Supplementary Welfare Allowance provide financial support for rent and household expenses, complementing homelessness-specific services and helping prevent eviction. In the **Netherlands**, social assistance benefits (bijstandsuitkering) and housing allowances help low-income households maintain rent payments, reducing eviction risk, while municipalities provide targeted reintegration and employment support.

In **Portugal,** public social services are more centralised and generally more limited in scope. The Instituto da Segurança Social provides the primary formal support, but access can be hindered by strict bureaucratic requirements and the work of multidisciplinary teams is quite scarce, which results in civil society organisations having a stronger role than the public services, especially in some municipalities.

Understanding these differences is crucial for policymakers and practitioners across Europe, as the availability, accessibility, and flexibility of social services strongly shape strategies for addressing social exclusion, poverty, and homelessness. As highlighted in ENIPSSA, effective social services address root causes of vulnerability, offering not only crisis support but also pathways to economic and social inclusion. **Policies that coordinate these services across sectors help ensure that no one falls through the cracks.**

Taken together, these public policy domains — housing, health, and social services — form the backbone of effective homelessness interventions. They shift the focus from reactive, short-term solutions to proactive, preventative, and holistic strategies. Without well-designed policies and adequate resources to implement them, individual and community-level interventions risk being fragmented, insufficient, or unsustainable. As ENIPSSA 2025–2030 and examples from Spain, the Netherlands, Ireland, and Portugal illustrate, integrating policies across sectors and grounding interventions in inclusive, data-driven approaches is essential to ensure that no one remains on the street due to systemic failures.

Funding and Resource Allocation

All the strategies, policies, and advocacy efforts discussed in this section ultimately depend on adequate, sustained funding and strategic resource allocation. Without sufficient financial and human resources, even the most well-designed legal frameworks, housing programs, and public service interventions risk being fragmented, inconsistent, or short-lived. Funding ensures that evidence-based initiatives like Housing First, integrated social services, and targeted support for vulnerable groups can be scaled, monitored, and maintained over time.

Resource allocation is not just about quantity but also about strategic distribution. Resources must reach the populations most at risk—migrants, older adults, women experiencing economic or domestic abuse, and people with disabilities—while supporting both emergency interventions and long-term prevention strategies. Funding shortages often force organisations to operate reactively, focusing on immediate crises at the expense of holistic solutions, and leave critical gaps in areas such as mental health care, legal support, and social protection. To prevent funding shortages, and subsequent costly emergency services, the CoR has pushed for more use of EU funds (e.g., cohesion funds, structural instruments such as **the European Social Fund Plus+ (ESF+)**) that are relevant for social inclusion and homelessness.

Moreover, funding enables multi-level collaboration across local, national, and European actors. It supports research, monitoring, and capacity-building activities that underpin evidence-based policymaking and advocacy. Civil society organisations, which frequently fill gaps left by state provision, rely on sustainable funding to maintain services, innovate approaches, and represent the voices of people experiencing homelessness in policy debates.

Section 2 | Definition of Advocacy

The **Institute of Global Homelessness**[12] defines advocacy as a process through which individuals, groups, or organizations educate the public and policymakers about the state of homelessness, its societal impacts, and potential solutions. Effective advocacy includes raising awareness, presenting clear calls to action, and promoting policy changes at various levels. A key component is highlighting how homelessness intersects with other societal issues, encouraging collaboration across different sectors to address the root causes and systemic factors contributing to homelessness.

Advocacy is a critical tool for civil society organizations working to address homelessness, as it allows them to influence public policy, raise awareness, and represent the interests of people experiencing housing insecurity. In particular, CSOs play a central role in challenging narrow definitions of homelessness and promoting inclusive policies that address both systemic and individual factors (*National Alliance to End Homelessness, 2011; University of Miami Law Review, 2011*). By engaging with policymakers, CSOs can highlight structural barriers such as inadequate social protections, limited access to affordable housing, and gaps in public health services, thereby advocating for comprehensive solutions.

Research has shown that homeless service managers recognize advocacy as essential but often encounter barriers, including concerns about funding constraints, organizational priorities, and political sensitivities (*Lee et al., 2012*). Despite these challenges, effective advocacy strategies involve coalition-building, grassroots mobilization, and careful communication with stakeholders to influence policy decisions and public perceptions. Engaging multiple sectors and fostering broad networks of advocates enhances the impact of these efforts, ensuring that interventions are both sustainable and responsive to the complex needs of individuals experiencing homelessness (*National Alliance to End Homelessness, 2011; Institute of Global Homelessness, n.d.*).

