ENG

HOME4HEALTH MOOC

Coordinated by:

In partnership with:

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HOME4HEALTH MOOC

MODULE 1:
HARM REDUCTION

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UNIT 1:

AN INTRODUCTORY OVERVIEW

UNIT 1 - LEARNING AND OBJECTIVE OUTCOMES

Coordinated by:
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a) Learning objectives and outcomes

- Define Harm Reduction and its relevance across different intervention areas
- Explain the origins, principles, methodology, and strategies of Harm Reduction
- Identify Harm Reduction strategies for supporting people experiencing homelessness, complex health issues, addiction, or trauma
- Analyse how these strategies can be applied in different intervention contexts

b) Competencies addressed

- Cultural Competence: Understanding and respecting the diverse applicability of Harm Reduction in the intervention addressing people experiencing homelessness, struggling with substance use or addiction and/or trauma, in different countries and cultures.
- Analytical Skills: Ability to analyze behavioral patterns related to psychoactive substance use and/or trauma for people experiencing homelessness.
- Critical Thinking: Evaluating the effectiveness and adequacy of various Harm Reduction strategies to psychoactive substances use or addiction and/or trauma, considering context-specific solutions.
- Communication Skills: Effectively communicating findings and insights regarding the use of psychoactive substance use by people experiencing homelessness to diverse audiences, as well as communicating effectively towards promotion of change.

UNIT 1:

SECTION 1

INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 1 - INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

ACTIVITY 1.1 - ICE BREAKER, INTRODUCE ONE ANOTHER

15 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

Prepare a few guiding questions for the group, choosing 2 or 3 from the following:

- What's your name and your role in harm reduction?
- How did you get into this type of work?
- What's something you love or find meaningful about what you do?
- What's one fun or surprising fact about you (work-related or not)?
- What's one challenge you've faced in this work—and what helped you get through it?
- Can you share a moment or story that really stayed with you from your work?
- Who or what inspires you in the field of harm reduction?
- If you could change one thing in the current system or context you work in, what would it be?
- What's something you've learned from the people you work with (colleagues or participants)?

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 1 - INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

ACTIVITY 1.1 - ICE BREAKER, INTRODUCE ONE ANOTHER

15-25 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Participants pair up, take a few minutes to talk, and then introduce their partner to the rest of the group by sharing a few key things they learned.
- Participants decide how you'll form pairs (randomly, nearby seats, or intentionally mixed).
- Each pair talks and learns about each other using the guiding questions, for about 5 to 7 minutes. Encourage equal time for both participants to speak.

Wrap up

- After the activity, bring the group back together. If the group is small, invite each participant to introduce their partner to the whole group in one minute or less. For larger groups, this step may not be recommended due to time constraints.

UNIT 1:

SECTION 2

DEFINITIONS

UNIT 1 - AN INTRODUCTORY OVERVIEW

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 just a methodology, a set of principles, or a theoretical approach, as it can be seen as a philosophy - a way of being and positioning oneself next to others and in life.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 2 - DEFINITIONS

The Origins of Harm Reduction

Harm Reduction Overview

Harm reduction developed in Europe as an alternative to the traditional War on Drugs model and the disease-only view of addiction (e.g., G. Alan Marlatt). Instead of punishment or moral judgment, it places **public health, dignity, and practical support** at the centre of policy. Harm reduction recognises diverse needs and promotes interventions that reduce harm, even if abstinence is not achieved.

The War on Drugs (United States)

- Framed substance use mainly as a **criminal issue**.
- Resulted in **high incarceration rates**, particularly among minority and marginalised communities.
- Reinforced **poverty, exclusion, and stigma**, discouraging many from seeking treatment.

Early Shifts: The Netherlands (1970s)

- Policy moved from moralistic to **pragmatic, health-focused approaches.**
- Recognised drug use as a matter of **health and social wellbeing.**
- Prioritised **safety and care over punishment**, showing that harm reduction could be implemented successfully in public policy.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 2 - DEFINITIONS

The Role of Dutch Substance Users in Policy Change

People Who Use Drugs Driving Change

- In 1980, **Junkiebond** was founded in Rotterdam.
- Believed that people who use drugs understand their **own needs best.**
- Organised **mutual support** and distributed **sterile needles and syringes**, helping reduce **HIV transmission** during the AIDS epidemic.
- Advocacy contributed to the development of **needle-exchange programmes**, now a key harm reduction strategy.

Key Historical Milestones in Harm Reduction

- **1920s, UK (Merseyside):** "Medicalization" approach – prescribing drugs (heroin, cocaine) for maintenance.
- **1960s–1970s:**
  - 1967, UK: first provision of **sterile injection equipment.**
  - 1968, Netherlands: **methadone** introduced for morphine addiction.
  - 1972, Netherlands: methadone extended for growing **heroin use.**
- **1980s:**
  - 1985: first **needle exchange programs** (UK – Merseyside; Netherlands – Amsterdam Junkiebond).
  - 1989: first **safe consumption sites** open in Netherlands, Switzerland, Germany, and Australia.

See next page for visual timeline

THE ORIGINS

TIMELINE

1920

The U.K. (Merseyside) model: pioneered the "medicalization" approach in which drug abusers can be prescribed drugs such as heroin and cocaine on a maintenance basis.

1960 - 1970

Methadone introduced; sterile injection equipment.

1970

Began in Europe as an alternative to the War on Drugs & disease models

Netherlands (1970s): shift to health & social well-being focus

1971 - 1973

War on Drugs (U.S.): punitive, led to mass incarceration & stigma

1980

Junkiebond (1980): user-led movement → needle exchanges, HIV prevention

First needle exchanges & safe consumption sites

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 2 - DEFINITIONS

Societal impact

Beyond Individual Benefits

- Harm reduction not only benefits individuals but also has important **societal implications.**
- In the context of **homelessness**, it can encourage **humane engagement** from civil society and policymakers.
- At the same time, there may be **resistance** to pragmatic and individualized approaches, often due to **moral assumptions** or fears about **public spending**

Housing-Led Solutions

- Research shows that **housing-first models** (Sam Tsemberis) are.
  - More **humane**
  - More **cost-effective** than traditional approaches
- Stable housing with support reduces:
  - **Emergency healthcare use**
  - **Policing and crisis interventions**

Targeted Interventions

- Malcolm Gladwell highlights that **chronic homelessness affects a small group**, which accounts for a large share of public spending.
- This means **targeted interventions** can achieve **large societal impact.**

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 2 - DEFINITIONS

- **An example** from research by Dennis Culhane **illustrates** this. A man living homeless for more than ten years generated extremely high public costs through repeated emergency care and justice involvement. When he received stable housing and professional support, he was able to manage daily life and reduce substance use. When the support ended, he returned to homelessness, highlighting the importance of long-term solutions.

Key takeaways

- *Harm reduction benefits not only individuals, but society as a whole.*
- *Housing-led approaches reduce long-term public costs.*
- *Chronic homelessness often involves a small group needing intensive support.*
- *Long-term housing and support are more effective than repeated crisis interventions.*

UNIT 1:

SECTION 3

APPLIED PRINCIPLES

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

Core Philosophy

- Harm reduction emphasizes **practical, non-judgmental, and inclusive strategies.**
- Focuses on the **individual's needs and goals**, recognizing the **complex and varied experiences** of people managing their health and behavior.
- Moves away from **moralistic and disease-focused models**, offering a holistic and humane response to substance use and high-risk behaviors.

Empowerment and Autonomy

- Involves individuals in decisions about their care.
- Fosters autonomy, responsibility, and respect

Key Principles of Harm Reduction

- **Pragmatism** – realistic approaches based on what works
- **Non-imposition of abstinence** – support without requiring sobriety
- **Humanism** – respect for dignity and humanity
- **Proximity** – being close to and understanding people's lives
- **Flexibility** – adapting interventions to individual needs
- **Gradualism** – recognizing small steps as progress
- **Horizontality** – collaborative, non-hierarchical relationships
- **Autonomy** – supporting personal choice and control
- **Responsibility** – shared accountability without termination; ownership of choices
- **Non-judgment** – avoiding moralizing or blaming

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

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 (Decision-making)**

  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 (Risk VS Safety)**

  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.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

Individual-Centered Care

Harm reduction prioritizes each person's needs and goals, making them central to all health and social care decisions. The idea of **"meeting people where they're at"** refers not only to physically bringing services into communities, but also to adapting care to each individual's situation.

Abstinence may be an ideal goal for some, but it is not a requirement. Individuals determine their own pace of change, which may range from abstinence to reducing specific risk behaviours. This flexible approach contrasts with the moral model, which positions abstinence as the only acceptable outcome (Marlatt, 1996).

Bottom-Up Approach

Harm reduction developed as a **bottom-up movement**, largely driven by people who use drugs themselves. In the Netherlands, for example, needle-exchange programs emerged from direct advocacy by local substance users who sought to reduce the harms of unsafe injection practices.

This grassroots foundation remains essential. Effective harm reduction policies depend on listening to those most affected.

Harm reduction therefore:

- Ensures that people who use drugs have a meaningful voice in policy and program development.
- Affirms people who use drugs as primary agents in reducing harm.
- Encourages peer support and the sharing of practical knowledge.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

Low-Threshold Services

A low-threshold approach removes barriers to care and ensures services are accessible and inclusive. It recognizes that not everyone is ready for abstinence or traditional treatment, and it offers support regardless of a person's current stage of change.

Examples include:

- Same-day access to detox or treatment.
- Walk-in models of care.
- Flexible policies for missed appointments.
- Outreach services within communities.
- Support for both active substance users and those maintaining abstinence.

This contrasts with high-threshold systems that require abstinence before treatment begins.

Because harm reduction accepts that full abstinence may not be realistic or desirable for everyone, it values **incremental progress**, such as safer use practices or reduced consumption. Small steps still represent meaningful harm reduction.

Judgment -Free Approach

Harm reduction actively seeks to eliminate stigma and judgment associated with substance use. It uses **person-first language**, referring to "people who use drugs" or "people with substance use disorder" rather than stigmatizing labels.

Unlike the moral model, which frames substance use as wrong or immoral, harm reduction focuses on **reducing harmful consequences**, regardless of legal or moral interpretations. It evaluates behaviours based on their impact on individuals and society.

By shifting attention from the act of substance use itself to its consequences, harm reduction moves from a purely clinical model toward a **biopsychosocial framework.**

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

An Integrated Framework

Together, these principles create a comprehensive and compassionate framework that includes:

- Individual-centred care
- Bottom-up participation and lived experience
- Low-threshold, accessible services
- Non-judgmental and stigma-free environments

Harm reduction also recognizes that broader social determinants—such as poverty, racism, social exclusion, trauma, and gender-based discrimination—shape both vulnerability to harm and the ability to cope with risk.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

ACTIVITY 1.2- CASE STUDIES

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Materials needed

- Printed or digital case studies with guiding questions (1 per group, from different countries) - For this material check toolkit
- Pens and paper for group notes or a shared digital document where to take notes.

Preparation

- Divide the participants into small groups of 3-4.
- Provide each group with a brief case study from a different country.
- Include a few guiding questions to help structure group discussion.

UNIT 1 - AN INTRODUCTORY OVERVIEW

SECTION 3 - APPLIED PRINCIPLES

ACTIVITY 1.2- CASE STUDIES

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- In groups, participants read and discuss their assigned case study.
- Using the guiding questions, they identify:
  - What harm reduction strategies are present?
  - Which principles of harm reduction are reflected?
  - What barriers are visible?
  - What could be improved?

Wrap-Up

- Each group shares a brief summary of the case study with the whole room.
- The participants are encouraged to draw connections between the examples of the case studies, identifying similarities and contrasts across countries.

UNIT 2:

MODELS AND METHODOLOGIES OF INTERVENTION

UNIT 2:

SECTION 1

MODELS OF INTERVENTION

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

Models of intervention

In this 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

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).

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

The Person-centered and Humanistic Approach

Author: Carl Rogers

Objective: Carl Rogers developed this humanistic perspective, in which he emphasized the creation of a relationship of trust with the other person, as a way for change and personal development to occur (Rogers, 1961). Applying a person-centered and humanistic approach requires professionals to understand who people are, what their history has been, what they have experienced, and what is meaningful to them.

People are the best experts on their own lives. They live within unique ecosystems made up of their personal stories, relationships, identities, values, and aspirations. They understand what has happened to them and what holds meaning for them. Our goal is to **recognize and appreciate the individuality of each person 's journey and perspective.**

Tools:

According to Rogers, the relationship of trust is based on certain principles, such as:

- Genuineness and authenticity, making it possible for the person to feel comfortable, to be conscious of his own feelings, as well as expressing them.
- Unconditional acceptance of one's condition, behavio and feelings, viewing the other as a separated person, and as someone with unconditional self-worth.
- A deep empathetic understanding, leading to freedom within the person to explore all conscious and unconscious feelings that may arise.

Rogers believes that the individual has within itself the motivation for change and the capacity to mature, even if not evident at first sight, and the relationship can be used as a tool for growth.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

The Transtheoretical Model

– Stages of Change

Authors: James Prochaska & Carlo DiClemente

Objective: The Transtheoretical model for Behavioral Change has for main assumption that **successful self-changes rely on applying the right strategies at the right time.** It focuses on individual decision making, rather than on sociobiological influences on behavior, with the underlying principle that behavioral change is a process in which people go through distinct levels of motivation for change.

This theoretical program design addresses **changing personal behavior patterns,** while helping to frame the experience of the person and their moment of life. The stages of change correspond to implicit or explicit activities in which people are engaged into changing affect, thought, behavior or relations related to the problem-behavior.

Tools

This model conceptualizes 5 stages to this progression, although typically people might recycle through these stages several times before effective changes happen:

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 should not be considered linear. **Motivation Interviewing strategies** are most relevant tools of intervention, regarding stages from 1 to 4, whereas from stages 5 and 6, one will use essentially **Prevention Relapse strategies.**

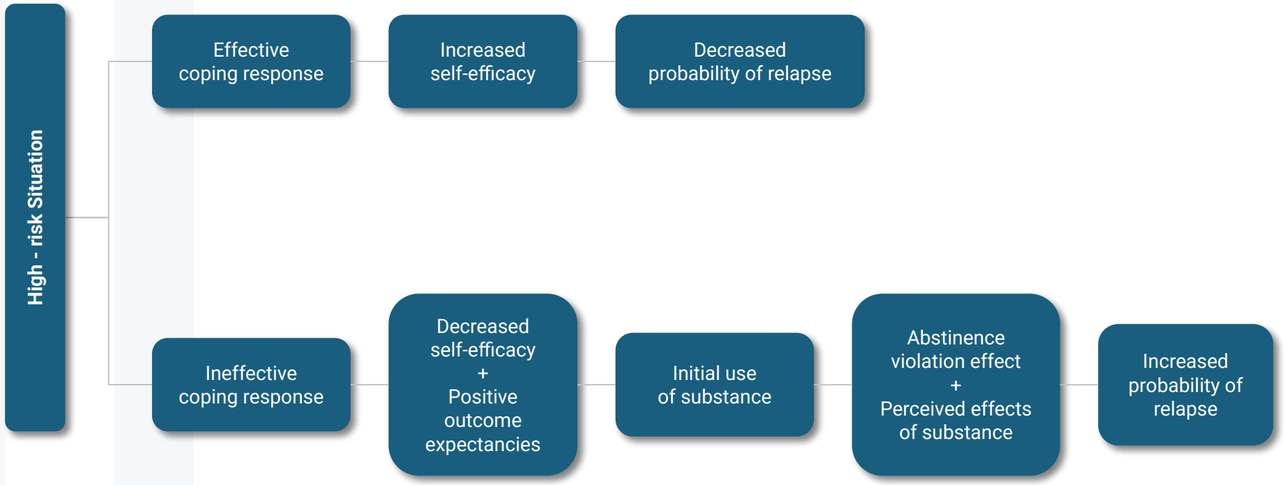
UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

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.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

Relapse Prevention Model Tools

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.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

Relapse Prevention Model Tools (2)

Global Lifestyle Self-Management Strategies

- *Lifestyle balance and positive coping:*
  - Assessing lifestyle factors associated with stress and imbalance.
  - 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.

UNIT 2:

SECTION 2

METHODOLOGIES AND TOOLS OF INTERVENTION

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Methodologies and Tools of Intervention

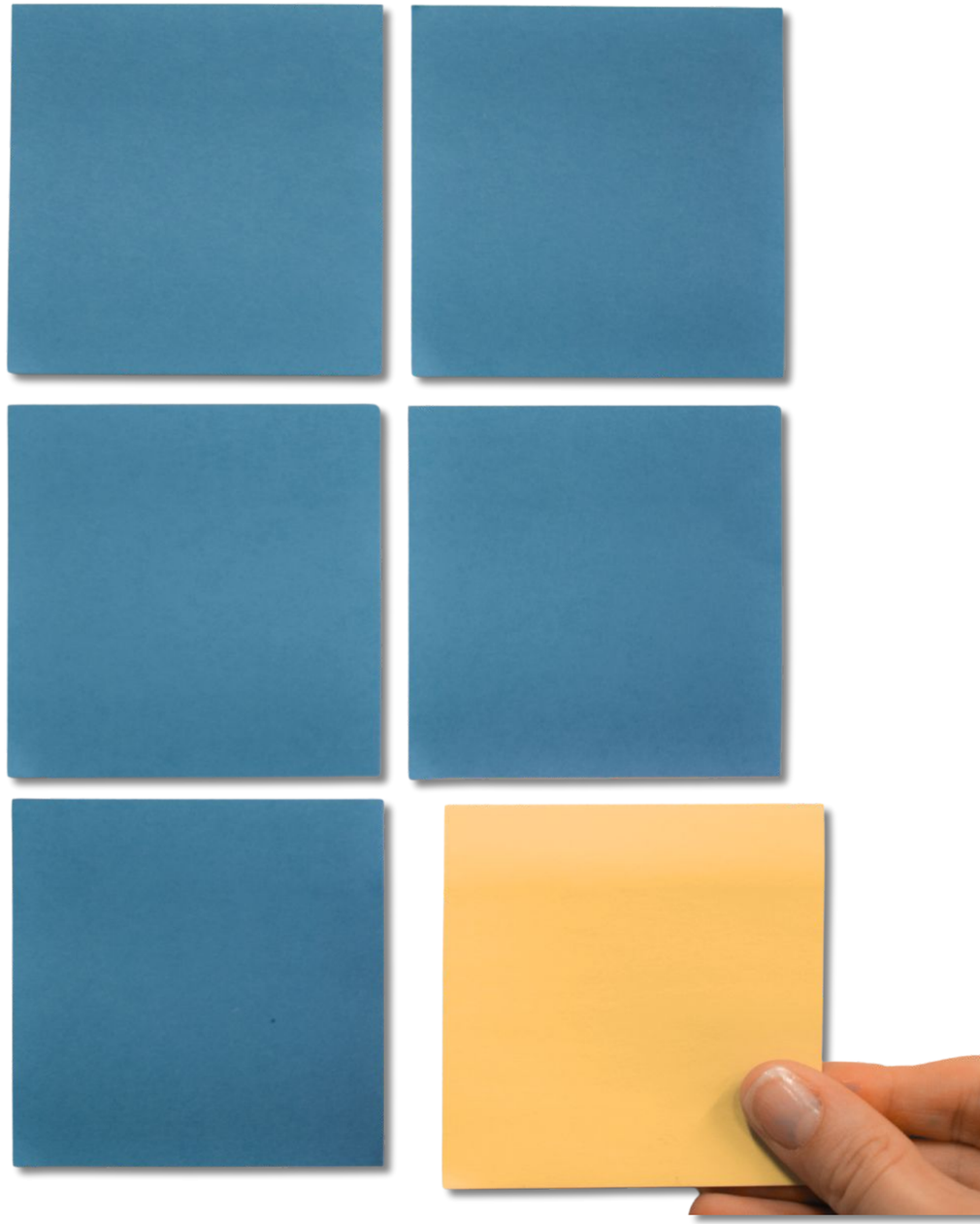
After introducing the main theoretical models that form the framework of a **harm reduction–based approach**, this section presents key **methodologies and tools** useful for professionals working with people experiencing **homelessness and complex issues related to health, trauma, and addiction.**

These approaches are explored within the context of a **supportive helping relationship that promotes positive change.**

Some of the methodologies and tools presented are drawn from two central models:

- Motivational Interviewing
- Integrative Harm Reduction Psychotherapy

Other transversal methodologies and tools will also be explored in the **final topic of this section**, which focuses on **communication techniques in support interventions.**



UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Motivational Interviewing

Authors: William R. Miller & Stephen Rollnick

Objective: Motivational Interviewing (MI) is a **person-centered counselling approach** that helps clients discover their **internal motivation for positive change**. It is based on the idea that everyone has the **capacity to change**, while professionals act as **facilitators in this process.**

MI is a well-researched and structured methodology that provides **clear guidelines and practical techniques for professional intervention.**

It also helps professionals recognize **ineffective practices** that may hinder change. Instead of focusing on difficulties, MI emphasizes **clients' strengths**, which helps build **confidence and self-efficacy**.

Finally, MI understands **ambivalence as a natural part of the change process,** avoids moral judgment, and views **resistance as a form of communication and an opportunity to work collaboratively with the client.**

Tools

Built on 4 basic principles:

1. **Express empathy**, by the use of active listening;
2. **Develop discrepancy,** by implementing strategies to promote cognitive dissonance in the individual;
3. **Roll with resistance** - to avoid direct confrontation; to make use of the person's resistance to change, to promote change, instead of arguing against it;
4. **Support self-efficacy**, bearing in mind that by constructing a perception of self-efficacy one is promoting hope on the possibility of change.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Motivational Interviewing

Five important methods used from the start and throughout MI:

1. **Ask open questions –** encourages clients to explore thoughts and feelings
2. **Listen reflectively –** shows understanding and validates experience
3. **Affirm –** directly support and reinforce client strengths
4. **Summarize –** integrates information and ensures clarity
5. **Elicit change talk** – consciously directs towards resolving ambivalence while maintaining a **collaborative approach**

Exploring Ambivalence

Tools like **Decisional Balance** or **Balance Sheet** can help:

- **Decisional Balance** – weigh perceived benefits and costs of each side of a conflict
- **Balance Sheet** – specify benefits and costs associated with a particular behavior

Principles of Motivational Interviewing

1. **Express empathy**
   Accomplished throught validating the client's experience and communicating an understanding of that experience.

2. **Roll with resistance**
   Accomplished by encouraging client autonomy in decision making and asking questions that assist the client in making their own best decisions.

3. **Develop discrepancy**
   Accomplished by asking questions that help the client discover incongruencies between their stated goals and their current behaviors.

4. **Support self-efficacy**
   Accomplished by leveraging affirmations and reflections from the client about their own ability to achieve their stated goals.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Important aspects to facilitate change are:

Five important methods used from the start and throughout MI:

- *The 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:
  - disadvantages of the status quo
  - advantages of change
  - optimism about change
  - intention to change

Complementarity of Models

It should be noted that Stages of Change, Relapse Prevention and Motivational Interviewing models/methodologies are complementary in the intervention with people who use drugs, according to the phase in which they found themselves, oughting to be adapted to peoples' specific circumstances (IDT, 2009).

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Integrative Harm Reduction Psychotherapy

Author: Andrew Tatarsky

Objective: Based on the idea that **behaviors**, particularly potentially risky ones such as substance use, are best understood by considering the **whole person** and their **sociocultural context**.

- Seeks to identify **psychological, biological, and social factors** that contribute to addiction.
- Clarifies the **multiple meanings and functions** substance use may have in a person's life.
- Tailors the **psychotherapeutic process** to each client's **unique needs** (Tatarsky & Kellogg, 2010; Tatarsky, 2013).

Foundational Principles

- Follows **basic principles of good psychotherapeutic practice**, emphasizing the **therapeutic relationship.**
- Integrates **psychodynamic and cognitive-behavioral models** with a **biopsychosocial perspective** on substance use.

Tools:

- **Self-observation skills**: help clients understand the role of **substance use** in their lives, including **situational triggers, associated thoughts and feelings,** and **positive and negative consequences**.
- **Developing an "ideal plan"**: a **realistic, person-centred guide** to maximize the **positive value** of substance use while minimizing **negative impact**.
- **Exploring meanings and functions**: identify **vulnerabilities** and develop **adaptive, effective solutions** for each factor influencing substance use.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

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

01

Managing the therapeutic alliance

Build a **secure, collaborative, non-judgmental relationship** that supports exploration and change

02

Using the therapeutic relationship as a source of healing

Recognize that relational experiences in therapy can model **safety, trust, and new interpersonal possibilities**.

03

Strengthening self-management skills

Support the development of **practical and emotional regulation skills** to enhance **autonomy** and reduce harm.

04

Evaluation as treatment

Use ongoing **assessment as a therapeutic tool** to increase insight into **patterns, motivations, risks, and opportunities for change**.

05

Embracing ambivalence

View ambivalence as a **natural part of the change process** and work with both sides of the internal conflict instead of pushing for a specific outcome.

06

Establishing harm reduction goals

- Collabov **person-centred goals** aligned with the client's **readiness, needs, and priorities**.
- Goals may include **safer use, reduced use, moderation, or abstinence**.

07

Active strategies for positive change

- **Harm reduction education**
- **Experimental and non-judgmental attitude** toward behavior 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**
- Identifying, managing, or resolving **triggering factors**
- Developing a **game plan** to implement desired changes in contexts where previous behaviors occurred

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

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 to prevent misunderstandings in what is aimed at being a helping relationship, to promote significant social change, especially in the care of people experiencing homelessness, in striving to meet their needs in a comprehensive way. Aspects such as empathy, open and respectful communication, horizontality, acceptance of people as they are, providing services in a non-judgmental way and with minimal barriers are in line 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.

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CATIE (2022) describes supportive practices that help service providers build **trust, safety, and respect** when working with people who use drugs. Important everyday practices include:

- **Open and welcoming body language**
  Sitting at eye level, relaxed posture, gentle eye contact.
- **Creating a safe and inclusive environment**
  Private space, offering water or a seat, avoiding jargon, visible harm-reduction information.
- **Protecting confidentiality**
  Not discussing clients in public spaces, explaining how information is stored.
- **Consistency in policies and procedures**
  Clear rules, predictable schedules, shared staff approach.
- **Taking time for difficult conversations**
  Allowing silence, slowing down, acknowledging emotions.
- **Reflecting on personal biases**
  Noticing assumptions and adjusting behaviour.

These small actions help people feel respected and more willing to engage with support.

Active Listening

Active listening means paying attention to both the **facts and emotions** in what someone says. Carl Rogers described this as listening with empathy and presence.

Examples:

- Reflecting feelings: “It sounds like the last few days have been exhausting.”
- Minimal encouragers: nodding, “I hear you,” allowing silence.
- Observations: “I noticed you became quieter when you mentioned your family.”

*Active listening builds **trust**, reduces defensiveness, and helps people feel heard.*

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

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Listening Responses

Listening responses keep the focus on the client's experience. According to counselling frameworks described by Sherry Cormier, they include:

- **Clarification** – asking for more detail.
- **Paraphrasing** – restating in your own words.
- **Reflection** – identifying feelings or meaning.
- **Summarizing** – pulling together key points.

These responses help organize thoughts and deepen understanding.

Influencing Responses

Influencing responses gently help people consider new options. They are always used with empathy and respect.

Examples:

- Asking open questions about past successes.
- Providing information about safer practices.
- Appropriate self-disclosure when trust is established.

*These strategies support **empowerment** rather than forcing change.*

Reflective Listening

Reflective listening communicates understanding by restating or summarizing meaning. It is central in motivational interviewing approaches developed by William R. Miller and Stephen Rollnick.

Types of reflections:

- **Simple reflection** – repeating the main idea.
- **Amplified reflection** – exaggerating slightly to explore meaning.
- **Reflection of feelings** – naming emotions.
- **Double-sided reflection** – showing both sides of ambivalence.

This helps clients explore change without feeling judged.

Why This Matters:

*Supportive communication practices help create a **trauma-informed and harm-reduction environment** . They reduce stigma, build trust, and support people in making changes at their own pace.*

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

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ACTIVITY 1.3 - ROLE PLAY FROM CASE STUDIES

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To develop practical harm reduction skills by applying intervention tools and communication strategies in realistic scenarios, fostering empathy, self-reflection, and confidence in supporting people who use drugs.

Materials needed

- Printed examples of case studies For this material check toolkit
- Pens and paper for reflection.
- Timer or clock.

Preparation

- Print 4 brief case study scenarios from the previously worked cases on Activity 1.2 -
- ***For this material check toolkit***
- Arrange the space for pairs to talk privately.
- Assign roles (support worker and person struggling with substance addiction)

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SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

ACTIVITY 1.3 - ROLE PLAY FROM CASE STUDIES

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Introduction: The facilitator explains the activity, emphasizes the importance of empathy, active listening and confidentiality.
- Each pair will receive a case study scenario, where one will play the harm reduction worker, and the other the client. Participants should be encouraged to apply harm reduction tools and methodologies discussed earlier in the module (e.g., motivational interviewing, transtheoretical model – stages of change, relapse prevention model, integrative harm reduction psychotherapy, communication tools, etc).
- Switch roles or partners and do a second role play with a different scenario (optional / if enough time left).

Wrap-Up

After each group has completed their role-play, bring everyone back together for a debrief, and to reflect on the following questions?

- What worked and felt effective?
- What challenges were encountered?
- What strategies or tools were useful?

UNIT 2:

SECTION 3

SHOWCASE OF PRACTICAL COMMUNICATION TOOLS

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 1 - MODELS OF INTERVENTION

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.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

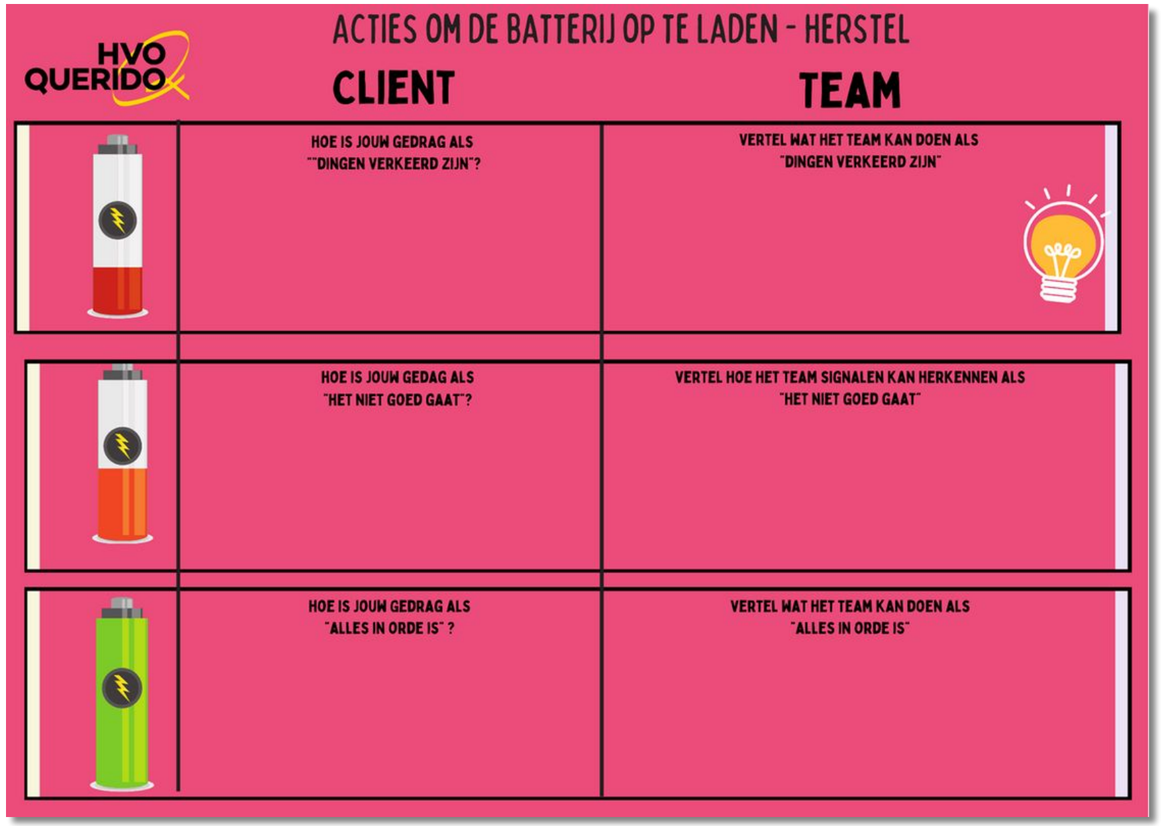
SECTION 1 - MODELS OF INTERVENTION

The battery

This tool works as a mini prevention plan for clients and professionals, offering a visual aid to identify when situations are going wrong, slightly wrong or good. It also facilitates discussions about how the technician can provide support, simplifying the process compared to traditional long-term plans.

It can be used among co=workers, in teams, in social support relationships and many others.

As an exercise, you could reflect and fill in your part about your battery. Imagine sharing it with a co-worker, a manager, a service user or your mother. What would you share? Would there be different things you would fill in or leave out?



UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

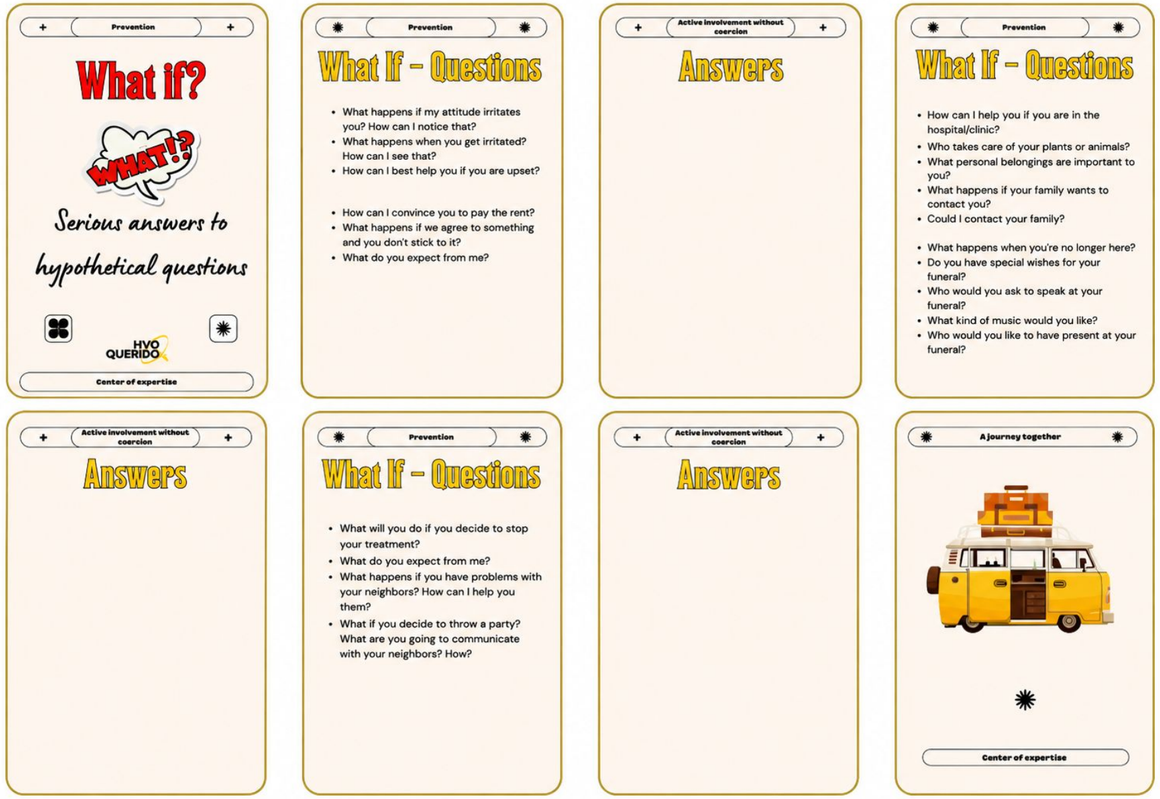
SECTION 1 - MODELS OF INTERVENTION

What if? Hypothetical questions

This tool is intended for clients and professionals, as a prevention resource to identify signs of imbalance. It includes a brochure with questions about future situations, useful after a tenant receives their home in a Housing First project.

Questions can be addressed in each consultation, aligning with the Housing First principle of "engaging in activity without coercion", covering topics such as people to report in the event of death and pet care during hospital stays.

As an exercise, relating it to Harm Reduction, what hypothetical questions would you ask?



UNIT 3:

GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE AND TRAUMA

UNIT 3:

SECTION 1

PEER WORK PERSPECTIVE

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE AND TRAUMA

SECTION 1 - PEER WORK PERSPECTIVE

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.

01 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.

02 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.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE AND TRAUMA

SECTION 1 - PEER WORK PERSPECTIVE

Peer Work Perspective

03 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.

04 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.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE AND TRAUMA

SECTION 1 - PEER WORK PERSPECTIVE

Peer Work Perspective

05 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.

06 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.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE AND TRAUMA

SECTION 1 - PEER WORK PERSPECTIVE

Peer Work Perspective

07

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.

08

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.

UNIT 3:

SECTION 2

BASIC LIVING CONDITIONS:
SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

Homelessness takes many forms, and this means that there is no single answer to providing sustainable exits from homelessness. While all people experiencing homelessness need adequate, sustainable, and affordable housing, the extent to which they will require additional support varies considerably.

Self Care

Self-care in the context of homelessness and substance use **is not about idealized notions of "taking care of oneself"**, but about **practical, realistic, low-threshold strategies** that align with harm reduction, autonomy, and person-centered work.

1. Self-Care as Survival

People experiencing homelessness already practice self-care simply to survive.

Examples:

- Protecting important documents.
- Managing belongings.
- Finding safer places to sleep.
- Rationing substances.
- Maintaining small routines.

Avoid moralistic messages such as "you should take better care of yourself"; focus on what is possible, not ideal.

2. Realistic Hygiene and Personal Care

Access to basic hygiene is essential and often limited.

Barriers:

- Safety concerns.
- Restricted schedules.
- Stigma or embarrassment.

Low-threshold strategies:

- Small hygiene kits for quick cleaning.
- Identifying safe spaces for washing or changing.
- Outreach support providing essential items.

Menstrual hygiene considerations:

- Sanitary pads, tampons, reusable pads, or cups.
- Wet wipes and disposable bags for safe disposal.
- Clean underwear and discreet storage pouches.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

3. Managing Physical and Mental Health

From a harm reduction perspective:

Physical health:

- Monitor basic signs of discomfort or deterioration.
- Hydration and nutrition.
- Safer sleeping arrangements.

Substance use self-care:

- Avoid using alone.
- Test substances when possible.
- Don't share equipment.
- Start with smaller doses.
- Be mindful of polysubstance use.
- Keep naloxone accessible where available.

Emotional self-awareness:

- Recognize stress, exhaustion, sadness, irritability.
- Use simple grounding or regulation strategies.

4. Minimal Daily Structure

Small routines can reduce chaos and provide stability:

- 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.

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SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

5. Relationships and Social Support

Social connections can support self-care:

- Identify safe vs unsafe relationships.
- Connect with supportive individuals: friends, peers, outreach workers, community volunteers.
- Small strategies for help:
  - One or two trusted contacts for stressful moments.
  - Create a “help plan” with clear steps.
  - Use text or reminders if speaking is difficult.
- Promote informal support networks and community participation: workshops, peer-support circles, creative activities, sports groups.

6. Autonomy and Self-Determination

Self-care is a **choice, not an obligation**.

Professionals should:

- Explore what the person already does.
- Reinforce existing strengths.
- Co-create small, achievable goals.
- Support individuals in defining self-care **in their own context.**

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

Housing

Housing First

Model 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

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SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

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.

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.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

Low threshold employment

Low-threshold employment opportunities **allow individuals to engage at their own pace**. Key features include:

- **Flexible engagement** – participants can choose how many hours or days to commit, and gradually increase involvement based on motivation and capacity.
- **Training pathways** – some programs offer structured training that qualifies participants for specific professions.
- **Supportive staff approach** – workers maintain a respectful, non-judgmental, strengths-based attitude, fostering trust and empowerment.
- **Positive impact on well-being** – even if participants do not transition directly into the regular labor market, engagement can improve self-esteem, sense of purpose, and daily structure.

For many people experiencing homelessness, poverty, or social exclusion, **participating in meaningful activities** can represent an important turning point.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

Access to Healthcare

Harm reduction emphasizes **flexible, accessible, and person-centered care**. Access to healthcare is improved through **decentralization**, bringing services to where people are rather than expecting them to navigate rigid systems.

Decentralization of Care

Definition:

Decentralization shifts away from single-model, clinic-only interventions toward **networks of interconnected services** that meet people in their daily environments.

Goals:

- Remove barriers to care.
- Expand engagement opportunities.
- Integrate harm reduction with treatment, housing, employment, and social support.

Examples of decentralized services:

- Mobile harm reduction units delivering supplies and support.
- Street outreach teams providing flexible, consistent engagement.
- Low-threshold drop-in centers offering counseling, basic needs support, and connection to services.
- Supervised consumption sites with safer use environments and health monitoring.
- Harm reduction integrated into shelters or housing programs (EUDA, 2023).

Decentralized approaches reduce barriers caused by bureaucracy, abstinence requirements, and stigma, increasing access for people experiencing homelessness.

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SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

ACTIVITY 1.4 - VIDEO FORUM WITH EXAMPLES OF GOOD PRACTICES IN SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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 inspire the adaptation and application of these approaches within their own professional contexts.

Materials needed

- Links to the videos (next slide)
- Computer, projector and internet connection

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 2 - BASIC LIVING CONDITIONS: SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

ACTIVITY 1.4 - VIDEO FORUM WITH EXAMPLES OF GOOD PRACTICES IN SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

30 MINUTES

Preparation

Watch 2 or 3 of the following videos

- https://www.youtube.com/watch?v=sN9Md6m_6Io
- https://www.youtube.com/watch?v=QZdIYvSE-f8
- https://vimeo.com/586709594?fl=pl&fe=sh
- https://www.corksimon.ie/50-faces/jj/
- https://www.corksimon.ie/50-faces/marguerite/
- https://www.youtube.com/watch?v=h4nMm8dJH8g&list=WL&index=7&t=86s
- https://www.youtube.com/watch?v=Y8EoXA3W7MM&t=322s
- https://www.linkedin.com/feed/update/activity:7366877241890328577

And check out these good practices:

Housing First

- CRESCER - É UMA CASA, Lisboa Housing First project

Rapid Re Housing

- Cork Simon Community – 12 weeks project
- CRESCER – Municipal Unit of Employment and Autonomy (UMEA)

Diversion

- Cork Simon Community – Diversion intervention community emergency service
- CRESCER – Municipal Unit for Prevention and Autonomy (UMPA)

Low threshold employment

- CRESCER – É Um Restaurante/Social business
- Cork Simon Community – Social, Integration and Participation Service

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

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ACTIVITY 1.4 - VIDEO FORUM WITH EXAMPLES OF GOOD PRACTICES IN SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

30 MINUTES

Activity

After each video, participants have approximately 5 minutes to discuss what they observed, reflect on the practices presented, and share their thoughts on the approach.

Wrap-up

- What aspects of the program shown in the video seemed most effective, and why?
- What challenges or limitations might this approach face in practice?
- How do you think people experiencing homelessness perceive this kind of intervention?
- What similarities or differences do you notice compared to other approaches (e.g., Housing First vs. shelters, abstinence-based models vs. managed alcohol programs)?
- If this program were applied in your local context, what adaptations would be needed?
- Which practice inspired you most, and how could you apply it in your own work?

UNIT 3:

SECTION 3

PSYCHOACTIVE SUBSTANCE USE

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Psychoactive Substance Use

Harm Reduction and Substance Use

- **Substance use** can lead to **chronic and acute health problems**, influenced by:
  - **Properties of the substances**
  - **Route of administration**
  - **Individual vulnerability**
  - **Social context**
- To reduce harm, a range of **accessible, low-threshold interventions** is needed.
- **Historical focus:**
  - Expanding access to **opioid agonist treatment** and **needle exchange programs**
  - Mainly targeting **injecting heroin use** and the **HIV/AIDS epidemic**
- **Recent developments (last 30 years):**
  - Broader harm reduction responses including **drug consumption rooms** and **naloxone programs** (EUDA, 2024)

Needle exchange program

- Aim to **prevent transmission of infectious diseases** through intravenous drug use by promoting **aseptic practices**.
- Provide **clean syringes and needles**, as well as other materials:
  - **Filters, wipes, distilled water, citric acid**, etc.
- Include **education** and **awareness-raising** about **lower-risk practices**.
- Offer a space for clients to **reflect on their consumption** and discuss with **harm reduction workers**.

Implementation and Reach

- Can be delivered via **mobile units, outreach teams, drug consumption rooms, drop-in centers**, etc.
- Serve as **a bridge between individuals and social/health services**.
- Outreach work is key for **contacting populations with limited access to services**.

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Low-threshold Opioid Substitution Programs

- Provide support for people who **do not want or cannot stop using heroin**, improving **health, social, and economic well-being**.
- **Medication-assisted treatment**: usually **Methadone Hydrochloride** prescribed under **medical supervision**.
- Prevents **withdrawal symptoms and cravings**, allowing **psychological stabilization**.
- Methadone has a **long half-life (≥24 hours)**, which helps clients **organize their lives** and **normalize interpersonal relationships**.
- **Daily administration** reaches a **steady state after ~5 days**, supporting consistent stabilization.

Societal Benefits of Opioid Substitution Programs (OSPs)

- Improve **physical and mental well-being** of the individual and their family.
- Reduce **public health costs** and **burden on the judicial system.**
- Can be delivered through **fixed structures** or **mobile units** adapted for this purpose

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Drug consumption rooms

Professionally supervised healthcare facilities where people can use drugs in **safer, hygienic conditions** without fear of **arrest or legal consequences**.

Main goals:

- Provide a **safe environment**
- Offer **medical supervision**
- Ensure access to **sterile equipment**
- Reduce **health risks** such as **overdoses** and **infectious diseases**

Serve **highly marginalized populations** facing barriers to **healthcare and social services**.

Act as **gateways to support services**.

Typically located near **open drug scenes** to:

- Reduce **public drug consumption**
- Improve **public amenities** (fewer discarded syringes and drug-related waste)
- Address **public order and safety**, benefiting local residents

Additional Benefits of Drug Consumption Rooms (DCRs)

- **Combat stigma** by treating people who use drugs with **dignity**.
- Support **social integration**, including **pathways to employment and housing**.
- Often among the first to **detect new or unfamiliar drug use patterns**.
- Contribute to **early identification of emerging risks** in high-risk populations (EUDA, 2024).