[1] *Institute of Global Homelessness. (n.d.). Global advocacy. Institute of Global Homelessness. https://ighomelessness.org/globaladvocacy/*

Through these approaches, CSOs not only provide direct services but also work to transform the social and policy environment that perpetuates housing insecurity. By combining evidence-based recommendations with public engagement and political advocacy, NGOs contribute to creating systemic changes that improve access to housing, healthcare, and social support, ultimately promoting social inclusion and protecting the rights of people experiencing homelessness.

Research shows that informal social support, such as friends or family who provide guidance and encouragement, can play a critical role in improving outcomes for people experiencing homelessness. Individuals with strong informal advocates are more likely to report higher quality of life and may spend less time in homelessness. While professional advocacy from social workers and service providers is valuable, these personal networks often have a stronger influence on day-to-day wellbeing and resilience (*Babayan, Futrell, Stover & Hagopian, 2021*).

These findings highlight the importance of considering social connections and community ties in the design of homelessness interventions. Programs that support clients in reconnecting with or strengthening informal support networks—in addition to providing professional services—can enhance quality of life and help stabilize housing situations. This perspective encourages a more holistic, person-centered approach, where the lived experiences and social networks of people experiencing homelessness are incorporated into policy and practice (Babayan et al., 2021).[13]

Activity 6.3 | Advocacy Campaign Analysis

Objective

To deepen participants' understanding of harm reduction advocacy through the analysis of real-world campaigns. This activity promotes critical thinking, comparative analysis, and shared learning, while offering concrete examples of advocacy strategies from diverse contexts.
All the instructions and materials for the activity are available on the Toolkit.

[1] *Babayan, M., Futrell, M., Stover, B., & Hagopian, A. (2021). Advocates make a difference in duration of homelessness and quality of life. Social Work in Public Health, 36(3), 354–366. https://doi.org/10.1080/19371918.2021.1897055*

Section 3 | Active Advocacy for Systemic Change in the Field of Homelessness

Advocacy in the field of homelessness requires a deliberate combination of evidence-based argumentation, community engagement, and strategic political communication. Its central purpose is to transform lived experience, empirical data, and needs identified in the field into concrete policy action. This may include promoting effective housing policies, influencing the design of homelessness services, or strengthening social and labour rights for people experiencing extreme marginalisation. Building on existing frameworks such as those proposed by JASS (2007) and more recent civil society analyses, several key strategies can be identified.

- **Public Demonstrations**

Public demonstrations and marches rely on the visibility generated by large numbers of participants and compelling messages. They are particularly effective when timed to coincide with key political moments such as budget approvals, elections, or legislative debates. Although demonstrations do not usually enable sustained dialogue with policymakers, they can serve as a powerful last-resort instrument for signalling urgency and mobilising public concern about homelessness.

- **Awareness-Raising Activities**

Awareness campaigns aim to generate public support and shift cultural narratives around homelessness. These may involve creative communication tools—music, theatre, visual campaigns, digital storytelling, short videos, exhibitions, or public debates. In the context of homelessness, awareness-raising also works to counter stigma by presenting evidence of structural causes (such as lack of affordable housing or labour precariousness) and elevating personal stories that humanise those affected.

- **Media Engagement**

Media strategies help build public legitimacy and influence political agendas. They include the dissemination of data, opinion articles, alternative policy proposals, and human-interest stories to journalists and media outlets. Evidence-based narratives are especially impactful when highlighting systemic gaps—such as insufficient shelter capacity, inadequately funded housing-first programmes, or barriers faced by women, migrants, and young people experiencing homelessness.

- ***Collaboration with Institutions***

When there is alignment between civil society organisations, community-based groups, and government institutions, collaboration can lead to co-design and implementation of public services. In the homelessness sector, such collaboration might take the form of joint working groups on housing-first expansion, advisory councils on rough sleeping, or co-developed protocols for emergency accommodation. Constructive collaboration requires clarity of roles, trust, and shared decision-making mechanisms.

trust, and shared decision-making mechanisms.