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Alcohol management programs (MAPs)

Managed Alcohol Programs (MAPs)

- Target individuals with **severe alcohol use disorder** who face barriers such as **homelessness, poverty, stigma,** and **previous trauma**.
- Aim to **reduce health, social, and structural harms** associated with problematic alcohol use.
- Provide an **alternative to abstinence-based approaches**, aligning goals with the **person's needs**.
- Offer **low-threshold access to services**, allowing clients to engage **despite continued alcohol use**.
- Often delivered within **low-barrier housing**, where clients can access:
  - **Basic needs support**
  - **Medical, psychological, and social care**

How Managed Alcohol Programs (MAPs) Work

- Provide **measured amounts of alcohol** at **timed intervals** throughout the day.
- Paired with **psychosocial support** and **regular assessments** for intoxication.
- Help clients:
  - **Reduce overall consumption**
  - **Prevent deadly withdrawal symptoms**
  - Avoid **non-beverage alcohol use**
  - **Stabilize daily life** and access needed **support services**
- Aim to **improve quality of life** for individuals with severe alcohol use disorder (Help With Drinking, 2025).

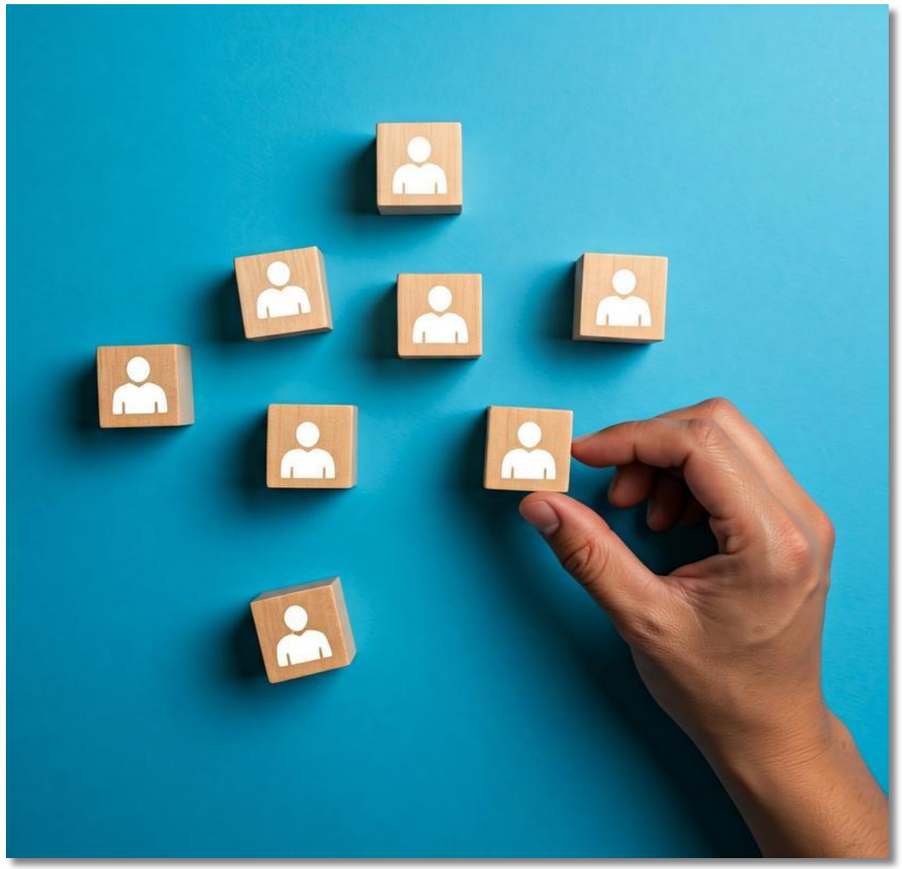
UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Drug checking services

Drug Checking Services

- **Enable substance users** to have their drugs **chemically analysed**.
- Provide **information on content** and **harm reduction advice**, warning users about **different drugs on the market**.
- Testing sites:
  - **Fixed laboratories** – submit samples, results in **days**
  - **Mobile laboratories** – at festivals/clubs, provide **near-immediate results**
- Potential benefits:
  - Identify drugs with **unwanted or unknown chemicals**
  - Enable **early public health responses**
  - Help **avoid overdoses** by providing information on **substance potency**
- Engage **young recreational users** often not reached by existing services
- Particularly important given the rise of **synthetic drugs**, including **high-potency synthetic opioids**



UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - PSYCHOACTIVE SUBSTANCE USE

Naloxone administration and training

Naloxone for Opioid Overdose

- **Medication** available in **nasal spray format**.
- Reverses **life-threatening CNS and respiratory depression** during opioid overdose, allowing the person to **breathe normally**.
- **Life-saving** if administered promptly while waiting for **emergency medical help**.
- **Non-addictive**; only works if **opioids are present in the system** (Correlation, 2024).

Intervention and Training

- Involves more than providing naloxone: **training clients and harm reduction workers** to **recognize overdose signs** and **respond appropriately**.
- Freely available naloxone for opioid users and their contacts can **increase first response** and **reduce drug-related deaths**.

Key Considerations

- *Not a standalone solution for drug-related deaths.*
- *Part of a wider range of treatment and support offered by drug services.*
- *Safe, cost-effective, and life-saving (Homelessness Link, 2020).*

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - SUBSTANCE USE

ACTIVITY 1.5 - VIDEO FORUM

30 MINUTES

Objective

To expose trainees to real-life examples of harm reduction programs, especially those focusing on substance use, in order to deepen their understanding of effective, person-centered responses and inspire context-appropriate application in their own practice.

Materials needed

- Links to the videos (next slide)
- Computer, projector and internet connection

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - SUBSTANCE USE

ACTIVITY 1.5 - VIDEO FORUM WITH EXAMPLES OF GOOD PRACTICES IN SELF-CARE, HOUSING, EMPLOYMENT, ACCESS TO HEALTHCARE

30 MINUTES

Preparation

Watch 2 or 3 of the following videos

- ABD - Consumo y me cuido:
  https://www.youtube.com/watch?v=GNbhHjM102k
- ABD - Recovery seeds:
  https://www.youtube.com/watch?v=ZIK5LO_EEhM
- ABD - Fight4YourLife: A Blow of Hope in the Fight Against Drug Addiction:
  https://www.youtube.com/watch?v=aVo84cyraWs
- CRESCER - REACH_U:
  https://www.youtube.com/watch?v=mbnbjzv65iQ
- Ten Working agreements Housing First of the city of Amsterdam:
  https://www.youtube.com/watch?v=NLcMF04Eh_k
  Inside America's First Legal Drug Use Site - Onpoint NYC
  Boyle Street — Managed Alcohol Program

And check out these good practices:

- Metzineres - Shelter Environments for Women who Use Drugs Surviving Violence (WUDSV)
- ABD – The Alcohol Maintenance Program
- ABD – The Programme of Early Intervention with Drug Dependents in a Situation of Social Emergency
- CRESCER – REACH_U project
- Centro Residencial Integral La Galena – The Shelter for Homeless Individuals Who Use Illegal Substances and/or Alcohol

UNIT 3 – GOOD PRACTICES ON HOMELESSNESS, SUBSTANCE USE & TRAUMA

SECTION 3 - SUBSTANCE USE

ACTIVITY 1.5 - VIDEO FORUM

20-30 MINUTES

Activity

After each video, participants have approximately 5 minutes to discuss what they observed, reflect on the practices presented, and share their thoughts on the approach.

Wrap-up

- What aspects of the program shown in the video seemed most effective, and why?
- What challenges or limitations might this approach face in practice?
- If this program were applied in your local context, what adaptations would be needed?
- Which practice inspired you most, and how could you apply it in your own work?

HOME4HEALTH MOOC

MODULE 2:
TRAUMA - INFORMED CARE APPROACH

MODULE OVERVIEW:

Unit 1: Understanding complex trauma

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

Section 2: Definition of trauma

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 2: Intersectionality between trauma, homelessness and drug use

Section 1: Trauma, drug use and attachment

Section 2: Survival adaptations

Unit 3: Post traumatic growth

Section 1: Definition

Section 2: The window of tolerance

Unit 4: Vicarious trauma

Section 1: Introduction

Section 2: Burnout

UNIT 1:

UNDERSTANDING COMPLEX TRAUMA

UNIT 1 - UNDERSTANDING COMPLEX TRAUMA

Coordinated by:
In partnership with:
Co-funded by the European Union
2023-1-ES01-KA220-VET-000165764

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.

UNIT 1:

SECTION 2

DEFINITION OF TRAUMA

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 2 - DEFINITION OF TRAUMA

Definition

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?

- Trauma refers to **situations or events we find traumatic** and how we are affected by our experiences.
- It can happen at **any age** and can cause **long-term harm**.
- Reactions to trauma vary between individuals; effects may appear **immediately** or **long after the event**.
- **Adversity** is a broader term used to describe challenging life experiences, which often interact with trauma.

Examples of adversity include:

- **Social exclusion** or dislocation
- **Discrimination** or systemic oppression
- **Poverty, abuse, addiction**, or neglect

Trauma does not occur in a vacuum—it is influenced by **systemic, relational, cultural, political, and wider environmental factors**.

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 2 - DEFINITION OF TRAUMA

The **impact and consequences of trauma** are broad, complex, and multilayered. Whether an event is experienced as traumatic depends not only on the event itself but also on:

- Previous life experiences, history, and prior trauma
- Severity, type, frequency, timing, and duration of trauma
- Location and context of the trauma
- Relationship to the person causing harm
- Responses of others to the trauma (validation, disbelief, or neglect)
- Personal meaning-making and sense of understanding the trauma
- Expectations, beliefs, and assumptions about self, others, and the world
- Associated losses or violations experienced
- Social, emotional, and developmental context
- Presence of protective factors, such as supportive relationships and community resources
- Cultural, socio-political, economic, and environmental context
- Family scripts, parenting models, intergenerational trauma, and attachment styles
- Individual temperament, biological identity, and genetic factors

Key Points

- *Trauma and adversity are **pervasive and widespread**, affecting individuals in multiple ways.*
- *Effective support requires **adversity-informed, culturally sensitive, and trauma-informed approaches.***
- *Professionals and services should adopt a **universal approach**, recognizing the broad impact of trauma on health, behavior, and well-being.*

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 2 - DEFINITION OF TRAUMA

ACTIVITY 2.2 - "IF TRAUMA COULD TALK, WHAT WOULD IT SAY, SHOW OR TELL US"

15 MINUTES

Preparation

Close your digital devices and make sure you are somewhere where you can concentrate and focus on this activity.

Activity

Have an empty (large) paper and marker in front of you. Set a timer for 10 min. Ask yourself the question: "If trauma could speak, what would it say?" Allow yourself to write down everything that comes up to you when you ask yourself that question.

Wrap up

Look at the paper and read what you have written. Save the paper if you want so you can always get back to it.

UNIT 1:

SECTION 3

TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Trauma

Trauma awareness is the understanding that past **adverse experiences**, especially in childhood, can significantly impact an individual's **reactions, behavior, and overall well-being**.

It involves:

- Recognizing that individuals may be **sensitive to triggers**.
- Understanding that reactions may seem **unrelated to the current situation**.
- Creating **supportive and safe environments** that minimize **re-traumatization**.

(Working definition of trauma-informed practice – UK Government, 2022)

Key aspects of trauma awereness:

- **Understanding the impact of trauma:** Recognize effects on **physical and mental health**, behavior, and relationships.
- **Recognizing signs and symptoms:** Identify **behavioral changes, emotional distress, or physical manifestations**.
- **Awareness of triggers:** Know that certain **situations, environments, or stimuli** can evoke trauma reactions.
- **Promoting safety and trust:** Foster **physical and emotional safety** and reduce the risk of re-traumatization.
- **Adopting trauma-informed practices:** Offer **choices, collaboration, and empowerment**.
- **Preventing re-traumatization:** Avoid actions or situations that **re-trigger past trauma**.
- **Seeking professional support:** Encourage individuals to access **therapists or qualified professionals** when needed.

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Why is trauma awareness Important?

- Enhances understanding of trauma and its **impact on the individual**.
- Improves the **support** offered to affected people.
- Helps **reduce stigma**.
- Promotes **healing**.
- Leads to better **personal and social outcomes**.

Trauma can be broadly categorized into **acute, chronic, and complex** types:

- **Acute trauma:** Single stressful event.
- **Chronic trauma:** Prolonged exposure to stressful situations.
- **Complex trauma:** Repeated or varied traumatic experiences.

Examples include:

- **Single event trauma** – happened once.
- **Developmental trauma** – early-life trauma affecting growth and relationships.
- **Intergenerational trauma** – trauma passed down through generations.
- **Historical trauma** – institutional abuse, e.g., physical, sexual, or emotional abuse.
- **Trauma in immigrants, refugees, marginalized or ethnic minority groups**.
- **Secondary trauma** – indirect trauma through connection to another's experience.
- **Vicarious trauma** – emotional/psychological distress from empathic exposure to others' trauma; cumulative effect, impacting worldview and causing anxiety, intrusive thoughts, and irritability.

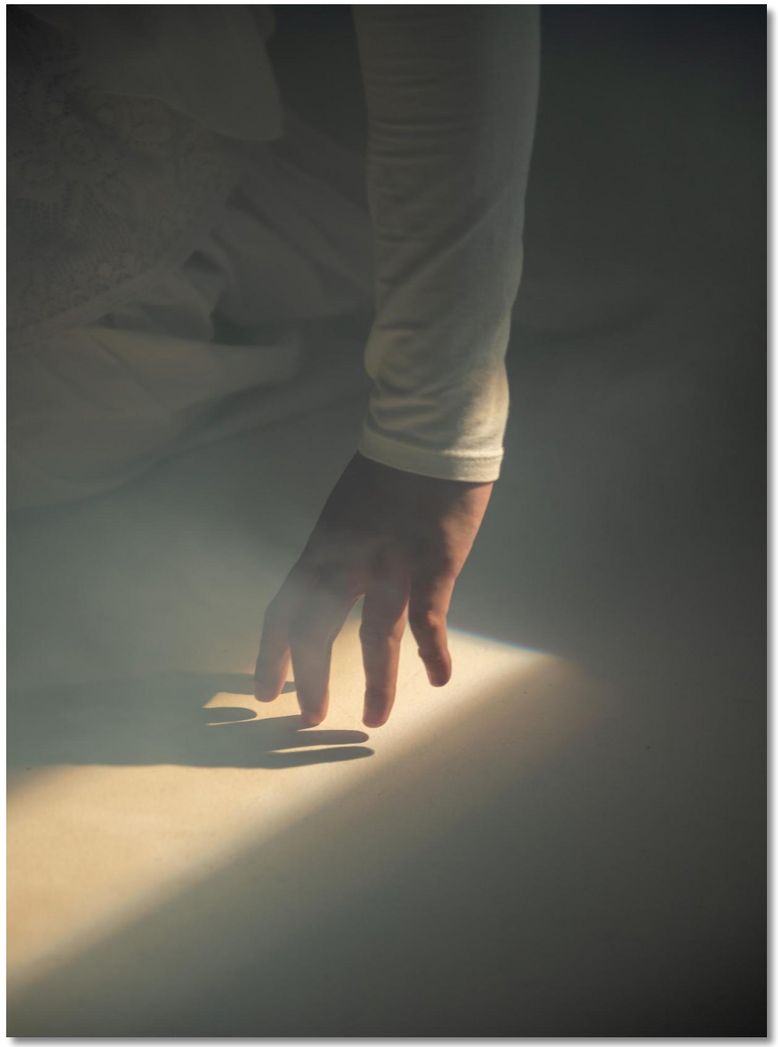
UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Early or developmental trauma occurs during **childhood**, often involving disruptions in caregiving, neglect, or repeated abuse. These experiences affect:

- **Social, emotional, and physical development**
- Ability to **form and maintain relationships**
- **Sense of safety, security, and trust**

Unresolved trauma can **live on in the body**, influencing day-to-day life profoundly.



Recommended watching: Video on developmental trauma

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Post-traumatic stress disorder (PTSD)

PTSD is a mental health condition caused by an **extremely stressful or terrifying event**, either by experiencing it directly or witnessing it.

Common symptoms include:

- **Flashbacks**
- **Nightmares**
- Severe **anxiety**
- **Uncontrollable thoughts** about the event

Distinction between PTSD and Complex PTSD

PTSD can result from a **single traumatic event**.

Complex PTSD is linked to **prolonged or repeated trauma**, often in **interpersonal relationships**.

Complex PTSD includes all **PTSD symptoms**, plus:

- **Difficulty regulating emotions**
- Challenges with **identity**
- Problems in **relationships**

*Note: Most people recover over time with care. Symptoms lasting **months or years** and affecting daily functioning may indicate PTSD. **Treatment is important** to ease symptoms and improve daily life.*

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Symptoms of PTSD

Symptoms can appear **within 3 months** of the traumatic event, but sometimes **years later**. They may last long and affect:

- Social interactions
- Work or school performance
- Daily routines

PTSD symptoms are usually grouped into **five categories**:

1. Intrusive Memories

- Repeated distressing memories
- Flashbacks (reliving the event)
- Nightmares
- Severe emotional or physical reactions to reminders

2. Avoidance

- Avoiding thoughts or conversations about the event
- Staying away from places, activities, or people that trigger memories

3. Changes in Physical and Emotional Reactions (Arousal)

- Being easily startled
- Always on guard
- Self-destructive behaviors (e.g., drinking too much, risky driving)
- Sleep problems
- Concentration difficulties
- Irritability, anger, aggression
- Physical reactions: sweating, rapid heartbeat, shaking

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

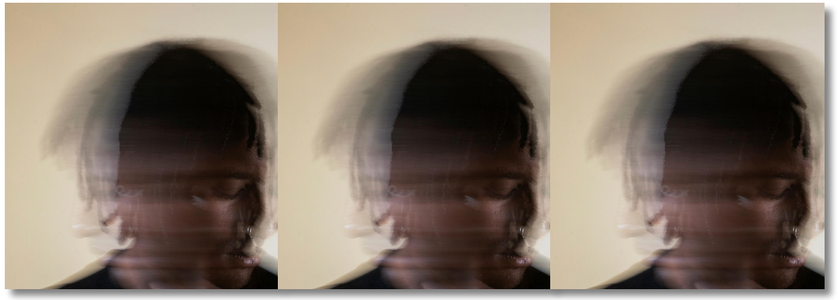
Symptoms of PTSD

4. Negative Changes in Thinking and Mood

- Negative thoughts about self, others, or the world
- Persistent negative emotions: fear, guilt, shame, anger
- Memory problems related to the trauma
- Feeling detached from family or friends
- Difficulty feeling positive emotions
- Emotional numbness

5. Changes in Physical and Emotional Reactions (Arousal)

- Being easily startled
- Always on guard
- Self-destructive behaviors (e.g., drinking too much, risky driving)
- Sleep problems
- Concentration difficulties
- Irritability, anger, aggression
- Physical reactions: sweating, rapid heartbeat, shaking

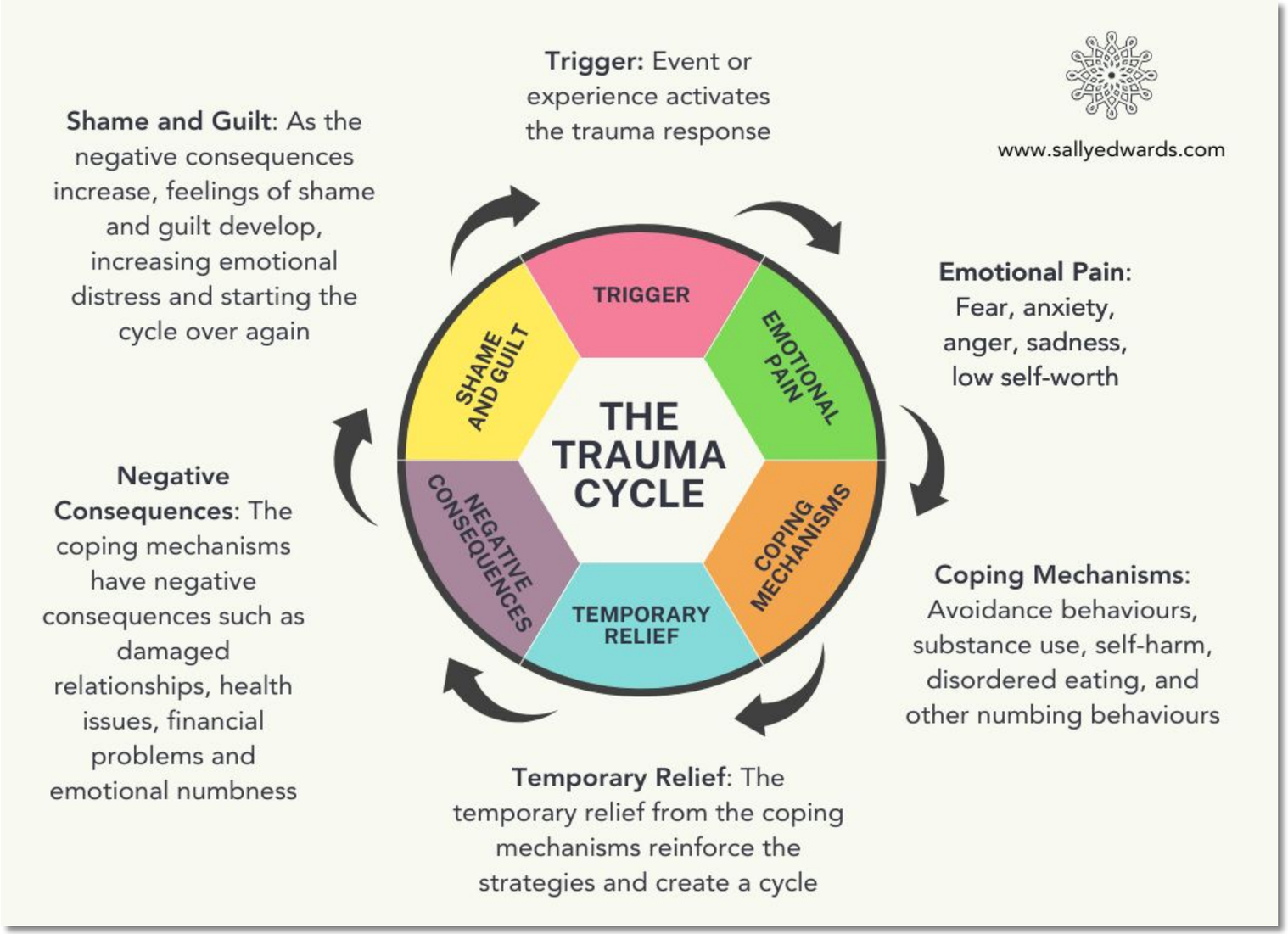


For children under 6 years old:

- *Reenacting trauma through **play***
- ***Frightening dreams**, with or without direct trauma content*

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA



UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Intensity of Symptoms

- Symptoms can **fluctuate** over time.
- Stress or **reminders of trauma** (places, events, anniversaries) can **increase symptoms**.
  - Example: A car backfiring may trigger **combat flashbacks**
  - Seeing news reports may trigger **memories of assault**

Recommended watching: Video on recognizing trauma by Professor Van der Kolk

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Trauma amongst women who experience homelessness

Trauma may differ by **gender**.

Women tend to experience more interpersonal and gender based violence.

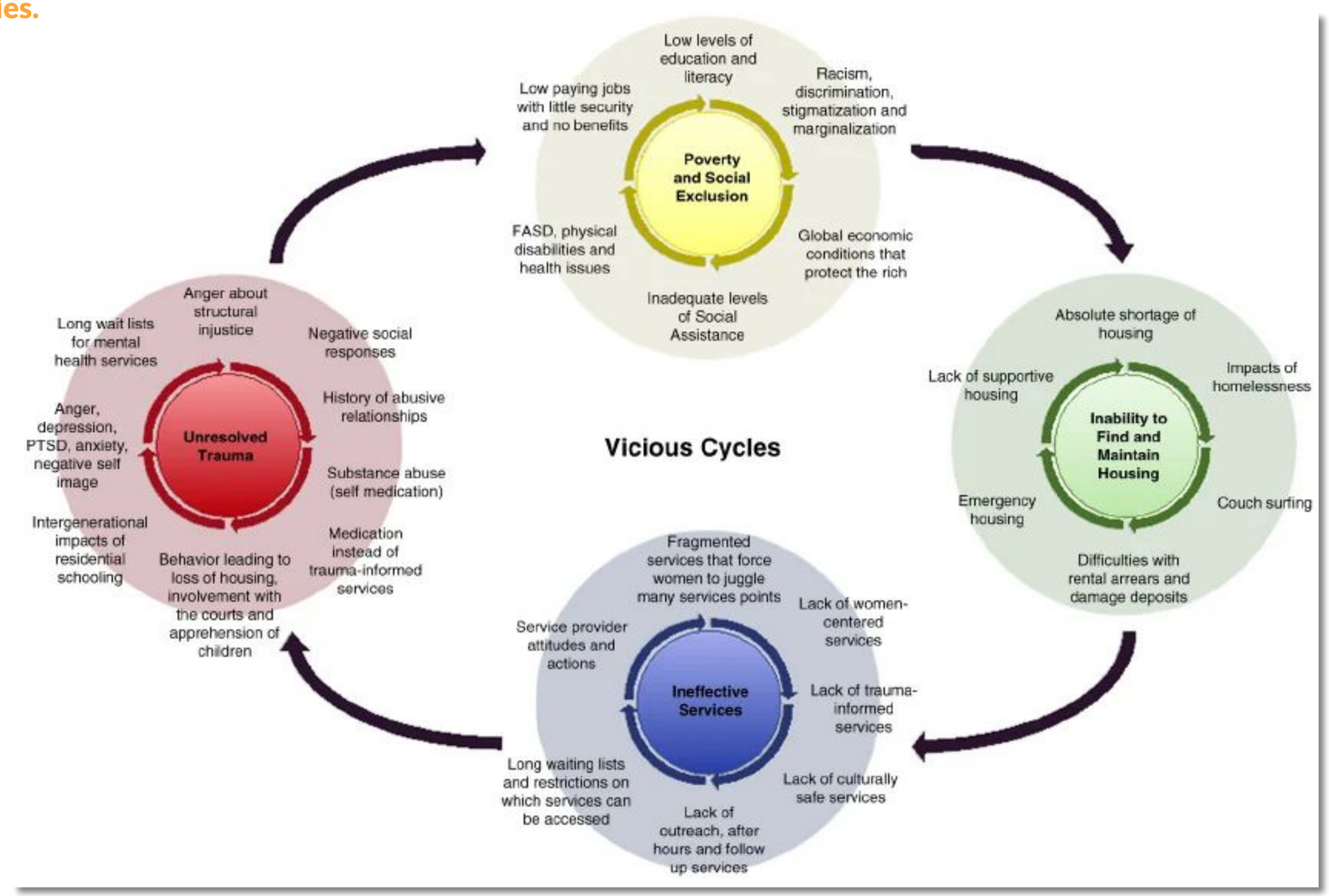
Types of trauma women may experience:

1. **Childhood trauma**
2. **Intimate Partner violence**
3. **Sexual violence and exploitation.**
4. **Trauma while homeless.**

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 3 - TRAUMA AWARENESS AND DIFFERENT TYPES OF TRAUMA

Trajectories of women's homelessness in Canada's three Northern territories.



UNIT 1:

SECTION 4

BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

Behavioural impacts

Trauma can have **significant effects on behaviour**, influencing how people act, think, and interact with the world.

How Trauma Affects Us Internally

When experiencing trauma, individuals may function in **survival mode**:

- Feeling **unsafe** and hyper-vigilant
- **Relationships** may feel confusing or threatening
- Alternating between **hyperarousal** (high alert) and **hypoarousal** (numbness, low energy)
- Perceiving others as **threatening** based on tone, posture, or expression
- Experiencing **physical discomfort** due to chronic stress
- Difficulty **understanding and expressing emotions**
  - Emotions may feel **unmanageable** or **threatening**
  - Trouble **identifying or naming emotions**
  - Emotional **numbness**, chronic **emptiness**, limited **empathy**
- Development of **unhealthy coping strategies**: avoidance, suppression, rumination, denial, self-blame
- **Cognitive impacts**: impaired decision-making, judgment, reasoning, planning, problem-solving, retention, and impulse control

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

Behavioural Signs of Trauma

People who have experienced trauma may:

- Struggle with **self-regulation** and **impulse control**
- React **defensively or aggressively**
- Have difficulties considering **consequences** of actions
- Appear **detached, spaced out, or disconnected from reality**
- Have **meltdowns** over minor events
- Show **unpredictable, oppositional, or extreme reactions**

High-risk behaviours may include:

- Self-harm
- Unsafe sexual practices
- Substance use or misuse
- Illegal activities
- Assault
- Running away
- Sex work

Guidelines for Working With People Who Have Experienced Trauma

Practical ways to respond:

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

Avoid:

- Judgement
- Taking over situations
- Power struggles
- Removing unhealthy coping strategies without supportive alternatives

REALIZE what trauma is.

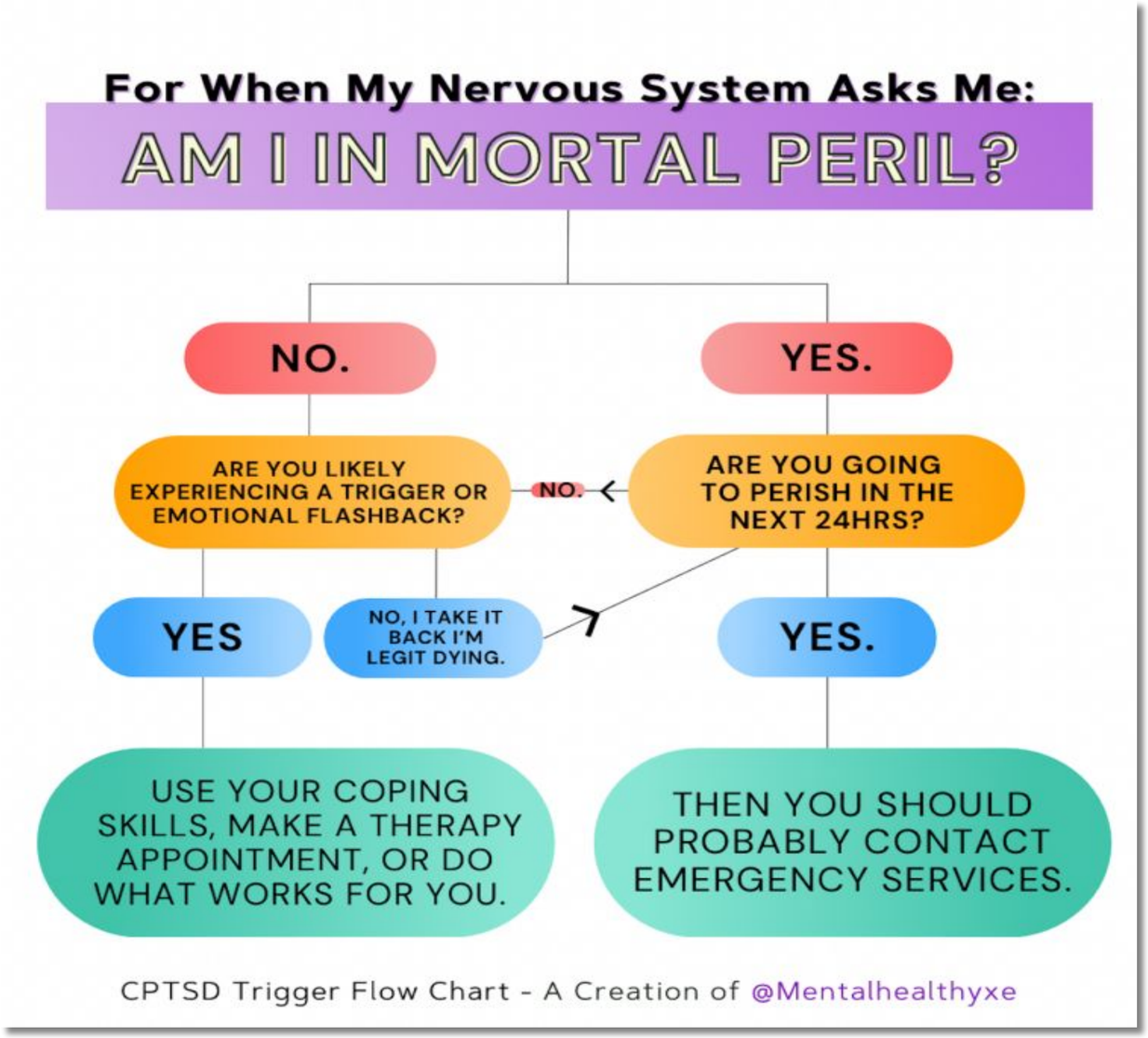
RECOGNIZE trauma in your clients

KEEP your own mental health supported ("fill your cup")

RESPOND with compassion and co-regulation

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL



UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

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.

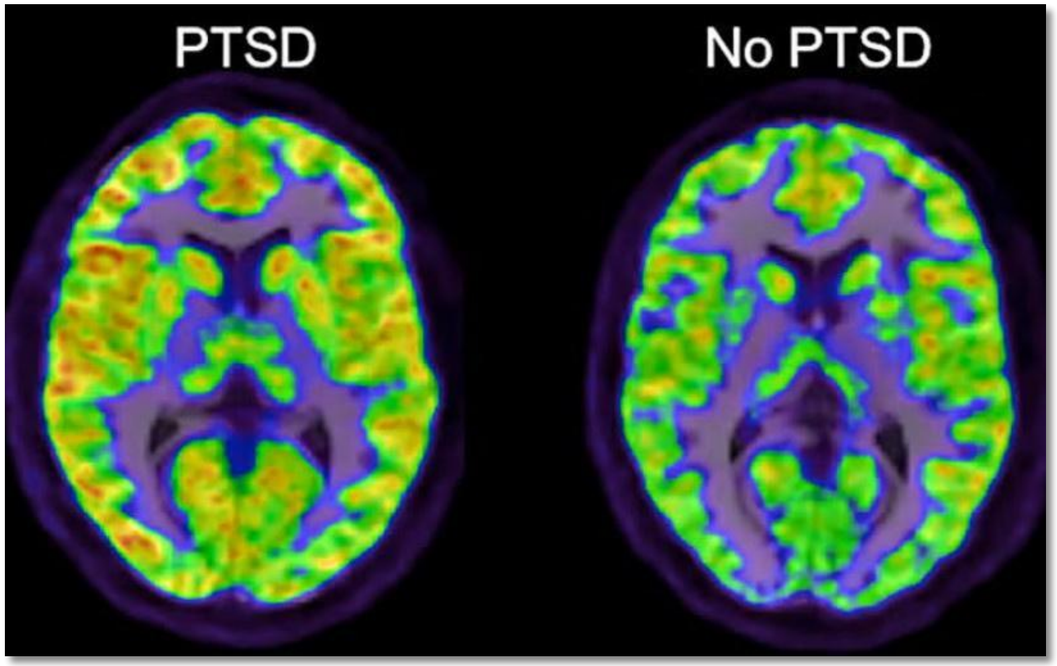
- **Prefrontal cortex**

  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.



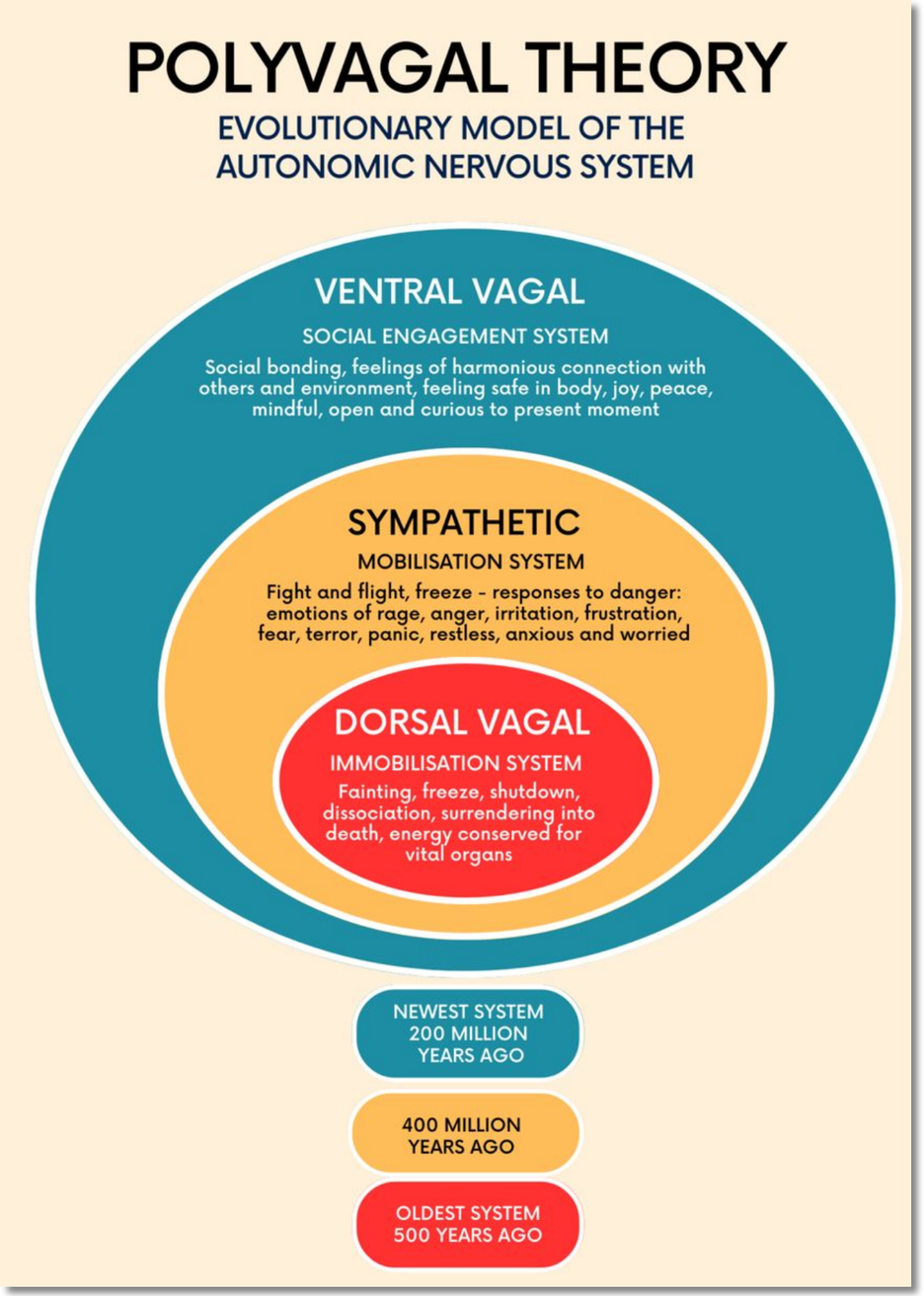
UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

A polyvagal theory (1)

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 one stays in this ready-to-react mode.



UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 4 - BEHAVIOURAL AND NEUROLOGICAL IMPACTS OF TRAUMA ON THE INDIVIDUAL

A polyvagal theory (2)

Watch the video to understand and learn more about the polyvagal perspective.

Video on Trauma and the Nervous System: A Polyvagal Perspective

Sources of hope:

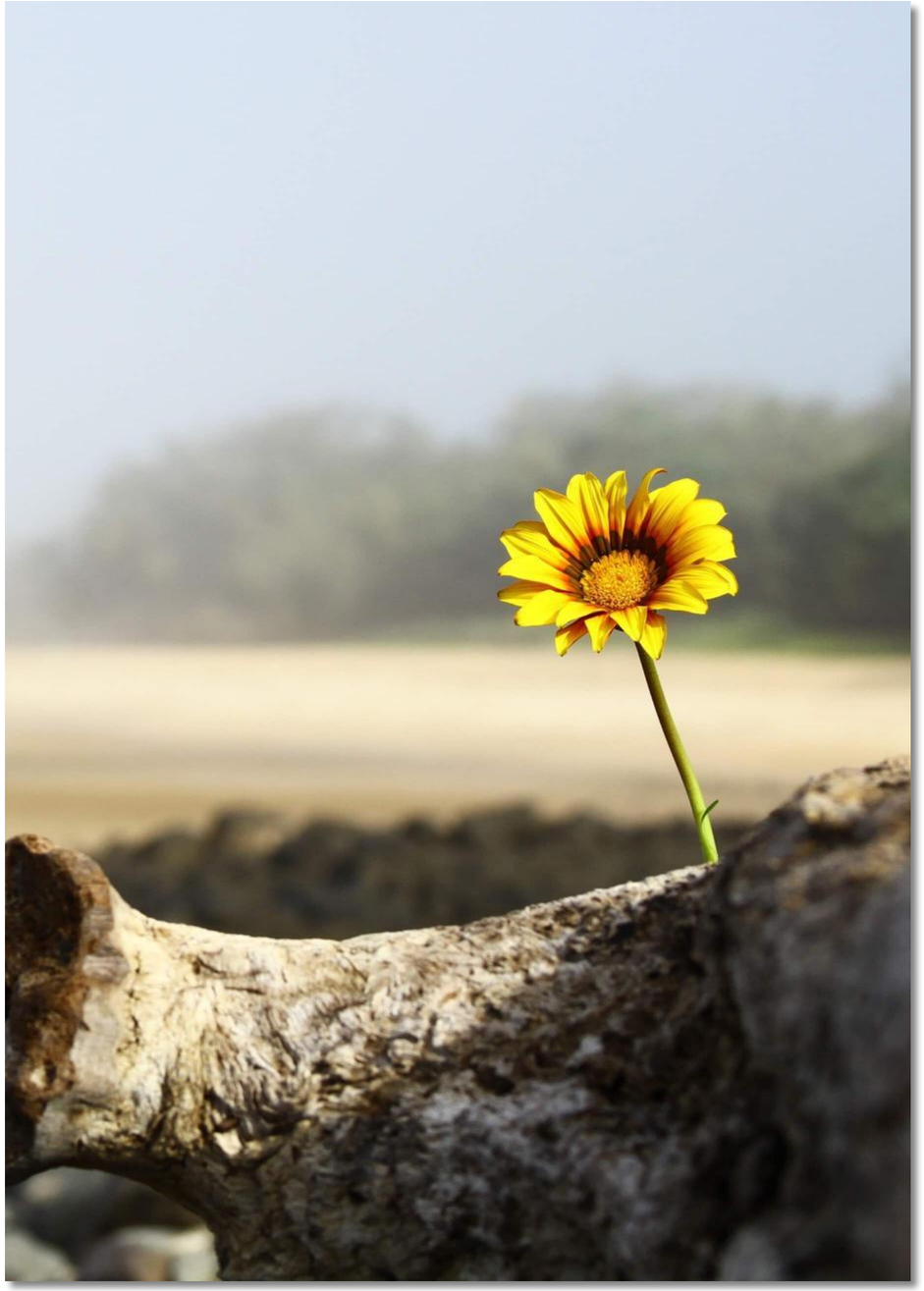
Brain plasticity: The brain continues all our lives to rewire in response to experience.

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.



UNIT 1:

SECTION 5

PEER SUPPORT

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 5 - PEER SUPPORT

Peer Support in Trauma-Informed Care

Support from peers is unique and benefits trauma survivors by providing various types of support, **practical advice**, and hope for the future. It also helps trauma survivors feel like they are **not alone** in their journey.

Why peer support is important:

Peer support fosters a sense of **safety, connection, and empowerment**. By sharing **lived experiences** and offering mutual support, peer supporters help break down **feelings of isolation**, build trust, and promote **healing and recovery**.

Important considerations for peer supporters:

- Must have **personal experience** with mental health conditions, substance use, homelessness, or other significant challenges.
- Should be **actively in recovery** or have demonstrated overcoming these obstacles for at least one year.
- Be comfortable **sharing personal experiences** and navigating systems they have experienced.
- Able to build **trusting relationships** based on **mutual respect, empathy, and non-judgment**.
- Maintain a **positive outlook** and inspire **hope**.
- Able to **advocate** for themselves and others, understanding rights and systems.
- Be in a **healthy place in their recovery journey**, managing their own well-being while supporting others.
- Assess **support needs** and refer clients to appropriate resources when necessary.
- Require **appropriate training** and **ongoing supervision**.

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 5 - PEER SUPPORT

What is the peer support role?

Role of peer support:

Peer support promotes **recovery and well-being**. Sharing experiences helps reduce **isolation and stigma**. Peer support offers **practical advice, empathy, and encouragement**, reminding individuals they are **not alone**.

It can include:

- **One-to-one interactions**
- **Peer support groups**
- A **strength-based framework** emphasizing **physical, psychological, and emotional safety**
- Opportunities for survivors to **rebuild a sense of control and empowerment**

Four tasks of peer support:

1. Build connections
2. Help each other understand how we come to know what we know (worldview)
3. Redefine health as a shared learning and growing process (mutuality)
4. Focus on moving toward what we want, rather than away from what we don't want

*According to SAMHSA (2024), peer support is "a system where individuals with **lived experience** of mental health conditions, substance use disorders, or both, provide support to others navigating similar challenges."*

UNIT 1 – UNDERSTANDING COMPLEX TRAUMA

SECTION 5 - PEER SUPPORT

Facilitating peer support:

- Be **available**
- Provide a **safe space** for sharing thoughts
- **Listen attentively, openly, and non-judgmentally**
  Be **kind, empathic, and understanding**, sharing experiences to ensure the person **does not feel alone**

Types of peer support:

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

UNIT 2:

INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

UNIT 2:

SECTION 1

TRAUMA, SUBSTANCE USE AND ATTACHMENT

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

Trauma, Substance Use and Attachment

When examining the relationship between **trauma, homelessness, and drug use**, it is helpful to consider an **attachment lens**.

Attachment theory, developed by John Bowlby, explains humans' **biological need for connection**. Substance use can be understood as **"self-medication"**, a way to compensate for **lacking attachment strategies**. Attachment theory suggests a pathway from **insecure attachment** to **substance use disorders**, and, conversely, that substance abuse can negatively affect attachment security.

In **infancy**, a **secure attachment** forms when a caregiver is **warm, nurturing, consistent, and attuned** to the child's needs. **Insecure attachment** arises when caregivers are inconsistent in responding to physical or emotional needs. Early attachment creates a **template for future relationships**, influencing how we relate to **others, the world, and ourselves**.

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

How does this relate to trauma?

Humans have two fundamental needs: **authenticity** (connection to self) and **attachment** (connection to others). A lack of a **secure base** can lead to **insecure attachment patterns**, including **negative self-images** and expectations about relationships.

Trauma changes how the brain and body respond to stress. The **fight-or-flight response** is natural, but when over-activated, it can lead to **chronic stress, anxiety, and other mental health issues**. Turning to **drugs or alcohol** can temporarily numb pain or manage intense emotions, but over time this may develop into **substance use disorders**. Research shows that individuals who experience trauma are **more likely to develop addiction** (Dr. Britt Gottlich, 2024).