- **Scientific Research and Evidence Production**

Research-backed advocacy strengthens credibility. In the realm of homelessness, robust evidence often includes needs assessments, service evaluations, ethnographic accounts, and data on housing outcomes. Community-based organisations, due to their proximity to affected populations, generate essential forms of knowledge that complement academic studies. This combined evidence base can reinforce alliances, inform public discourse, and support long-term structural change

- **Persuasion and Lobbying**

Advocacy also involves direct and indirect persuasion techniques. Direct lobbying consists of communicating directly with policymakers—through meetings, briefings, or expert consultations—to advocate for specific policy reforms, such as expanding social housing stock or improving access to healthcare for people experiencing homelessness.

Complementarily, indirect lobbying mobilises organisations, community members, and the general public to contact decision-makers. Campaigns encouraging citizens to send letters, emails, or petitions to local authorities are common examples. Influence is also built by demonstrating legitimacy—through credible claims, public mobilisation, cross-sector

- **Alliance Building and Network Development**

Effective advocacy around homelessness requires strong alliances across sectors. These may include networks of social service organisations, housing activists, academic institutions, healthcare providers, and community groups. Successful alliances depend on shared leadership, clear roles, transparent communication, and members with analytical capacity and trust-based relationships.

- **Community Empowerment Strategies**

Empowerment focuses on strengthening confidence, knowledge, and political agency among people experiencing homelessness. Approaches such as peer support groups, leadership training, and participatory governance processes help ensure that advocacy is grounded in lived experience. Empowerment reinforces active citizenship by enabling individuals to claim rights, challenge discriminatory practices, and participate in shaping policies that affect their lives.

Recent Civil Society Insights (2024)

In 2024, the Correlation – European Harm Reduction Network consulted civil society experts to identify the most effective advocacy strategies for harm reduction and related areas. Many of these recommendations are directly relevant to homelessness advocacy.

One of the most emphasised strategies was the creation of collaborations and networks among civil society organisations working on related themes—such as mental health, substance use, youth services, or domestic violence. These networks pool expertise, amplify messages, and generate collective campaigns capable of influencing both local and regional policy agendas.

Peer networks and lived-experience engagement were also highlighted as essential. Meaningful advocacy on homelessness must start from the involvement of people who have experienced housing exclusion in service design, implementation, and political mobilisation. Community-led initiatives and advisory boards composed of peers constitute effective mechanisms for ensuring representation and accountability.

Another central recommendation concerned strengthening the evidence base and providing training in advocacy skills. Sharing case studies, successful interventions, and strategic methodologies enhances the capacity of organisations to advance coherent and influential arguments.

Finally, experts underscored the importance of engaging key stakeholders—neighbours, media professionals, police authorities, and local and national policymakers. Developing supportive relationships with these actors and maintaining open channels of dialogue significantly increases the likelihood of achieving advocacy goals.

Advocacy Strategy Framework

One of the most widely used tools for planning and understanding advocacy work is the Advocacy Strategy Framework, developed by Julia Coffman and Tanya Beer at the Center for Evaluation Innovation. It is a simple, one-page framework that helps advocates map out their theory of change — essentially, how their activities are expected to influence people and ultimately shape policy decisions. Rather than presenting advocacy as a neat, linear sequence, the framework acknowledges that change is complex and often unpredictable.

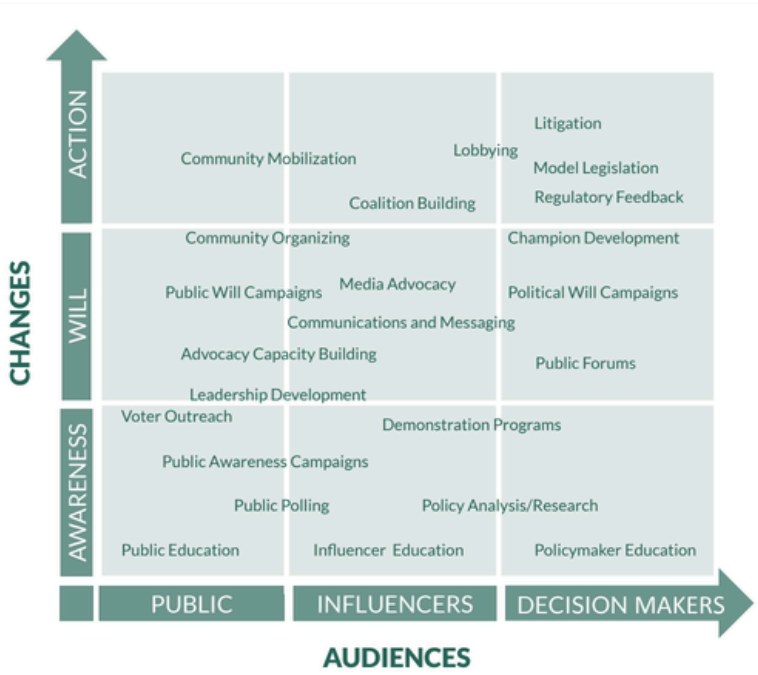

Image 7

The framework is built around **two key dimensions: who you are trying to influence and what kind of change you hope to create in them**. It groups potential audiences into the public, influencers, and decision-makers, recognizing that each plays a different role in shaping policy environments.