Recommended video: Trauma and Addiction

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

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

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

Applying an Attachment Lens

- Stay **interested in the relationship**
- Encourage service users to **verbalize needs** with **support, curiosity, and exploration**
- For **highly enmeshed attachment**:
  - Encourage **autonomy**
  - Provide **regular but brief contact**
  - Avoid constant reassurance

Key point: *Knowing one's own attachment style helps staff remain mindful, attuned to both verbal and nonverbal cues, and encourage clients to express needs and rebuild connections.*

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

Trauma, homelessness and drug use

These factors are **interconnected**, often creating a **vicious cycle**:

- **Trauma and Mental Health:**

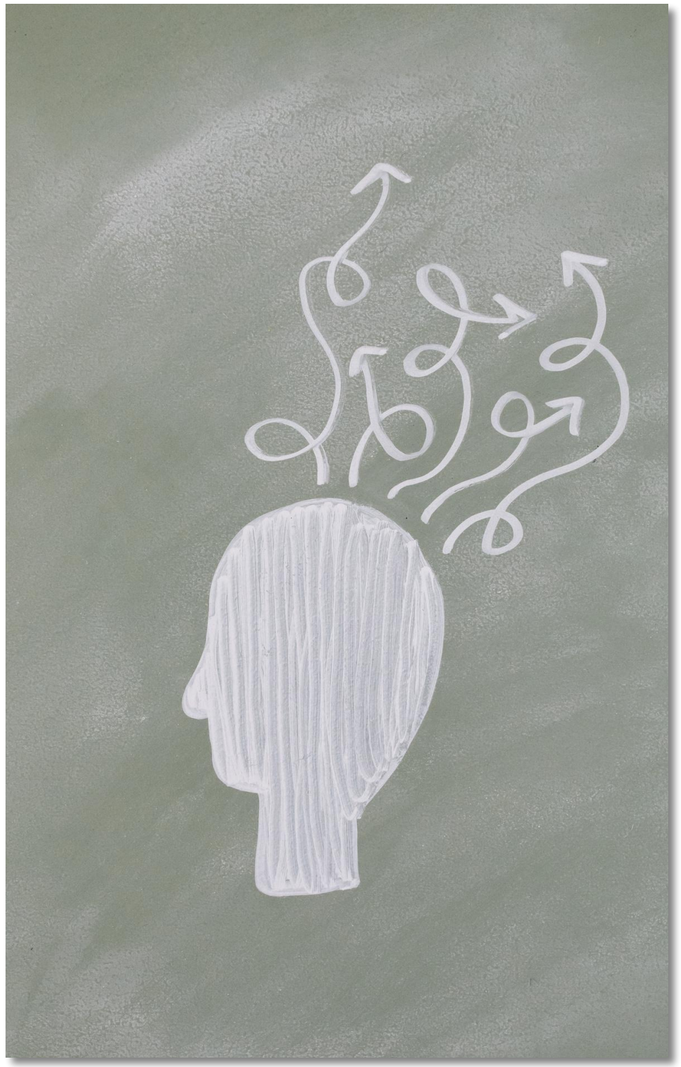
  Trauma can lead to **PTSD, depression, and anxiety**, making emotion regulation difficult and increasing the risk of **substance use**.

- **Trauma and Homelessness:**

  Trauma can disrupt **social connections, employment, and housing stability**, increasing the risk of homelessness. For example, **domestic violence** can force someone to leave home and create long-term challenges.

- **Homelessness and Drug Use:**

  Environmental stressors like **social isolation, lack of resources, and exposure to drugs** increase vulnerability. Easy access to drugs within unhoused communities may contribute to **substance use**.



UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

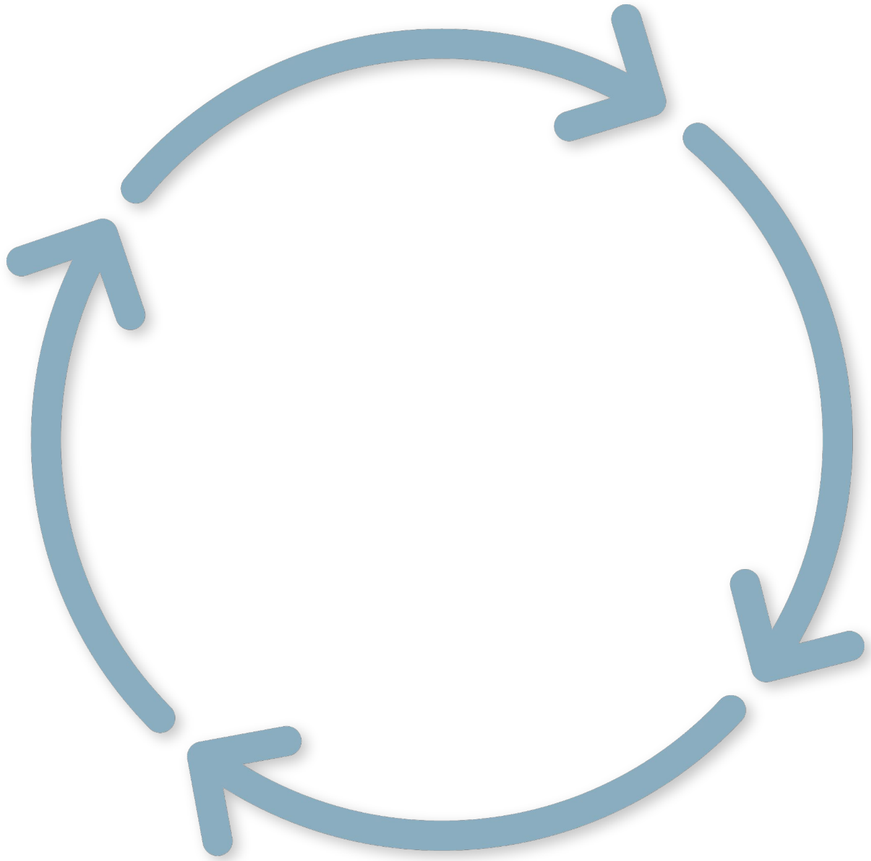
SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

The Cycle:

Trauma → mental health challenges → stress of homelessness → **substance use** → worsened mental health → prolonged homelessness.

Addressing the Cycle:

- **Trauma-informed care**: helps individuals develop **healthy coping mechanisms**
- **Mental health services**: provide **therapy and medication**
- **Housing and employment support**: stabilize lives and reduce risk of homelessness



UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

FEANTSA

FEANTSA emphasizes **measuring the impact of interventions** to understand what works. Trauma-informed care is **effective without increasing costs** if it involves changes in **work attitude and approach** rather than new resources.

Key recommendations:

- Create a **safe physical environment**
- Develop services assuming **service users manage trauma effects**
- Minimize **barriers to access** (low threshold, harm reduction)
- Avoid traumatizing practices (e.g., strict authoritarian rules)
- Apply a **gendered approach**
- Establish **caring, long-term relationships**
- Provide **training and trauma-informed care**
- Make services **client-driven** and **strengths-based**
- Support **staff emotional wellbeing**

FEANTSA

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

The Adverse Childhood Experiences (ACE's) study:

ACEs are traumatic events before age 18, including **abuse, neglect, or household dysfunction**. Children's brains are highly sensitive; early adversity can alter **brain development** and affect the **immune system**, leading to long-term negative impacts on **physical, mental, and social health**.

Key findings:

- Strong link between **ACE count** and **poor adult health outcomes**
- ACEs include: physical, sexual, and emotional abuse; neglect; parental mental illness; household substance abuse; incarceration; loss of a parent; witnessing domestic violence

ACE Scores:

- Range from 0–10, with higher scores indicating **greater exposure to adversity**
- High scores (4+) are associated with **increased risk to health and well-being**

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

Cork Simon Community Study (2017)

In 2017, **Dr. Sharon Lambert and Graham Gill Emerson** conducted a study titled *"Moving towards trauma-informed care – research and practice"* to examine the levels of **trauma among Cork Simon service users** and to explore how services could better respond to individuals with trauma histories. The study involved **50 service users** supported by the **Adult Homeless Integrated Team (AHIT)**, a multidisciplinary team funded by the Health Service Executive that operates across Cork Simon's **emergency shelters and other homelessness services** in the city.

Demographics of participants:

- **Average age:** 31 (range 20–45)
- **Gender:** 77.6% men, 20.4% women
  Duration of homelessness:
  - Less than 5 years: 50%
  - 5–9 years: 30%
  - 10 years or more: 20%
- **Current living situations:** rough sleeping, emergency accommodation, unstable housing, and more stable forms of accommodation.

Key findings:

- **100%** of participants experienced **at least one ACE**
- **77%** experienced **four or more ACEs** – a threshold linked to significantly increased risks to health and well-being

Highest scoring ACEs:

- **Verbal abuse:** 75% (10 times higher than the general public)
- **Family substance misuse:** 71% (2.6 times higher than general population)
- **Physical abuse:** 67% (2.4 times higher than general population)

- Over **one-third** of participants experienced **sexual abuse**, a quarter experienced **physical neglect**, and two-thirds endured **emotional neglect**
- More than **70%** lived with someone with an **addiction issue**, over **50%** lived with someone with **mental health difficulties**, half grew up in **one-parent families**, and around a third grew up with **family members in prison**
- **Domestic violence:** 40% witnessed violence against their mother

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 1- TRAUMA, DRUG USE AND ATTACHMENT

Gender differences:

- **Women** reported higher rates of **sexual abuse (60% vs. 30% men), emotional neglect (100% vs. 59% men), and parental loss (60% vs. 43% men)**
- **Men** reported higher rates of **verbal abuse (78% vs. 70% women) and family substance abuse (76% vs. 60% women)**

Key insight:
*The study demonstrates the **extremely high prevalence of childhood adversity** among people experiencing homelessness and highlights the importance of **trauma-informed care**. Understanding these experiences allows services to respond more effectively and tailor interventions that **support recovery, resilience, and engagement**.*

Impact of ACEs on homelessness:

- High ACE scores strongly correlate with **longer periods of homelessness**
- ACE scores of 4+ were associated with **worse outcomes across multiple health and wellbeing factors**, including **poorer mental health, increased exposure to trauma, and critical illnesses**
- High ACE scores also affected **engagement with services**, leading to challenges such as:
  - Difficulty **reading social and facial cues**
  - **Heightened startle responses**
  - **Avoidance behaviors**
  - **Memory problems**
  - **Poor decision-making**
  - **Aggression**

UNIT 2:

SECTION 2

SURVIVAL ADAPTATIONS

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 2- SURVIVAL ADAPTATIONS

Survival adaptations

*Trauma survivors often develop **adaptations** to manage the impact of their experiences. These can be **healthy** or **unhealthy**, affecting emotions, behavior, thinking, and physical health. Understanding these adaptations is key to fostering **healing, resilience, and recovery**.*

Healthy adaptations support emotional processing and regulation. Techniques such as **self-compassion** and **mindfulness** help survivors recognize and validate their emotions, reducing the negative impact of trauma. Building a strong **support system** with trusted individuals or engaging in **supportive networks** provides safety and validation. Seeking **professional support**, including trauma-focused therapies like **EMDR** or **CBT**, helps process traumatic memories, develop coping strategies, and restore a sense of safety. Engaging in **self-care activities** such as exercise, hobbies, and healthy routines promotes emotional balance, while identifying **personal strengths and setting achievable goals** fosters hope and empowerment. Creative expression, journaling, and trauma-informed movement or yoga practices can also reconnect survivors with their bodies and help process trauma.

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 2- SURVIVAL ADAPTATIONS

Survival adaptations (2)

Unhealthy adaptations may provide short-term relief but hinder long-term recovery. These include:

- **Emotional suppression or avoidance**, such as silencing feelings or avoiding triggers.
- **Behavioral changes**, like social withdrawal, aggression, or substance use.
- **Negative cognitive patterns**, including self-blame, distorted thinking, or difficulties trusting others.
- **Physical symptoms**, such as chronic pain, fatigue, or digestive issues, reflecting unresolved trauma.

Addressing these adaptations requires **awareness and intentional support**. Self-reflection helps survivors recognize their survival strategies, while professional guidance distinguishes healthy from unhealthy coping mechanisms. By combining **self-compassion, strong social support, and self-care**, individuals can adopt more adaptive strategies, manage emotions effectively, and promote long-term well-being.

Further learning: Video on trauma and coping:
https://youtu.be/BVg2bfqblGI?si=i80BY_ZkYZIxXh8p

Key points to remember:

- *Healthy coping strategies include mindfulness, self-compassion, and creative expression.*
- *Unhealthy adaptations often involve avoidance, substance use, or negative thought patterns.*
- *Professional support is crucial for processing trauma and building resilience.*

UNIT 2 – INTERSECTIONALITY BETWEEN TRAUMA, HOMELESSNESS AND DRUG USE

SECTION 2- SURVIVAL ADAPTATIONS

ACTIVITY 2.4 - CASE CLINIC

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

The trainer should divide participants into groups of 6–7 people and provide each group with a printed case study, paper, and markers.

The trainer should ask the group to assign:

- One person to read the case study aloud
- One person to take notes
- One person to present feedback to the larger group

Allow 15 minutes for group discussion and preparation.

Activity

- Instruct each group to analyse the trauma experienced by the individual(s) in the case study and discuss what support might be needed.
- Encourage participants to apply trauma-informed principles and draw on personal and professional experience.
- Remind groups to consider both what to do and what to avoid when working with people who have experienced trauma.

Wrap up

- Ask each group's representative to present their key findings and recommendations to the whole group (1–2 minutes per group).
- The facilitator records common themes, innovative solutions, and important insights on a flip chart.

Summarise and highlight effective strategies identified during the feedback session.

UNIT 3:

POST - TRAUMATIC GROWTH

UNIT 3:

SECTION 1

DEFINITION

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 1- DEFINITION

Post traumatic growth:

Definition

Post-traumatic growth (PTG) refers to the **positive psychological changes** that can occur after experiencing a traumatic event. While trauma often causes significant distress, PTG highlights that individuals can also find **meaning, resilience, and transformation** in response to adversity. These changes may involve altered beliefs, new understanding of the self, others, and the world, or a deeper appreciation for life.

Key aspects of post-traumatic growth
PTG emphasizes that growth can occur **alongside the pain of trauma**, rather than replacing or diminishing it. It encourages individuals to find strength, purpose, and personal insight through their struggles.

Positive outcomes may include:

- **Increased personal strength** – feeling more capable of handling future challenges.
- **Greater appreciation for life** – valuing everyday experiences and relationships.
- **Spiritual or existential changes** – reevaluating beliefs or finding new meaning.
- **Improved relationships** – deeper empathy, closeness, and connection with others.
- **New possibilities** – discovering opportunities for personal growth or life changes.

While PTG can occur naturally without formal therapy, it is not guaranteed for everyone and often unfolds over time. Tedeschi et al. (2018) define PTG as *"a positive psychological change experienced as a result of the struggle with trauma or highly challenging situations."*

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 1- DEFINITION

Post traumatic growth

Facilitating post-traumatic growth

PTG can be supported through:

- **Education** – learning about trauma and its effects.
- **Emotional regulation** – developing skills to manage distressing feelings.
- **Disclosure** – sharing experiences safely with others.
- **Narrative development** – making sense of the trauma by creating a personal story.
- **Service** – helping others or engaging in meaningful activities.

Supporting survivors

Individuals can also work on PTG by processing the traumatic experience and reducing its interference in daily life. Evidence-based therapies for trauma, such as **prolonged exposure therapy** and **cognitive processing therapy**, along with medication for symptom management, can help survivors cope and promote growth.

UNIT 3:

SECTION 2

THE WINDOW OF TOLERANCE

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 2- THE WINDOW OF TOLERANCE

The window of tolerance

The **window of tolerance** describes the optimal range of emotional and psychological arousal in which a person can function effectively and regulate their emotions. Within this window, individuals can think clearly, manage their feelings, and respond appropriately to everyday challenges.

When someone is **outside their window**, they may experience **hyper-arousal**—feeling overwhelmed, anxious, or angry—or **hypo-arousal**, which can appear as numbness, withdrawal, or disconnection.

Importance of the Window of Tolerance

Understanding the window of tolerance is essential because it:

- Supports **emotional regulation**, helping people manage stress and respond adaptively.
- Guides **trauma recovery**, as trauma survivors often have a narrower window and benefit from strategies that help them stay within it.
- Informs **therapeutic interventions**, aiding professionals in supporting clients who experience dissociation or heightened stress responses.

Strategies of the Window of Tolerance

- Mindfulness 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.

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 2- THE WINDOW OF TOLERANCE

How to explain the window of tolerance to clients

Introduce the concept by describing three zones:

1. **Within the window:**
   Calm, alert, able to think and make decisions.

2. **Hyper-arousal:**
   Overwhelmed, reactive, or anxious;
   fight-or-flight responses dominate.

3. **Hypo-arousal**
   Numb, detached, withdrawn; may feel shut down or depressed.

Encourage clients to reflect on how trauma, stress, or other challenges affect their personal window and to learn ways to expand it over time.

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 2- THE WINDOW OF TOLERANCE

Supporting clients to self-regulate

Helping clients stay within their window can involve:

- Maintaining routines for meals, sleep, and activity to create stability.
- Encouraging self-care practices such as hobbies, exercise, and mindfulness.
- Teaching grounding and emotional regulation techniques.
- Strengthening social support networks.
- Offering trauma-informed therapy to process past experiences and reduce distress.
- Identifying triggers and developing coping strategies to prevent dysregulation.

Clients can benefit from exploring creative or physical practices, including journaling, art, or trauma-informed movement, which support reconnection with the body and regulation of the nervous system.

Understanding survival adaptations

Trauma can lead to both healthy and unhealthy coping strategies. Healthy adaptations may include self-compassion, mindfulness, and connecting with supportive networks. Unhealthy adaptations can involve emotional suppression, avoidance, social withdrawal, aggression, substance use, or distorted thinking patterns.

Through self-reflection and professional guidance, clients can recognize these adaptations and learn healthier ways to cope, manage emotions, and engage with life.

You can watch a video for further information: Window of Tolerance.

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 2- THE WINDOW OF TOLERANCE

Trauma - informed organizations

A **trauma-informed organisation** prioritizes understanding and responding to the impact of trauma on both individuals and staff. Trauma-informed principles are integrated into all aspects of the organisation, from policies and procedures to daily interactions.

Key elements include:

- **Understanding trauma**: Recognizing the lasting impact trauma can have on behavior, relationships, and well-being.
- **Creating a safe environment**: Ensuring physical and emotional safety for all individuals.
- **Empowerment and choice**: Supporting individuals to make decisions and participate in their care.
- **Collaboration and partnership**: Working jointly with clients, staff, and other agencies.
- **Staff training and support**: Equipping staff to understand trauma, manage vicarious trauma, and prevent burnout.
- **Cultural humility and inclusivity**: Respecting diversity and ensuring culturally responsive practices.
- **Ongoing assessment**: Regularly evaluating policies and practices for effectiveness.
- **Addressing systemic trauma**: Recognizing the influence of historical, racial, and structural trauma.

UNIT 3 – POST - TRAUMATIC GROWTH

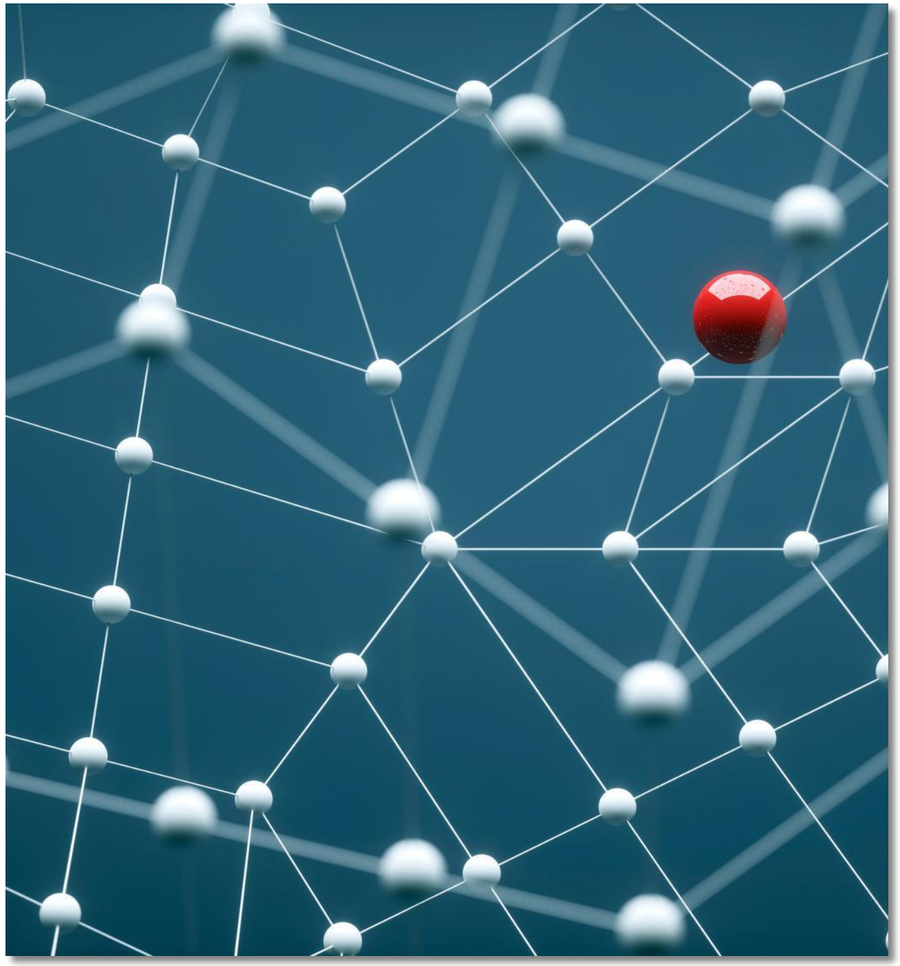
SECTION 2- THE WINDOW OF TOLERANCE

What are the benefits of becoming trauma informed as an organization?

Adopting a trauma-informed approach can:

- Improve outcomes for individuals by creating supportive and healing environments.
- Enhance staff well-being and reduce burnout.
- Strengthen relationships between staff, clients, and the wider community.
- Increase engagement and retention in services.
  Improve the organisation's capacity to respond effectively to crises.

As Karen Treisman highlights in *A Treasure Box for Creating Trauma-Informed Organisations*, weaving trauma awareness into everyday practice enhances both service quality and organisational culture, making it safer and more supportive for everyone involved.



UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

ACTIVITY 2.5 - PROMOTING POST-TRAUMATIC GROWTH STRATEGIES

30 MINUTES (20 MIN GROUP WORK + 10 MIN FEEDBACK)

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

- Divide participants into groups of 6–7 people.
- Ask each group to nominate one person to take notes and one person to present feedback to the larger group.

Activity

- Allow 15 minutes for discussion and preparation.
- Increased awareness of strategies that foster post-traumatic growth
- To recognize potential growth without minimising trauma.
- Apply post traumatic growth principles in complex, ongoing trauma environments.
- Balance immediate needs with longer term needs.

Wrap up

- Each group's nominated presenter shares their strategies with the whole group (1–2 minutes per group).
- The facilitator records key strategies and common themes on a flip chart.
- Summarise by noting particularly innovative or widely applicable ideas.

UNIT 4:

VICARIOUS TRAUMA

UNIT 4:

SECTION 1

DEFINITION

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 1- DEFINITION

What is vicarious trauma?

Vicarious trauma refers to the indirect emotional and psychological distress that can result from empathic engagement with people who have experienced trauma. It occurs when professionals or supporters are repeatedly exposed to traumatic stories, situations, or emotions, even though they did not experience the trauma themselves.

Through deep empathy, helpers may absorb elements of another person's fear, grief, anger, or despair. Over time, this can lead to feelings of burden, overwhelm, or hopelessness. Like direct trauma, vicarious trauma can change how a person sees the world and affect their sense of meaning, trust, and hope.

Key aspects of vicarious trauma

Vicarious trauma develops through **indirect exposure** to trauma (e.g., hearing stories, witnessing suffering, working with survivors)

It is a **gradual, cumulative process**, rather than something that appears suddenly
Possible mental health impacts include:

- Anxiety
- Intrusive thoughts
- Sleep problems
- Difficulty concentrating

It can also affect:

- Relationships
- Beliefs and worldview
- Emotional well-being

Difference from compassion fatigue:

- Compassion fatigue: mainly emotional exhaustion
- Vicarious trauma: deeper changes in beliefs, identity, and worldview

It can affect anyone who deeply empathizes with trauma survivors (professionals, volunteers, friends, and family members)

UNIT 3 – POST - TRAUMATIC GROWTH

SECTION 1- DEFINITION

Signs and Reactions

Vicarious trauma can appear in different areas of life:

- **Physical reactions**: feeling on edge, sleep difficulties, frequent illness.
- **Emotional reactions**: sadness, irritability, anxiety, anger, or feeling unsafe.
- **Cognitive reactions**: trouble concentrating, memory problems, intrusive images, or "zoning out."

It can also affect relationships and beliefs. People may become more distrustful, withdraw socially, experience conflict in relationships, or struggle with hope and meaning.

Recognizing these signs early is important so that support can be sought before symptoms worsen.

Strategies to Reduce Risk

Working in helping roles is demanding, and acknowledging this is an important first step. The work is hard because it involves caring deeply about others' suffering. However, there are practical ways to protect ourselves.

Helpful strategies include:

- Increasing **self-awareness** and noticing early signs of stress.
- Practicing emotional and physical **self-care**, including rest, exercise, and relaxation.
- Balancing caseloads and taking regular breaks.
- Using supervision, peer support, and opportunities to debrief.
- Continuing training and professional development.

Remembering why we chose this work can also be empowering. Many people are drawn to helping roles because they value empathy, compassion, patience, and resilience. Recognizing these strengths can help sustain motivation while maintaining healthy boundaries.

UNIT 3 – POST - TRAUMATIC GROWTH

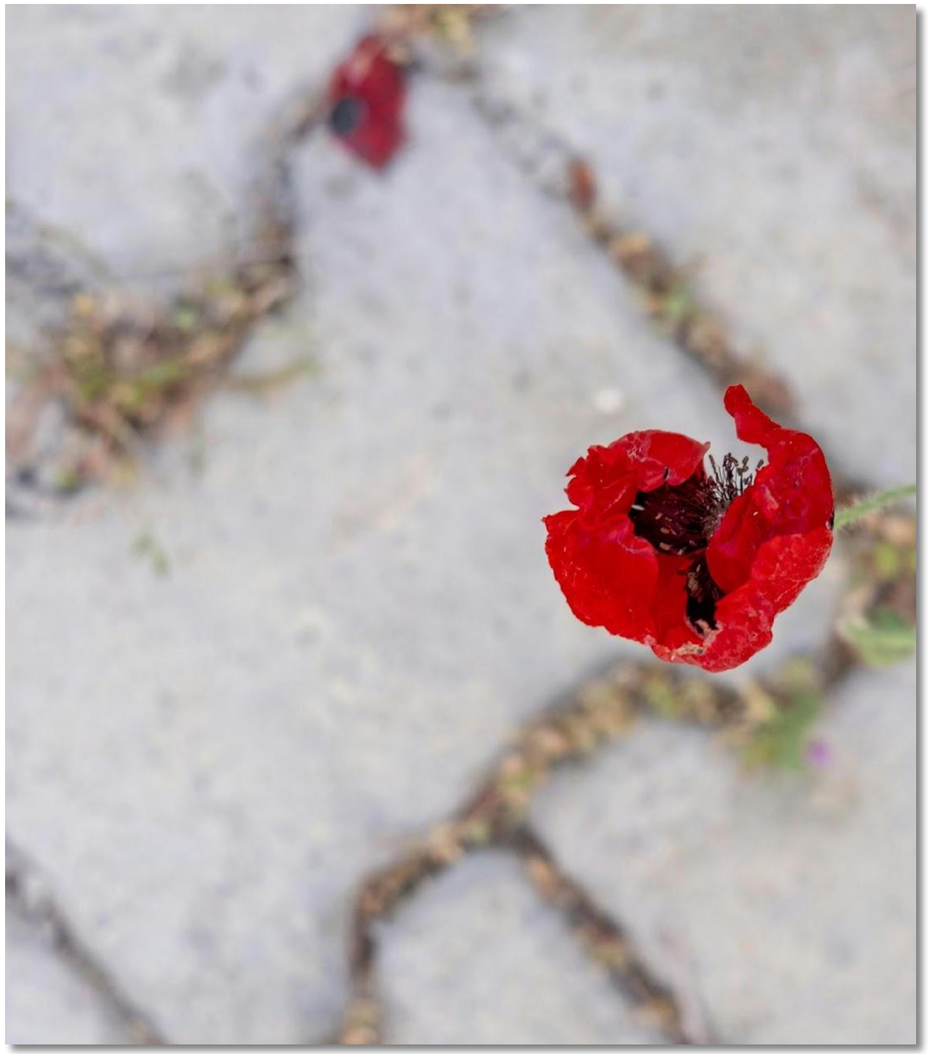
SECTION 1- DEFINITION

Vicarious resilience

Vicarious resilience refers to the positive psychological effects helpers may experience when witnessing the strength and recovery of people they support. Seeing clients cope, adapt, and grow can inspire hope, meaning, and renewed purpose.

This emerging area of **research** highlights that while exposure to trauma can be challenging, it can also reveal **resilience**, **courage, creativity, and problem-solving** in others. These experiences can strengthen helpers' own sense of resilience and remind them of the possibility of recovery.

Examples of vicarious resilience include noticing clients' **persistence, creativity in coping, or ability to rebuild relationships despite hardship**. These moments can reinforce hope and deepen commitment to compassionate work.



UNIT 4:

SECTION 2

BURNOUT

UNIT 4 – VICARIOUS TRAUMA

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.

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.

UNIT 4 – VICARIOUS TRAUMA

SECTION 2 - BURNOUT

What is burnout?

Staff supports:

- Health and safety policies and guidelines
- Critical Incident debriefing
- Supervision
- Counselling
- Access to wellness activities such as yoga, mindfulness.

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.

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.

UNIT 4:

SECTION 3

SELF CARE

UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

Self-care- 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.

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.

UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

Why is self-care important?

It reduces stress. Improves mental health. Enhances physical health and increases resilience and promotes a sense of purpose.

What is self-compassion?

Mindfulness: Self compassion involves recognizing when we're stressed or struggling without being judgmental or overreacting.

Self-kindness: Being supportive and understanding towards ourselves when we're having a hard time, rather than being harshly self-critical.

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.

UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

GROUNDING EXERCISE

5 - 4 - 3- 2 - 1

GROUNDING

Take a deep breath and identify ....

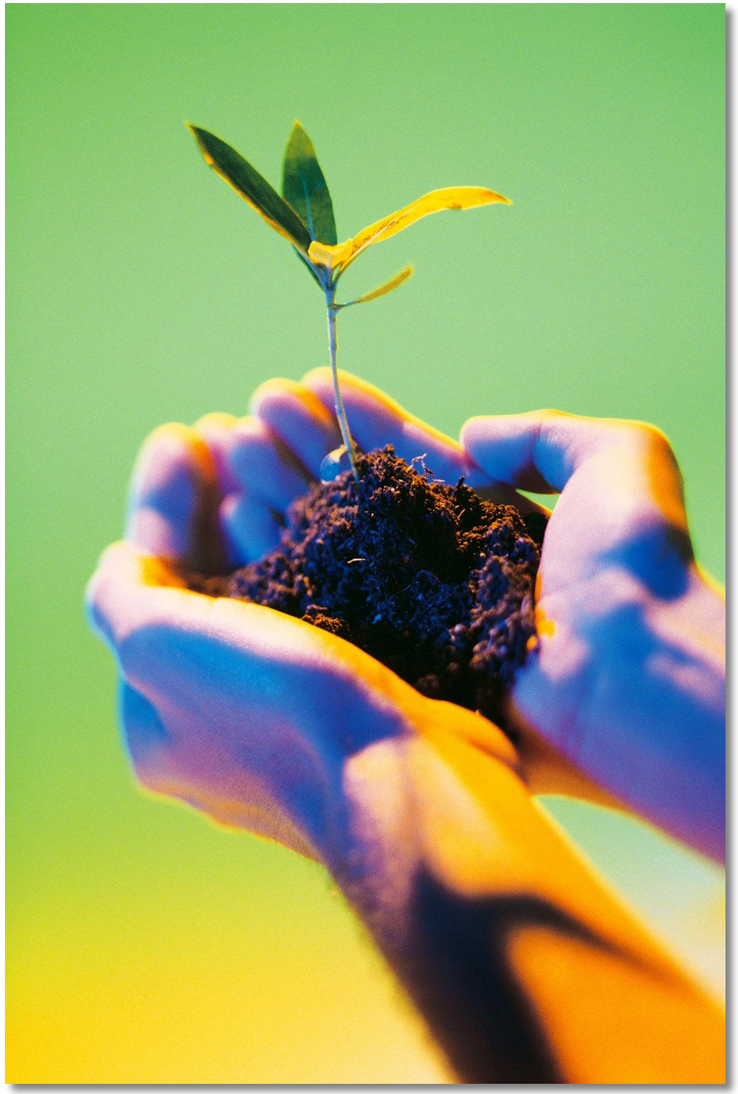
5 things you can **SEE**

4 things you can **FEEL**

3 things you can **HEAR**

2 things you can **SMELL**

1 thing you can **TASTE**



UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

Sensory integration strategies

Sight:

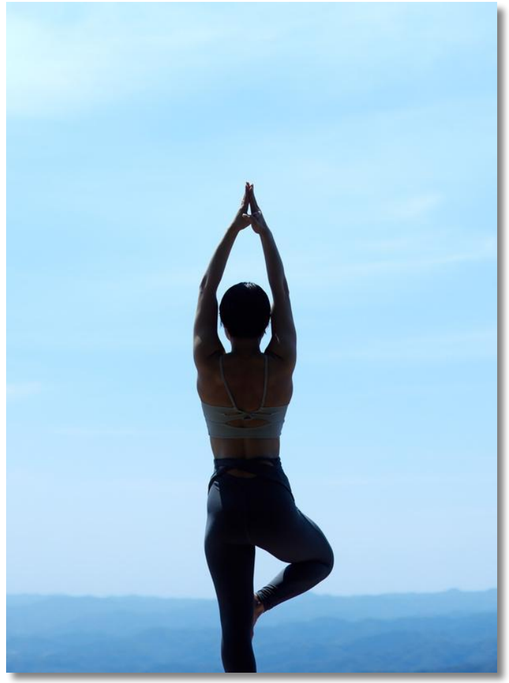
- Reduce harsh lighting.
- Use blue light glasses
- Going for a short walk, enjoy a change of scenery or a scenic stop.

Smell:

- Essential oils
- Scented moisturizer
- Spray your perfume

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

UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

Create your self care plan

Emergency self-care plan

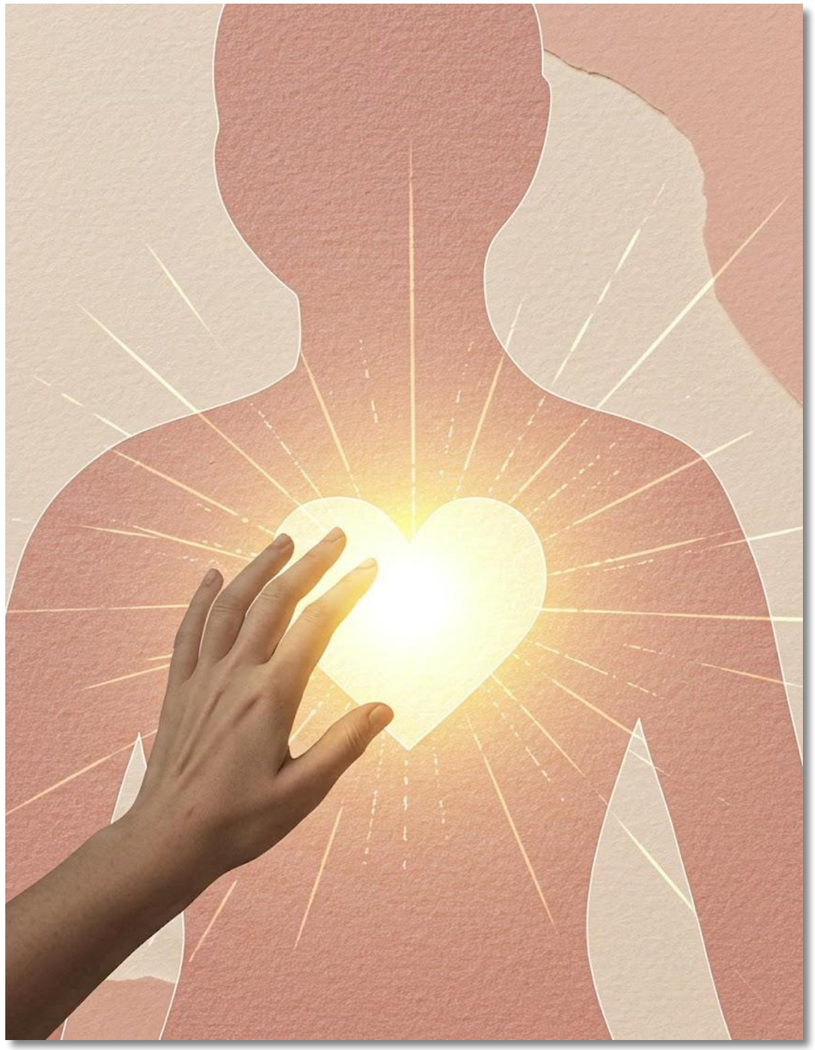
Answer the following:

- 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?



UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

ACTIVITY 2.6 - CREATE YOUR OWN EMERGENCY CARE PLAN AND PREVENTATIVE CARE PLAN.

20 MINUTES

Preparation

Print the preventative care plan and an emergency care plan **material you can find in the toolkit**

Activity

Think about your own self care and what is essential for you in order to promote your own self care both as prevention and emergency.

A self-care plan can consist of activities, practical things to ease stress, people who can help, etc.

Answer the following questions/topics:

- Make a list of things that you can do when you are upset that will benefit you.
- Make a list of people you can contact if you need support.
- Make a list of positive things to say to yourself when you are having a difficult time.
- Make a list of who and what to avoid when you are going through a tough time.
- Listen to yourself and practice self compassion.

Wrap up

Keep your plan and use it as a guide.

HOME4HEALTH MOOC

MODULE 3:
TRAUMA - MENTAL HEALTH

MODULE OVERVIEW:

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 mental health

Unit 2: Common Mental Health-Related Problems Among People Experiencing Homelessness

Section 1: Mental health problems

Section 2: The Self-medication Theory

Unit 3: Harm Reduction Strategies and Evidence-Informed Care Models

Section 1: Harm reduction strategies

Section 2: Peer work perspective

Section 3: Evidence-informed care models

Section 4: Cultural consideration and diversity

UNIT 1:

UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

UNIT 1:

SECTION 1

INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

Coordinated by:
In partnership with:
Co-funded by the European Union
2023-1-ES01-KA220-VET-000165764

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) 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.

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"

20-25 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

- The trainer should gather all participants (up to 20 people) in a large, open space where they can form a circle or loose group.
- The trainer should choose one volunteer to be the "Detective." Ask them to step out of the space temporarily and explain they will be trying to identify a mystery person when they return.
- Trainer should select another volunteer to be the "Conductor" and explain to the group that the Conductor will start a series of simple, repetitive physical movements (e.g., clapping, tapping feet, raising arms, swaying, etc.), and everyone else must copy them immediately, trying not to make it obvious who they're watching.
- The group must be reminded that the identity of the Conductor must stay secret. They should subtly shift movements with the Conductor but avoid giving away who's leading.

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"

20-25 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Invite the Detective back into space. Their task is to stand in the center of the group and try to figure out who the Conductor is.
- The Conductor should begin leading one movement (e.g., dancing), and then slowly change it every 15–30 seconds. The rest of the group copies each new motion as soon as they notice.
- The Detective can observe for 2–3 minutes and then make a guess. If they guess wrong, they may have one more guess or the facilitator can reveal the Conductor.
- Roles should rotate once or twice if time allows to let new people try being the Detective or Conductor.

Wrap Up

- Questions for reflection:
- How did it feel to try and keep the conductor hidden?
- What strategies helped you figure it out as the detective?
- What does this say about observation, awareness and group dynamics?

UNIT 1:

SECTION 2

INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

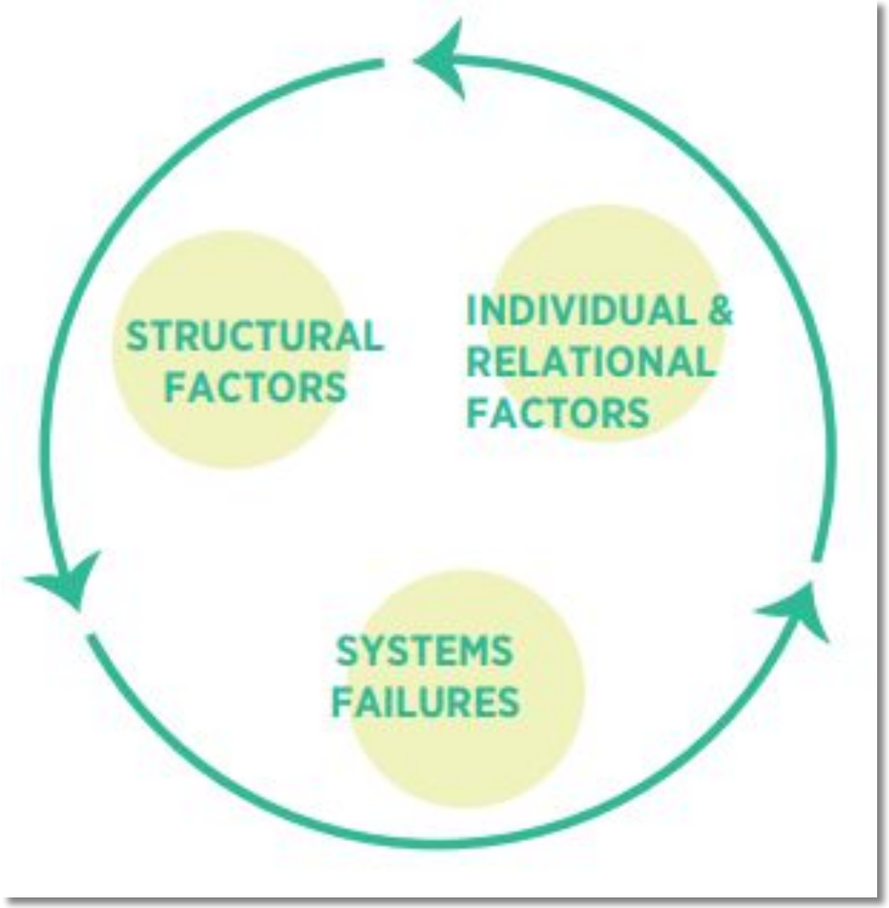
Understanding the Causes of Homelessness

The social–ecological model, described by Stephen Gaetz and colleagues, explains that homelessness usually results from a combination of structural factors, system failures, and individual circumstances.

Homelessness is rarely caused by a single event. It is usually the result of multiple pressures over time.

Individual and relational factors can increase someone's risk of homelessness. These may include **mental health challenges**, substance use problems, or disabilities that affect cognitive functioning, such as acquired brain injury or fetal alcohol spectrum disorder.

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



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

The Bidirectional Relationship Between Mental Health and Homelessness

Mental health disorders and homelessness influence each other in complex ways.

On one hand, untreated conditions such as schizophrenia, bipolar disorder, or major depression can make it difficult to maintain employment, stable housing, daily routines, or social relationships. This increases the risk of homelessness.

On the other hand, homelessness itself creates **chronic stress**, instability, and exposure to trauma. These experiences can trigger new mental health problems or worsen existing ones. Organisations such as FEANTSA and the National Coalition for the Homeless highlight how homelessness can directly harm mental well-being.

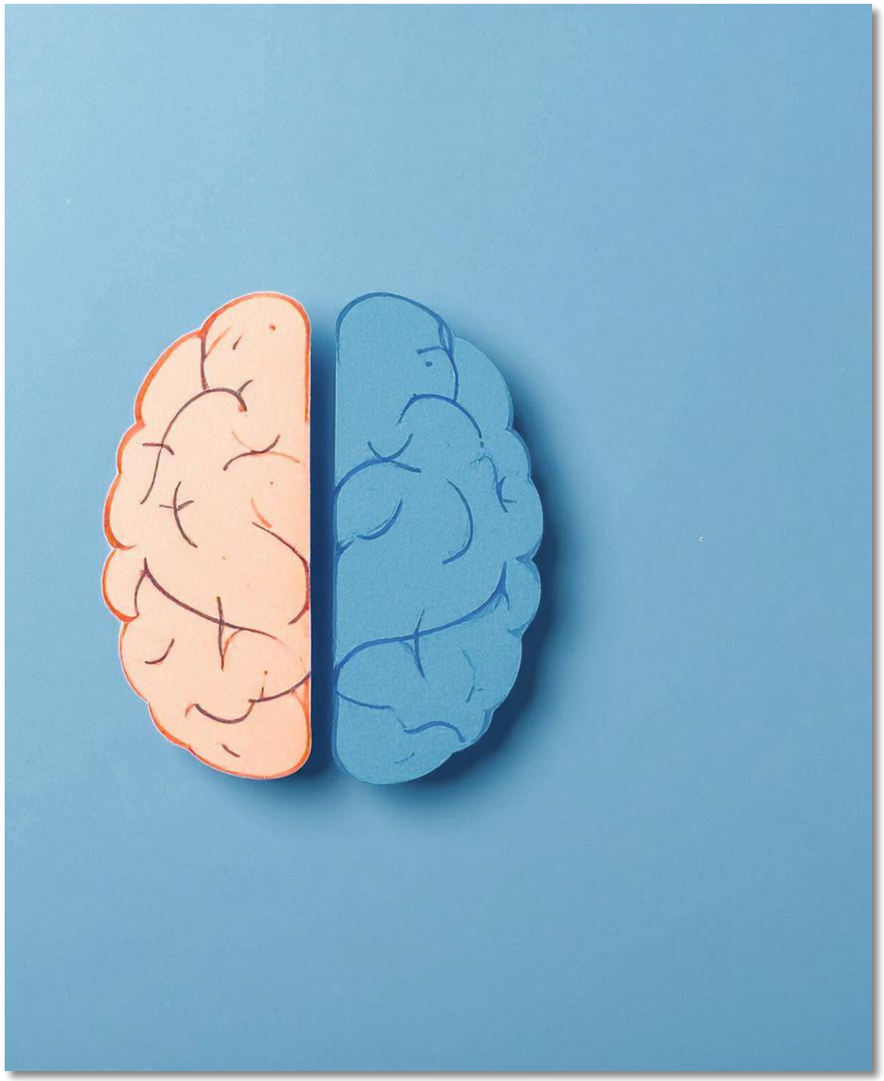
UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

The Role of Trauma

Traumatic stress is common among people experiencing homelessness. Trauma increases the risk of developing mental illness and can make symptoms more severe.

Research shows that trauma often occurs before mental illness begins, but mental illness can also increase the risk of experiencing trauma. This creates another **bidirectional relationship**, similar to what we see between trauma and substance use.



A Self-Reinforcing Cycle

Together, these dynamics create a vicious cycle:

- Poor mental health increases vulnerability to housing instability and trauma.
- Homelessness and trauma worsen psychological distress.

As researcher Deborah Padgett explains, mental health can be both a **cause and a consequence of homelessness**.The harsh realities of homelessness—such as insecurity, stigma, lack of safety, and repeated trauma—have serious effects on mental well-being.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

Why Housing Must Be Seen as a Health Issue

International studies show very high rates of mental illness among people experiencing homelessness—often between 60% and 93%. These numbers are far higher than in the general population.

Because of this, organisations like FEANTSA argue that homelessness should be understood as a **health issue**, not only a housing or social problem. Secure housing is essential for stability, recovery, and overall well-being.

Key Take-aways

- *Mental health is a basic human right.*
  Housing is a major determinant of mental health.
- *Homelessness and mental illness have a bidirectional relationship.*
- *Trauma plays a central role in this cycle.*
- *Stable housing is essential for mental health recovery.*

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

Psychological Impact of Homelessness

Mental health problems are very common among people experiencing homelessness. Research from the European Union Drugs Agency shows that the **longer and more severe** the homelessness experience is, the worse a person's mental health tends to be.

Mental health difficulties can reflect **pre-existing vulnerabilities**, which, when combined with structural and system failures described by the Homeless Hub, increase the risk of homelessness. At the same time, mental health problems can also develop as a **direct consequence** of homelessness.

Chronic Trauma and Stress

People experiencing homelessness are often exposed to **chronic and repeated trauma**. According to Daya Somasundaram Jayatunge, this cumulative trauma has serious effects on both physical and mental health.

The psychological impact is not only about lacking housing. It also comes from the daily accumulation of stress, uncertainty, and social exclusion.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

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Daily Life Stressors

Life without stable housing often includes persistent insecurity, hunger, physical discomfort, sleep deprivation, and unsafe environments.

These conditions can lead to or worsen mental health problems such as anxiety, depression, and post-traumatic stress disorder, as described by researcher Deborah Padgett.

Violence, Fear, and Isolation

People experiencing homelessness face higher risks of physical violence, sexual assault, and exploitation. These experiences create fear, mistrust, and constant hypervigilance.

At the same time, loss of social status, weak support networks, and exclusion from society can lead to isolation, hopelessness, and low self-worth. This makes it harder to seek help and recover.

Organisations such as FEANTSA highlight how these social factors deepen mental health difficulties.

Intersectional Vulnerabilities

Some groups face additional risks. Factors such as gender, ethnicity, sexual orientation, migration status, or substance use history can increase exposure to stigma and discrimination.

These intersectional vulnerabilities often intensify the psychological impact of homelessness.

Barriers to Care

People without stable housing often struggle to access mental health services. Long waiting lists, lack of documentation, transport problems, or stigma can prevent consistent care.

Research by Kimberley Amore and Philippa Howden-Chapman shows that the longer someone remains unhoused without support, the higher the risk of severe mental illness and long-term health problems.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

Comorbidity: Mental Health and Substance Use (Dual Diagnosis)

Dual diagnosis—the co-occurrence of **mental illness** and **substance use disorder**—is highly prevalent among people experiencing homelessness. Many individuals use alcohol or drugs as **self-medication** to cope with **trauma**, emotional pain, and harsh living conditions. Although substances may offer temporary relief, they often **worsen mental health** and create additional barriers to recovery. High-risk drug use is especially common among people experiencing **long-term or recurrent homelessness** (European Union Drugs Agency, 2023).

Substance use can function as a coping strategy for **unmanaged trauma**, but it also becomes an obstacle to **treatment engagement**. People experiencing homelessness often face **discrimination**, **harassment**, and **systemic barriers** that limit access to care. Many programmes are **abstinence-oriented**, excluding people who still use substances. Administrative requirements such as a **fixed address** or **health insurance** can make treatment nearly impossible for people without stable housing.

Survival needs like food, safety, and shelter often take priority, reducing the ability to reduce substance use. Even when motivation exists, substances remain accessible, and recovery without a **supportive environment** is extremely difficult (National Coalition for the Homeless, 2017).

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

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Research shows a strong overlap between **substance use disorders** and **mental illness** among unhoused populations, together with low adherence to treatment. This highlights the need for **low-threshold**, **integrated care models** that address both issues at the same time (NPISA Lisboa, 2021).

Comorbidity is also well established in the general population. Data from Australia show that **9%** of people with anxiety or mood disorders also had a substance use disorder, while **46%** of people with substance use disorders had at least one additional mental illness (Australian Institute of Health and Welfare, citing Australian Bureau of Statistics, 2024). Among people entering alcohol and drug treatment, **50–76%** meet criteria for another mental health condition.

People with co-occurring disorders experience **poorer outcomes**, including greater functional impairment, heavier symptom burden, **higher mortality**, and reduced life expectancy. **Housing instability**, lack of access to services, and transitions such as **release from prison** further hinder treatment. Addressing comorbidity therefore requires **holistic**, **integrated interventions**, recognising **stable housing as essential healthcare**.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

Summary Box – Key Insights

- **Comorbidity (dual diagnosis)** is very common in homelessness.
- **Self-medication** may reduce distress short term but worsens long-term mental health.
- **Systemic barriers** and abstinence-only models limit access to treatment.
- **Survival needs** and easy access to substances make recovery difficult.
- Comorbidity leads to **poorer health outcomes** and higher mortality.
- **Integrated care** and **stable housing** are essential for recovery.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 2 - INTERSECTION BETWEEN HOMELESSNESS AND MENTAL HEALTH

ACTIVITY 3.2 - VIDEO FORUM

25 MINUTES

Objective

To raise awareness and understanding of how mental health issues contribute to and are impacted by homelessness.

Preparation

Watch the following videos about the relation between homelessness and mental health:

- Anxiety and homelessness | Ben's Mental Health Story | Mind
- Luis, 40 years old, 4 years unhoused

Activity

Question yourself:

- What stood out to you in the videos?
- How do mental health challenges increase vulnerability to homelessness?
- How might homelessness worsen mental health conditions?
- What roles can communities and professionals play in addressing this dual issue?

Wrap up

Summarize key insights., highlighting how stigma, lack of access to services, and social exclusion are central challenges.

UNIT 1:

SECTION 3

BARRIERS TO ACCESS MENTAL HEALTH CARE

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

People experiencing homelessness, especially those living with **mental health problems** and **substance use issues**, face multiple barriers when trying to access care. These barriers can be **structural**, **service-related**, and **individual**, and they often interact to create major 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 and safe housing is essential for both **mental** and **physical well-being**. Without housing, people often cannot access or benefit from care because:

- They lack a **fixed address** for registration or communication.
- **Treatment continuity** is disrupted.
- Medication cannot be safely stored.
- Exposure to **violence**, **trauma**, and environmental stress increases.
- Opportunities for **early intervention** are reduced.

Homelessness itself therefore becomes a barrier to care, and discharging people into homelessness can worsen outcomes (European Union Drugs Agency, 2023). Housing instability also limits access to employment, social support, and health services.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

B. Stigma and Discrimination

Stigma is another major barrier. People experiencing homelessness and mental illness are among the most **stigmatized groups**, especially when substance use is present (EUDA, 2023).

Forms of stigma identified by Mental Health Europe (2024) include:

- **Public stigma:**

  Negative stereotypes from society or professionals.

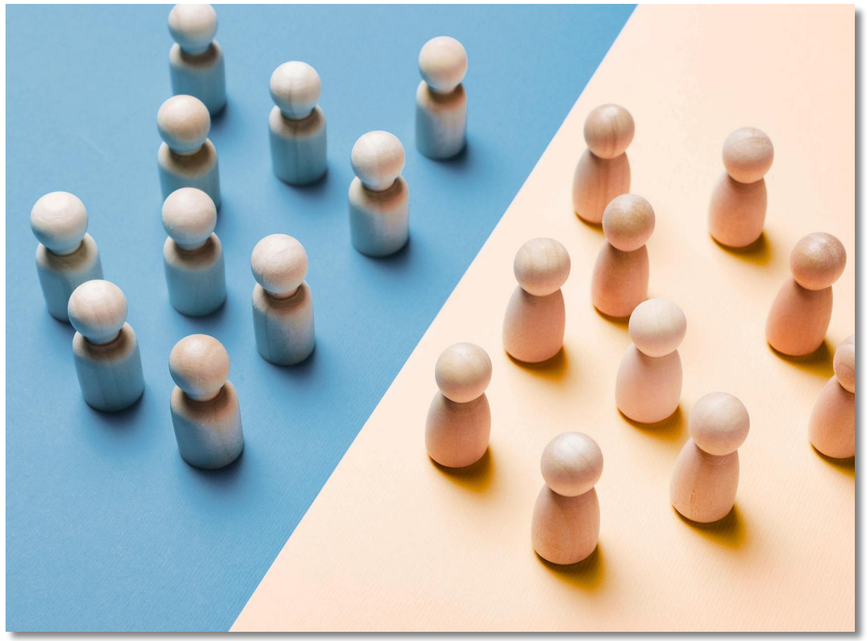
- **Self-stigma:**

  Internalised shame that reduces help-seeking.

- **Structural stigma:**

  policies that create unequal access.

These experiences create **mistrust**, fear of judgement, and reluctance to seek care.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

C. Intersectional Vulnerabilities

Certain groups face higher risks due to intersecting factors such as **gender**, **ethnicity**, **migration status**, **sexual orientation**, or **substance use history**. These factors increase exposure to **discrimination** and reduce access to culturally competent care (FEANTSA & Fondation Abbé Pierre, 2023).

Women experiencing homelessness face additional barriers. Social expectations around caregiving mean homelessness is often seen as a deeper failure for women. Fear of **moral judgement**, **child protection interventions**, or loss of custody discourages many from seeking help. Experiences of **gender-based violence** further increase mistrust and avoidance of services.

Asylum seekers, refugees, and migrants in insecure housing also face high risks of mental health problems.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

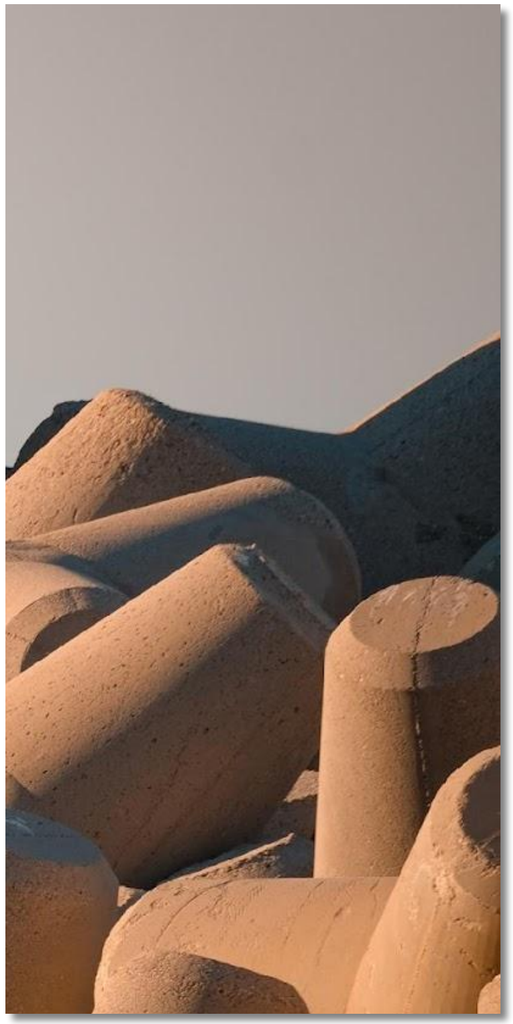
SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

D. Material and Bureaucratic Barriers

People experiencing homelessness often encounter practical obstacles such as:

- Lack of **identification documents** or proof of residence.
- No secure address for correspondence.
- Limited transport or funds to attend appointments.
- Conflict between attending services and meeting **basic survival needs**.

Additional barriers include long waiting lists, limited free services, and complex administrative procedures (NPISA Lisboa, 2021). Repeated discrimination can lead people to disengage from services entirely, losing access to healthcare and rights.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

Summary Box – Key Insights

- **Homelessness itself** is a major barrier to mental health care.
- **Housing stability** is essential for treatment continuity.
- **Stigma and discrimination** reduce help-seeking and trust in services.
- **Intersectional vulnerabilities** increase exclusion and inequality.
- **Material and bureaucratic barriers** make care practically inaccessible.
- **Integrated, low-threshold, and culturally competent services** are needed.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

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:**

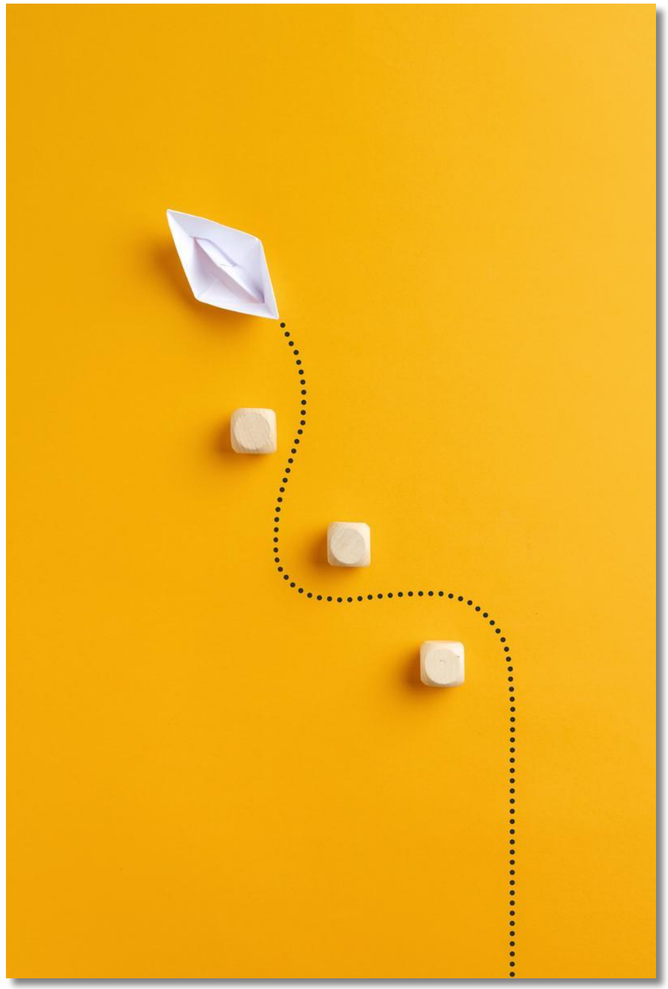
  Long waiting lists for psychotherapy or psychiatric evaluations, under-resourced services, high psychiatric bed occupancy, and poor integration with wider healthcare systems.

- **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.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

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:

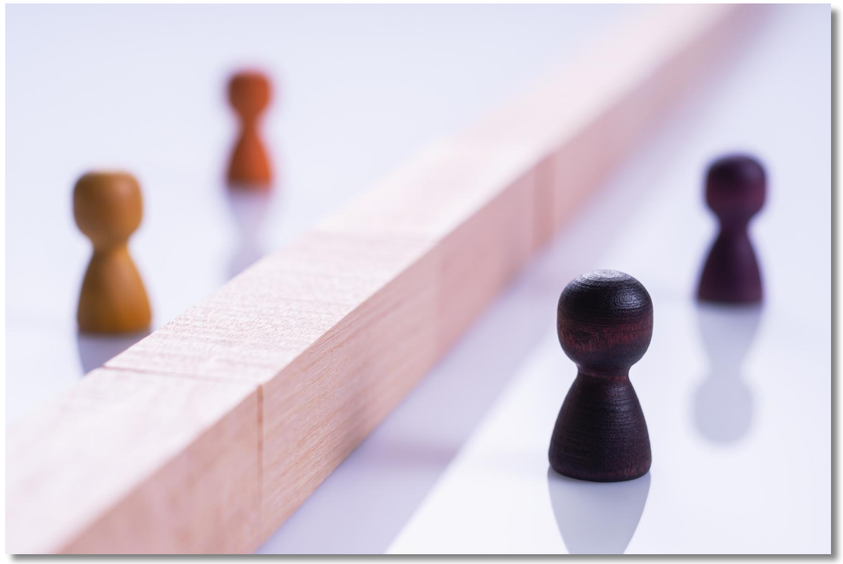
Often rooted in previous negative or discriminatory interactions with institutions and service providers.

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.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

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).

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

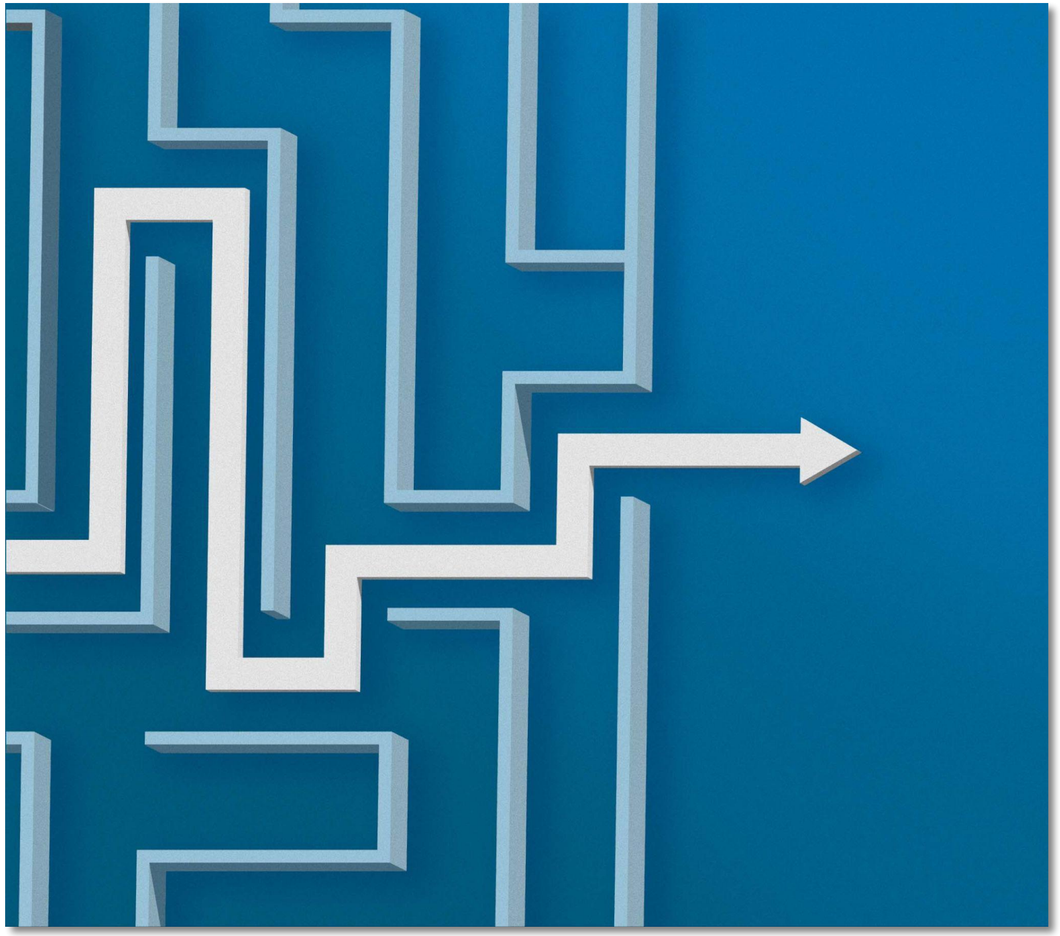
SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

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.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

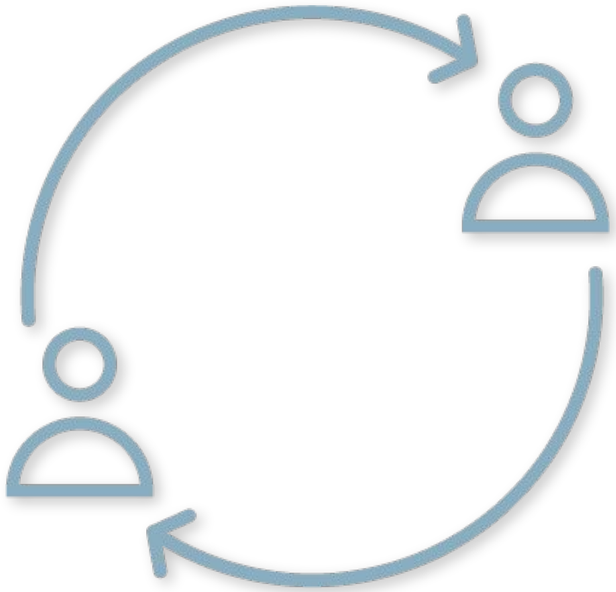
SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

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.



UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

ACTIVITY 3.3 - FACILITATORS

35-45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To help harm reduction professionals identify their roles as facilitators in real-life situations and determine strategies to assist individuals in overcoming structural, service-based, and personal barriers to care and support.

Preparation

- The trainer should prepare cards with real-life situations based on common challenges faced by people in harm reduction contexts. Each card should describe a specific scenario (e.g., someone struggling to access healthcare due to perceived discrimination).
- The trainer should divide participants into small groups of 3-5 people. Give each group a set of situation cards.

UNIT 1 - UNDERSTANDING MENTAL HEALTH ISSUES IN THE CONTEXT OF HOMELESSNESS

SECTION 3 - BARRIERS TO ACCESS MENTAL HEALTH CARE

ACTIVITY 3.3 - FACILITATORS

35-45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

- Explain the goal of the activity: Each group will analyse a real-life situation described on their card, identify the role they would play as facilitators, and determine how they can assist the person in overcoming barriers.
- Each group discusses the situation on their card and reflect on the following:
  - What is the role of the facilitator in this situation?
  - What type of barriers (structural, service-based, personal) are present?
  - How would they help the individual overcome these barriers?
  - What tools or approaches could be used in the scenario to reduce harm and improve access to services?

Encourage groups to consider both immediate and long-term solutions.

Wrap up

Summarize the key insights shared by the groups and discuss any recurring themes across the situations.

UNIT 2:

MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

UNIT 2:

SECTION 1

PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

UNIT 2 -MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

SECTION 1 - PREVALENCE OF MENTAL HEALTH 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.

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

UNIT 2 -MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

SECTION 1 - PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

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%	0.4%
Mood disorders	18%	1-10%
Bipolar disorder	8%	0.7%
Post-traumatic stress disorder	10.5%	1.1%
Substance use disorders	44%	12-15%
Antisocial personality disorder	26%	0.6-4%

TABLE: 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.

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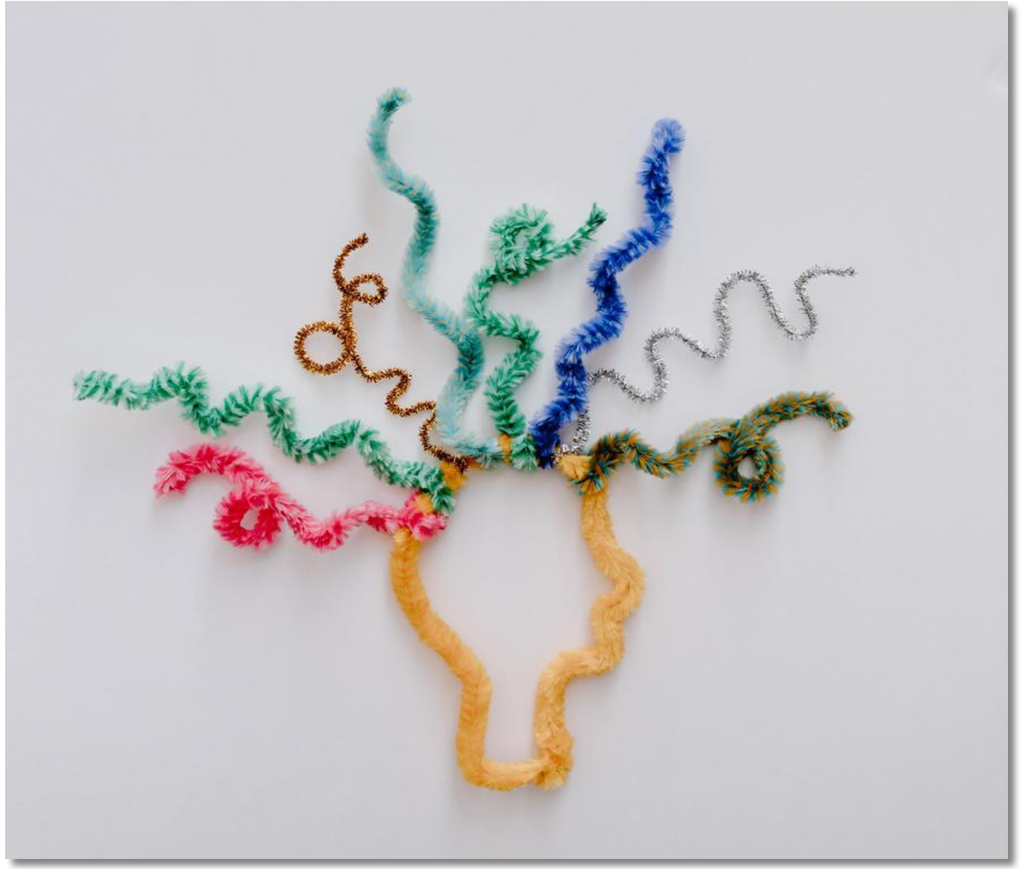
Neurodiversity and Homelessness: Focus on ADHD

ADHD is much more common among people experiencing homelessness than in the general population. Research suggests around 32% of homeless adults may have ADHD, compared with 5–8% overall.

Among homeless children and adolescents, studies estimate that about 1 in 4 has ADHD, with higher rates among older youth. ADHD-related difficulties—such as problems with organisation, concentration, and impulse control—can affect education, employment, finances, and relationships.

Many adults with unrecognised ADHD also use substances to cope with symptoms, which can increase risks and make housing stability harder. Recognising and supporting ADHD is therefore an important part of effective homelessness prevention and care.



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SECTION 1 - PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

Hoarding Among People Experiencing Homelessness

Research shows that hoarding behaviours are more common among people with a history of homelessness or housing instability than in the general population. Studies in supported housing found hoarding in about 18–23% of residents, compared with 2–5% overall.

Hoarding is strongly linked to eviction risk and housing loss. Studies of people facing eviction found high rates of hoarding disorder, along with related challenges such as alcohol dependence, personality difficulties, and adverse childhood experiences. Many affected individuals were not receiving mental health support, even while facing legal eviction.

Early life trauma—such as poverty, neglect, loss of caregivers, or unstable housing—may also contribute to hoarding behaviours. These experiences are common among people who have experienced homelessness or substance use problems.

Recognising hoarding early is important. With appropriate mental health support and practical housing assistance, services can reduce eviction risk, improve housing stability, and address related health needs.

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SECTION 1 - PREVALENCE OF MENTAL HEALTH PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

Suicide and Self-Harm Among People Experiencing Homelessness

A large population study in Denmark followed more than 5 million residents and found that over 56,000 people experienced homelessness. Within 10 years of their first shelter contact, suicide and self-harm rates were much higher than in the general population.

About 1.3% of men and 0.9% of women who had experienced homelessness died by suicide. Around 9–10% of both men and women self-harmed. Compared with people who had never been homeless, suicide risk was 2–4 times higher, and self-harm risk was more than 3 times higher.

Risk was especially high during periods of current homelessness, and even higher among people with psychiatric disorders. Previous self-harm strongly increased the risk of later suicide.

These findings show how closely homelessness, mental health problems, and suicide risk are connected, highlighting the need for early identification and coordinated support.

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Suicide and Self-Harm Among People Experiencing Homelessness

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.

UNIT 2:

SECTION 2

KEY SYMPTOMS OF COMMON MENTAL HEALTH PROBLEMS AND SELF-HARMING BEHAVIOURS AMONG PEOPLE EXPERIENCING HOMELESSNESS

UNIT 2 -MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - KEY SYMPTOMS OF COMMON MENTAL HEALTH PROBLEMS AND SELF-HARMING BEHAVIOURS AMONG PEOPLE 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.

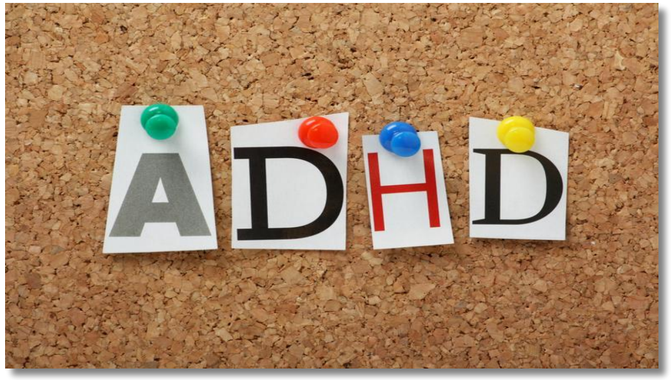
1. Attention-Deficit/Hyperactivity Disorder (ADHD)

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.



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Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD Across the Lifespan

- **Children:** hyperactivity and impulsivity are most noticeable; inattentiveness becomes clearer as school and social demands increase
- **Adolescents:** hyperactivity decreases, restlessness remains; inattention and impulsivity persist
- **Adults:** inattention, restlessness, and impulsivity may continue Additional challenges may include **irritability**, **low frustration tolerance**, **stress sensitivity**, and **mood swings**

Impact on Daily Life

- Difficulties in school, work, and relationships
- In children: **anxiety**, **low self-esteem**, conflicts with peers, **oppositional behavior**
- Increased risk of **substance use** and **depressive symptoms**
- Often co-occurs with other issues such as **sleep problems** (up to 70% of adults with ADHD), anxiety, and depression

Diagnosis and Considerations

- Symptoms must be present **before age 12**
- Many adults are diagnosed later due to:
  - Mild symptoms in childhood
  - Effective early coping strategies
  - Lack of recognition by family or teachers
- Important: other factors like **stress**, **sleep disorders**, **anxiety**, or physical health issues can mimic ADHD symptoms

Prevalence

- About **5% of children** meet the diagnostic criteria for ADHD (OPP, 2025)
- Symptoms of **inattention** often persist into adulthood, while hyperactivity and impulsivity may decrease

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2. Anxiety Disorders

ADHD Across the Lifespan

Everyone experiences **anxiety**, especially in **stressful, unfamiliar, or challenging situations.** It is a feeling of **worry, nervousness, restlessness, or fear** about what may happen (OPP, 2025). Normal anxiety may affect **sleep, appetite, and concentration,** but usually **subsides once the situation passes** and can even increase **alertness and focus.**

When anxiety becomes **overwhelming, persistent, or disruptive**, it may signal an **anxiety disorder.** People may feel **out of control, fearful of dying, or like they are "losing their mind".**

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**

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2. Anxiety Disorders

Key takeaways:

Physical symptoms

May include: muscle tension, headaches, nausea, rapid heartbeat, “butterflies” in the stomach, or frequent bathroom use.

Psychological symptoms

Include restlessness, irritability, difficulty concentrating, repetitive negative thoughts, and social avoidance.

Generalized Anxiety Disorder (GAD)

- Often begins around **age 30**, can start in childhood
- More common in **women** than men
- Signs include **excessive worry, difficulty controlling worry, restlessness, fatigue, irritability, sleep problems, and physical symptoms**

Recognizing and addressing **anxiety early** is important to maintain **wellbeing, daily functioning, and social connections.**

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3. Cognitive Impairment (including Drug-induced Cognitive Impairment)

Cognition refers to the mental processes involved in **learning, thinking, understanding, and perceiving,** including **attention, memory, decision-making, planning, reasoning, language, and visuospatial skills** (Dhakal et al., 2023).

Cognitive impairment (or cognitive deficit) describes difficulties in one or more of these domains. It is **not a disease itself,** but a **symptom that may indicate an underlying condition.**

Common Signs of Cognitive Impairment

- Memory problems (repeating questions, retelling stories)
- Difficulty learning or concentrating
- Problems with language or vision
- Confusion or agitation
- Trouble recognizing people or places
- Changes in mood, behaviour, or speech
- Difficulty performing routine daily tasks

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3. Cognitive Impairment (including Drug-induced Cognitive Impairment)

Causes Across the Lifespan

- **Early life:** genetic syndromes, prenatal drug exposure, malnutrition, prematurity, trauma, abuse
- **Childhood/adolescence:** cancer therapy side effects, metabolic or immune disorders, autism
- **Adulthood/older age:** stroke, delirium, dementia, depression, schizophrenia, chronic alcohol or substance use, brain tumours
- Certain **medications** (sedatives, anticholinergics, opioids, glucocorticoids)
- **Brain injury or infections**

Drug-Induced Cognitive Impairment (DICI)

DICI refers to cognitive decline caused by **medications**, even those not directly acting on the brain (Reimers et al., 2024). It can range from **mild symptoms** to **domain-specific impairments, delirium, or mild cognitive impairment**.

- **High-risk drugs:** benzodiazepines, sedating antipsychotics, opioids, certain antidepressants
- **Predisposing factors:** older age, neurological disease, substance dependence
- Often **mistaken for dementia**, especially in older adults (Bowen & Larson, 2012)

Key takeaway: *Cognitive impairment can appear at any age, and recognizing it early—especially when drug-induced—is crucial for support, safety, and intervention.*

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4. Complex Trauma and Post-Traumatic Stress Responses

Exposure to traumatic events is strongly linked to the development of mental health problems. **Post-Traumatic Stress Disorder (PTSD)** was first recognised as a distinct diagnosis in 1980 (DSM-III). However, PTSD did not fully capture the impact of **recurrent, prolonged, or early-life interpersonal trauma**, especially when trauma occurred within close relationships, such as caregivers or intimate partners.

This led to the concept of **Complex PTSD (Complex Trauma)**, initially described in the DSM-IV as **Disorders of Extreme Stress Not Otherwise Specified (DESNOS)**. While not officially a separate diagnosis in DSM-IV, it highlighted the broader psychological and functional disturbances caused by chronic trauma.

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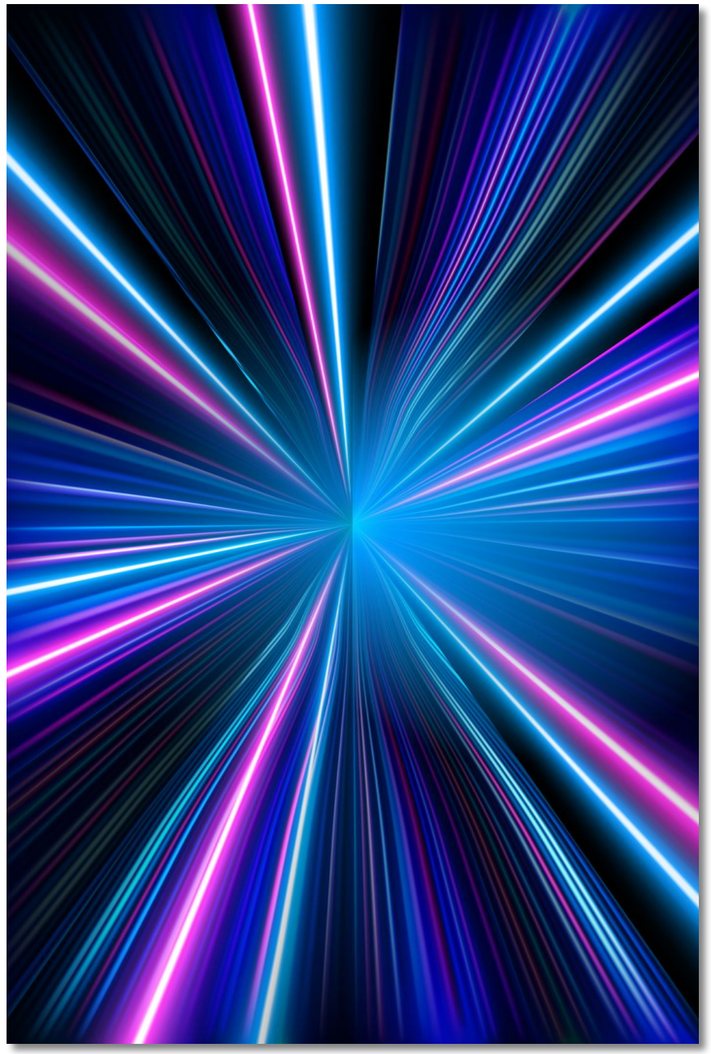
4. Complex Trauma and Post-Traumatic Stress Responses

Modern classifications differ:

- DSM-5 includes some complex trauma responses within PTSD criteria.
- ICD-11 recognises Complex PTSD as a separate diagnosis.

Despite differences, there is strong consensus that Complex Trauma involves:

- Interpersonal victimisation
- Multiple traumatic events
- Chronic or prolonged exposure, with early-life trauma having especially severe effects



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4. Complex Trauma and Post-Traumatic Stress Responses

Key domains affected by Complex Trauma:

1. **Regulation of affect and impulses** – extreme or rapidly changing emotions, self-harm, eating disorders, suicidal ideation, impulsive sexual behaviour, difficulty managing anger.
2. **Attention or consciousness** – dissociation, depersonalisation, memory disturbances (amnesia or hypermnesia), "losing time" under stress.
3. **Self-perception** – persistent negative self-view, feelings of helplessness, shame, guilt, self-blame, or feeling "damaged" or stigmatised.
4. **Relationships with others** – chronic distrust, difficulty forming safe attachments, patterns of revictimisation, or sometimes victimising others as a survival strategy.
5. **Somatisation** – chronic pain or bodily symptoms affecting digestion, circulation, cardiopulmonary, or sexual functioning without a clear medical cause.
6. **Systems of meaning** – loss of core beliefs, hopelessness, existential distress, difficulty sustaining purpose or sense of future.

Takeaway: *Complex Trauma reflects the profound impact of repeated or prolonged interpersonal trauma, especially in early life, affecting emotional, cognitive, relational, and physical functioning. Effective recognition and support require understanding these multiple domains rather than focusing solely on PTSD symptoms.*

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5. Depressive Disorders (1)

Depression is one of the most common mental health problems worldwide, affecting about **5% of adults**, with **women more frequently diagnosed than men** (WHO, 2023). The WHO recognises depression as the **leading cause of disability globally** (OPP, 2021).

Depression involves **persistent sadness, hopelessness, and emotional distress**. These feelings can appear naturally in response to life events such as bereavement, loss, or disappointment, which may be **healthy and adaptive**. Normally, these emotions are **proportional to the event** and decrease over time.

However, when sadness or hopelessness **persists for more than two weeks**, **recurs frequently**, or **interferes with daily functioning**, it 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).

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5. Depressive Disorders (2)

Common symptoms of depression affect emotions, thoughts, behaviours, and physical health:

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 or low energy**
- Sleep disturbances (insomnia, oversleeping, nightmares)
- Changes in **appetite or weight**
- Increased use of **substances** such as alcohol or tobacco

Risk-related symptoms

- Thoughts of death or suicide, or suicide attempts
  Increased anger, irritability, or restlessness
- Withdrawal from social contact or responsibilities
- High-risk or impulsive behaviours
  Changes in sexual desire or performance

Key point: *Depression is* ***individualized****. People experience it differently, and symptoms may range from mild interference with daily life to severe impairment with life-threatening risks. Early recognition and support are essential to improve wellbeing and prevent harm.*

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6. Hoarding Disorder and Hoarding Behaviours

Hoarding generally refers to a **persistent pattern of acquiring and keeping items**, often leading to clutter that interferes with daily life.

Severe hoarding (Tompkins, 2015) is defined by:

- **Risk of serious injury or death** due to a compromised living environment
- **Low functional capacity,** meaning difficulties performing daily activities due to physical, psychological, or social limitations (Soniat et al., cited in Tompkins, 2015)

When discussing hoarding, it is important to distinguish between **hoarding behaviours and Hoarding Disorder.**

Hoarding behaviours

- May appear in the context of various **medical, genetic, or psychological conditions**
- Prevalence: **2–5% of adults** show significant hoarding behaviours (Iervolino et al., cited in Options Bytown, 2024)

Hoarding Disorder

- A **complex, multidimensional condition** involving cognitive, behavioural, and emotional processes
  Often co-occurs with other mental health conditions:
  - **92%** of people with Hoarding Disorder have a co-occurring condition such as **depression, anxiety, OCD, or social phobia** (Mass Housing Conference, cited in Options Bytown, 2024)
  - **ADHD symptoms** are commonly present (Hartl et al., 2005)
  - Compulsive **acquiring behaviours**, sometimes classified as an **impulse control disorder**, may occur (McElroy et al., cited in Options Bytown, 2024)
  - **Social phobia** may also contribute, with possessions acting as **emotional safety barriers**

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6. Hoarding Disorder and Hoarding Behaviours

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.

Interventions

Interventions 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.

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6. Hoarding Disorder and Hoarding Behaviours

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.

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7. Hoarding Disorder and Hoarding Behaviours

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).

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7. Personality Disorders, including Borderline Personality Disorder

- **Personality** refers to the relatively stable patterns in how people **think, feel, behave, and relate to others.** These patterns develop in childhood and continue to evolve throughout life, shaping what makes each person unique.
- A **personality disorder** is an **enduring and inflexible pattern of inner experience and behaviour** that causes significant distress or impairment and clearly deviates from cultural expectations. These patterns are not explained by medical conditions, substance use, or normal developmental stages.

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

Diagnosis must be made by a trained mental health professional and is rarely given before age 18 because personality is still developing.

The **DSM-5-TR** describes ten personality disorders grouped into three clusters. Although they differ, they share core features such as:

- Unusual or rigid ways of perceiving self and others
- Emotional responses that deviate from expectations
- Difficulties with impulse control

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7. Personality Disorders, including Borderline Personality Disorder

People with personality disorders often experience **co-occurring mental health problems,** including anxiety, depression, substance use disorders, eating disorders, and relationship conflict.

Historically, personality disorders were sometimes considered “untreatable,” but research now shows that **effective treatments exist**, and early identification improves outcomes. Newer diagnostic approaches also view personality disorders on a **continuum**, focusing on levels of impairment rather than rigid categories.

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7. Personality Disorders, including Borderline Personality Disorder

Borderline Personality Disorder

Borderline Personality Disorder affects about **1 in 100 people** and strongly impacts emotional regulation, self-image, and relationships.

Common symptoms include:

- **Intense mood swings** and overwhelming emotions
- **Chronic feelings of emptiness**
- **Impulsive or risky behaviours** (e.g., overspending, unsafe sex, substance use)
- **Unstable self-image** and changing goals or values
- **Fear of abandonment** and unstable relationships
- **Self-harm or suicidal thoughts**
- **Intense anger** or difficulty controlling emotions
- **Dissociation** (feeling detached from oneself or reality)

Not everyone experiences all symptoms, and severity varies widely.

Because of its impact, BPD can lead to **relationship instability, job or school difficulties, and conflicts with social or legal systems.** People with BPD are also at higher risk for depression, anxiety, PTSD, eating disorders, and substance use disorders.

Early diagnosis and treatment are essential, helping people learn emotional regulation skills, improve relationships, and build a more stable and fulfilling life.

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8. 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**. It often involves major distortions in how reality is perceived.

Common examples include:

- **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

Schizophrenia can affect many areas of daily life. People may experience:

- Difficulty managing everyday activities
- Challenges with relationships, work, or independence
- Periods where symptoms last weeks or become long-term

However, **effective treatments exist,** and many people with schizophrenia can live meaningful, independent lives. Treatment usually combines **medication, psychosocial support, and rehabilitation services.**

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Symptom Categories

Symptoms vary among individuals but generally fall into three groups (NIMH, 2024):

01 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.

02 Negative Symptoms

- Loss of motivation
- Reduced interest or pleasure in daily activities
- Social withdrawal
- Reduced emotional expression
- Difficulties performing everyday tasks

03 Cognitive Symptoms

- attention problems
- difficulty concentrating
- memory impairments

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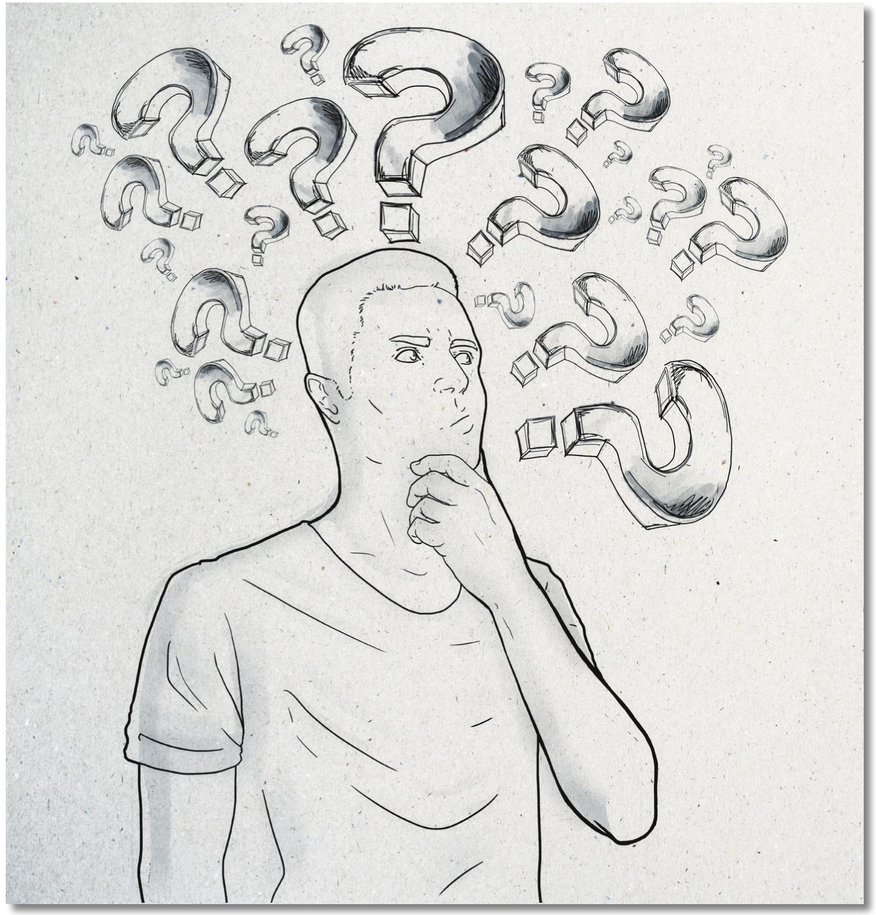
Violence and Schizophrenia: Clarifying Misconceptions

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).



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New Psychoactive Substances (NPS) and Psychosis

New Psychoactive Substances (NPS) are **synthetic drugs designed to mimic controlled substances** while avoiding existing drug laws. They are constantly modified chemically, which makes regulation and monitoring difficult.

Common categories include:

- **Synthetic cannabinoids**
- **Phenethylamines**
- **Cathinones**
- **Plant-based substances**
- **Piperazines**
- **Ketamine-type substances**

Mental Health Risks of NPS

Research shows that NPS use is linked to serious mental health problems, including:

- **First-episode psychosis**
- **Self-harm and suicidal thoughts**
- **High psychological distress**
- **Social and functional problems**

Substance-induced psychosis appears **more common among NPS users** than among users of traditional drugs.