At the same time, it identifies **three levels of change that advocates might aim for: raising awareness, building will, and prompting action.** A distinctive strength of the model is its attention to the "will" stage, which highlights the reality that knowing about an issue is not enough; people also need to care about it, hold an opinion, feel a sense of urgency, and believe they can do something before they actually take action.

By placing specific advocacy tactics within this two-dimensional space, advocates can clarify who they want to reach and what kind of shift they are realistically working toward. For instance, a public-awareness campaign may target broad audiences to build understanding, while litigation or direct lobbying may focus on decision-makers and aim for concrete policy action. The framework also encourages users to consider how other actors — allies, opponents, or neutral groups — are positioned in relation to their goals. Overall, it offers a clear, flexible way to think about strategy, interim outcomes, and the pathways through which advocacy can contribute to meaningful social or policy change.

You can get to know this framework in greater depth here.

Section 4 | Language Used When Communicating on Homelessness

Language is deeply intertwined with identity and power; how society talks about homelessness can influence not only public attitudes but also how individuals experiencing homelessness see themselves. Research shows that common labels such as “the homeless” or “homeless people” can reinforce stigma by reducing individuals to their housing status, perpetuating dehumanizing stereotypes around personal failure, appearance, or addiction (*King’s College London, 2022*).

Using person-first language, such as “people experiencing homelessness,” helps maintain dignity by putting the person before their situation (*Watson et al., 2022*). This linguistic approach is supported by community psychology scholarship, which emphasizes that categorical labels contribute to historical oppression and inequality (*Watson et al., 2022*). A national survey among service providers, researchers, and the public found that person-first terms are broadly accepted, although preferences vary; this highlights the importance of engaging individuals with lived experience when choosing terminology (*Brown et al., 2022*).

Scholars have also introduced the concept of “homeism” to describe systemic devaluation and discrimination against people because of their housing status (*Fitzpatrick et al., 2021*). Such stigma, perpetuated through everyday language, can erode self-worth and self-efficacy by reinforcing social exclusion and identity degradation (*Fitzpatrick et al., 2021*). Conversely, using language that acknowledges both a person’s humanity and their lived experience can help restore agency, bolster confidence, and foster social inclusion (*Goffman, 1963; Watson et al., 2022*).

From a practical perspective, a recent report by King’s College London and the Centre for Homelessness Impact provides a checklist for non-stigmatizing language in public discourse, recommending person-first phrasing, avoidance of unnecessary labeling, and the rejection of stereotypes linked to personal failure or addiction (*King’s College London, 2022*).

The Role of Language in Social Relations

Language is a powerful instrument in shaping social identities and perceptions. The terms and labels used to describe individuals can significantly influence how they are viewed by society and, consequently, how they perceive themselves. This process is particularly evident in the context of homelessness, where language can either reinforce stigma or promote dignity and respect.

Stigmatizing Language and Its Consequences

Stigmatizing language can lead to the marginalization and exclusion of individuals experiencing homelessness. Terms that reduce individuals to their circumstances, such as "the homeless," can perpetuate negative stereotypes and dehumanize those affected. Research indicates that such language reinforces societal biases and contributes to the social exclusion of these individuals (*Chauhan & Foster, 2025*).

Furthermore, the use of stigmatizing language can affect the self-perception of individuals experiencing homelessness. When society labels them in negative terms, it can internalize these perceptions, leading to diminished self-worth and self-efficacy. This internalization can create a cycle of exclusion and disadvantage, making it more challenging for individuals to reintegrate into society.

Inclusive Language as a Means of Empowerment

Conversely, inclusive language that emphasizes the person before their condition can foster a more positive social environment. Person-first language, such as "person experiencing homelessness," focuses on the individual rather than their circumstance, promoting dignity and respect. This approach aligns with the principles of person-first language, which aims to avoid reducing individuals to their conditions or circumstances (*Palmer, 2018*).