For example, one Scottish psychiatric ward found that **22.2% of adult inpatient admissions involved NPS**, contributing to symptoms in nearly **60% of cases**. Reported acute symptoms included hallucinations, aggression, and bizarre or psychotic behaviour. Synthetic cannabinoids were most often involved.

Importantly, NPS can also trigger **psychotic-like experiences in people without prior mental illness**. Research is complicated by underreporting, polydrug use, and constantly changing drug formulas.

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Understanding Psychosis

Psychosis refers to a group of symptoms that affect thinking, perception, behaviour, and emotional regulation. Key features often include:

- **Delusions** (false beliefs)
- **Hallucinations**
- **Disorganised speech or behaviour**
- Difficulty thinking clearly or making decisions

Psychosis can occur in several conditions, including:

- **Brief Psychotic Disorder** (<1 month)
- **Schizophreniform Disorder** (1–6 months)
  Schizophrenia (≥6 months)
- **Schizoaffective Disorder**
- **Delusional Disorder**

Psychotic symptoms may also occur in mood disorders, brain injury, or medical conditions.

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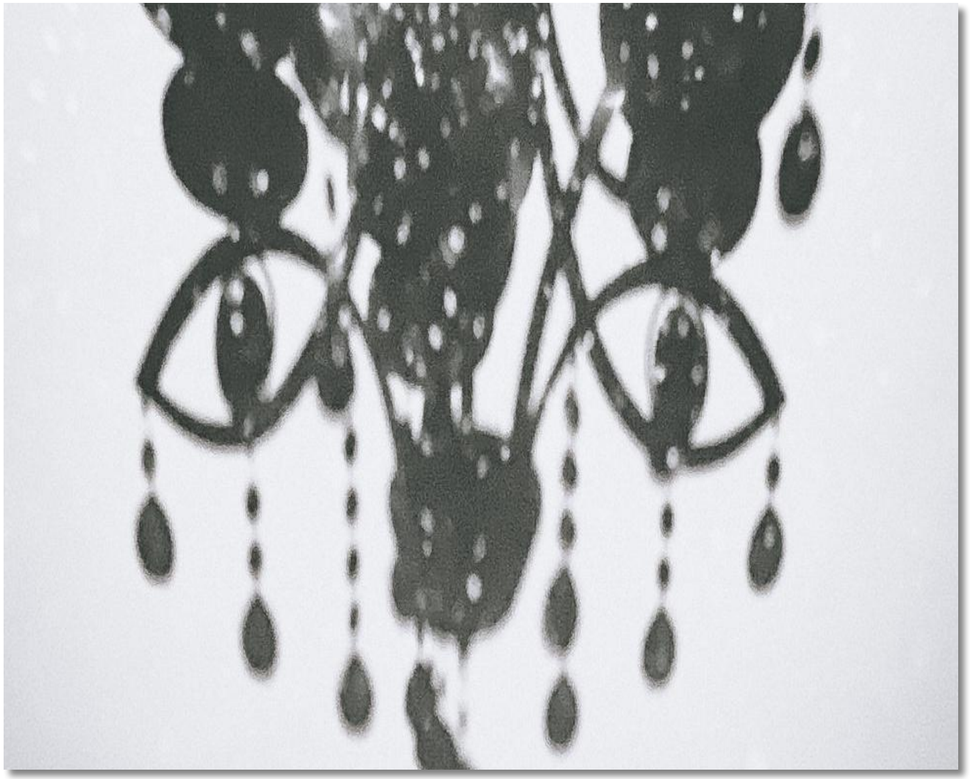
Psychosis and Substance Use

There is a strong two-way relationship between psychosis and substance use:

- People with psychosis are **more likely to develop substance-use problems.**
- Some substances increase the risk of psychotic symptoms, especially in vulnerable individuals.

For example, surveys have found that more than **half of adults with psychotic disorders have harmful substance use,** far higher than in the general population.

Because of this overlap, research shows that **integrated treatment**—addressing both psychosis and substance use together—is far more effective than treating them separately.



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Substance-Induced Psychosis

Substance-induced psychosis occurs when psychotic symptoms begin during or shortly after substance use and may continue even after the drug is no longer active.

These episodes can:

- Trigger longer-term psychotic disorders in vulnerable people
- Signal an underlying risk for mental illness
- Recur with repeated drug exposure

Importantly, substance use does **not always cause mental illness directly.** Shared risk factors—such as trauma, genetic vulnerability, early adversity, and social stress—contribute to both.

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Typical 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

Cannabis

- altered time perception
- intensified sensory experiences
- panic, fear, or paranoia
- hallucinations and delusions
- depersonalisation or loss of identity

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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

*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.*

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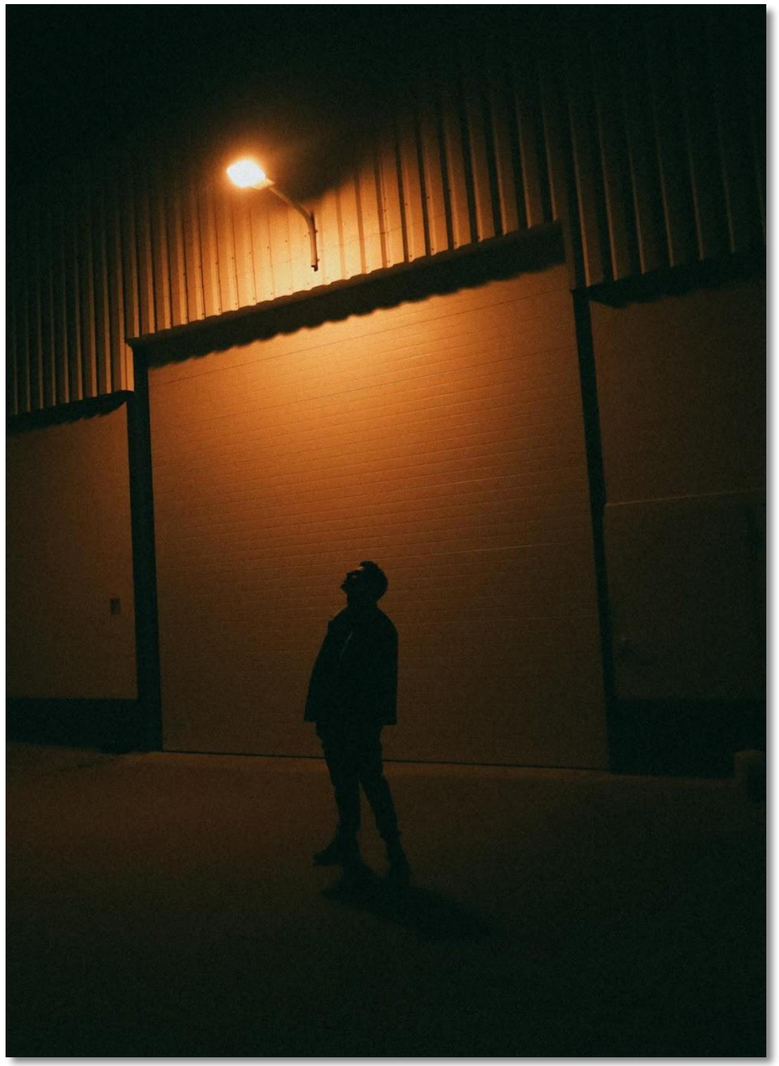
9. Self-Harm Behaviors

Self-harm refers to intentionally injuring one's own body **without the intention to die** (for example cutting, burning, or trying to break bones). Many people report that **physical pain feels easier to manage than overwhelming emotional pain**, and these behaviours often occur **in secrecy.**

Self-harm is usually an **unhealthy coping strategy** used to deal with unbearable emotions. It may serve as:

- a way to **communicate distress** when words are difficult
- a way to **feel something** during emotional numbness
- a form of **self-punishment** linked to guilt or shame
- a way to **temporarily relieve emotional tension**

The relief is short-lived, and the underlying problems remain. Over time, self-harm can become a **habitual pattern.**



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9. Self-Harm Behaviors

Self-harm is a **serious mental health concern** often associated with other conditions such as **depression, anxiety, borderline personality disorder, substance use disorders, PTSD, eating disorders, and experiences of abuse or trauma**. Although it is different from suicidal behaviour, people who self-harm have an **increased risk of suicide**, so these behaviours must always be taken seriously.

Self-harm can occur at any age but is **more common among adolescents and young adults.**

Possible warning signs include:

- **cuts, scars, burns, or unexplained bruises**
- repeated or unlikely explanations for injuries
- **wearing long sleeves in hot weather** or avoiding situations where the body may be seen
- changes in sleep or appetite
- **secretive behaviour or social withdrawal**

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10. Suicidal Thoughts and Behaviours

Suicide is a major **public health issue** that affects individuals, families, communities, and society worldwide. It occurs in every region—not only in high-income countries—and **73% of global suicides occur in low- and middle-income countries**. Suicide is also the **third leading cause of death among young people aged 15–29** (World Health Organization).

The reasons behind suicide are complex and influenced by **social, cultural, biological, psychological, and environmental factors** across the lifespan. One of the strongest predictors of suicide is a **previous suicide attempt.**

Understanding Suicidal Thoughts

Thinking about death occasionally is normal. However, when people feel there is **no solution to their problems** or no control over their lives, the idea of dying may seem like relief. This is called **suicidal ideation.**

Having suicidal thoughts does **not always mean someone wants to die**, but when these thoughts become frequent and overwhelming, they can be dangerous and require attention.

People experiencing suicidal ideation may feel:

- **worthlessness, guilt, shame**
- **anger, loneliness, rejection**
- confusion about wanting to live or die
- the belief that death is the only escape from emotional pain

Suicide can be **planned or impulsive**, often during moments of acute distress.

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10. Suicidal Thoughts and Behaviours

Warning Signs of Suicide

Some behaviours may indicate increased risk:

- Talking about **death, suicide, or wanting to disappear**
- Making plans, writing goodbye messages, or giving away belongings
- Expressing **hopelessness or unbearable emotional pain**
- Withdrawing from friends, family, or usual activities
- Major changes in sleep, appetite, mood, or behaviour
- Increased substance use or self-harm
- Sudden calmness after a long period of sadness

Risk Factors

Common risk factors include:

- **Mental disorders**, especially depression and substance use
- **Previous suicide attempts**
- Major life crises such as financial problems, relationship conflict, illness, or chronic pain
- Experiences of **violence, abuse, trauma, loss, or social isolation**
- Higher vulnerability among groups facing discrimination or marginalisation

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10. Suicidal Thoughts and Behaviours

Prevention

Suicide prevention begins with **open, supportive conversation**. Talking about suicide does **not increase risk**—it helps reduce isolation, anxiety, and stigma. Listening without judgement and taking someone's feelings seriously can make a critical difference.

Practical ways to help include:

- **Asking directly** if someone is thinking about suicide, and listening calmly
- Encouraging them to **seek professional help** (GP, mental health services, crisis teams)
- Staying with the person if they are in immediate danger and helping them reach support
- Reducing access to means of self-harm where possible
- Checking in regularly and offering ongoing support

Crisis helplines provide immediate, confidential support 24/7. Examples include:

- In the Netherlands: **113 Zelfmoordpreventie** – call **113 or 0800-0113**, or chat online
- In Ireland: **Samaritans Ireland** – call **116 123**
- In Portugal: **SOS Voz Amiga** – call **225 50 60 70** (and regional numbers)

Reaching out to these services can provide **immediate emotional support** and help people stay safe until further care is arranged. Recognising warning signs, offering empathy, and connecting someone to **coordinated mental health care** are among the most effective steps in preventing suicide.

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ACTIVITY 3.4– INFORMATION STATIONS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Preparation

Divide the room into 6 “information stations”, each focused on one mental health problem
(using the Information Station Handouts from the toolkit)

At each station, provide: (1) the case vignette (life story); (2) reflection questions; (3) the corresponding fact sheet

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ACTIVITY 3.4- INFORMATION STATIONS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Divide trainees into 6 groups and assign one group to each station.
- At each station, trainees should: (1) Read the case vignette and discuss it as a group; (2) Answer the reflection questions, based on their own knowledge and experience; (3) Review the fact sheet and compare it with their answers, validating, correcting, or adding missing information. (20 minutes)
- Each group selects a spokesperson to present to the large group: (1) the case summary; (2) their answers to the questions; (3) key learning points about the mental health condition. (10 minutes)

Wrap Up

Large-group reflection

Suggestions for a deeper dive into the theme:

- **Depression** – video I had a black dog, his name was depression
- **Complex Trauma** - video Remembering Trauma Official Film (2017)
- **Suicide** - Preventing suicide and coping with loss

UNIT 2:

SECTION 3

THE SELF-MEDICATION THEORY

UNIT 2 -MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

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).

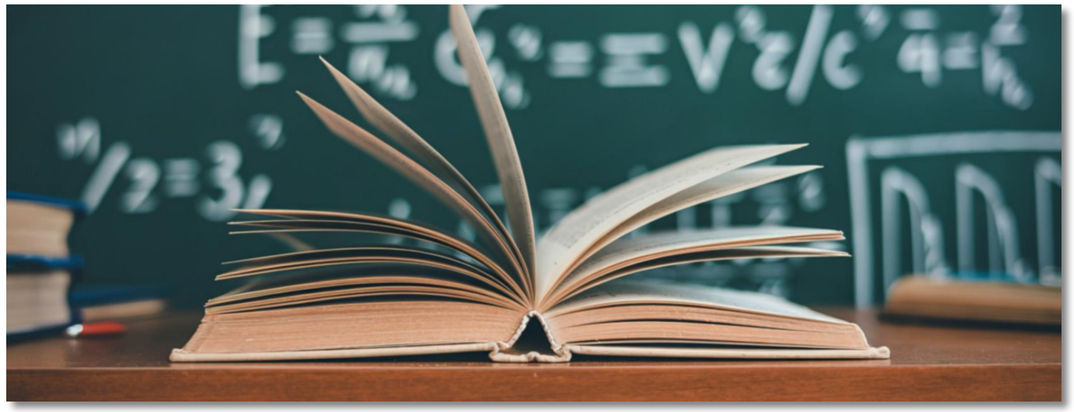
Key Versions of the Self-Medication Theory

Two main versions of this theoretical hypothesis exist and both approaches are primarily based on clinical observation of individuals struggling with addiction.

1. Psychoanalytic perspective – developed by Edward J. Khantzian and colleagues
2. Behavioristic perspective – developed by David F. Duncan

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.



UNIT 2 -MENTAL HEALTH-RELATED PROBLEMS AMONG PEOPLE EXPERIENCING HOMELESSNESS

SECTION 3 - THE SELF-MEDICATION THEORY

Addiction as a Self-Regulation Disorder

Addiction is understood as a **disorder of affect regulation**, where individuals struggle to manage emotions, maintain self-esteem, care for themselves, and maintain relationships. Substances become powerful because they **relieve unbearable feelings** or help regulate emotions, acting as a coping mechanism.

The psychotropic effects of a substance interact with existing psychiatric or emotional difficulties, making certain substances especially compelling. In the short term, substances help people cope with **internal distress** and **overwhelming external realities**.

Khantzian (1997) describes **self-selection**, where individuals tend to choose substances that best address their emotional vulnerabilities. Personality traits, psychological suffering, and the substance's effects guide these choices. Over time, people may switch substances to **counteract negative effects** or better manage their emotional state.

Common Signs of Cognitive Impairment

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.

UNIT 2 – MODELS AND METHODOLOGIES OF INTERVENTION

SECTION 2 - METHODOLOGIES AND TOOLS OF INTERVENTION

Duncan's Behavioristic Perspective

Duncan emphasizes the distinction between **substance use and substance abuse.** Most users do **not lose control;** only a minority develop addiction (Achalu, no date).

- **Substance use** is maintained by **positive reinforcement** (pleasurable effects).
- **Addiction** is maintained by **negative reinforcement** (removal of unpleasant emotional states).

Addiction often involves **avoidance or escape behaviours**, where substances provide temporary relief from distress caused by mental disorders, stress, or adverse experiences. These behaviours are **resistant to extinction** and may recur even after periods of abstinence.

Critiques of the Self-Medication Theory (SMT):

- Limited robust scientific evidence (Lembke, 2012; 2013)
- Overemphasis on individual psychological factors while **neglecting biological, social, and environmental influences**
- Risk of misleading treatment if applied in isolation

Khantzian positions SMT as **complementary to other addiction theories,** offering insight into why individuals turn to substances.

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)

UNIT 4 – VICARIOUS TRAUMA

SECTION 3 - SELF CARE

Epidemiological Evidence

National surveys show that individuals with mental health problems are **more likely** than adults without such conditions to **engage in risky substance use** (NDSHS, 2022–2023, cited in AIHW, 2024):

- Alcohol at risky levels: 37% vs. 32%
- Daily smoking: 15% vs. 7.4%
- Use of any illicit drug: 29% vs. 16%

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:

SECTION 1

HARM REDUCTION STRATEGIES SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS WITH MENTAL HEALTH CONCERNS

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 1 - HARM REDUCTION STRATEGIES SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS WITH MENTAL HEALTH CONCERNS

Key Strategies

1. Noticing early signs

- Observe changes in behaviour, mood, appearance, sleep, or appetite.
- Early detection allows timely intervention and referral, helping prevent crises.

2. Providing a safe space to talk

- Offer a **non-judgemental and consistent environment.**
- Encourage individuals to share fears, experiences, or symptoms they may not disclose to formal services.

3. Validating feelings without judgment

- Acknowledge emotions, e.g., “It makes sense you’re feeling overwhelmed.”
  Contextualise behaviours that may seem unusual—they may serve as **survival strategies** on the street.

4. Assessing immediate safety

- Identify acute risks such as **self-harm, suicidal thoughts, psychosis, overdose, or exposure to violence.**
- Activate crisis protocols or mobile mental health teams when needed.

*Harm reduction strategies aim to **support individuals with mental health conditions** while respecting their autonomy and unique circumstances. These strategies are useful for professionals and frontline staff, even without formal mental health training (NHCHC, 2024; SAMHSA, 2020; Hwang & Burns, 2014; Hopper et al., 2010; WHO, 2021; Padgett et al., 2016).*

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 1 - HARM REDUCTION STRATEGIES SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS WITH MENTAL HEALTH CONCERNS

5. Supporting access to services

- Explain available services, help with referrals, accompany clients to appointments, and address practical barriers (transport, documentation, medication).
- **Peer workers** can be particularly effective due to lived experience.

6. Maintaining regular contact

- Frequent check-ins, street outreach, or drop-in interactions help sustain engagement, monitor changes, and prevent clients from falling out of care.

7. Coordinating with mobile or crisis teams

- Harm reduction workers act as connectors, guiding specialized services using real-time knowledge of a person's history and context.

8. Medication support and health literacy

- Assist clients with understanding, storing, and taking **prescribed medication.**
- Explain interactions between medications and substances to reduce risk (e.g., **avoiding alcohol with benzodiazepines**).

9. Compensating for cognitive or physical challenges

- Help with **appointments, forms, medication routines**, or breaking tasks into manageable steps.
- Establish predictable routines to reduce **anxiety, disorganisation, and crisis risk.**

10. Reducing isolation and supporting relational consistency

- Brief, repeated interactions, remembering names and history, or structured social activities can reduce feelings of invisibility and foster trust.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 1 - HARM REDUCTION STRATEGIES SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS WITH MENTAL HEALTH CONCERNS

11. Addressing basic needs and structuring routines

- Stabilize food, water, hygiene, and safety before interventions.
- Establish predictable routines to reduce **anxiety, disorganisation, and crisis risk.**

12. Advocating within systems

- Challenge unfair barriers, request priority assessments, and ensure symptoms are not dismissed due to **diagnostic overshadowing.**

13. Motivational support and crisis management

- Use **motivational interviewing** to explore goals, reduce ambivalence, and strengthen readiness for care.
- Apply de-escalation and emotional regulation strategies during acute distress.

14. Recognising and responding to trauma triggers

- Maintain a **trauma-informed approach**, asking “What happened to this person?” rather than “What’s wrong with them?”
- Avoid retraumatisation while protecting personal safety and boundaries.

15. Documenting and collaborating across sectors

- Keep factual, neutral records to support continuity of care.
- Coordinate with **mental health services, addiction programs, housing providers, social services, justice systems, and NGOs** to reduce fragmentation and improve outcomes.

UNIT 3:

SECTION 2

EVIDENCE-INFORMED ACTIONS

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Attention-Deficit/Hyperactivity Disorder (ADHD)

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 (1)

- 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.

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Attention-Deficit/Hyperactivity Disorder (ADHD)

5. Practical Daily Interventions (2)

- 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.

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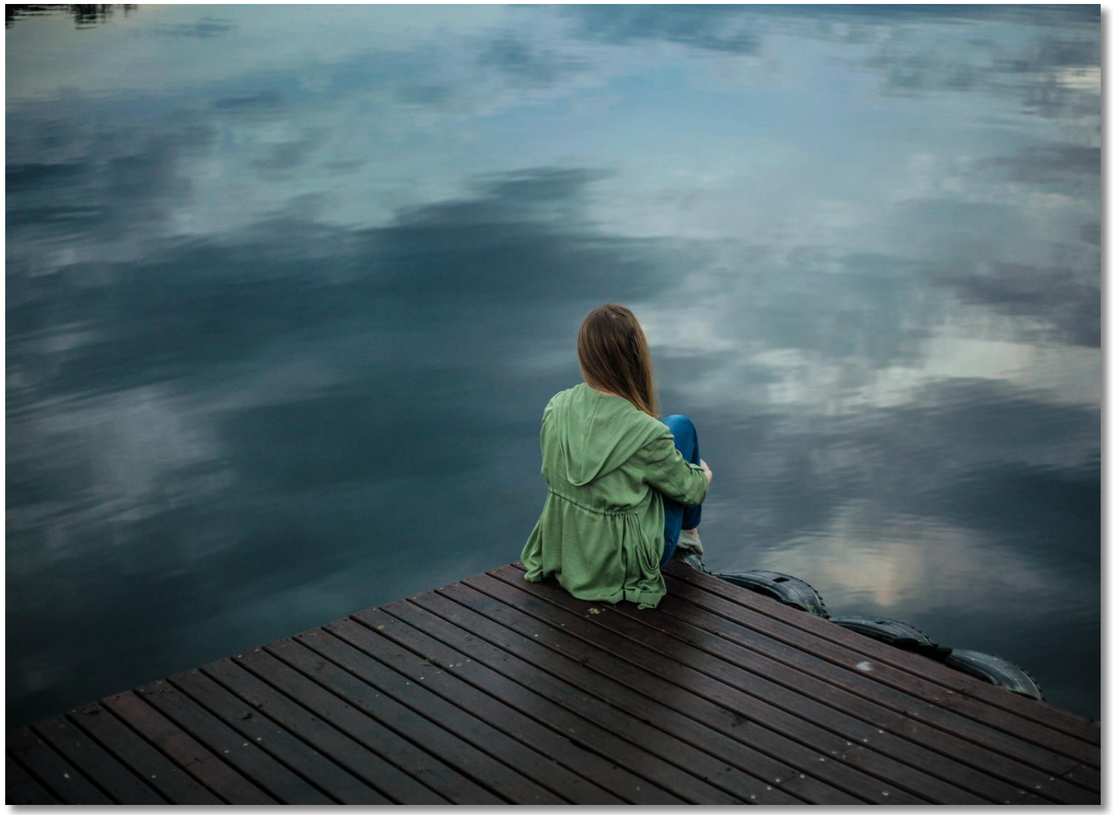
SECTION 2 - EVIDENCE-INFORMED ACTIONS

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)



UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Anxiety Disorders

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?"
- 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
- 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
- Consider environmental triggers:
  - Unstable, noisy, or unsafe spaces can increase baseline anxiety
  - "Aggressive," "irritable," or "uncooperative" behaviour may reflect panic or overwhelm

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

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Anxiety Disorders

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
- Observe interplay with substance use:
  - Stimulants (cocaine, methamphetamine): agitation, paranoia, panic
  - Cannabis: may reduce anxiety or trigger panic depending on dose and individual
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Anxiety Disorders

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.

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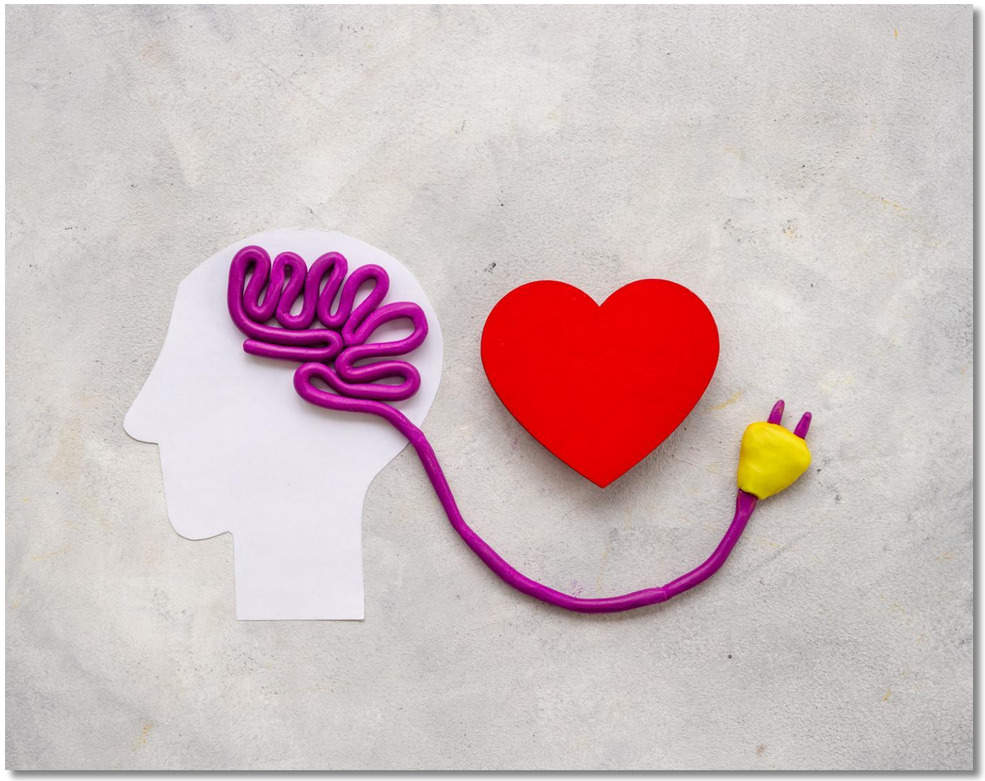
Anxiety Disorders

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



UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

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)
  - Problems completing familiar daily tasks
  - Involvement in unsafe situations without anticipating negative consequences (e.g., crossing busy streets without caution, interacting with risky individuals, or mishandling hazardous objects).
- **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

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Cognitive Impairment, including Drug-Induced Cognitive Impairment

2. Key Warning Signs That Require Special Attention

Observe the following functional and behavioural indicators:

- 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

Observe the following functional and behavioural indicators:

- 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

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Cognitive Impairment, including Drug-Induced Cognitive Impairment

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

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Cognitive Impairment, including Drug-Induced Cognitive Impairment

- 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

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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.

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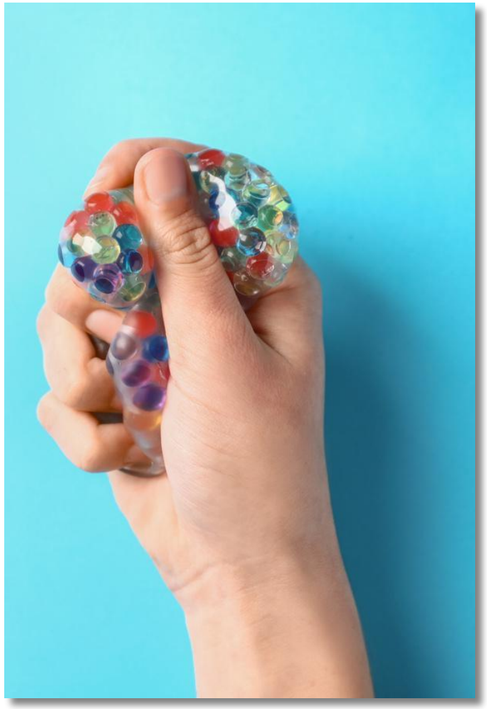
Complex Trauma and Post-Traumatic Stress Responses

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



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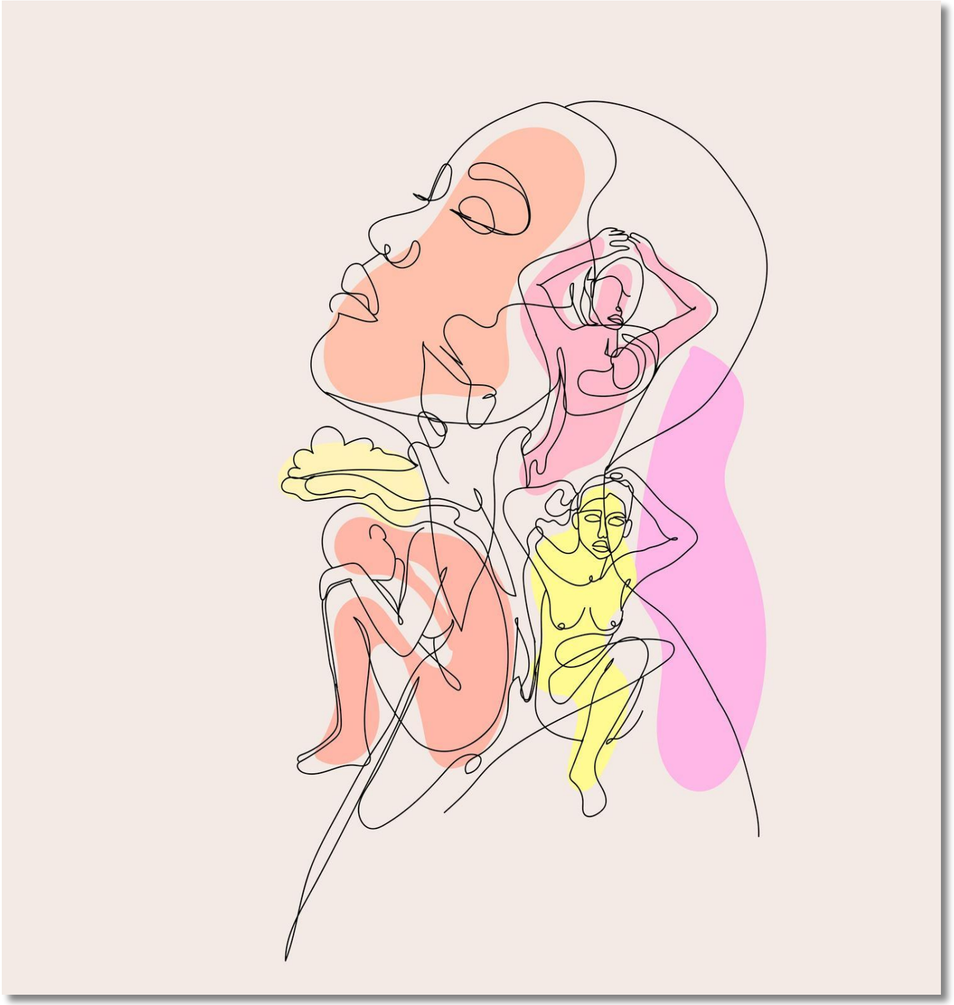
Depression

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.



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SECTION 2 - EVIDENCE-INFORMED ACTIONS

Depression

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.

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Depression

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.”

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SECTION 2 - EVIDENCE-INFORMED ACTIONS

Depression

- 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

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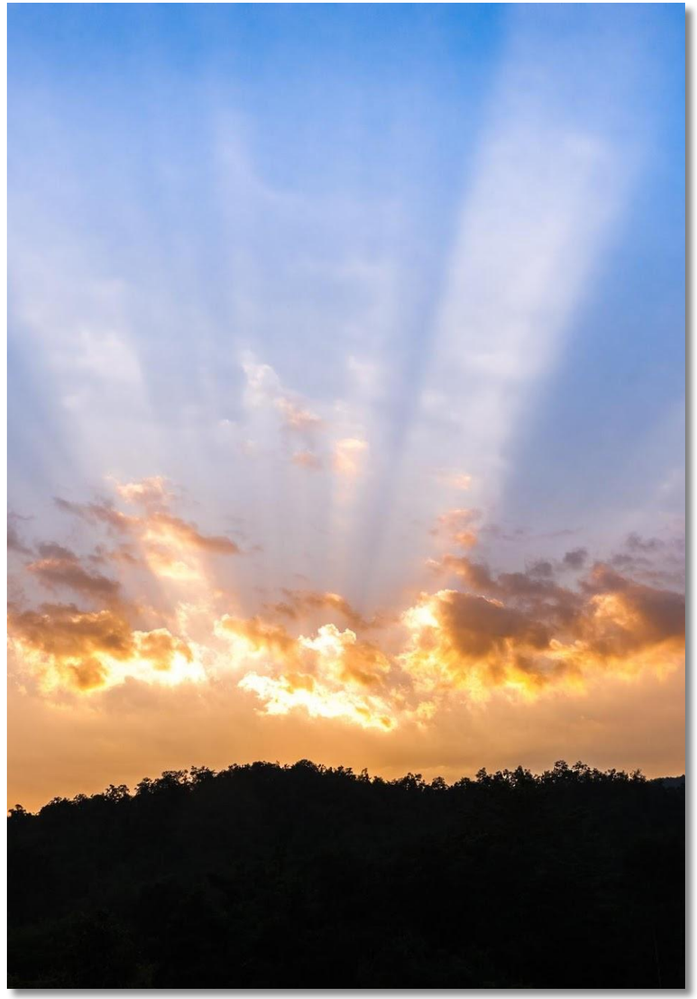
Depression

- 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.



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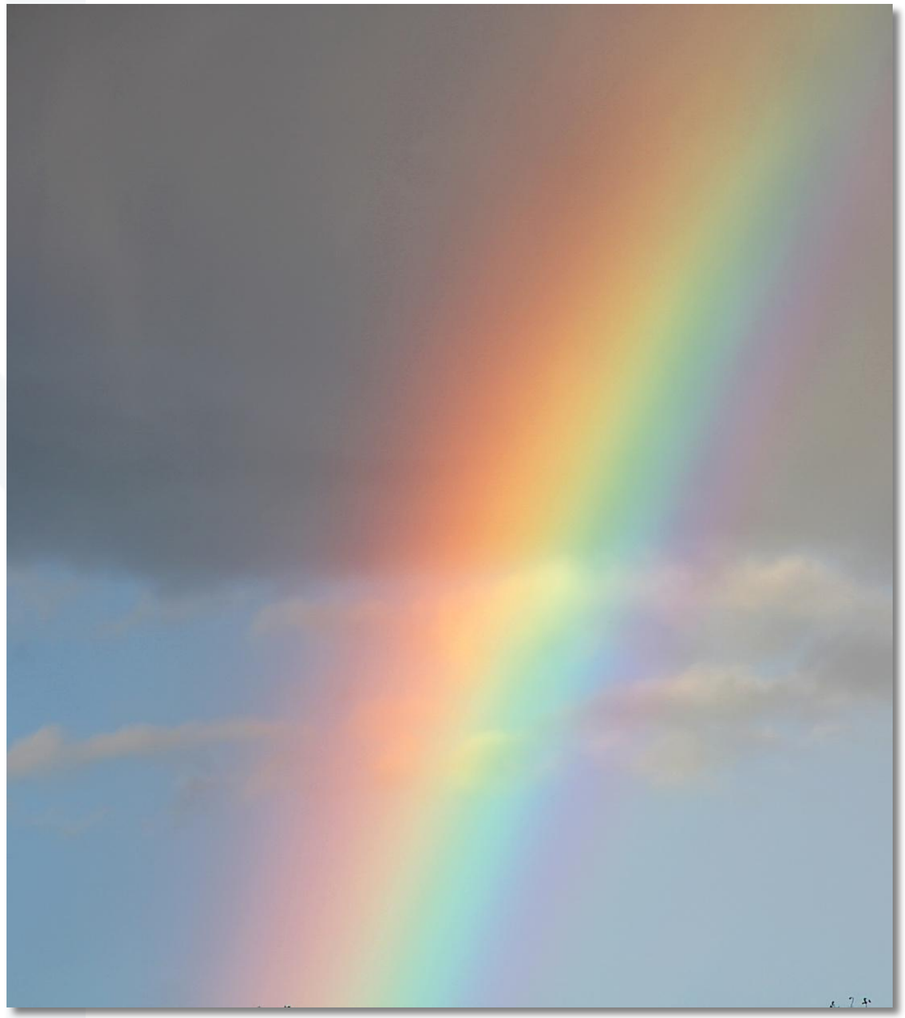

Hoarding Disorder and Hoarding Behaviours

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.

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Hoarding Disorder and Hoarding Behaviours

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.

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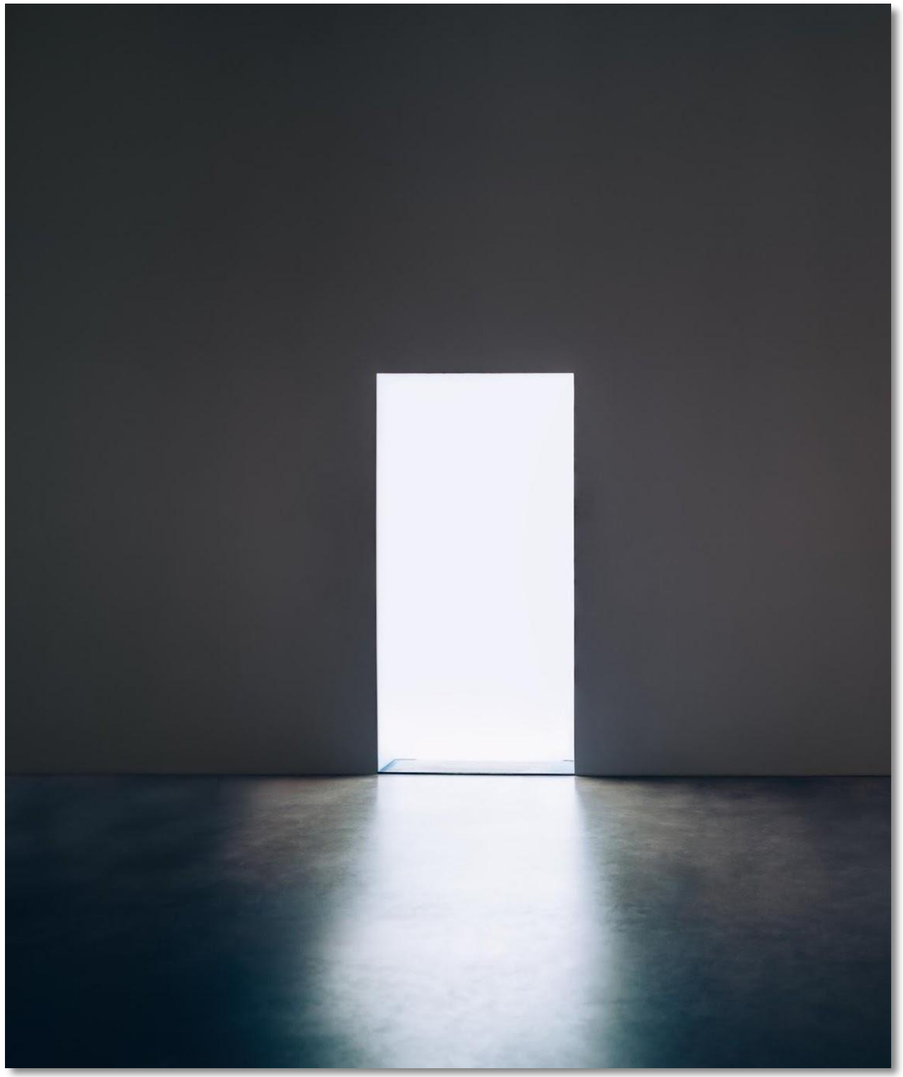
SECTION 2 - EVIDENCE-INFORMED ACTIONS

Hoarding Disorder and Hoarding Behaviours

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).



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Hoarding Disorder and Hoarding Behaviours

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Hoarding Disorder and Hoarding Behaviours

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Hoarding Disorder and Hoarding Behaviours

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Personality Disorders

2. Practical Daily Interventions

- 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. Practical Daily Interventions

- 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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Personality Disorders

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

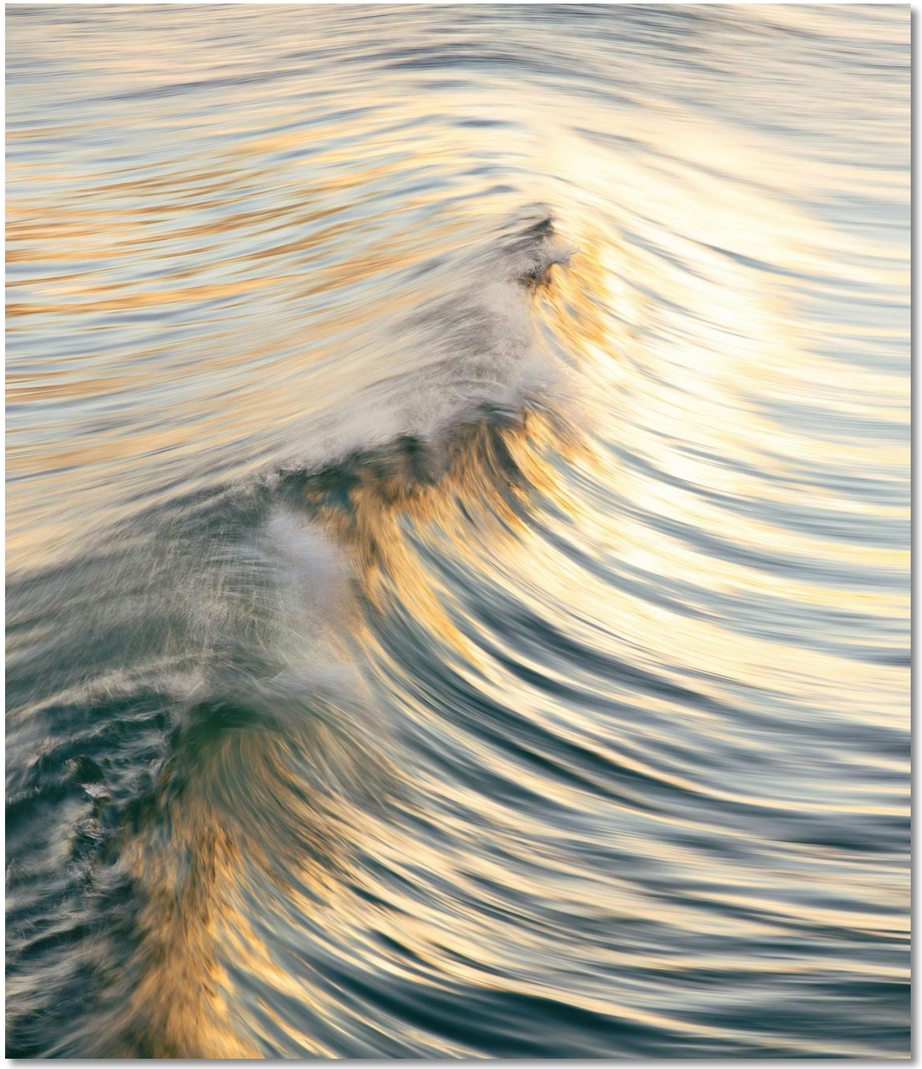
Schizophrenia and Other Psychoses

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)



UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

Schizophrenia and Other Psychoses

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

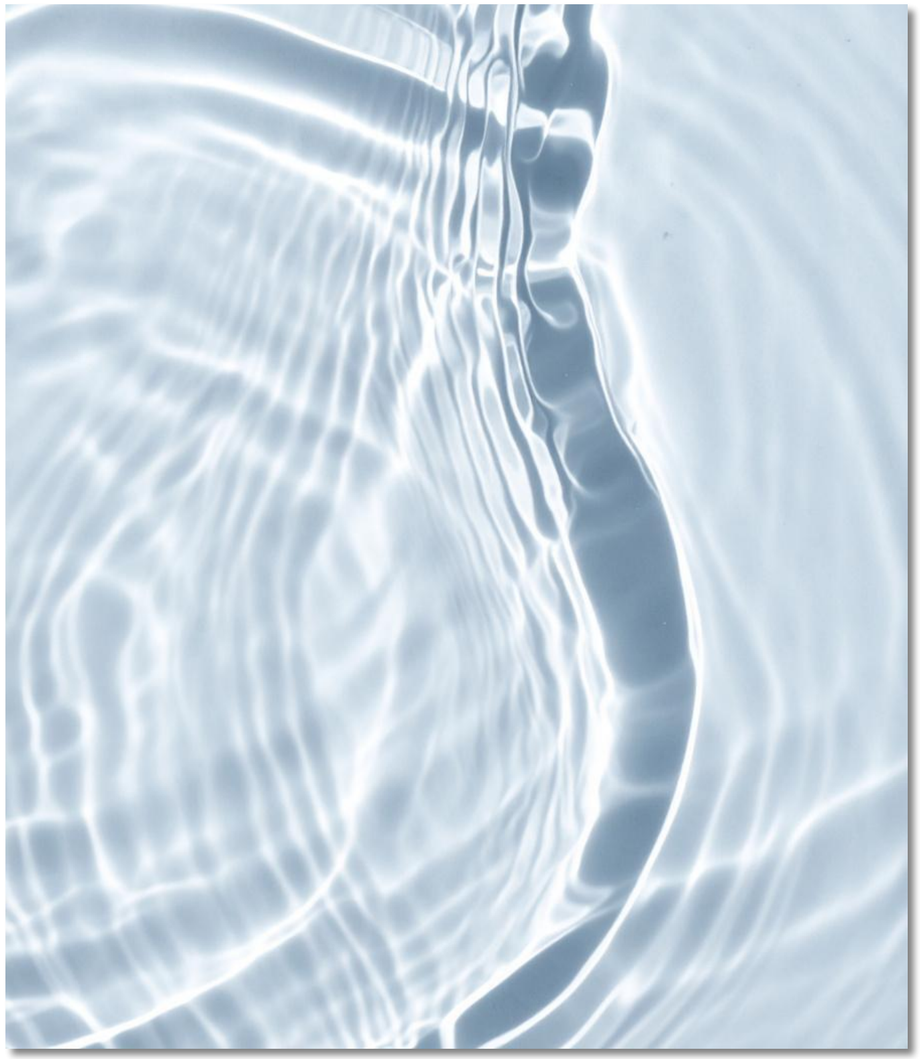
UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

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.



UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

Substance-Induced Psychosis

2. Key Warning Signs That Require Special Attention

Conversational / Non-clinical Questions:

- 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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Psychosis

Substance-Induced Psychosis

3. 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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Self-Harm Behaviours

1. Practical Screening Considerations

Observational Indicators:

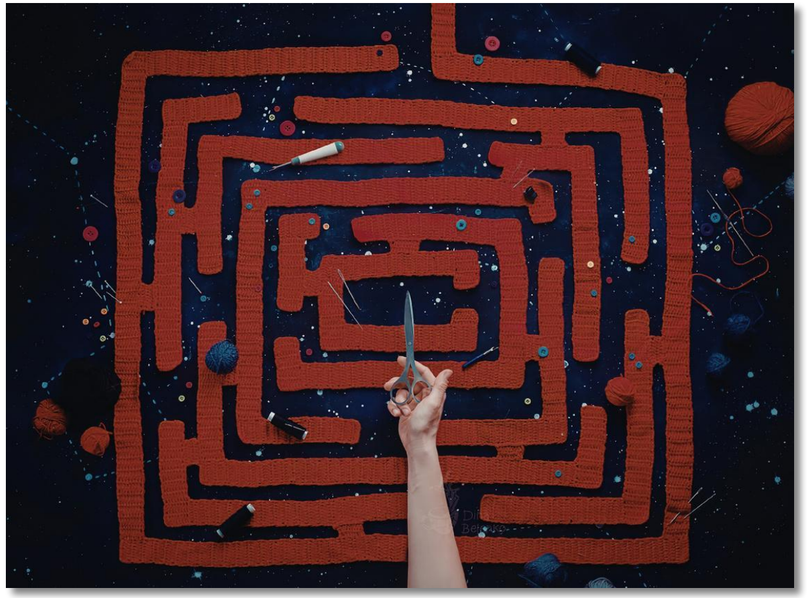
- Fresh cuts, scars, burn marks, or unexplained injuries
- Bandages or improvised dressings
- Wearing long sleeves/pants even in hot weather
- Sudden withdrawal or mood changes
- Avoidance of showers, changing rooms, or medical care

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



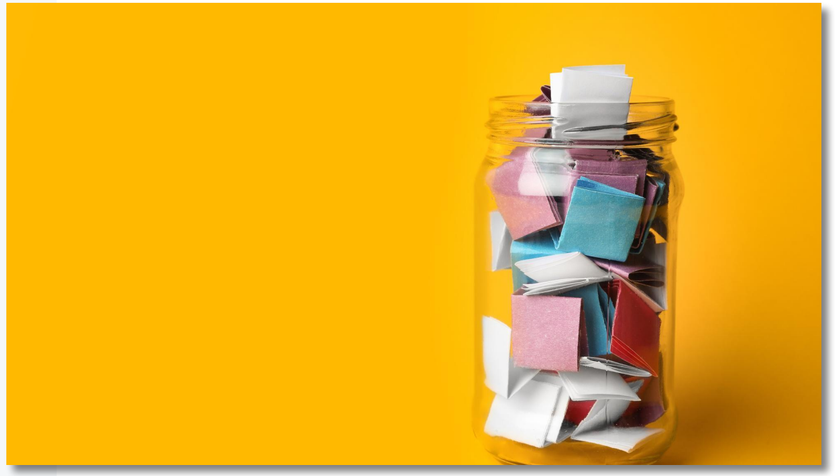
UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Self-Harm Behaviours

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Self-Harm Behaviours

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Self-Harm Behaviours

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
  - Signs of infection (redness, swelling, fever, spreading cellulitis)
  - Acute suicidal ideation (intent, plan, and/or means)
  - Recent or escalating self-injury that the person cannot safely manage
- Explore links with substance use
- Provide harm-reduction tools when relevant (e.g., naloxone, wound-care supplies)

Worker Well-being:

- Stay calm and consistent
- Seek supervision after difficult disclosures
- Follow agency protocols for risk

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

Suicidal Ideation & Suicide Risk

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

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

ACTIVITY 3.5– SUCCESS STORIES IN ENGAGEMENT

30 MINUTES

Objective

To present practical examples of successful interventions, showcasing how professionals can apply effective strategies in their fieldwork to build trust, reduce harm, and support long-term stability for clients with complex needs.

Preparation

- Arrange trainees into small groups (4–6 participants per group).
- Distribute the success stories and the discussion questions. (find the material in the toolkit)
- Provide each group with sticky notes and pens.
- Assign a facilitator in each group (or plan to rotate the role during the discussion).

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 2 - EVIDENCE-INFORMED ACTIONS

ACTIVITY 3.5– SUCCESS STORIES IN ENGAGEMENT

30 MINUTES

Activity

- Each group reads one success story.
- The group facilitator ensures everyone has a chance to contribute.
- Groups discuss the story using the guiding questions.
- Allow 20 minutes for groups to discuss at least 4/8 questions.
- At the end of the discussion, each group writes 2–3 key insights on sticky notes.

Wrap Up

Each group shares at least one main insight or practical takeaway (1–2 minutes per group/10 minutes total).

UNIT 3:

SECTION 3

CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

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

Modern psychiatric and mental health frameworks have largely been developed in the **Global North and are grounded in Western biomedical and individualistic models** that prioritise diagnosis, symptom classification, and standardised treatments. Although often presented as universal (e.g. through the DSM and ICD), these frameworks reflect specific socio-cultural and historical contexts and **do not always account for how mental distress is experienced and expressed in diverse or marginalised communities.**

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

Research shows that **understandings of health and illness** are **culturally shaped** and may emphasise spiritual, social, moral, or structural factors rather than individual pathology. These perspectives influence **help-seeking, coping strategies, and engagement with care, including reliance on community networks or traditional practices**. When dominant mental health models overlook these differences, they risk misdiagnosis, pathologising adaptive responses to adversity, and reinforcing epistemic dominance. This highlights the **need for culturally responsive, context-sensitive, and participatory approaches to mental health care.**

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from

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 and ongoing trauma linked to colonialism and systemic oppression **continue to affect many immigrants in Europe**. These experiences contribute to increased stress, mistrust of institutions, and reduced engagement with health and social services. Structural inequalities, racialisation, and everyday discrimination in host countries can **reactivate intergenerational trauma**, shaping mental health, coping strategies, and help-seeking behaviours. Recognising these contexts is essential for developing culturally informed and respectful interventions.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

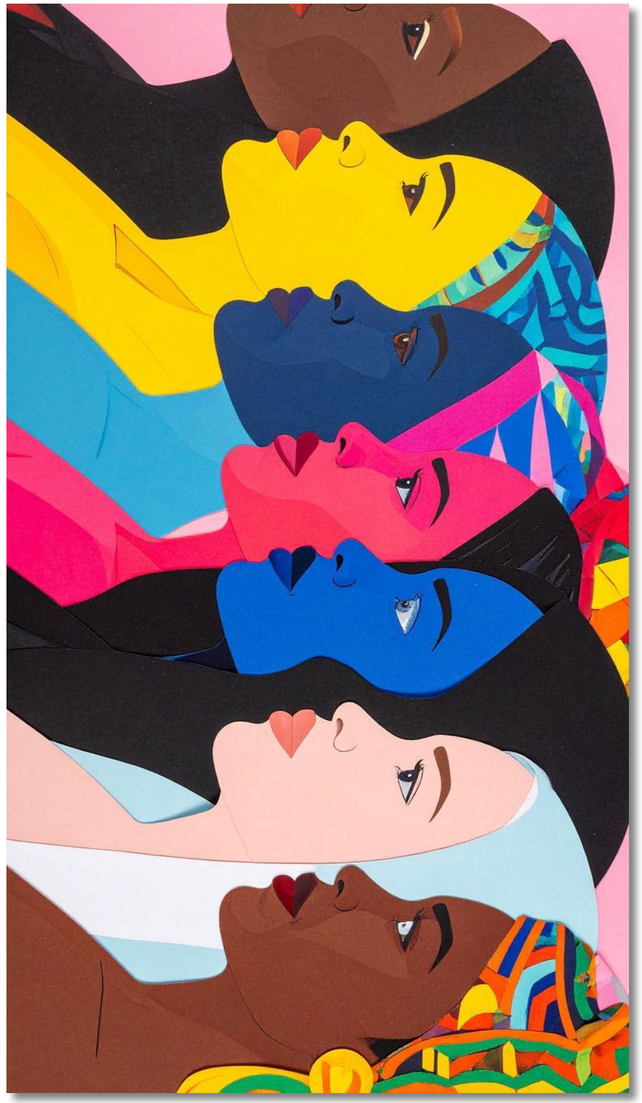
SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

Working with culturally diverse populations in situations of homelessness and/or drug use

Culturally sensitive practice is essential when working with people experiencing homelessness who use drugs, as distress, substance use, and pathways into homelessness are shaped by cultural beliefs, social structures, and historical contexts. Transcultural mental health research shows that these factors influence how individuals understand their experiences and engage with services.

Marginalised groups, including migrants and racialised communities, often **face dual stigma** related to substance use and cultural identity, which can delay or prevent help-seeking. Research on homelessness also shows that **substance use may function as a social or survival strategy** within contexts of exclusion, rather than solely as pathology. **Recognising these meanings is key to effective and respectful care.**



UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

Culture also strongly **shapes service engagement and trust in systems**. People from culturally diverse backgrounds often experience **institutional mistrust** due to discrimination, systemic racism, or exclusion within health and social services. This mistrust is intensified for people experiencing homelessness who use substances, as services are frequently perceived as punitive or surveillance-oriented rather than supportive.

Culturally responsive care must therefore go **beyond language and communication.** It should also address structural barriers such as insecure migration status, limited access to culturally competent providers, and rigid treatment models that restrict equitable access to care.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

What to Take into Consideration When Working with Clients from Diverse Cultural Backgrounds

Cultural norms shape both **therapeutic relationships and how distress is expressed. Transcultural psychiatry** shows that people communicate suffering through culturally specific idioms that may not fit standard diagnostic categories, increasing the risk of misinterpretation or misdiagnosis. In homelessness settings, behaviours seen as "**resistance**" may instead reflect culturally shaped **autonomy or survival strategies.** Culturally adapted assessments, interpreter use, and reflective practice are therefore **essential.**

Culturally grounded **strengths**—such as family and community networks, spiritual practices, and peer support—are **key sources of resilience.** Interventions that build on these strengths and address systemic inequities improve engagement and support more sustainable recovery.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

Overall Directions in Cultural Diversity & Mental Health

a. Systems must recognise diversity, not only add tools

The **DSM-5 Cultural Formulation Interview** is a useful step, but professionals must adapt tools to the realities of homelessness and substance use. This ensures assessments consider cultural background, experiences of cultural shock, and the effects of housing instability or substance use on perception, capacity, and decision-making.

b. Move toward holistic and integrated care

Holistic, biopsychosocial, and recovery-oriented models support culturally relevant care, addressing social, psychological, and biological factors. Integrating services into primary care can reduce stigma, improve accessibility, and accommodate medical pluralism, allowing space for Western, traditional, and community-based healing approaches.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

Overall Directions in Cultural Diversity & Mental Health

c. Strengthen community-based and traditional supports

Many culturally diverse individuals prefer guidance from elders, traditional healers, or religious leaders. Collaborating with these community-based resources can enhance engagement, validate lived experiences, and complement clinical care, especially for those experiencing homelessness and substance use.

d. Address the limits of cultural competence

Cultural competence is not value-neutral. Effective practice requires examining power, historical trauma, and systemic racism, which intersect with homelessness and substance use to affect service access, discrimination, and social exclusion. Addressing these structural factors ensures interventions respond to deeper contextual realities, not just surface differences.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

Overall Directions in Cultural Diversity & Mental Health

e. Build cultural partnerships

Effective support involves co-designing programs with community members and peers, sharing power, and reflecting the cultural backgrounds of the populations served. Partnerships between mental health, substance use services, and cultural communities foster trust, accessibility, continuity of care, and better outcomes.

f. Promote interdependence, not hierarchy

Care should integrate support networks, cultural identity, spiritual practices, and local knowledge. Building on these resources strengthens resilience and ensures interventions reflect the lived realities and strengths of individuals and communities.

g. Broader societal context

Structural factors such as racism, migration, globalization, and the loss of traditional supports can intensify mental distress for populations facing homelessness or poor housing. Mental health professionals working across cultures may need to act as social advocates, addressing systemic inequities that shape well-being.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

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.

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

ACTIVITY 3.6 – ROUNDTABLE

30 - 40 MINUTES

Objective

To help explore how cultural background, trauma experiences, and harm reduction intersect, and to identify ways to apply strategies respectfully and effectively across diverse contexts. This activity fosters reflection, sharing of real-world experiences, and practical takeaways for culturally sensitive, trauma-informed care.

Preparation

Read the following printed discussion questions:

- How can cultural background influence how someone experiences and expresses trauma?
- What are some common assumptions or biases professionals should be aware of when working with culturally diverse clients?
- In what ways can harm reduction strategies be adapted to better meet the needs of individuals from different cultural or ethnic backgrounds?
- What does trauma-informed care look like in practice when supporting people experiencing homelessness?
- Can you think of examples where a lack of cultural understanding created barriers to care or trust?
- What are some practical DOs and DON'Ts when approaching harm reduction from a trauma-informed lens?

UNIT 3 -HARM REDUCTION STRATEGIES AND EVIDENCE-INFORMED PRACTICES

SECTION 3 - CULTURAL DIVERSITY AND MENTAL HEALTH: CONSIDERATIONS FOR PRACTICE

ACTIVITY 3.6 – ROUNDTABLE

30 - 40 MINUTES

Activity

- Choose at least 3–4 questions, for examples from personal or professional experience. And think about an answer.
- Write 2–3 key insights or recommendations on your paper.

Wrap Up

Highlight one main insight or practical takeaway.

HOME4HEALTH MOOC

MODULE 4:
PSYCHOACTIVE SUBSTANCE USE

MODULE OVERVIEW:

Unit 1: Psychoactive Substances

Section 1: Introduction to the course and participants

Section 2: Psychoactive Substances

Unit 2: Harm Reduction Strategies for Psychoactive Substance Use

Section 1: Types of routes of administration of psychoactive substances

Section 2: More harm reduction strategies

Section 3: Peer work Perspective

Unit 3: Harm reduction specific to people experiencing homelessness

Section 1: Introduction to situations of homelessness

Section 2: Harm reduction in cases of homelessness

UNIT 1:

PSYCHOACTIVE SUBSTANCES

UNIT 1 - LEARNING AND OBJECTIVE OUTCOMES

Coordinated by:
In partnership with:
Co-funded by the European Union
2023-1-ES01-KA220-VET-000165764

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.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 1 - INTRODUCTION TO THE COURSE AND PARTICIPANTS

ACTIVITY 4.1 ICEBREAKER "FACTSHEETS: TRUTH OR FALSE?"

30 - 40 MINUTES

Preparation

- Create a sheet of paper with two clearly labeled columns: “TRUE” and “FALSE.”
- Shuffle the Factsheet cards For this material check toolkit and place them face down on the table.

Activity

- Pick one **Factsheet card** from the table and read the statement.
- Based on your current knowledge, place the card under “TRUE” or “FALSE.”
- Continue until all cards have been sorted.

Wrap-Up

- Reveal the correct answers and compare them with your own choices.
- Were there any surprising results?
- Take this new information with you as you continue through the rest of the module.

UNIT 1:

SECTION 2

PSYCHOACTIVE SUBSTANCES

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

What Are Psychoactive

Any chemical that changes how the brain works.

It can affect mood, perception, thinking, behaviour, or consciousness.

From a medical perspective, these substances interact with the **central nervous system**, influencing neurotransmitters such as dopamine, serotonin, GABA, glutamate, and norepinephrine

This can lead to

short-term effects

- euphoria
- alertness
- sedation
- hallucinations

long-term effects

- tolerance
- dependence
- neuroadaptation

This neurobiological view is common in European health systems, but it is only **one way** to understand substance use.

Substance use is also shaped by context

Factors that influence effects include

- mental and physical health
- sleep, nutrition, stress levels
- social environment and peer group
- stigma or legal risk
- cultural beliefs about the substance

The same substance can produce very different experiences.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Definition of psychoactive substances and Neurobiological Interaction

History, culture, and laws matter

What we call a “drug” is not just a chemical category. It is shaped by history, politics, and culture.

Some substances that are illegal today have long histories of ritual or medicinal use in Indigenous communities, while other substances with major health impacts remain legal.

This shows that substance classification is not always based only on scientific evidence.

Substance use is not only about harm, people use psychoactive substances for many reasons, for example:

- pleasure or curiosity
- connection with others
- coping with emotional pain
- creativity or self-exploration
- cultural or spiritual practices

Understanding these motivations helps professionals respond with empathy instead of judgement.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Definition of psychoactive substances and Neurobiological Interaction

Why language matters

In this module, we try to avoid the word “drug” when possible.

The term often carries stigma and groups together very different substances and uses.

Using precise and respectful language helps reduce discrimination and improves care.

Key idea

- **biology** → how substances affect the brain
- **psychology** → why people use them
- **social and cultural context** → how meaning and environment shape use

Only by combining these perspectives can we support people in a realistic and compassionate way.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Categorization of Psychoactive Substances

International control of psychoactive substances comes from **treaties developed in the 20th century protect public health, prevent addiction, and regulate trade**, but they were also influenced by **colonial, racial, and geopolitical agendas.** This has shaped **which substances are considered dangerous and which populations are targeted**. Two main United Nations treaties structure the current classification system.

The 1961 Single Convention on Narcotic Drugs

Consolidated and **replaced earlier drug control treaties.**

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).

Table: Schedules of the 1961 Single Convention

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)

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

The 1971 Convention on Psychotropic Substances

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).

Video for further insight: What is the Drug War?

With Jay-Z & Molly Crabapple

Table: Schedules of the 1961 Single Convention

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

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

National Interpretations and Legal Diversity

International schedules provide guidance, but each country applies them differently, influenced by cultural, legal, and political factors. National laws shape how substances are regulated, creating significant variation in practice across the world.

SPAIN

- Recreational **cannabis is decriminalized** for personal use in private spaces-**v** to grow, sell, or consume in public.
- Cannabis clubs operate in a legal grey area (non-profit model, unclear status)
- Medical cannabis regulation under development (since 2022)

NETHERLANDS

- Tolerated cannabis sales in licensed coffee shops (strict rules apply)
- Supply remains illegal (“backdoor problem”); legal cultivation pilots underway

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

PORTUGAL

- Personal use decriminalized (up to 10-day supply)
- Larger amounts may lead to sanctions or trafficking charges
- Medical cannabis legal with prescription (since 2019)
- CBD widely available (non-psychoactive)

IRELAND

- Cannabis possession illegal; minor cases may receive a caution (since 2020)
- Supply and larger quantities carry stricter penalties
- Health-led drug strategy in place (2017–2025)
- Medical cannabis program introduced in 2019 (expanded in 2023)

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Classification of psychoactive substances by neurobiological mechanism of action

This classification is common in clinical and educational contexts, as it helps to understand pharmacological risks, interactions, and subjective experiences.

However, psychoactive **substances do not produce the same effects in all people or in all contexts.**

Many substances produce a range of effects that vary depending on dose, individual physiology, and social or emotional context.

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

Example: *Alcohol is pharmacologically classified as a CNS depressant. Yet at low doses and in stimulating environments it often produces disinhibition, talkativeness, and temporary euphoria, effects that resemble those of a stimulant. As blood alcohol levels increase, sedation and motor impairment become more prominent, and the depressant effects dominate. This biphasic effect is not unique to alcohol; many substances show dose-dependent shifts in their effects.*

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Classification of psychoactive substances by neurobiological mechanism of action

Under polysubstance use, substances may mask, enhance, or unpredictably interact with one another.

The effects of any psychoactive substance are co-produced by multiple interacting factors:

- 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 interaction is often described through the "drug, set and setting" model, a foundational framework for understanding psychoactive experiences.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

New Psychoactive Substances (NPS)

Synthetic or semi-synthetic substances that are not listed under the **1961 or 1971 UN Conventions,** but may still pose **serious public health risks.** They are often marketed as *"legal highs," "research chemicals,"* or *"designer drugs."*, according to the United Nations Office on Drugs and Crime.

Researchers commonly group NPS into several main families, such as:

- Phenethylamines
- Tryptamines
- Piperazines
- Synthetic cathinones
- Synthetic cannabinoids
- Other substances (for example designer benzodiazepines, novel opioids, dissociatives)

These substances **vary widely in their effects, risks, and toxicity.**

NPS change rapidly and lack long-term studies, making them a major challenge for harm reduction, healthcare, and drug policy.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

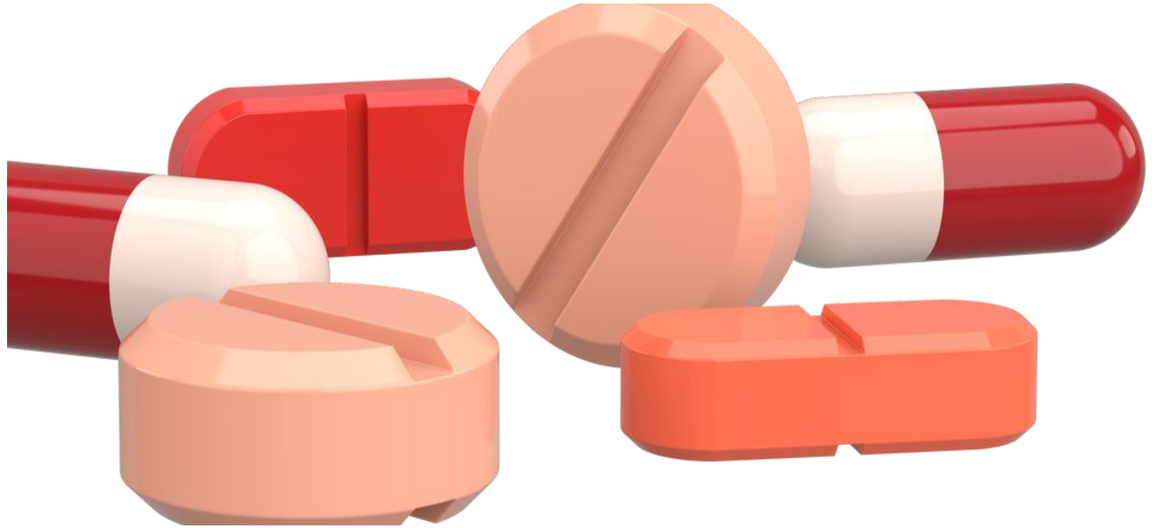
New Psychoactive Substances (NPS)

In the **Netherlands**, NPS are a growing concern because they can be slightly modified chemically to avoid existing drug laws. This means they may be sold legally until they are specifically banned.

The government usually adds new substances to the national drug law, the Opium Act, once they are identified and assessed.

However, this process often lags behind the rapid appearance of new substances.

To improve control, the Netherlands is exploring broader legal approaches and works with the EU Early Warning System to monitor emerging trends.



UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Understanding Use Through Function: When Substances Help to Survive

To understand psychoactive substance use—especially from a harm reduction and social care **perspective—it is important to move beyond asking *"What substance is being used?"* and instead ask *"What function does this substance serve in this person's life?"***

- The effects of a substance cannot be separated from the person's emotional state and environment.
- Important to understand why someone uses a substance at a particular moment. Use is rarely random; it often reflects unmet needs, structural barriers, or an attempt to regulate emotions or the body.

For **people experiencing homelessness or housing exclusion,** psychoactive substances may serve practical or survival-related purposes. Research across different countries shows that substances are sometimes used to:

- **Stay awake** and alert in unsafe environments
- **Fall asleep** in harsh outdoor conditions
- Cope with **pain, cold, hunger,** or exhaustion
- **Manage trauma**, grief, or constant fear
- Maintain a **sense of routine**, connection, or temporary relief

Homelessness is a **structural condition** that can change the meaning and function of substance use.

What may look like risky behaviour from the outside can be a rational adaptation to unsafe living conditions.

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

Understanding Use Through Function: When Substances Help to Survive (2)

This does not mean ignoring risks → it **encourages professionals to understand the logic of survival** behind some patterns of use. Approaches based on harm reduction and social justice therefore aim to:

- Understand the needs behind the behaviour
- Avoid moral judgment or simplistic diagnoses
- Focus on improving living conditions, not only on stopping use

When systems such as housing, healthcare, or social support fail people often develop their own ways to cope.

*Understanding substance use through its **function** helps professionals respond with empathy, realism, and effectiveness. It allows support workers to see the person behind the behaviour and to design interventions that address both **immediate risks** and **underlying needs.***

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

ACTIVITY 4.2 - "FORTUNE WHEEL" ON PSYCHOACTIVE SUBSTANCES / INTERACTION

45 MINUTES

Activity

- Spin the wheel, which contains several questions about the use of psychoactive substances.
- For each question, provide an answer—whether it is right or wrong.

Once the substance is revealed, ask yourself to:

- Describe a real situation where substance use influenced a person's vulnerability.
- What harm reduction strategy would you apply in that situation, and why?
- How might this situation relate to different recovery pathways (abstinence, stabilization, managed use)?
- What risks might be overlooked in this case?
- How would you approach this person from a non-judgmental perspective?

Link to online fortune wheel

UNIT 1 – PSYCHOACTIVE SUBSTANCES

SECTION 2 - PSYCHOACTIVE SUBSTANCES

ACTIVITY 4.2 - "FORTUNE WHEEL" ON PSYCHOACTIVE SUBSTANCES / INTERACTION

45 MINUTES

Facilitator Instructions

Participants take turns spinning the wheel and responding to the question that appears. The facilitator should:

- Encourage concise answers (1–2 minutes per participant) to avoid repetition.
- Prompt participants to give real-life examples from their professional experience whenever possible.
- Facilitate brief group reflection after each turn, connecting answers to harm reduction practice.
- Ensure a respectful, non-judgmental space where different perspectives can emerge.

Reflection Prompts

After several rounds, invite participants to reflect:

- How does substance use interact with people's life conditions (e.g. homelessness, trauma, isolation)?
- What different recovery pathways can be identified in the cases discussed?
- How can harm reduction strategies adapt to each pathway instead of imposing a single model?
- What role do professionals play in supporting safer practices without requiring abstinence?

UNIT 2:

HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

UNIT 2:

SECTION 1

TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

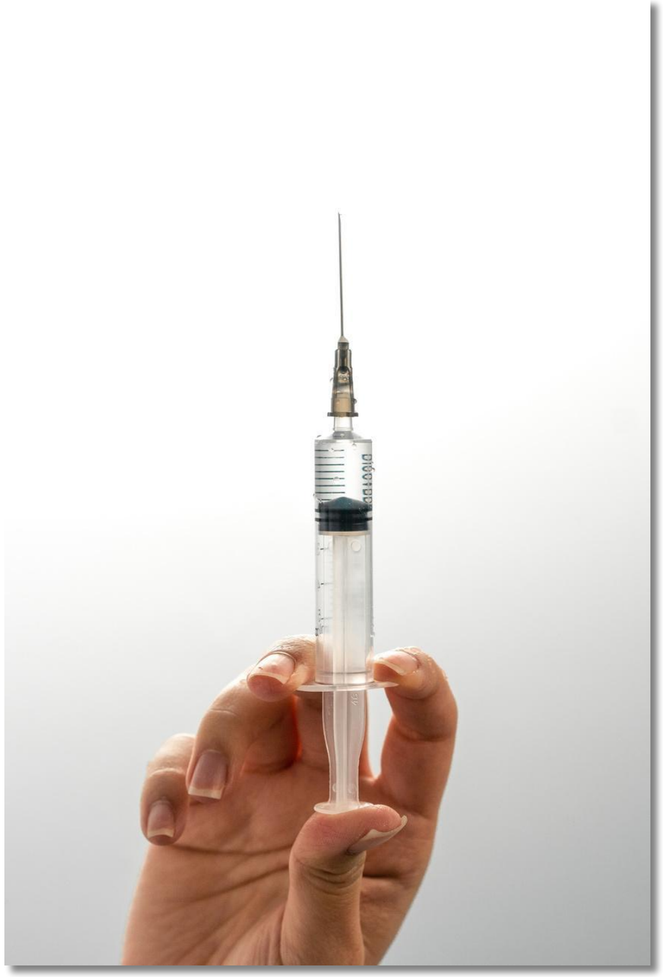
UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Harm Reduction in Europe: Core Concepts

Public health approach that aims to reduce the negative **health and social consequences** of psychoactive substance use — **without requiring abstinence**.

- In Europe, HR has developed as a **pragmatic and evidence-based response**, grounded in **dignity**, **inclusion**, and **human rights**
- A key factor in harm reduction is the **route of administration** which strongly influences both **risk levels** and the **type of intervention needed**
- The **physical properties** of substances shape **risk profiles** and determine access to appropriate **harm reduction tools** (HRI, 2021).



UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Injecting Route

1. Needle and Syringe Programs (NSP)

NSPs are a **cornerstone of harm reduction**, providing **sterile injecting equipment** to prevent **blood-borne infections**.

Key insights:

- Available in **all EU countries + Norway**
- Only **7 countries meet WHO coverage targets** (200 needles/person/year)
- **Urban > rural access disparities**
- **Very limited access in prisons** (Spain, Luxembourg, 1 German facility)

Ongoing challenges:

- HIV outbreaks linked to **stimulant injection** (e.g. cocaine, methamphetamine)
- Need for **high-frequency access** and removal of restrictive policies (e.g. one-for-one exchange)

2. Opioid Agonist Therapy (OAT)

OAT (e.g. **methadone**, **buprenorphine**) reduces the need to inject and lowers **overdose risk**.

Key insights:

- Available in **all EU countries**
- **Uneven coverage**, especially in Eastern Europe
- **Interrupted access in prisons** increases post-release risks

Best practice: combine **OAT + NSP** in both **community and prison settings**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Injecting Route

3. Drug Consumption Rooms (DCRs)

DCRs offer **supervised, hygienic spaces** for safer use, preventing **fatal overdoses** and connecting people to care.

Key insights:

- Present in **13 EU countries + Norway**
- Expanding in **Portugal and Greece**
- Increasingly include **inhalation rooms** and **drug checking**

Evidence shows:

- No increase in **crime or drug use**
- Improved **survival rates** and **service engagement**

4. Overdose Prevention & Naloxone

Naloxone is a **life-saving opioid antagonist** that reverses overdoses.

Key insights:

- Community programs in **≥7 countries**
- Some countries allow **over-the-counter access**
- **Training gaps** remain for peers and frontline workers

Emerging challenge:

- **Synthetic opioids (e.g. fentanyl)** require **multiple doses + ventilation support**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Injecting Route

Examples:

Portugal

Outreach teams distribute naloxone with **peer training**

Growing integration into **national drug strategy**)**Local Practice**

Netherlands

The **gebruikersbus** by **De Regenboog Groep** in Amsterdam provides a **low-threshold, mobile HR service**:

- Safe space for **up to 6 people**
- **Hygiene, food, and rest facilities**
- **Safe disposal** of syringes
- Referrals to **care, shelter, and support services**

Helps reduce **public drug use** and improves **engagement with care**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Injecting Route

- **Cross-Cutting Challenges**
  - Limited harm reduction in prisons despite high need
  - Persistent access inequalities across regions
- **Gender & migration matter:**
  - Women face stigma, violence, and invisibility
  - Migrants face language barriers, legal fears, and limited access
- **Effective HR requires:**
  - Gender-responsive approaches
  - Culturally sensitive, low-threshold services
  - Peer-led outreach

Key Takeaways

- Injecting = highest-risk use → requires comprehensive HR response
- NSP + OAT = core interventions
- DCRs and naloxone save lives and improve access to care
- Coverage gaps and prison access remain critical issues
- Equity-focused approaches are essential

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Inhaled route

Inhalation (smoking or vaporizing) of psychoactive substances includes **crack cocaine**, **heroin (chasing the dragon)**, **methamphetamine**, **cathinones**, **cannabis**, and **synthetic cannabinoids**.

Although often seen as less risky than injecting, inhalation carries significant **health risks**, including:

- **Pulmonary damage**
- **Burns and oral injuries**
- **Tuberculosis (TB) transmission**
- **Overdose**, especially with **stimulants** or **adulterated substances**

In contexts like the **Dutch prison system**, inhalation is a **growing concern**, partly due to **dosage unpredictability** (e.g. substances on paper).

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Inhaled route

1. Safer Smoking Kits

Reduce harms linked to **improvised or shared equipment** and support **non-injecting practices**.

Typical contents:

- Heat-resistant **pipes** or foil
- **Personal mouthpieces**
- **Disinfectant wipes**

Impact:

- Prevent **cuts, burns, and infections (HCV, TB)**
- Reduce **equipment sharing**
- Support people with **damaged veins** or who prefer not to inject

Challenges:

- Limited availability
- **Legal barriers**
- **Funding gaps**

Beyond Equipment: Meaning & Practice

Providing materials alone is not enough:

- Pipes are not neutral tools → they carry cultural, personal, and symbolic meaning
- Use practices are shaped by experience, identity, and survival strategies

Effective harm reduction requires:

- Peer-informed education
- Respect for lived experience
- Co-creation of safer tools with users

Imposing a purely **biomedical approach** risks **exclusion** and **low uptake**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Inhaled route

2. Drug Consumption Rooms (DCRs) for Inhalation

Many **Drug Consumption Rooms (DCRs)** now include **ventilated inhalation spaces**.

Benefits:

- Reduce **public use** and **street-level risks**
- Lower exposure to **violence and criminalization**
- Improve access to **health and social services**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Inhaled route

3. Preventing Transition to Injecting

A key goal of inhalation-focused harm reduction is to prevent or delay injecting.

People may shift to injecting due to:

- Tolerance
- Economic pressure (more efficient use)
- Vein access issues
- Social influence

Evidence shows:

- Access to smoking kits + education reduces transition to injecting
- Early intervention supports safer consumption trajectories

Changing Visibility & Service Gaps

Inhalation is often **less visible** than injecting:

- No clear indicators like **discarded syringes**
- Use often occurs in **private or indoor settings**
- Leads to **underestimation of risks**

Implications:

- Harder **outreach and engagement**
- Gaps in **data and service design**
- Risk of **institutional neglect**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Sniffing Route

Commonly used for substances such as **cocaine hydrochloride**, **ketamine**, **amphetamines**, **synthetic cathinones**, and **crushed medications** (e.g. benzodiazepines, opioids).

This route leads to a **rapid onset of effects** due to the highly vascularized **nasal mucosa**, but also involves specific **health risks**:

- **Mucosal damage**
- **Nasal septum perforation**
- **Chronic sinusitis**
- **Infection transmission** (e.g. hepatitis C) through shared equipment

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Sniffing Route

1. Safer Sniffing Kits

Safer sniffing kits aim to reduce **injury and infection** linked to shared or improvised tools.

Typical contents:

- Individual **straws** (plastic, glass, cardboard)
- **Cards** for crushing substances
- **Saline spray** (or seawater)
- **Tissues + educational materials**

Impact:

- Reduce **nasal trauma**
- Prevent **sharing of equipment**
- Lower risk of **blood-borne infections** (via micro-blood particles)

Challenge:

- Limited availability, often only via grassroots or pilot programs

Beyond Equipment: Meaning & Use

Sniffing tools are not just functional:

- Often **self-made or improvised**
- Carry **cultural meaning, identity, and autonomy**
- Standard kits may feel **unnatural, stigmatizing, or controlling**

Effective harm reduction requires:

- **Co-design with users**
- Respect for **lived experience**
- Avoiding **one-size-fits-all approaches**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Sniffing Route

2. Nasal Hygiene & Education

Education is key to reducing long-term nasal harm.

Safer use practices:

- **Finely crush** substances → less abrasion
- **Alternate nostrils** during use
- Avoid use when there is **bleeding or wounds**
  Use **saline rinse after consumption**
- **Moisturize nasal passages** to prevent cracks

Peer-led education can significantly reduce cumulative damage

3. Dosing & Risky Combinations

The rapid onset of snorted substances can lead to repeated dosing and binge patterns.

Key risks:

- Frequent redosing → increased toxicity
- Combining stimulants with depressants (e.g. alcohol, benzodiazepines)
- Masked overdose symptoms

Example:

- Alcohol + cocaine → cocaethylene, increasing cardiotoxicity

Harm reduction should promote:

- Dosing awareness
- Safer pacing
- Access to drug checking services

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Sniffing Route

Key Takeaways

- Sniffing = fast effects but specific health risks
- Sharing equipment increases infection risk
- Safer sniffing kits are effective but underprovided
- Hygiene and education are essential
- Binge use and drug combinations increase harm
- User involvement improves effectiveness of interventions

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Oral Route

The **oral route** means the ingestion of pills, liquids, edibles, or powders and is one of the most **common and socially accepted** forms of substance use.

It applies to a wide range of substances, including **opioids**, **stimulants**, **depressants**, **psychedelics**, and **synthetics**.

- Slow onset of effects (30–90 minutes), combined with longer-lasting impact.
- Key risk: Unintentional overdose due to premature re-dosing. Especially relevant for substances like MDMA, LSD, GHB/GBL, and synthetic opioids

Safer practices:

- Wait at least 60–90 minutes before re-dosing
- Build body awareness
- Start with low doses

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Oral Route

1. Accurate Dosing (Capsules & Liquids)

Precision matters in oral use.

Recommended tools:

- **Gelatin capsules** → controlled, hygienic dosing
- **Droppers / oral syringes** → essential for liquids (e.g. GHB/GBL)

Risks of unsafe methods:

- "Eyeballing" doses
- Using improvised wraps (e.g. paper)
  → **Uneven dosing & overdose risk**

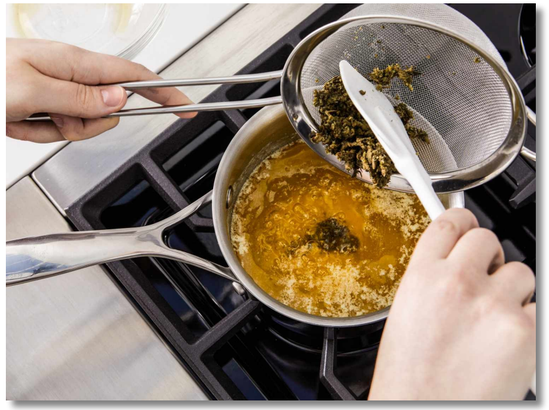
2. Edibles & Natural Substances

Edibles (e.g. cannabis) and **psychedelic mushrooms** pose specific risks:

- **Delayed onset + long duration** (up to 8+ hours)
- High risk of **overconsumption**

Safer practices:

- Use **accurate scales**
- Understand **dosage thresholds**
- Educate on **preparation and potency**



UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Oral Route

3. Hydration & Environment

Substances like **MDMA** and **methamphetamine** can cause:

- Dehydration
- Overheating
- Electrolyte imbalance

Harm reduction should promote:

- Regular hydration
- Cooling down
- Awareness of serotonin syndrome

4. Polyconsumption & Interactions

Oral use is often combined with other substances, increasing risks.

Common dangerous combinations:

- Alcohol + benzodiazepines
- Opioids + pregabalin
- Stimulants + antidepressants

Possible outcomes:

- Respiratory depression
- Sedation
- Toxic overload

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Oral Route

5. Social Patterns & Inequalities

The oral route is shaped by **context and accessibility**:

- Shifts from illegal → **legal substances** (e.g. alcohol, medication)
- Driven by **stigma**, **cost**, or **availability**

These shifts are **not necessarily safer** and may increase:

- **Dependence**
- **Organ damage**

6. Gender, Autonomy & Invisibility

Oral use is often more **discreet**, making it more common among:

- Women
- Gender-diverse people
- People in vulnerable situations

Risks:

- **Under-recognition by services**
- **Hidden harms**

Needed:

- Gender-sensitive approaches
- Peer-led support
- Integration with reproductive health services

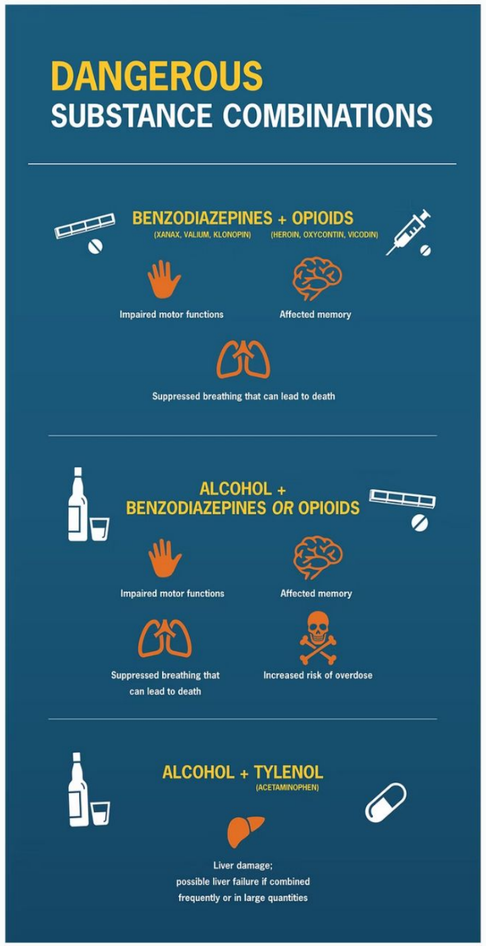
UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

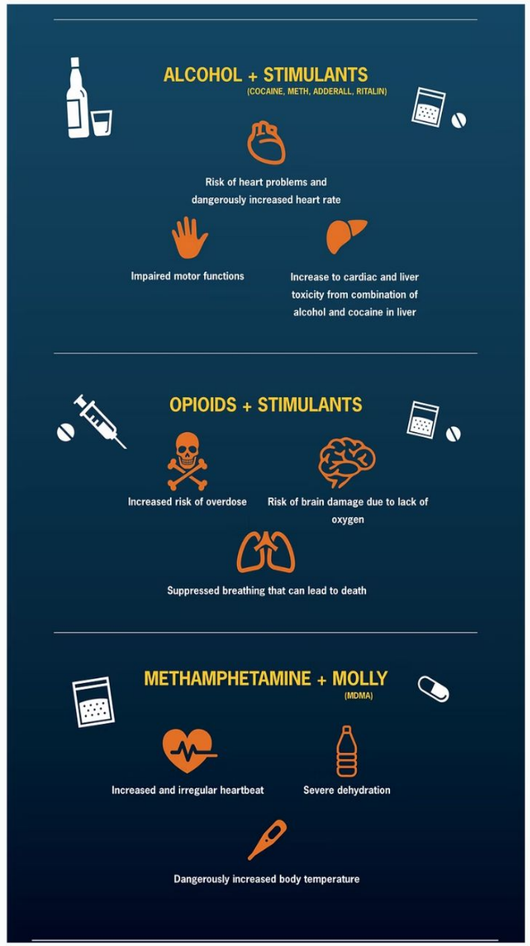
SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Sniffing Route

Key Takeaways

- Oral use = common but not low-risk
- Delayed onset → major overdose risk
- Accurate dosing tools are essential
- Edibles and liquids require extra caution
- Poly-use significantly increases harm
- Invisible use → risk of neglect → adapt services





UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

ACTIVITY 4.3 - VIDEO FORUM: MATERIAL FOR SAFER CONSUMPTION SHOWCASE

Activity

- Spin the wheel, which contains several questions about the use of psychoactive substances.

Video Screening

Watch the videos on the next page.

Try to observe practical strategies and contextual factors.

Please reflect on and write down:

- What surprised you the most.
- New strategies you learned.
- Barriers faced by the people in the videos.
- How these ideas could be adapted to your local context.
- Any misunderstandings you were able to clarify and recurring themes you noticed.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

- *EMCDDA webinar: Drug consumption rooms in Europe* – https://www.youtube.com/watch?v=3P52cjmD_qM
- *Lessons from the Field: Safer Smoking Supplies* – https://www.youtube.com/watch?v=RuwUrtfESIA
- *Ireland's First Safe Injection Rooms* – https://www.youtube.com/watch?v=_3cP1yqBzFI
- *Drug Consumption Rooms Around the World* – https://www.youtube.com/watch?v=m3tZPxKoqPM
- *Safer smoking: Using aluminum foil to reduce risks* – https://www.youtube.com/watch?v=WrhNmO5aN9o

UNIT 2:

SECTION 2

MORE HARM REDUCTION STRATEGIES

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Drug Checking

Drug checking is a **harm reduction intervention** that allows people to test the **content, composition, and potency** of substances before use. It can identify:

- **Active substances**
- **Adulterants (cuts)**
- **Unexpected compounds**
- **Strength/potency**

Originally linked to **nightlife settings**, drug checking is now recognized as **essential in urban and vulnerable contexts**, especially where **polyuse** and **street-based markets** are common (Measham, 2020; EMCDDA, 2021).

Why Drug Checking Matters

For people in **situations of exclusion** (e.g. homelessness, mental distress):

- Limited ability to **choose or question dealers**
- Higher exposure to **unknown substances**
- Increased risk of **harm and overdose**

Drug checking provides:

- **Accessible, anonymous, non-punitive services**
- **Knowledge instead of blame**
- Tools for **informed decision-making**

(Aranda-Rodriguez, 2022; Vidal Giné et al., 2021)

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Drug Checking

Novel Psychoactive Substances (NPS)

The rise of **Novel Psychoactive Substances (NPS)** makes drug checking **life-saving**:

- Often sold as **common drugs** (MDMA, cocaine, benzodiazepines)
- **No visible difference** to users
- **High potency & unpredictable effects**

Examples of risks:

- **Levamisole in cocaine** → immune damage
- **Caffeine in MDMA** → cardiovascular stress
- **Synthetic cannabinoids** → severe mental health risks
- **Nitazenes in fake opioids** → extreme overdose risk

Example: Alerts in the Netherlands about **fake oxycodone with nitazenes** (Trimbos Institute, 2024)

From Testing to Communication

Drug checking is not just about results — it's about **how results are communicated**.

Effective services provide:

- Clear explanation of risks and effects
- Information on interactions
- Tailored advice (safer use or avoidance)

A **non-judgmental, respectful dialogue** builds:

- Trust
- User engagement
- Self-protection capacity

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Drug Checking

Rapid Test Strips (Fentanyl & Nitazenes)

Rapid test strips are transforming drug checking:

- Detect **fentanyl** and **nitazenes**
- Work on **powders, pills, residues**
- Provide **fast, low-cost results**

Critical because:

- Synthetic opioids are appearing in **non-opioid markets**
- Users may be **unaware of exposure**

Now considered a **frontline overdose prevention tool**, especially in:

- Community outreach
- Public use settings
- Peer-led interventions

Key Takeaways

- Drug checking = informed, safer decision-making
- Essential beyond nightlife → crucial for vulnerable populations
- NPS and adulterants increase unpredictability and risk
- Communication & trust are as important as testing
- Test strips are a scalable, life-saving innovation

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Take-home Naloxone

Take-home naloxone (THN) programs are a highly effective **harm reduction intervention** to prevent **opioid overdose deaths**. **Naloxone** is an **opioid antagonist** that reverses **respiratory depression** — the main cause of overdose death — within minutes when administered **intranasally** or **intramuscularly**.