Inclusive language not only alters public perception but also empowers individuals by acknowledging their humanity and potential. By shifting the narrative from one of deficiency to one of resilience and agency, inclusive language can facilitate greater social inclusion and support for individuals experiencing homelessness.

Practical Implications for Social Interactions

The language used in everyday interactions can have profound effects on social relations. Professionals working with individuals experiencing homelessness should be mindful of their language choices, ensuring that they use terms that affirm the dignity and humanity of those they serve. Training programs that emphasize the importance of inclusive language can equip individuals with the tools to communicate effectively and empathetically.

Moreover, media and public discourse play a significant role in shaping societal attitudes. Journalists, policymakers, and advocates should adopt inclusive language to challenge stereotypes and promote a more accurate understanding of homelessness. By doing so, they can contribute to a more informed and compassionate society

Good Practices in Language Use		
Good practice	**Why?**	**Examples**
Person-First Language	Adopting person-first language emphasizes the individual before their condition, recognizing their humanity rather than defining them by their circumstances. This shift reduces stigma, promotes dignity, and reinforces that homelessness or other challenges are one aspect of a person's life, not their defining identity.	Say "person experiencing homelessness" instead of "homeless person". Say "individuals living with substance use challenges" instead of "addicts". Say "people with lived experience of mental health difficulties" instead of "the mentally ill." Say "people with lived experience of mental health difficulties" instead of "the mentally ill."
Avoiding Dehumanizing Terms	Certain words or labels can reduce individuals to a problem or object, reinforcing negative stereotypes. Dehumanizing language strips people of individuality and can unconsciously influence social attitudes, policy decisions, and professional interactions.	Avoid language that frames people as "issues" or "burdens." Avoid "the homeless", "vagrants", or "bums". Avoid phrases like "drug abuser"; instead use "person who uses drugs." Avoid "cases" when referring to people in shelters or support programs.
Using Empowering Language	Empowering language emphasizes agency, resilience, and strengths rather than deficits. It can inspire hope and support engagement in solutions. This approach encourages a strengths-based perspective, acknowledging efforts and potential, rather than reinforcing helplessness or victimhood.	"Individuals seeking stable housing" instead of "homeless people." "Participants in housing programs" instead of "clients" or "beneficiaries", when contextually appropriate. Highlight achievements: "successfully transitioned to independent housing" instead of focusing only on problems.

Being Mindful of Tone and Context	Tone, framing, and context shape how language is received. Even neutral words can convey judgment or bias if delivered insensitively. Compassionate, solution-focused framing fosters constructive dialogue, reduces stigma, and encourages collaborative action.	Frame discussions around solutions, pathways, and support, rather than only deficits: e.g., “What steps can help individuals secure stable housing?” instead of “What’s wrong with them?” Use inclusive pronouns and respectful descriptors: e.g., “they” instead of assuming gender or labeling by condition. Adjust tone for public communication: in media or presentations, avoid sensationalizing homelessness as a “crisis” without context.
Avoiding Stereotype Reinforcement	Language can unintentionally reinforce societal stereotypes, even when unintentional. Challenging stereotypes reduces prejudice and supports more nuanced understanding, which is crucial for professional, policy, and advocacy work.	Avoid implying causality from personal traits: e.g., “lazy” or “irresponsible” as causes of homelessness. Instead say “facing structural barriers such as lack of affordable housing.” Highlight diversity: not all people experiencing homelessness have the same experiences; avoid homogenizing terms.
Using Language as Advocacy	Language choices can actively support advocacy and social change. Strategic language can influence public perception, policy priorities, and professional practices, supporting structural change as well as individual empowerment.	In reports, use “people experiencing housing exclusion” to reflect systemic factors. In public campaigns, use positive framing: “Everyone deserves a safe home” instead of negative phrasing like “End homelessness now” without context. Educate colleagues and stakeholders on why word choice matters in funding, policy, and service delivery.

Tabele 6

Activity 6.4 | Making Our Voice Heard: Designing an Advocacy Campaign With the Advocacy Strategy Framework

Objective

To equip participants with practical advocacy skills by collaboratively designing a homelessness-focused advocacy plan using the Advocacy Strategy Framework. This activity strengthens strategic thinking, collaboration, and the ability to connect theory to real-world policy challenges.
All the instructions and materials for the activity are available on the Toolkit.

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