THN places this **life-saving medication** in the hands of:

- **People who use opioids**
- **Peers and family members**
- **Frontline workers**

Why THN works The core principle is simple:

Overdose deaths are preventable — and often witnessed

THN enables:

- **Immediate response** before emergency services arrive
- **Decentralized care** (community-based action)
- Increased **survival rates**

Evidence shows THN:

- **Reduces mortality**
- Improves **speed and effectiveness of response** *(WHO, 2014; McDonald & Strang, 2016)*

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Take-home Naloxone

Case Example: Catalonia

The **Catalan Naloxone Program** (since 2009) is a leading example of **integrated THN implementation**:

Key features:

- **low-threshold services** (harm reduction centres, outreach, treatment)
- **Wide distribution** of naloxone kits
- **Brief, practical training** (recognition + response)

What makes it strong:

- Embedded in a **public health system**
- Continuous **monitoring & evaluation**
- **Tailored training** for different groups
- Focus on **trust & non-judgmental communication**
  (Ventura et al., 2018)

Peer-Based Impact

A key success factor is the **peer approach**:

- Many overdose reversals are done by people who use drugs themselves
- Users are treated as active agents of care

Effects:

- Reduces stigma
- Builds community capacity
- Strengthens engagement

Important insight:

- THN works **without requiring abstinence**

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Take-home Naloxone

Emerging Risks: Synthetic Opioids

The rise of **synthetic opioids** (e.g. fentanyl) increases urgency:

- **Extremely potent**
- Often found in **adulterated heroin or fake pills**
- May require **multiple naloxone doses**

Example:

- In the U.S., fentanyl drives **tens of thousands of deaths annually**

European programs (e.g. Catalonia) now include:

- **Fentanyl-specific training**
- **Preventive education**

Key Takeaways

- THN = simple, life-saving intervention
- Naloxone reverses overdose within minutes
- Peers are critical responders
- Community distribution saves lives
- Synthetic opioids increase urgency and complexity

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Managed Alcohol Programs

Managed Alcohol Programs (MAPs) are a **harm reduction intervention** for people with **severe alcohol dependence**, especially those experiencing **homelessness** or **extreme marginalization**. Alcohol is often the **most common substance associated with long-term homelessness**.

Instead of requiring abstinence, MAPs provide **controlled doses of alcohol** at regular intervals in a **supervised setting**.

Core goal: **stability, safety, and engagement with care**

MAPs reduce harm by:

- Stabilizing **consumption patterns**
- Preventing **withdrawal risks**
- Reducing **binge drinking**
- Avoiding **non-beverage alcohol use** (e.g. hand sanitizer)
- Connecting people to **health and social services**

Evidence & Impact

A strong evidence base shows MAPs lead to:

↓ Hospital admissions
↓ Emergency service use
↓ Criminal justice contact
↓ Use of toxic alcohol substitutes

And improvements in:

- Quality of life
- Mental health
- Housing stability
- Social reintegration

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Managed Alcohol Programs

Case Example: Ireland (Dublin Pilot)

The Irish MAP (2021–2022) targeted people:

- With **severe dependence**
- Not benefiting from **abstinence-based services**
- At high **risk of harm**

Program features:

- **Private rooms** in supported housing
- Alcohol doses every **90 minutes**
- Access to:
  - **Medical care**
  - **Psychosocial support**
  - **Meals & case management**

Results:

↓ Overall alcohol consumption

↓ Hospital admissions

↑ Medication adherence

↑ Sleep & wellbeing

No return to rough sleeping

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Managed Alcohol Programs

Role of Frontline Workers

Frontline workers are central to MAP success:

- Build **trusting relationships**
- Monitor **health and safety**
- Provide **non-judgmental support**
- Facilitate access to **care pathways**
- Balance **structure with autonomy**

Their role shifts from control → **support, engagement, and harm reduction**

Addressing Criticism

MAPs are sometimes criticized for "enabling" use. This overlooks key realities:

- **Abstinence is not always safe or realistic**
- Unmanaged use leads to:
  - **Overdose risk**
  - **Health deterioration**
  - **Repeated crisis cycles**

MAPs instead offer:

- **Structure and predictability**
- **Reduced harm**
- A pathway to **stability and care**

Key Takeaways

- MAPs = harm reduction, not abstinence-based care
- Focus on stability, dignity, and engagement
- Strong evidence of reduced harm and improved wellbeing
- Frontline workers are essential for trust and delivery
- MAPs can act as a gateway to recovery and housing stability

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Psychoeducation and Emotional Support for Psychedelic Use

Psychedelics such as LSD, psilocybin, mescaline and 2C-B are generally not associated with physical dependence, but they can produce **intense and unpredictable psychological experiences**. Effects like altered perception, emotional release, or anxiety are strongly influenced by **"set and setting"**—a person's mindset and environment. For this reason, harm reduction focuses not only on substances, but on **preparation, support, and integration**.

Core Harm Reduction Approach

Rather than only giving pharmacological information, effective support combines **psychoeducation and emotional accompaniment**:

- Preparing people before use (expectations, duration, environment)
- Supporting them during difficult experiences
- Helping them process and integrate afterwards

This approach reduces the risk of so-called "bad trips" and can turn challenging experiences into meaningful ones.

Key Practices for Safer Use

A few essential principles are consistently emphasized:

- **Understand duration and intensity** → avoid unexpected long experiences
- **Choose a safe, familiar setting** → calm environments reduce anxiety
- **Be with trusted people** → social safety is critical
- **Avoid use during emotional instability**
- **Do not mix with alcohol or stimulants**
- **Use grounding strategies** → hydration, breathing, music, rest
- **Have a sober "sitter" present** for reassurance if needed

These practices are simple, but highly effective in preventing escalation of distress.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Psychoeducation and Emotional Support for Psychedelic Use

Example: Kosmicare

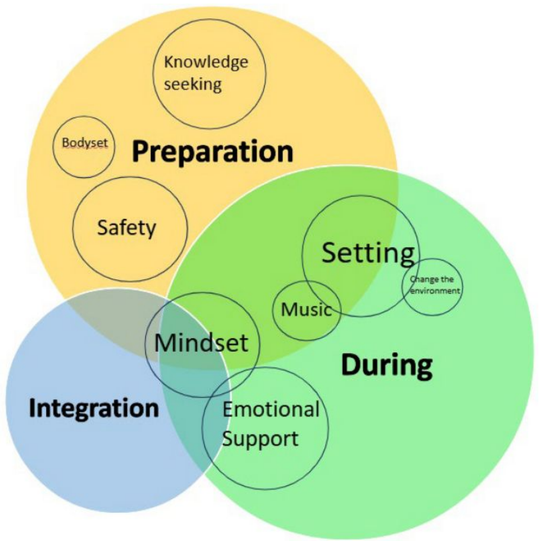
Kosmicare is a pioneering harm reduction initiative from Portugal.

- Founded in 2002, initially at **Boom Festival**
- Provides **non-medical emotional support spaces** at festivals
- Supports people during difficult psychedelic experiences
- Uses **empathetic listening, calm presence, and reassurance** instead of coercion

At festival settings, Kosmicare creates dedicated "safe spaces" where individuals can recover from overwhelming experiences with trained volunteers. The focus is on **containment, acceptance, and human connection**, rather than control.

Why This Matters

- Challenging psychedelic experiences are **not rare**, but they are manageable
- Emotional support can **prevent escalation into panic or trauma**
- Proper guidance can transform distress into **insight and personal meaning**
- Services like Kosmicare show that **care-based responses are effective and scalable**



Key Takeaways

- Psychedelic harm reduction is not just about the substance—it is about people, context, and care. By combining knowledge, preparation, and compassionate support, risks can be significantly reduced while preserving the potential for meaningful experiences.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 1 - TYPES OF ROUTES OF ADMINISTRATION OF PSYCHOACTIVE SUBSTANCES

Responding to Stimulant-Induced Psychosis

Stimulant use can lead to **acute psychiatric symptoms** such as paranoia, hallucinations, agitation, and severe anxiety. In some cases, this develops into **stimulant-induced psychosis**, a condition resembling schizophrenia but directly linked to substance use.

These episodes are often intensified by **sleep deprivation, trauma, unsafe environments, and social isolation**, especially among people experiencing homelessness.n.

Challenges in Traditional Responses

Conventional mental health systems often struggle in these situations:

- People may be **fearful, distrustful, or disoriented**
- Interventions can escalate quickly (e.g., police involvement, restraint)
- Experiences of coercion can **increase trauma and distrust**

From a harm reduction perspective, these responses risk worsening the crisis rather than resolving it.

Harm Reduction Approach: De-escalation and Presence

Frontline harm reduction services offer a more grounded and effective model, centered on:

- **Calm presence and non-threatening communication**
- **Reducing stimuli** (noise, light, crowding)
- **Providing safe, quiet spaces**
- **Maintaining trust and connection**
- **Avoiding unnecessary coercion**

The focus is not on control, but on **stabilization and emotional safety**.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Responding to Stimulant-Induced Psychosis

Practice Example: CAS Baluard

In Barcelona, **CAS Baluard** has developed practical, low-threshold responses to rising cases of stimulant-induced psychosis:

- Offers **safe shelter during acute episodes**
- Uses **simple, respectful language** to reduce paranoia
- Maintains **visual presence without intrusion**
- Prepares individuals emotionally if hospital care is needed

Rather than pathologizing behavior, the team prioritizes **containment, dignity, and relationship-building**.

CAS BALUARD

Continuity of Care

Support does not end after the crisis:

- Accompaniment to follow-up care and services
- Brief psychological support after stabilization
- Access to **low-demand or supported housing**
- Involvement of **peer workers and outreach teams**

Early recognition of distress and trust-based intervention can prevent escalation.

Key Principle

Even in moments of severe psychological distress, the person remains central.

Psychosis does not erase agency—it calls for **adapted, compassionate care grounded in safety, trust, and dignity**.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Cannabis Social Clubs

Cannabis Social Clubs (CSCs) are non-profit associations where adult members collectively **cultivate, distribute, and consume cannabis** within a **closed and regulated network**. Originating in Spain, this model has expanded across Europe as a **community-based alternative** to prohibition and unregulated markets (Decorte, 2015).

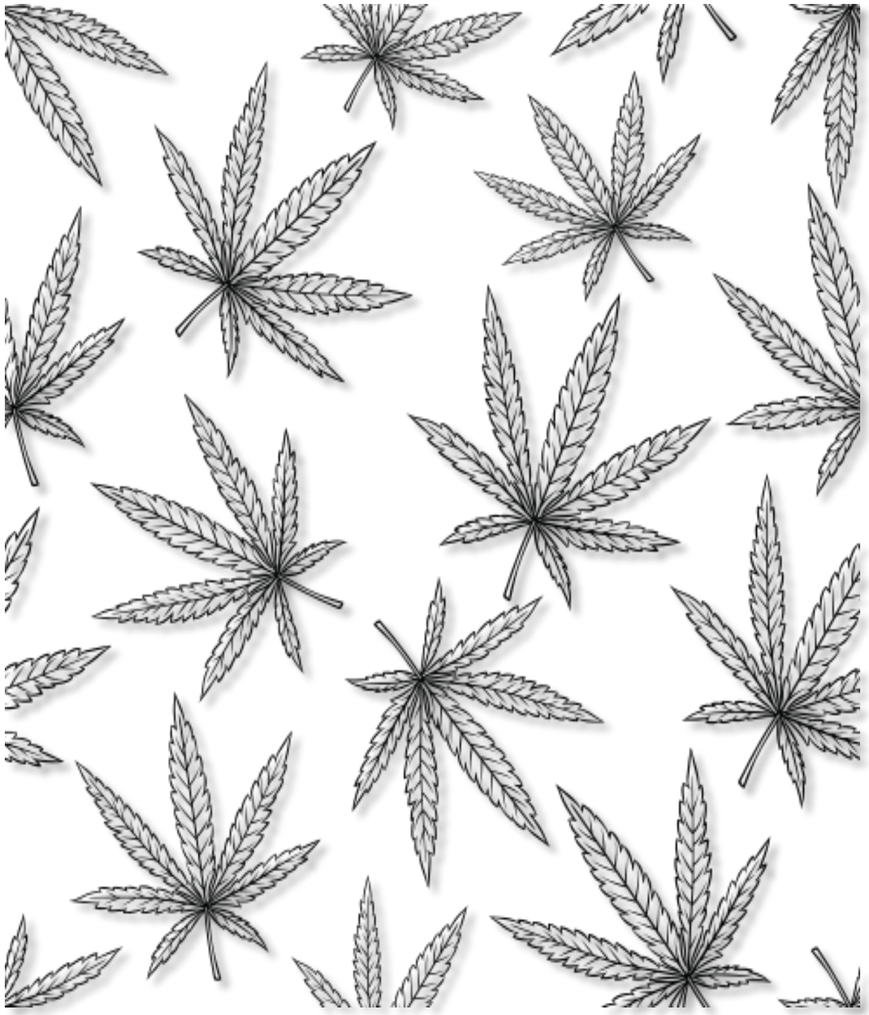
CSCs aim to reduce harms such as **criminal market exposure, unknown potency, and contaminated products**, while promoting **public health, transparency, and safer use**.

Core Principles

CSCs operate under clear ethical guidelines:

- **Members-only access** (closed circuit)
- **Non-profit and limited production** (personal use only)
- **Transparency and accountability**
- **Public health over profit**

Many clubs also provide **education on responsible use**, including alternatives to smoking and support for problematic consumption.



UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Cannabis Social Clubs

Policy Example: Amsterdam Pilot

A related regulatory approach is the Dutch **"closed coffee shop chain" experiment**, now piloted in serveral Dutch cities. This model addresses a long-standing contradiction: cannabis sale was tolerated, but supply remained illegal.

Key features of the pilot (2023–2024):

- **Controlled, legal cultivation** under government oversight
- **Traceable supply chain** (seed to sale)
- **Lab-tested cannabis** (THC/CBD levels, no harmful pesticides)
- **Distribution to licensed coffee shops only**
- **User education on risks and responsible use**

The pilot (WODC, 2023; Government of the Netherlands, 2023) evaluates impacts on **public health, user experience, and organized crime**.

Harm Reduction Impact

From a harm reduction perspective, CSCs and similar models:

- Reduce reliance on the **unregulated market**
- Ensure **quality control and safer products**
- Enable **clear dosage information (THC/CBD)**
- Create space for **education and prevention**
- Support **informed, lower-risk consumption choices**

Key Insight

CSCs show that **regulation without commercialization** is possible.
By prioritizing **health, safety, and community accountability**, they move cannabis policy from ambiguity toward **evidence-based and transparent systems**.

UNIT 2:

SECTION 3

PEER WORK PERSPECTIVE

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 3- PEER WORK PERSPECTIVE

Peer Work in Harm Reduction: A Multilevel Strategy

Peer work in harm reduction is **not an add-on**.
It is a **core, multilevel strategy** that improves:

- Effectiveness
- Reach
- Equity

Peer workers (people with lived experience of substance use) operate across:

- Individual level
- Community level
- Service level
- Policy level

Their role is **not only supportive** — it is **transformative**, especially in substance-specific strategies (see Section 2).

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 2- MORE HARM REDUCTION STRATEGIES

Individual Level: Trust & Safer Practices

Peers are often the **first point of contact**.

They create:

- **Trust**
- **Non-judgmental spaces**
- **Mutual recognition**

This is essential for introducing harm reduction strategies:

Take-home naloxone

- Peers distribute naloxone
- Explain use through **real-life overdose experiences**
- Make the process clear and accessible
- Reinforce: *people who use drugs can save lives — including their own*

Psychedelic support

- Peers provide **emotional accompaniment**
- Example: Kosmicare model
- Offer calm presence during intense experiences
- Support people in **altered states of consciousness**

Safer use education

Peers share practical, experience-based tips on:

- Dose management
- Hydration
- Pacing
- Sleep

Especially relevant for:

- Stimulant use
- Chemsex contexts

Grounded in:

- First-hand knowledge of effects
- Risk moments
- Coping strategies

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 3- PEER WORK PERSPECTIVE

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**, **novel substances** like **nitazenes**) and help integrate strategies into **community routines**:

- **Drug checking**: Peers interpret **test results** in **accessible language**, discuss **adulterants** (e.g., **levamisole**, **synthetic cannabinoids**), and facilitate **informed decisions** about consumption. They also help identify when people feel **ashamed** or **afraid** to engage.
- **Smoking and sniffing kits**: Peers explain **safe use** of pipes, foil, or snorting straws, validate **user improvisations**, and promote **hygiene** without moralizing. Their guidance reduces **transitions to injecting** and prevents **infection**.
- **Polydrug education**: Peers share insights on **substance combinations**, 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** for those who do not want to stop drinking, and encourage **daily routines** that improve **stability**.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 3- PEER WORK PERSPECTIVE

Organisational Level: Service Design, Accessibility and Continuity

Inside **services**, **peers** support **low-threshold**, **person-centred interventions**. Their input ensures 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 for **crack** or **meth smoking**, peers explain **ventilation**, **mouthpiece hygiene**, and **overdose risks**. They also provide **grounding** after **high-dose use**.
- **Encapsulated dosing and oral strategies**: Peers advise on **measuring** and **timing doses**, especially for **MDMA, GHB, or mushrooms**. They explain **delayed onset effects** and how to avoid **re-dosing mistakes**.
- **Sniffing hygiene**: Peers teach 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 of care**, **following up** with users across contexts and helping them **return to services** after **interruptions or crises**.

UNIT 2 – HARM REDUCTION STRATEGIES FOR PSYCHOACTIVE SUBSTANCE USE

SECTION 3- PEER WORK PERSPECTIVE

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 shapes **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 market shifts** (e.g., **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.
- **Advocacy**: Networks like **EuroNPUD** or **LANPUD** promote **decriminalization**, **housing rights**, and **legal protections**, ensuring harm reduction includes **social justice**, not just health.

UNIT 3:

HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 1 - INTRODUCTION TO SITUATIONS OF HOMELESSNESS

Across Western countries, homelessness is increasing (FEANTSA, 2023). This is not an individual failure, but the result of **intersecting structural crises**:

In this context, psychoactive substance use is often not a moral choice, but a **functional survival strategy**:

- Staying awake to avoid violence
- Numbing pain, cold, or trauma
- Coping with stress and isolation
- Creating routine in an unpredictable environment

Implications for Harm Reduction

- Harm reduction must go beyond purely biomedical or behavior-change models
- Interventions must respond to **material living conditions**: instability, hunger, trauma, exposure
- Criminalization and exclusion reinforce a vicious cycle of homelessness and risk

*Harm reduction in contexts of homelessness is not a side issue — it is central to advancing **health equity and human dignity**.*

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

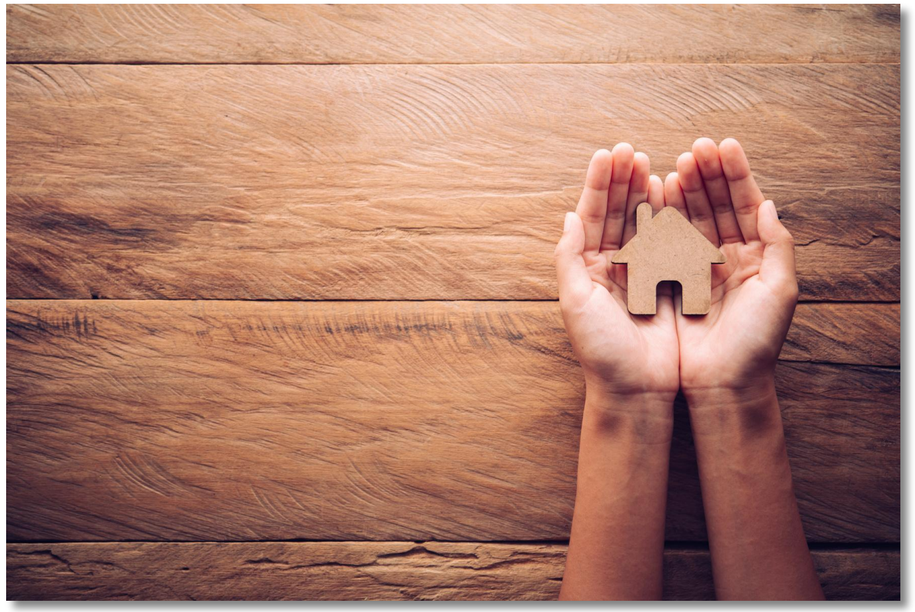
SECTION 1 - INTRODUCTION TO SITUATIONS OF HOMELESSNESS

Key Characteristics of Harm Reduction in Homeless Contexts

Harm reduction in homelessness 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 **person-centered**, meeting individuals **where they are** in their homelessness, mental health, and/or substance use journey.



UNIT 3:

SECTION 2

HARM REDUCTION IN CASES OF HOMELESSNESS

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Outreach Teams (1)

For people experiencing homelessness, **outreach is often the only point of access to care**.

What outreach does

- Distributes **harm reduction supplies** (sterile equipment, naloxone, safer-use kits)
- Provides **emotional support and overdose response**
- Offers **informal advocacy and community education**

Outreach is built on **presence, repetition, and trust**.

Why it matters

- Reduces **stigma** through consistent, empathetic engagement
- Protects **public health and dignity**
- Mediates **community tensions (NIMBY)**
- De-escalates interactions with **law enforcement** and promotes **non-punitive responses**

Key message:
Mobile harm reduction is not just service delivery — it is frontline public health, stigma reduction, and human rights practice.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Outreach Teams (2)

- Example: In **Cork**, *Cork Simon* trains **Community Safety Wardens** to promote constructive engagement with homeless people and drug-related issues
- Bridges safety initiatives and **harm reduction principles**

Reaching the Most Excluded

Outreach connects with **structurally excluded groups**, including:

- Women and trans people
- Undocumented migrants
- People with severe mental health needs or histories of institutional violence

Teams:

- Detect early crisis signals
- Respond to wounds and overdoses
- Provide referrals and accompaniment
- A Street-Based Practice
- Built on relational skills and everyday trust-building
- Requires constant risk assessment and adaptation
- Operates in policed and unstable environments
- Grounded in trauma-informed and culturally competent approaches

Key message:
Effective outreach is adaptive, relational, and inclusive — combining frontline crisis response with long-term trust-building in complex public spaces.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Shelter Inclusion and Low-Threshold Housing Models

Access to **stable housing** is central to harm reduction — yet many systems still operate through **punitive or abstinence-based models**. This creates a structural paradox:

> People are excluded from housing because they use drugs — and continue using because they lack housing.<

Structural factors such as **housing market liberalization, gentrification, and migration restrictions** further limit access, especially for people with **irregular status**, who are often confined to temporary night shelters without continuity.

Most shelters remain

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Shelter Inclusion and Low-Threshold Housing Models

Access to housing is central to reducing drug-related harm. Promising models show that **housing does not need to be conditional on abstinence**.

Positive Practice Examples

- **CRI Galena (Barcelona)**: housing support, supervised consumption, MAP, trauma-informed care — designed with community input and focused on safety and continuity.

- **É UMA CASA – Lisboa Housing First (CRESCER)**: immediate, permanent housing with 24/7 support, no sobriety or documentation requirements, and housing fully separated from treatment.

These programs integrate **targeted harm reduction at home** (sterile equipment, naloxone, home-based testing, safer-use support) to promote **stability, safety, and self-determined recovery**.

Stable housing without coercion is one of the most effective harm reduction interventions available.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

24/7 Service Coverage

For people living in street-based conditions, survival does not follow office hours. Limited service schedules create **structural gaps** that increase risk.

Why 24/7 access matters

- Crises and overdoses often happen **at night**
- Many avoid daytime services due to **stigma or anxiety**
- Night hours are critical for **women, trans people, and people leaving prison**

Providing continuous access through **mobile outreach, night shelters, and low-threshold centers** reduces preventable harm and aligns services with the real rhythms of life on the street.

Harm reduction must adapt to people's realities — not expect people to adapt to institutional schedules.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

24/7 Service Coverage

Continuous harm reduction requires **uninterrupted access to safer use materials** and **safe spaces at any hour**.

- 24/7 availability of sterile equipment and naloxone reduces infections, overdoses, and high-risk coping strategies.
- All-hours supervised consumption sites provide emergency response, emotional support, and trauma prevention.

For **women and LGBTIQ+ people**, night-time access is especially vital, creating protection in contexts marked by violence and exclusion.

Reliable, round-the-clock harm reduction is both a public health intervention and a safety net for those most exposed to harm.

Around-the-clock harm reduction strengthens **continuity between street outreach and formal services**, enabling follow-up after crises and aligning care with people's real-life rhythms.

- Provides safety, warmth, rest, and ongoing access to naloxone and support.
- Prevents harm caused by service "closing hours," especially for people sleeping rough.

The lack of 24/7 services often reflects **efficiency-driven systems**, rather than equity-driven responses.

Continuous harm reduction is not a luxury — it is essential for equitable, life-saving care.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Managed Alcohol Programs (MAPs)

Managed Alcohol Programs (MAPs) are **harm reduction interventions** for people with **severe alcohol dependence**, particularly those who are **unhoused or chronically excluded**. Unlike **abstinence-based models**, MAPs provide **measured doses of beverage alcohol** at regular intervals in a **supervised, structured, and supportive environment**, often integrated within **housing facilities**.

When embedded in housing, MAPs provide more than symptom control — they offer **stability, dignity, and reconnection**. They aim to:

- Prevent **life-threatening alcohol withdrawal**
- Reduce **non-beverage alcohol consumption**
- Limit **binge drinking and public high-risk use**
- Increase engagement with **health and social care systems**
- Promote **daily structure and trust-building**

Housing-based MAPs recognize that alcohol use can serve a **functional survival role** (coping with trauma, loneliness, emotional regulation). By removing **chaos and criminalization**, they create a contained environment for **gradual harm reduction without coercion**.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Managed Alcohol Programs (MAPs)

Evidence Base

- **Ireland's National Pilot MAP (2021–2022)** (McCann et al., 2024): improved health, reduced emergency service use, better sleep, nutrition, and medication adherence; strengthened trauma-informed engagement.
- **Barcelona MAP pilot (ABD & Public Health System)** (Filomena-Velandia et al., 2024): reduced emergency healthcare use, improved emotional wellbeing, strong user satisfaction, and demonstrated **cost-effectiveness**.

From a housing rights perspective, MAPs challenge **moralizing shelter models** and affirm that **housing and harm reduction are mutually reinforcing**.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Mobile Units in Dispersed and Non-Urban Areas

In many peri-urban, industrial, or semi-rural territories, substance use does not take place in visible city centers. Instead, it unfolds in **abandoned factories, forest areas, roadside peripheries, or informal settlements**, often far from infrastructure and completely disconnected from health and social services. In these areas, there are no fixed harm reduction centers—only distance, invisibility, and risk.

In this context, **mobile harm reduction units** are not an accessory to the system; they are the system. Vans, outreach vehicles, or temporary pop-up points may be the only public health presence for kilometers. They provide sterile equipment, overdose prevention, naloxone distribution, first aid, and emotional support—often to people who are entirely outside institutional statistics and have no other contact with care structures.

Their role is not only operational, but **territorial and relational**. Mobile teams:

- Reach people who avoid urban centers due to policing or stigma
- Adapt routes after evictions or police displacement
- Respond to seasonal or shifting consumption patterns
- Build long-term presence in unstable environments

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Mobile Units in Dispersed and Non-Urban Areas (2)

In agricultural zones, industrial outskirts, or areas with high migratory turnover, substance use can appear suddenly and without warning. Fixed-site models cannot respond fast enough. Mobile units offer **flexibility, continuity, and local knowledge**, allowing harm reduction to move with the people it seeks to support.

These environments also present complex challenges. Many people encountered may have no phone, no identification, no health coverage, and deep mistrust of institutions. Physical and psychological deterioration may be advanced, and group dynamics can involve violence, dependency, or silence. In such conditions, engagement requires **time, patience, and repeated presence**. The vehicle becomes more than transport—it becomes a recognizable and safer point of contact.

In territories without fixed facilities, the mobile unit may be the only opportunity to:

- Reverse an overdose
- Identify untreated wounds or infections
  Provide accurate health information
- Ask someone how they are, without judgement

For women, trans people, and racialized communities in isolated areas, it may also be the only space where they are treated with dignity and listened to without suspicion.

Mobile harm reduction in dispersed areas is not just about delivering materials. It is about **making care geographically possible** in places where abandonment has become normalized.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

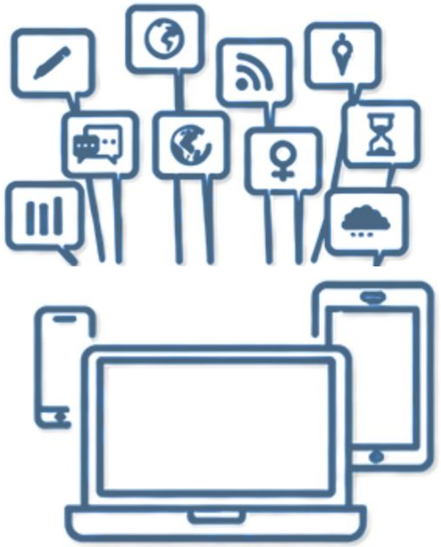
SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Harm Reduction and Digital Rights

In contexts of homelessness and drug use, **digital access** is often overlooked, yet it is essential for **harm reduction, safety, and social inclusion**. For people living on the street or in unstable housing, the ability to charge a phone, connect to Wi-Fi, or use a device can mean staying in contact with family, reaching support services, or simply staying safe.

Low-threshold services increasingly recognize that offering **phone charging and internet access** is not a luxury but a basic support. Without digital connection, people risk becoming **institutionally invisible**—missing medical appointments, housing updates, legal procedures, or social benefits.

At the same time, the digitalization of bureaucracy creates new barriers. Systems expect people to download documents, manage emails, or confirm appointments through apps, while ignoring that they may not have a working phone, data credit, or a safe place to charge it. A **lost SIM card**, **broken screen**, or **forgotten password** can suddenly block access to housing, healthcare, or legal rights. In this way, digital systems can unintentionally reproduce stigma and exclusion.



UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Harm Reduction and Digital Rights

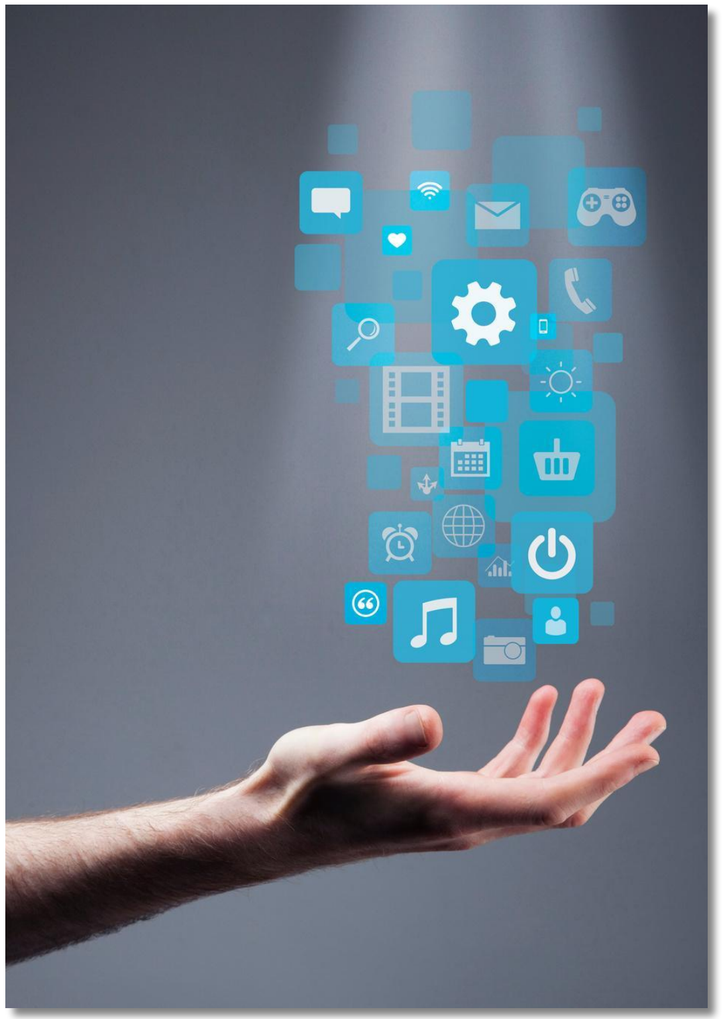
Digital access is also a direct harm reduction tool. It allows people to:

- receive alerts about contaminated substances
- find nearby services and safer-use information
- stay connected with outreach workers or peer networks
- regulate stress through music, videos, or games

For younger people, women, and LGBTIQ+ users, digital connection may be a vital link to safer support networks when immediate environments feel unsafe.

Despite this, many programs still do not see connectivity as part of care. Yet simple actions—**safe charging points, free Wi-Fi, help with online forms or passwords**—can greatly improve continuity of care, autonomy, and dignity.

In short, digital access is not an extra service. It is part of **modern harm reduction**, helping people stay connected, informed, and safe while supporting their right to participate fully in society.



UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Hygiene, Privacy and Body Care

In harm reduction work with people who use drugs and live on the street, **hygiene and privacy** are often treated as secondary needs. In reality, they are essential to **physical health, emotional well-being, and dignity**. Without access to showers, toilets, laundry, menstrual supplies, or safe places to rest, people cannot care for their bodies—or even recognize early signs of illness.

Across many European cities, public infrastructure for hygiene has been reduced: toilets are scarce or paid, and showers or laundry often require navigating charity systems that may impose moral judgement or abstinence conditions. For people experiencing homelessness, simple routines like brushing teeth, washing clothes, or managing body odor become daily struggles. Over time, this affects not only social perception but also **self-image and mental health**, reinforcing shame and isolation.

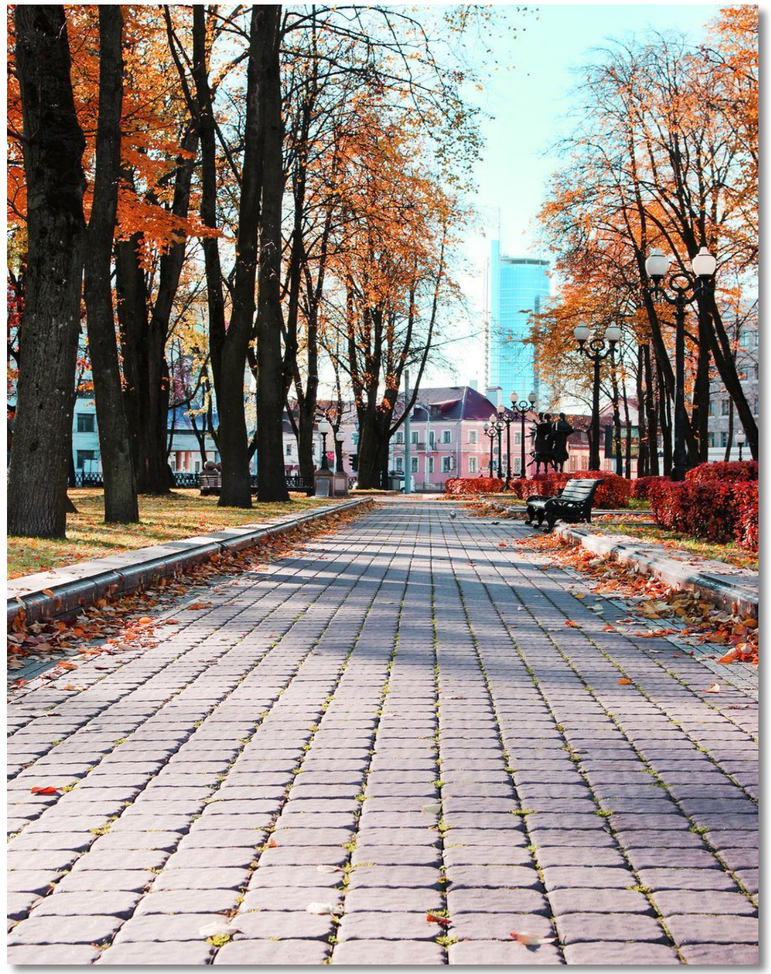
UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Hygiene, Privacy and Body Care (2)

For women, trans people, and gender-diverse users, these challenges are often intensified. Menstrual health while homeless is rarely discussed but deeply impactful. Substance use may disrupt menstrual cycles, and without private places to change products or wash safely, risks of infection increase and people may become further disconnected from their own bodies.

This situation feeds harmful stereotypes about people who use drugs being “unclean” or “irresponsible,” when in reality the barrier is structural. The problem is not a lack of motivation—it is the **absence of safe conditions for self-care**.



UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Hygiene, Privacy and Body Care (3)

From a harm reduction perspective, hygiene services are not extras; they are **core interventions**. Access to showers, clean clothes, toilets, and menstrual care supports:

- Skin and infection prevention
- Sexual and reproductive health monitoring
- Psychological resilience and self-esteem
- Reconnection with one's own body and identity

Low-threshold services can integrate simple but powerful supports: safe and gender-sensitive bathrooms, mirrors, lighting, hot water, laundry access, and private spaces. These facilities should be offered **without judgement or sobriety requirements**, recognizing dignity as a basic right.

Ironically, many cities avoid installing public hygiene facilities out of fear they will be used by homeless people—reinforcing the very stigma of "public uncleanliness" used to justify exclusion. This shows how access to hygiene is not only a health issue but also a **social and political one**.

Caring for the body is not a luxury. It is a form of survival, trauma prevention, and reconnection with health systems and with oneself.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Layered Stigma (1)

People who use substances and live on the street experience some of the most intense forms of stigma in contemporary societies. **Substance use** and **homelessness** are each heavily judged; when they intersect, the stigma multiplies. People become highly visible as "problems," yet invisible as individuals deserving care and protection.

This double stigma shows up in daily life. Services may deny access, professionals may lower expectations, police surveillance may increase, and communities may push people out of public space. The result is a cycle of **pathologization and punishment**, where individuals are blamed for their situation and seen as beyond help.

For women who are unhoused and use substances, stigma is even stronger. Gendered expectations about care, cleanliness, and emotional control collide with public substance use, leading to moral judgement, sexualization, and neglect. Many face **higher risks of gender-based violence**, exploitation, and loss of custody, while their vulnerability rarely brings protection.

When stigma intersects with racism, it becomes even more structural. Racialized people who use substances and are homeless are more likely to be stopped by police, excluded from shelters, or stereotyped as dangerous. A racialized woman in this situation may carry **multiple layers of stigma** at once, affecting access to safety, care, and basic rights.

These overlapping stigmas have deep consequences:

- Reduced access to healthcare and housing
- Fear of institutions and weaker trust in services
- Isolation from social networks
- Damage to self-worth and hope for change

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Layered Stigma (2)

From a harm reduction perspective, responding to layered stigma means more than providing supplies or shelter. It requires services that are:

- **Anti-stigmatizing and trauma-informed**
- **Culturally competent and gender-sensitive**
- **Built on trust, listening, and respect**

What may look like disengagement is often self-protection. Trust cannot be demanded—it must be built through consistent, respectful relationships that recognize each person's dignity and complexity.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Substance Use and Extreme Temperatures in the Context of Climate Change (1)

The climate crisis is already affecting people today—and **people who use substances and live on the street** are among the most exposed. Extreme heat, freezing nights, floods, and storms hit hardest where there is no shelter, no water, and no safe place to rest. Yet this group is rarely included in climate adaptation planning, making the intersection of **homelessness, substance use, and climate change** a growing public-health emergency.

Substances can alter how the body regulates temperature. **Stimulants** may increase body heat, while **opioids or alcohol** can dull awareness of cold or heat. Combined with dehydration, exhaustion, lack of shade, or inadequate clothing, the risk of **heatstroke or hypothermia** rises sharply. Across Europe, deaths during heatwaves or cold spells among unhoused people who use substances are increasingly predictable—and preventable.

Climate change intensifies these risks. Longer heatwaves, sudden cold snaps, and extreme rainfall disproportionately affect those living outdoors. Informal camps near rivers or under bridges may flood, and emergency plans often fail to reach people because of distance, policing, stigma, or abstinence-based shelter rules.

UNIT 3 – HARM REDUCTION STRATEGIES SPECIFIC TO PEOPLE EXPERIENCING HOMELESSNESS

SECTION 2 - HARM REDUCTION IN CASES OF HOMELESSNESS

Substance Use and Extreme Temperatures in the Context of Climate Change (2)

Common barriers during extreme weather

- Cooling or warming centers far from where people stay
- Fear of losing belongings when leaving a sleeping spot
- Shelters that require abstinence or ID
- Lack of information about where help is available

From a harm reduction perspective, responses must be **practical, low-threshold, and anticipatory**.

In heatwaves

- Free and visible access to **drinking water**
- Shade structures or air-conditioned safe spaces
- Outreach distribution of sunscreen, hats, electrolytes
- Safe places to rest without displacement

In cold weather

- Warm sleeping bags and insulated mats
- Clear information on **24/7 warm spaces**
- Low-threshold shelters tolerant of substance use
- Outreach teams trained to distinguish overdose from hypothermia and equipped with naloxone

More broadly, climate planning must include people who use substances and live in the street. Outreach teams need resources and training for extreme weather, and cities must recognize that climate vulnerability is shaped not only by geography, but by **poverty, exclusion, and policy choices**.

When cities hide water fountains, close public restrooms, or open cooling centers only during office hours, they are not simply unprepared—they are deciding whose lives are protected. Harm reduction in a warming world means ensuring that survival, dignity, and safety are available to everyone.

HOME4HEALTH MOOC

MODULE 5:
PEER WORK

MODULE OVERVIEW:

Unit 1: Peer Work – Roles and Profile

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

Section 2: What is peer work?

Section 3: The role of lived experience expertise

Section 4: Best Practices for integrating lived experience into Peer Work

Unit 2: Principles of peer integration

Section 1: Basis principles of peer institutional integration

UNIT 1:

PEER WORK; ROLES AND PROFILES

UNIT 1 - LEARNING AND OBJECTIVE OUTCOMES

Coordinated by:
In partnership with:
Co-funded by the European Union
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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.

UNIT 1:

SECTION 1

INTRODUCTION TO THE COURSE

UNIT 1 –PEER WORK; ROLES AND PROFILES

SECTION 1 - INTRODUCTION TO THE COURSE

ACTIVITY 5.1 -SOUP OF TRAITS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Materials

- Printed or displayed list of traits* /characteristics/hobbies/experiences (e.g., speaks multiple languages, meditates, plays an instrument, has lived abroad, punctual, etc.) **For this material check toolkit**
- Timer or clock

Expected outcomes

Participants will build rapport and connections within the group.

- Increased awareness of the diverse skills, experiences, and perspectives in the room.
- A positive, open atmosphere that fosters collaboration and mutual respect.

UNIT 1 –PEER WORK; ROLES AND PROFILES

SECTION 1 - INTRODUCTION TO THE COURSE

ACTIVITY 5.1 -SOUP OF TRAITS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

The trainer will use a printed list of 10–15 traits (appendix 1), characteristics, hobbies, and/or experiences that could apply to participants and ensure each participant receives a printed copy or has access to the list displayed in the room.

Activity

Explain that the goal is to find a different person in the group for each trait on the list.

Participants have 5–10 minutes to mingle. For each trait:

- Find someone who matches it.
- Ask about their experience or background related to that trait.
- Exchange brief information before moving on to meet another person.

Wrap Up

- Bring everyone back together.
- Invite 3–4 participants to share interesting or surprising facts they discovered about others.
- Highlight how the group's diversity can enrich collaboration and problem-solving in the training.

UNIT 1:

SECTION 2

WHAT IS PEER WORK?

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

Understanding peer work in homelessness support

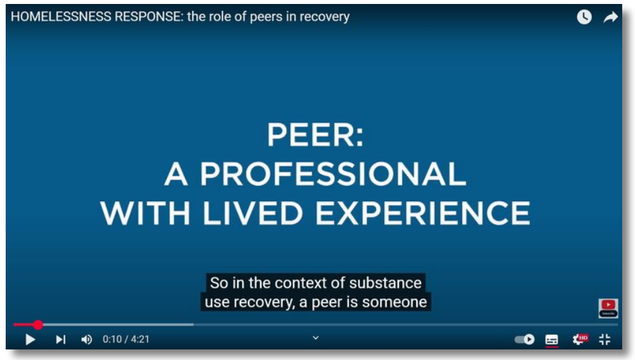
Peer work is an emerging profession grounded in lived experience. It involves people who have faced challenges such as homelessness, mental health issues, or substance use using their personal journeys to support others in similar situations. A peer is defined not by formal qualifications, but by the relevance and authenticity of their experiences and their ability to connect through shared understanding.

Peer work is based on mutual respect, empowerment, and the belief that recovery and stability are possible. Research and practice show that lived experience strengthens trust, engagement, and hope, and can support change at both individual and system levels.

In practice, peer workers may:

- Use their own **recovery journey** to **inspire** and **support** others
- Build **trust** through **shared understanding** and **recognition**
- Offer **guidance**, **mentoring**, and **practical support**
- Act as **outreach workers**, **educators**, or **advocates**
- Contribute to **improvements** in **services** and **support systems**

In **homelessness support** specifically, peer work helps people turn their **lived experience** into a source of **knowledge** and **strength**, supporting others to rebuild **balance**, **confidence**, and **stability** in their lives.



link to video

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

Examples Europe

In countries like **Spain**, **Portugal**, and **The Netherlands**, **experiential knowledge** is increasingly 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.

Key roles and contributions of peers:

- **Empower individuals** and provide **meaningful work experience**
- Offer **opportunities for further employment**
- Serve as a **bridge** between **policy** and **practice**
- Ensure sex workers are 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.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

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.

Key contributions of peer workers:

- Use **experiential knowledge** to **assist clients** and **support recovery**
- Enhance the understanding of **other professionals** and **caregivers**
- Share **lived experiences** with clients, families, and communities to foster **deeper understanding**

This sharing promotes **greater equality** between **service providers** and **clients**, allowing **professional** and **experiential knowledge** to **complement** each other and strengthen the **overall support system**.

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UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

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 an important role in **mental health**, **substance use**, **homelessness**, and **social inclusion**, and is increasingly reflected in **European policy** and **practice**.

The **European Union** acknowledges peer support as an **empowering** and **effective approach**, particularly within **mental health** and **social inclusion strategies**. It supports people facing **marginalisation**, including those experiencing **homelessness**.

Support for peer work at the European level includes:

- **Policy recognition:** Highlighted in European frameworks on **mental health** and **wellbeing** as a **meaningful and empowering practice**
- **Funding programmes:** Initiatives like the **European Social Fund** support **peer-based projects** for reintegration of **vulnerable groups**
- **Training and development:** Funded projects provide **training programmes** to strengthen **peer roles and skills**
- **Community impact:** Peer workers are involved in **outreach**, **advocacy**, and **community-based support services**
- **Guidelines and standards:** European resources define **core values**, **competencies**, and **practical frameworks** to ensure **high-quality peer work** across countries

Together, these developments show growing recognition of **lived experience** as a valuable source of **knowledge** that strengthens **support systems** and promotes **social inclusion** across Europe.

Access the guidelines here:
https://www.grone.de/fileadmin/Projekte/Erasmus_/2022/The_IO1_product._European_standards_.I.Mazur__002_.pdf

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

Legal and professional recognition of peer work in Europe

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

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

Legal and professional recognition of peer work in Europe (2)

- **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: **Health Service Executive (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 **Hogeschool of Arnhem and Nijmegen (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**

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

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**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

What makes peer work unique? (2)

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**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

The core value:"Free space" in peer work

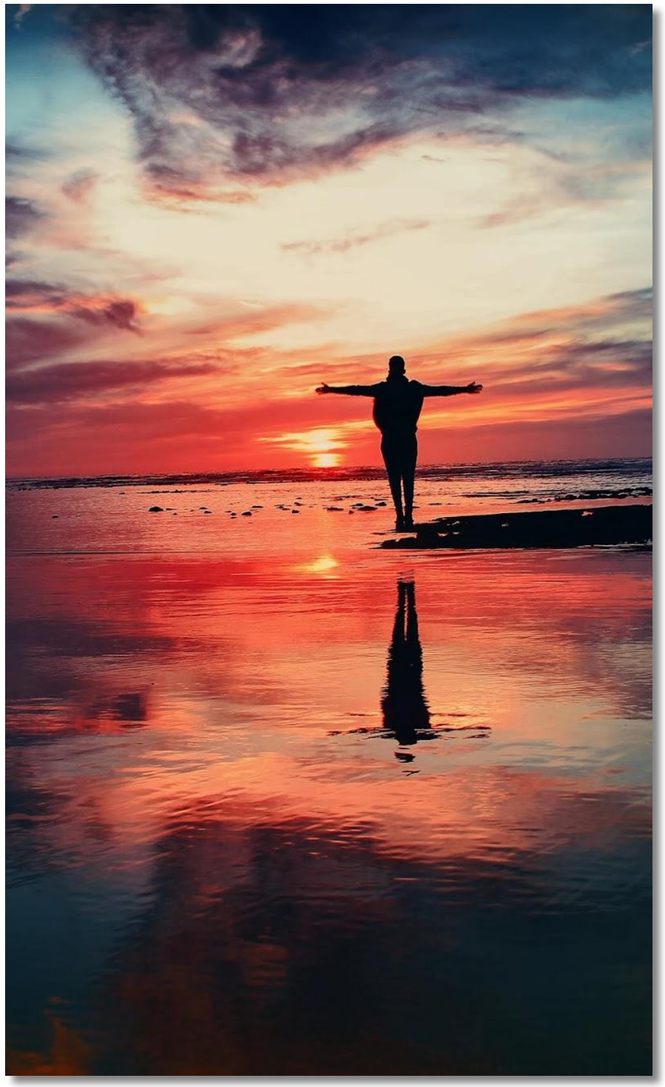
The core value:"Free space" in peer work

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.

Free space enables individuals to:

- Reconnect with their **inner strength**
- Make their own **decisions**
- Find **meaning** in their experiences
- Discover **new possibilities** for their lives

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.**



UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

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**.

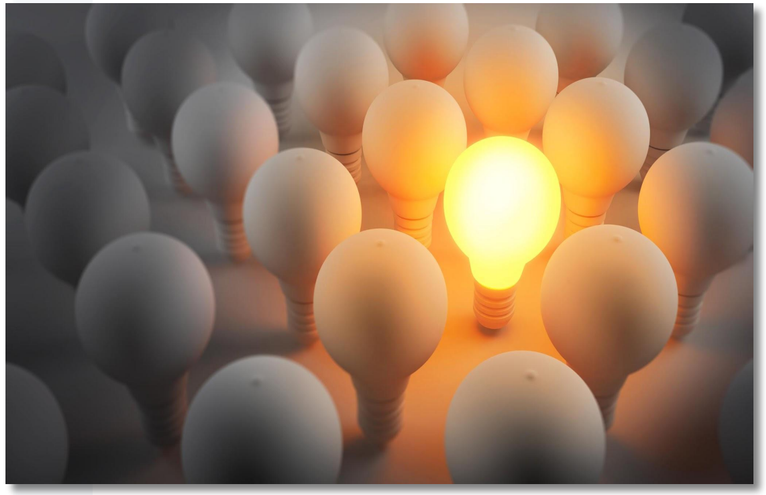
UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

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**.



Key Takeaways

- Lived experience strengthens professional support
- Recovery is supported through empowerment and inclusion
- Experiential knowledge complements professional expertise
- Creating space for personal stories enhances the healing process

UNIT 1:

SECTION 3

THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

The value of lived experience expertise in homelessness support

In **homelessness services**, it is important to recognise that **expertise** does not only come from **formal education** or **clinical training**. People with **lived experience of homelessness** bring valuable knowledge shaped by **personal journeys through adversity**. Their insights strengthen **empathy**, **relevance**, and the overall **impact of support**, contributing to more **person-centred care** and better outcomes for both **clients and teams**.

Understanding lived experience expertise

Lived experience expertise refers to the personal knowledge gained through directly facing challenges such as **homelessness**, **mental health issues**, **substance use**, or other disruptive life events. This knowledge offers a **unique perspective** that complements **professional and academic expertise**.

People with lived experience often contribute by:

- Offering **practical insights** into navigating homelessness and recovery
- Understanding **emotional and psychological challenges** from personal experience
- Building **trust and connection** through shared experience
- Recognising **hidden barriers** that may not always be visible to professionals
- Supporting others with **empathy, hope, and credibility**

This form of expertise goes beyond theory. It reflects a deep understanding of **crisis and recovery**, making support more **meaningful**, **responsive**, and **effective**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

Knowledge of survival strategies and blended expertise

An important and often overlooked part of **lived experience** is the practical **survival knowledge** that peer workers bring. Through their own experiences, they understand how **systems and daily realities** work in practice — not just on paper. These insights make support more **realistic**, **accessible**, and **responsive** to people's actual needs.

Peer workers often contribute by:

- Sharing **practical knowledge** about safer places to stay or rest
- Knowing how to access **informal, low-threshold, and non-stigmatizing support**
- Understanding how **services function in real-life situations**
- Helping bridge the gap between **policy, services, and lived reality**
- Offering strategies grounded in **everyday survival and resilience**

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

Blending lived and theoretical knowledge

While peer work is rooted in **personal experience**, it is increasingly supported by **training** and **professional development**. Many peer workers build skills in areas such as **trauma-informed care**, **recovery-oriented practice**, and **communication**.

This combination of **lived and learned knowledge** strengthens their role within **multidisciplinary teams** and supports:

- More effective **collaboration** between peers and professionals
- **Mutual respect** for different forms of expertise
  Support that is both **evidence-informed and deeply human**
- Services that better connect with the **real needs** of people experiencing homelessness

Understanding this **dual foundation** helps professionals work more closely with peer workers and create more **responsive and person-centred support systems**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

The key competencies of a peer worker (2)

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**
- A feeling of **safety**
- Stronger **engagement in recovery**

These conditions are critical for meaningful and sustainable **recovery**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

The key competencies of a peer worker (2)

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 **real-world insights** are critical for:

- Helping clients navigate **daily challenges**
- Making support more **practical and accessible**
- Informing **service design** that reflects real-world needs

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

The key competencies of a peer worker (3)

Breaking down barriers

Because they have experienced barriers such as **social isolation**, **lack of access to resources**, and **systemic discrimination**, peer workers are well-positioned to help others overcome them.

They contribute through:

- **Emotional support**
- **Practical guidance**
- **Advocacy**

In doing so, they reduce 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**
- **Respectful**

This strengthens support systems for the people they serve.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

ACTIVITY 5.2 - PEER WORKER COMPETENCY SIMULATION

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Materials

- Flipcharts or whiteboards
- Markers
- Printed scenario cards* (detailing different situations related to homelessness, stigma, recovery, etc.,

For this material check toolkit

Expected outcomes

By the end of the activity, healthcare professionals will have a better understanding of the core competencies that make peer workers effective in their roles. They'll also have a deeper appreciation for the challenges individuals experiencing homelessness face and how empathy, personal insight, and advocacy can improve support systems and outcomes.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

ACTIVITY 5.2 - PEER WORKER COMPETENCY SIMULATION

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

- Use a set of scenario cards that reflect real-life situations a peer worker might face **For this material check toolkit**
- Each scenario should highlight one or more of the key competencies (empathy, personal insight, breaking down barriers, advocacy).

Activity

Part 1: Introduction (5 minutes)

Brief introduction on the key competencies of a peer worker:

- Empathy and Understanding
- Personal Insight and Growth
- Breaking Down Barriers
- Advocacy and Systemic Change

In this activity, participants will simulate real-world interactions that test these competencies.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

ACTIVITY 5.2 - PEER WORKER COMPETENCY SIMULATION

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Part 2: Small group role-play (15 minutes)

- Form groups: Divide participants into small groups of 3-4 people.
- Assign scenarios: Each group is given a scenario card (e.g., "A client is reluctant to access services due to previous negative experiences with healthcare providers"). The scenario will challenge them to address one of the competencies listed above.
- Role-play: In the group, one person will play the "peer worker," another will be the "client," and others may take on supporting roles (e.g., healthcare provider, family member, etc.).
  - The "peer worker" must use empathy, personal insight, and advocacy skills to help the "Client" overcome their barriers.
  - The group must figure out how to break down the client's resistance or challenges and promote a pathway to recovery.

Time limit: Allow 5 minutes per group to act out their scenario.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 3 - THE ROLE OF LIVED EXPERIENCE EXPERTISE IN SUPPORTING PEOPLE EXPERIENCING HOMELESSNESS

ACTIVITY 5.2 - PEER WORKER COMPETENCY SIMULATION

45 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Part 3: Group debrief and discussion (10 minutes)

- After each group has completed their role-play, bring everyone back together for a debrief.
- Reflection questions:
- How did the peer worker demonstrate empathy and understanding?
- What personal insights were shared by the peer worker, and how did these impact the client?
- What barriers were identified, and how were they addressed?
- How did the peer worker advocate for the client or try to influence the system?
- How did the peer worker protect their own recovery and well-being during the interaction? What role does self-care play in sustainable peer work?
- Write key takeaways on a flipchart or whiteboard, encouraging participants to reflect on the competencies that were most challenging or effective in their role-play.

Wrap up

Wrap up the activity with a group discussion on how the competencies of a Peer Worker can be applied in their own professional practice. Highlight the value of lived experience and how these skills can foster a more inclusive, supportive environment for individuals facing homelessness.

UNIT 1:

SECTION 4

BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

Integrating lived experience expertise into homelessness support

Successfully integrating **lived experience expertise** into support for people experiencing **homelessness** requires **careful planning** and adherence to **best practices**.

The following principles are essential to ensure that **peer workers** are supported in their roles and that their contributions are fully valued and maximized.

Recognizing flexibility in peer roles

When working with peer workers, it is important to acknowledge that individuals 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 match their **strengths and capacities**
- Align their role with their **personal development**
- Maintain their **well-being**
- Strengthen the overall **effectiveness** of their contribution

Flexibility supports both the individual peer worker and the wider team.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

Benefits of peer work across all levels of an organization

Peer workers bring value not only in **direct service delivery**, but across the full **organizational hierarchy** — from **frontline practitioners** to **leadership and governance**.
As well its highly valuable to involve peer workers as **training facilitators** and include them in training sessions.

Their involvement at all levels:

- Strengthens the quality of **services**
- Promotes a culture of **inclusion**
- Enhances **organizational responsiveness**
- Supports more recovery-oriented systems
- Adds **value to training**

Integrating peer work at multiple levels helps build stronger, more person-centred organizations.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

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**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

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**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

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.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

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** providing **job security** and clarity
- Access to **professional development** and **career progression** opportunities
- **Safe spaces** to share insights, raise concerns, and reflect on challenges without fear of **stigma** or **judgment**

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

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**
- **Standard leave policies**

It 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.

Best practice example

Initiatives like **The Crack Users Project** (Home4Health Best Practices Report, 2024) highlight:

- Creating **working conditions** that respect **dignity**, **autonomy**, and **expertise** of peer workers
- How **inclusive practices** can lead to more **effective** and **compassionate service delivery**

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

Conclusion

Peer workers bring **essential lived experience** that enhances:

- **Trust** and engagement with clients
- The **relevance** of homelessness services
- **Collaboration** and inclusivity within teams

To maximize their contributions, organizations should provide:

- **Flexible roles**
- **Fair employment conditions**
- **Supportive work environments**
- Inclusion at **all levels** — from service delivery to leadership

Investing in the **development** of peer workers is key to:

- **Improving outcomes** for clients
- Driving **meaningful change** in homelessness support systems

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

ACTIVITY 5.3 - IN THEIR WORDS. VOICES OF PEER WORKERS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To foster empathy and deeper understanding of peer work through firsthand testimonials from peer workers.

Materials

- Pre-selected audio testimonials 2 clips, each 2–4 minutes
- Headphones or speakers
- Reflection worksheet or printed guiding questions (see 'preparation' next slide)

Expected outcomes

- Increased awareness of the role and impact of lived experience in peer work
- Personal reflection on how peer workers' perspectives contribute to professional practice
- Greater empathy towards individuals with lived experience of recovery

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

ACTIVITY 5.3 - IN THEIR WORDS. VOICES OF PEER WORKERS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Preparation

- Select 2 short audio testimonials or voice messages from peer workers in your organization or partner organizations.
- Ensure audio is clear and accessible for all participants (via headphones for individual listening or speakers for group listening).
- Prepare the reflection questions:
  - What stood out to you most in what you heard?
  - How does the speaker's lived experience enhance their professional role?
  - What feelings or insights did the testimonials evoke in you?

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 4 - BEST PRACTICES FOR INTEGRATING LIVED EXPERIENCE INTO PEER WORK

ACTIVITY 5.3 - IN THEIR WORDS. VOICES OF PEER WORKERS

30 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Play the audio testimonials for participants (individually or as a group)

  Audio 1 Audio 2

- Invite participants to reflect individually for a few minutes, either in writing or mentally, using the guiding questions.

Wrap Up

- Optionally, bring participants together in small groups or as a whole class for a short discussion.
- Encourage participants to share reflections or key takeaways, maintaining a respectful and open environment.
- Summarize common insights, highlighting the value of integrating lived experience into peer work.

UNIT 2:

PRINCIPLES OF PEER INTEGRATION

UNIT 2:

SECTION 1

BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

UNIT 2- PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

Challenges for Peer Workers in Shared Environments

Peer workers—those with **lived experience of homelessness**—face unique challenges when **living and working in the same environment**, which can create **boundary issues** requiring careful navigation. **Best practices for integration** focus on **decision-making** across multiple levels: **financial supporters**, **management**, **coordination**, and **team collaboration**.

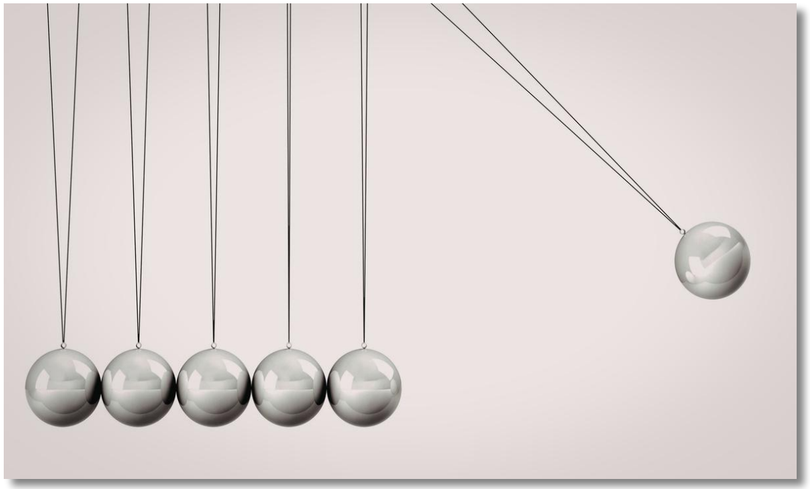
Critical Professional Situations and Tensions

- Peer workers, also called **"experts by experience"**, often encounter situations with **no clear-cut answers**.
- These situations involve **conflicting interests** and **multiple perspectives**, creating **tensions**.
- Effective responses require **professional competence** and careful **decision-making**.

Key Themes in Peer Integration

These themes often arise in supervision and peer-to-peer reflection:

- Closeness vs. distance
- Meaning vs. meaninglessness & tolerating pain
- Strength vs. vulnerability
- Pride vs. shame
- New vs. existing cultural values



UNIT 2- PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

1. Closeness vs. distance

Balancing proximity and professional distance is a common tension in peer work. A key strength of peer workers is their ability to build trust through shared experience and emotional presence. At the same time, maintaining clear and healthy boundaries is essential.

The balance between closeness and distance is dynamic and may differ per situation. Peer workers need to:

- Be emotionally present while maintaining professional boundaries
- Assert their own limits and respect those of clients
- Recognise and validate emotions without becoming overwhelmed
- Step back when emotional dynamics become too intense
- Navigate boundary challenges, especially with former peers or acquaintances

Managing emotions — both one's own and those of clients — is a core professional skill. Peer workers may be more emotionally open due to shared experiences, which can strengthen connection but also increase vulnerability.

Working closely with people in crisis can carry the risk of vicarious trauma or the reactivation of one's own past experiences. It should not be assumed that peer workers automatically know how to recognise or manage these processes.

Good practice includes:

- Explicit attention to emotional safety in training
- Structured reflection and supervision
- Open discussion about triggers and emotional impact
- Use of supportive frameworks and tools

Addressing these risks proactively reduces emotional burden and supports sustainable, healthy peer work.
Tools such as Transforming the Pain (Saakvitne & Pearlman, 1996) can offer valuable frameworks for this.

UNIT 2- PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

Clear professional boundaries are essential to define roles and ensure safe, effective support. In close community contexts, these boundaries can be challenging, making clear communication crucial to avoid confusion or role overlap (H4H Best practices report, 2024).

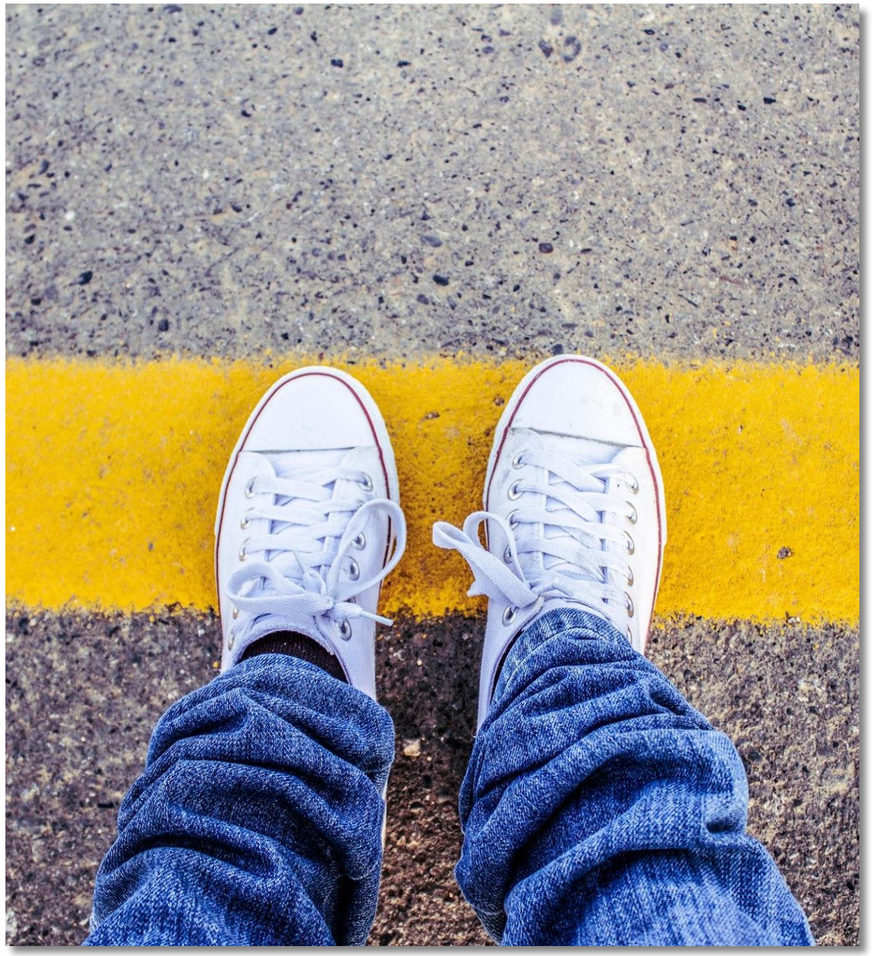
Professionals should:

- Maintain clear personal and professional limits
- Create enough emotional distance to prevent overload
- Be aware of risks of retraumatization, especially when working within the same community (Mason, 2006)
- Recognise and manage signs of stress or emotional activation

Managing emotional dynamics and stigma

Support roles can trigger strong emotions. Awareness of countertransference — when personal feelings influence professional relationships — helps maintain a healthy therapeutic alliance (Tatarsky & Kellog, 2010).

Because people who use substances often face stigma, professionals must actively avoid judgement. A harm reduction approach supports dignity, reduces stigma, and promotes constructive, trust-based care.



UNIT 2- PRINCIPLES OF PEER INTEGRATION

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Good practices related to boundaries in the supporting relation, may include:

Maintaining **healthy boundaries** is essential for peer workers and the wider support team. Good practices may include:

- **Personal psychotherapy** or **continuous supervision** to enhance **self-knowledge** and recognise **countertransference** (unconscious emotional reactions)
- Developing **communication skills** such as **assertiveness**, **empathy**, and **clarity**
- Access to **differentiated spaces and activities** for personal fulfillment, e.g., **counselling**, **reflective practice groups**, **yoga**, **mindfulness** (examples: Center of Recovery at HVO-Querido, Cork Simon)
- **Flexible boundaries** with discussion at both **peer and agency levels** about expectations, limits, and policies, particularly in the context of **harm reduction** (Mason, 2006)

Key principle:
*Balance **flexibility** with **clarity** regarding guidelines*
Support a healthy, effective work environment for both peers and clients

UNIT 2- PRINCIPLES OF PEER INTEGRATION

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2. In Meaning vs. meaninglessness and tolerating pain

In peer work, offering **hope** is central—sometimes through **action**, sometimes simply by **being present**. However, chronic challenges like **homelessness**, **mental health issues**, or **medication side effects** can undermine feelings of hope and **meaning**.

Key points:

- Encourage clients to find their **own meaning** and interpret experiences at their **own pace**
- Be careful not to let good intentions **cross client boundaries**
- Crisis moments can trigger **hopelessness** or **frustration** for both client and peer
- Peer work involves **supporting recovery** as a **learning process**, not a “fix”
- Setbacks are **opportunities for growth**, shifting focus from a **pathological model** to **learning and empowerment**

UNIT 2- PRINCIPLES OF PEER INTEGRATION

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3. Strength vs. vulnerability

Peer workers bring a unique strength through their lived experience, but this comes with vulnerability. This vulnerability helps them connect deeply with clients, yet it also carries risks if boundaries are unclear or others exploit it.

Key points:

- Vulnerability can enhance trust and empathy with clients
- Maintaining professional boundaries is essential
- Peer workers must understand and manage how they share personal experiences
- Balancing strength and vulnerability is central to sustainable peer work

4. Pride vs. shame

Peer workers may experience a mix of pride and shame related to their role and past experiences. While using personal history to help others is empowering, it can also bring feelings of stigma or embarrassment.

Key points:

- Sharing lived experiences can evoke both pride and vulnerability
- Feelings of shame are common and natural
- Learning to navigate this ambiguity helps maintain confidence and effectiveness in peer roles
- Ongoing reflection and support are important for managing these emotional tensions

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5. New vs. existing cultural values

Peer workers often bring new values to healthcare and social support systems, such as user autonomy and shared decision-making.

Key points:

- Peer workers act as change agents, advocating for values from lived experience
- Empathy and understanding of both sides help navigate cultural friction
- Clear boundaries are essential, especially when facing subtle forms of disqualification
- Cultivating a strong, independent voice supports effective advocacy
- Working as a change agent can sometimes feel isolating

Successfully integrating peer workers requires balancing tensions and supporting their growth.

Key points:

- Recognize the value of lived experience in teams
- Provide guidance to maintain professional boundaries
- Foster meaningful collaboration between peers and professionals
- Follow best practices to empower both peer workers and service users

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Best practice example: Peer work at HVO-Querido, Amsterdam, The Netherlands- The addendum for employees with lived experience

At **HVO-Querido**, a key practice for integrating **peer workers** is the **Addendum for employees with lived experience**. This formal framework supports peers to develop and apply their lived experience meaningfully in client support and recovery.

Key elements:

- Provides a clear **pathway for formal recognition** of lived experience competencies, documented in personnel files
- Focuses on **assessing and developing skills**, not just acknowledging past experiences
- Begins with a **conversation** between the employee, manager, and team about using lived experience professionally
- Available for both **new recruits and existing employees** seeking to expand their peer role

This approach ensures that peers can contribute effectively while developing professionally within the organization.

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Structured phases for development

The **Addendum** provides structured steps for peer workers to build their skills and integrate lived experience into professional practice:

Key steps:

- **Phase 1:** Orientation course **"Working with Own Experience"** (Recovery Bureau) to assess readiness and develop core skills
- **Phase 2:** Further training and education through **accredited courses**, such as:
  - **Howie the Harp** (MBO level 2 equivalent)
  - **MOED** (MBO level 4 qualification)
- Ensures peers are trained to apply their lived experience **professionally and recovery-focused**

This framework supports the **competent, safe, and effective integration** of peer knowledge into client care.

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1. Peer support and integration within teams

In this model, peer workers **actively integrate into teams** rather than working in isolation. They help shape **recovery-oriented practices** and ensure that lived experience knowledge is embedded in team processes.

Key points:

- Teams establish **agreements to support and use lived experience knowledge**
- Peer workers take an **active role**, sharing experiences to build **trust and understanding**
- The **peer role is clearly defined** for all team members to ensure effective collaboration

2. Supervision and continuous development

Peer workers are supported through **continuous professional development**, including **intervision sessions** and a **yearly training day**. This helps them refine their approach to recovery and service delivery while staying engaged in their roles.

Key points:

- Encourages **continuous learning** and skill development
- Supports effective contribution to **team and client outcomes**

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3. Outcome-Based Evaluation

Peer competence is evaluated based on **specific outcomes**, ensuring contributions are meaningful and professional.

Key points:

- Evaluation focuses on areas like **recovery support**, **group recovery opportunities**, and **promoting inclusivity and equal rights**
- **Line managers** assess performance, with feedback from the **Recovery Bureau** if needed
  Ensures peers contribute effectively while **maintaining professional boundaries**
- This approach reinforces **structured integration, clarity of role, and accountability** within the team.

4. Organizational Support and Flexibility

The Addendum provides **flexibility** for peers to balance lived experience with professional responsibilities. Recognition and competency development are **individualized**, allowing employees to tailor growth to their needs.

Key points:

- Supports a **personalized development pathway**
- Fosters an **inclusive work environment** that values lived experience
- Encourages a **culture of continuous learning** and professional growth

UNIT 2- PRINCIPLES OF PEER INTEGRATION

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Results and Impact

HVO-Querido's approach has achieved **strong professional integration** of peer workers, ensuring they can use their lived experience **effectively and safely**.

Key points:

- The **framework equips peers** to contribute meaningfully without being overwhelmed by emotional demands
- Combines **lived experience with professional training** to support clients while maintaining **well-being and integrity**
- Creates an environment where peers are **valued, supported, and empowered**
- Fosters an **inclusive, empathetic, and recovery-oriented workplace**, benefiting both peers and clients

This approach demonstrates how structured support and recognition can maximize the **impact and sustainability** of peer work.

UNIT 2- PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

Best practice example: Peer Work at Crescer, Lisbon, Portugal - Peer Meetings

The meetings promote **sharing experiences**, **mutual support**, and **empowerment** among colleagues facing similar challenges. They create a **safe, welcoming space** where participants can **share experiences**, receive **support and guidance**, and work together to **overcome challenges**. As one peer colleague describes: *"It is a very particular and intimate space."*

Goals of Peer Meetings:

- **Mutual Support:** Create a space where participants can **support each other**, **share experiences**, and offer practical **advice**.
- **Empowerment:** Help participants take **control of their lives** and make **informed choices** about **health**, **well-being**, and **work conduct**.
- **Harm Reduction:** Promote **harm reduction practices** in **substance use** and managing **leisure time**, including nights and weekends.
- **Social Inclusion:** Strengthen **peer relationships** and **community inclusion**, helping participants access **services** and **resources** to improve their **quality of life**.

UNIT 1 – PEER WORK; ROLES AND PROFILES

SECTION 2 - WHAT IS PEER WORK?

What is done in Peer Meetings?

- **Share experiences:** Participants share their **experiences** and **challenges**, offering **support** and practical **advice** to one another.
- **Discuss relevant themes:** Participants explore **themes** related to **health** and **well-being**, encouraging **critical reflection** and dialogue.
- **Plan actions:** Participants propose **actions** to improve **quality of life**, **well-being**, and **workplace procedures**.
- **Emotional support:** Participants provide **emotional support**, build **friendship bonds**, and extend their **support network** beyond work through activities like **weekend programs** or **dinners**.

UNIT 2- PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

Results and impact:

- **Integration of peer professionals:** these meetings can be a good practice for **integration** of **peer professionals**, who can offer **support** and **guidance** to participants, since they have distinct **challenges** from other professionals.
- **Deepened knowledge of the organization:** These meetings can augment the **knowledge** of the **working philosophy** of the organization, as well as the various existing **projects**, **procedures**, **rights**, and **duties** in the institution.
- **To reduce prejudice and stigma:** These meetings can help to reduce **stigma** and **prejudice** sometimes existing between **peer** and **non-peer professionals** or other points of view. Knowing that **intolerance** and **ignorance** are intimately related, intolerance often emerges from **ignorance**, lack of **understanding** of **differences** and of **others**.

Summing up, Peer Meetings are considered a good practice within the organization, since they promote **mutual support**.

UNIT 2 – PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

ACTIVITY 5.4: EXPLORING KEY TENSIONS IN PEER WORK

50 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To explore common professional tensions in peer work, reflect on different ways of handling them, and increase awareness of boundaries, support needs, and trauma-informed practice in peer integration.

Materials

- Printed tension cards (one tension per card) **For this material check toolkit**
- Flipchart or large sheets of paper
- Markers
- Guiding questions (printed or displayed)

Expected outcomes

- Increased understanding of core tensions in peer work integration
- Recognition that dilemmas often have no single “right” solution
- Greater awareness of the importance of supervision, boundaries, and organisational support
- Shared language to discuss difficult professional situations in peer work

UNIT 2 – PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

ACTIVITY 5.4: EXPLORING KEY TENSIONS IN PEER WORK

50 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Step 1 Small group work

Each group discusses their assigned tension using the following core guiding questions:

- What does this tension mean in peer work?
- How might this tension show up in daily practice?
- Why is this situation challenging for peer workers?
- What risks are involved (for the peer worker, client, and team)?
- What kinds of support, agreements, or structures help to manage this tension?

How to use the tension card

Read together:

- What is the tension?
- Why is this challenging?

Output for each group

Note key insights on flipchart paper:

- the core of the tension
- 1–2 concrete or recognisable examples
- what helps or is needed to handle the tension safely?

UNIT 2 – PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

ACTIVITY 5.4: EXPLORING KEY TENSIONS IN PEER WORK

50 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Step 2 Sharing insights

Each group briefly presents in 2-3 minutes:

- Their assigned tension
- The main challenges they identified
- Key forms of support or good practice

Wrap-Up

Collective reflection

- Which tensions felt most recognisable or relevant?
- What do these tensions tell us about the complexity of peer work?
- What do peer workers need to stay safe, supported, and sustainable in their roles?
- What role do organisations and teams play in supporting peer workers?
- Which examples or good practices help address these tensions?

HOME4HEALTH MOOC

MODULE 6:
EUROPEAN POLICY PERSPECTIVE ON HOMELESSNESS AND ADVOCACY

MODULE OVERVIEW:

Unit 1: Understanding Homelessness

Section 1: Introduction to the course and participant's introduction Section 2: Definition of Types of Homelessness

Section 3: Causes of Homelessness

Section 4: Approaches to Homelessness

Unit 2: Public Policy and Advocacy

Section 1: Public Policy

Section 2: Definition of Public Policy

Section 3: Advocacy for systemic change in the field of Homelessness

Section 4: Language used when communicating on Homelessness

UNIT 1:

UNDERSTANDING HOMELESSNESS

UNIT 1 - LEARNING AND OBJECTIVE OUTCOMES

Coordinated by:
In partnership with:
Co-funded by the European Union
2023-1-ES01-KA220-VET-000165764

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.

UNIT 1:

SECTION 1

INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

UNIT 1 – UNDERSTANDING HOMELESSNESS

SECTION 1 - INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

ACTIVITY 6.1 - "A DAY IN SOMEONE ELSE'S SHOES"

10-15 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To foster empathy and awareness about homelessness by exploring personal perceptions and associations with related concepts.

Preparation

Prepare a list of words related to homelessness to say aloud during the activity. Suggested words: Home; Safety; Food; Street; Shelter; Community; Support; Survival; Isolation; Hope

UNIT 1 – UNDERSTANDING HOMELESSNESS

SECTION 1 - INTRODUCTION TO THE COURSE AND PARTICIPANT'S INTRODUCTION

ACTIVITY 6.1 - "A DAY IN SOMEONE ELSE'S SHOES"

10-15 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

- Ask participants to sit comfortably and explain that you will say a word aloud, and they should respond with the first word that comes to mind.
- Go around the group (or have participants type their responses in the chat if online) for each word.
- Keep responses brief and spontaneous—there are no right or wrong answers.

After completing the list of words, invite participants to reflect briefly:

- Which words triggered the strongest reactions?
- Did anyone notice patterns or surprises in their responses?
- How might these associations influence how we think about homelessness?

Wrap Up

- Optionally, open a short discussion where participants share reflections or insights.
- Highlight common themes and encourage respectful dialogue.
- Conclude by emphasizing the importance of awareness, empathy, and challenging assumptions in addressing homelessness.

UNIT 1:

SECTION 2

DEFINITION AND TYPES OF HOMELESSNESS

UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS 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

[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

UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

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, whole 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).

UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

B. ETHOS CONCEPTUAL FRAMEWORK

To 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:

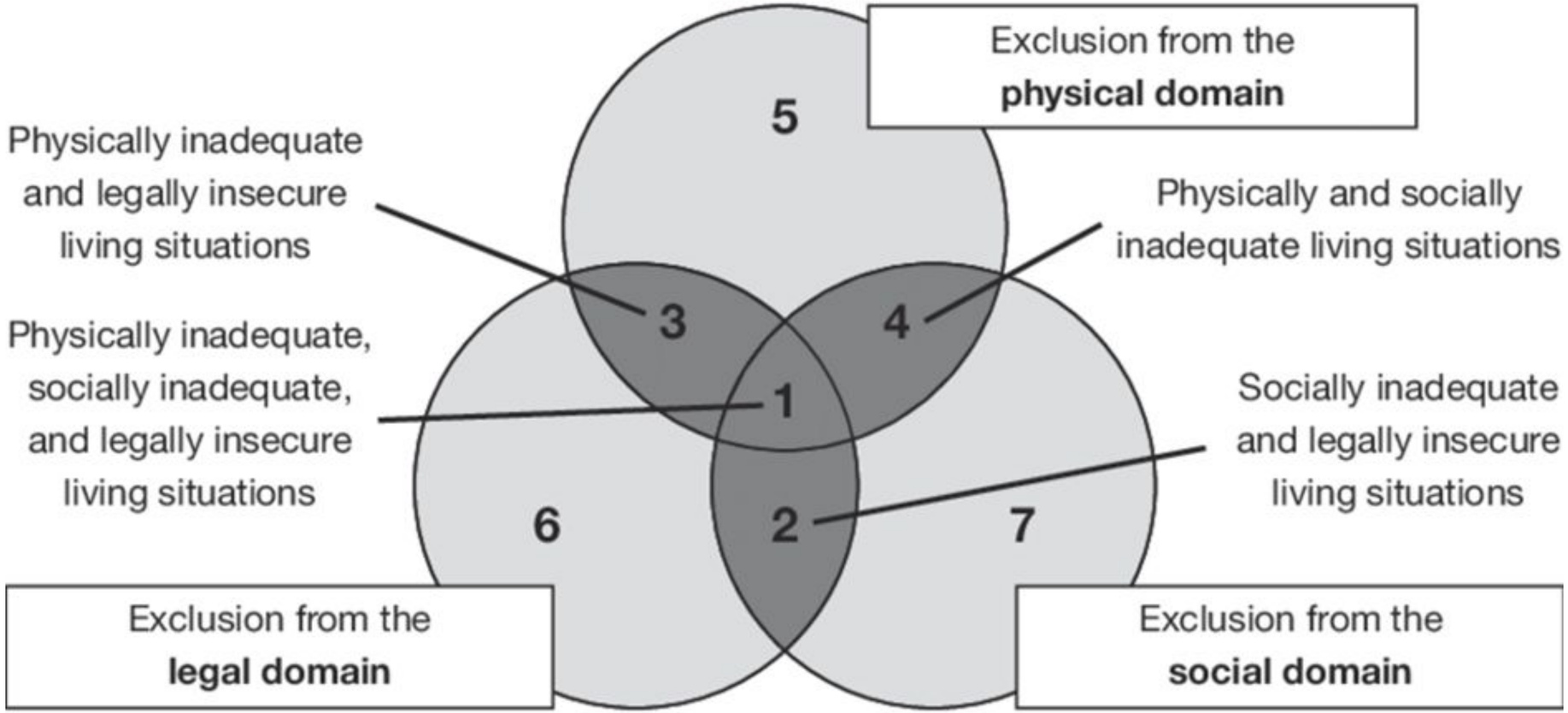
1. **The physical domain** – having an adequate dwelling (or space) in which to live.
2. **The social domain** – being able to maintain privacy and enjoy social relations.
3. **The legal domain** – possessing legal title (e.g., tenancy, ownership) that guarantees security of occupation.

From these domains (see fig 1), 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).

UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS



UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

B. ETHOS CONCEPTUAL FRAMEWORK

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.

[1] 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

UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

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.

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SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

D. DEFINITIONS ACROSS EUROPEAN COUNTRIES

Spain has no single national legal definition of homelessness. The National Statistics Institute (INE) surveys *personas sin hogar* (people without a home), mainly those using shelters or social services. The 2015 National Strategy for the Homeless adopted a definition similar to ETHOS Light, covering people living rough, in emergency shelters, longer-term shelters, or institutions without housing alternatives. However, broader housing exclusion, like insecure or inadequate housing, is usually not included in official statistics.

Ireland defines homelessness under the Housing Act of 1988. A person is homeless if they have no accommodation they can reasonably occupy, live in an institution due to lack of housing, or cannot provide housing from their own resources. The definition also covers “hidden homelessness,” including people living temporarily or insecurely with friends or family, rough sleepers, and those in institutional settings.

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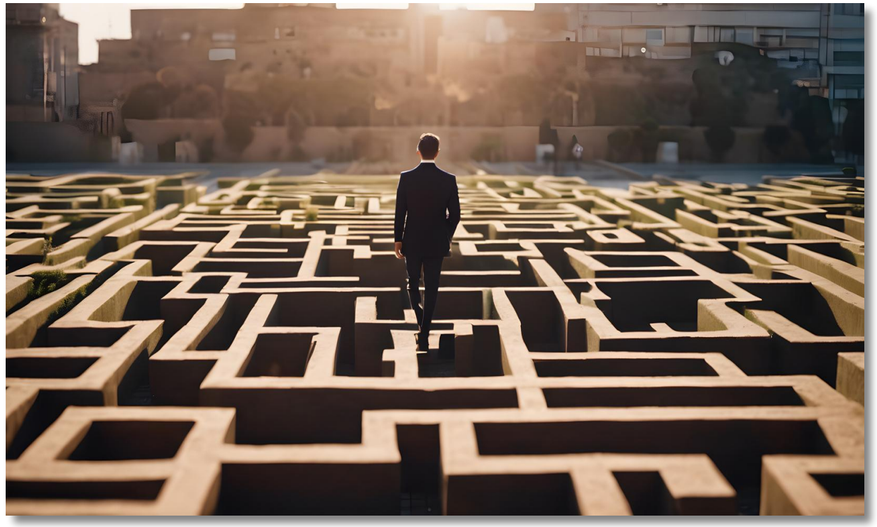
SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

D. DEFINITIONS ACROSS EUROPEAN COUNTRIES

Portugal aligns with the ETHOS typology and has developed a national framework through successive strategies. The latest, ENIPSSA 2025–2030, approved in 2024, shifts focus from emergency responses to prevention and holistic, integrated care. It includes early-warning systems, Housing First models, temporary and shared housing, street outreach, employment support, and mental health services.

ENIPSSA targets vulnerable groups such as older adults, people with disabilities, migrants, Roma communities, LGBTI individuals, and people with substance use or mental health challenges. However, Portugal's operational definition of homelessness remains limited: it covers only roofless (street) or houseless (temporary shelter) individuals. People in severe housing vulnerability—such as domestic violence victims without alternatives, those in prison or institutions without housing plans, or families in substandard housing—are excluded. This limits preventive planning and early intervention.



UNIT 1 - UNDERSTANDING HOMELESSNESS

SECTION 2 - DEFINITIONS AND TYPES OF HOMELESSNESS

D. DEFINITIONS ACROSS EUROPEAN COUNTRIES

Statistics **Netherlands** (CBS) historically defined homelessness narrowly: adults 18–65 without permanent residence, including rough sleepers, night shelter users, people in non-conventional housing, or temporarily staying with friends/family. This excludes minors, older adults, people leaving institutions, and those facing eviction or lacking civil registration.

In 2023, a nationwide ETHOS-based enumeration by Utrecht University and Kansfonds expanded the definition, including hidden homelessness and acute housing insecurity. Early results show homelessness is more widespread than CBS statistics suggested. Policy is shifting from visibility-based definitions toward a broader, ETHOS-aligned understanding.

Definitions of homelessness vary across these countries. Ireland has a relatively broad legal definition, though operational measurement is narrower. Spain and Portugal rely on strategy-based definitions similar to ETHOS Light, focusing on visible homelessness. The Netherlands historically used a narrow, visibility-based definition but is now adopting a broader ETHOS-based approach. None fully apply the ETHOS framework in legislation, but ETHOS informs policy and provides a reference for European comparability.

UNIT 2 – PRINCIPLES OF PEER INTEGRATION

SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

ACTIVITY 6.2 - VIDEO FORUM WITH EXAMPLES OF DIFFERENT TYPES OF HOMELESSNESS (1)

30-40 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Objective

To gain direct insights into the different types and causes of homelessness through firsthand accounts and real-life examples.

Preparation

Select 1 or 2 videos to watch

- What's driving the rise in homelessness and what can the EU do about it?
- Netherlands labour market: Thousands of migrant workers end up homeless
- Ireland Context: Profile and Scale of Homelessness in Ireland

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SECTION 1- BASIC PRINCIPLES OF PEER INSTITUTIONAL INTEGRATION

ACTIVITY 6.2 - VIDEO FORUM WITH EXAMPLES OF DIFFERENT TYPES OF HOMELESSNESS (1)

30-40 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Watch the videos ask yourself the following reflection questions:

- What aspects of homelessness stood out most to you in the videos?
- Did any of the stories or examples challenge your previous assumptions about homelessness?
- Which types of homelessness (roofless, houseless, insecure housing, inadequate housing) were most visible or emphasized in the videos?
- What social, economic, or political factors contributing to homelessness did you notice?
- How do the experiences of people in different European countries compare?
- What forms of support or interventions were highlighted, and which seemed most effective?
- How did the videos portray the human impact of homelessness beyond just housing?
- Are there gaps or issues that you think were not fully addressed in the videos?
- How might this information influence your perspective or approach when discussing or addressing homelessness?

Wrap-up

- Highlight common themes and encourage respectful dialogue.
- Conclude by emphasizing the underlying reasons for homelessness and providing messages of hope based on the methodologies that are being used across Europe to face this reality.

UNIT 1:

SECTION 3

CAUSES OF HOMELESSNESS AND MAIN STATISTICS

UNIT 1 – UNDERSTANDING HOMELESSNESS

SECTION 3 - CAUSES OF HOMELESSNESS AND MAIN STATISTICS

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.

Main Statistics Regarding Homelessness

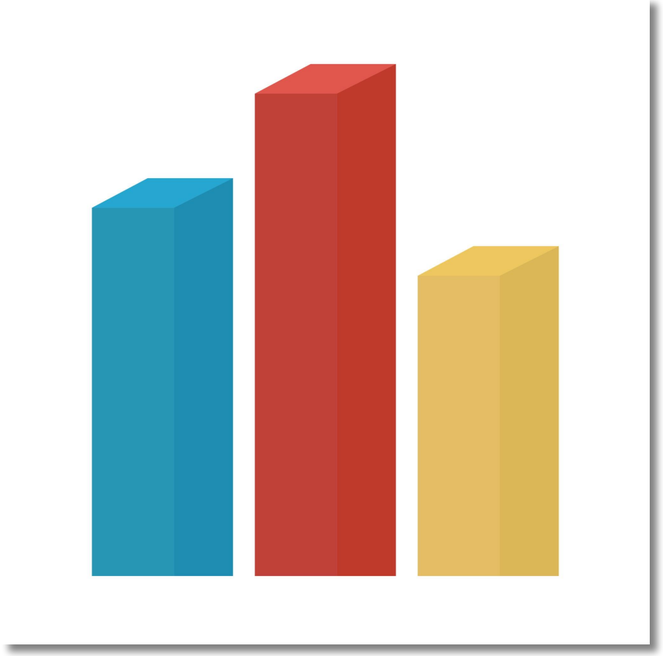
Homelessness is a growing social issue in Europe, with at least 850,000 people affected on any given night, though the real number is likely higher due to hidden forms of homelessness.

Homelessness in the European Union has more than doubled since 2009, largely due to rising housing costs, limited affordable housing, migration pressures, and the cost-of-living crisis.

Southern European countries have faced increased housing pressures from high housing costs, tourism-driven markets, and limited social housing, contributing to rising homelessness.

France and Italy report some of the highest numbers of homeless individuals, particularly concentrated in major cities where housing affordability has significantly worsened.

Spain and Portugal also face growing homelessness linked to housing instability and rising urban housing prices though estimates vary depending on measurement methods.



UNIT 1 – UNDERSTANDING HOMELESSNESS

SECTION 3 - CAUSES OF HOMELESSNESS AND MAIN STATISTICS

According to HomelessHub, these three domains collectively shape the pathways into and out of homelessness

Structural Factors

Structural drivers at the societal level increase the risk of homelessness. Key factors include poverty, housing shortages, and discrimination.

Poverty makes it difficult to afford basic needs like housing, food, and healthcare. People living in poverty are often “one illness, one accident, or one paycheck away from homelessness.”

Lack of safe, affordable, and stable housing worsens the problem. Families spending more than half their income on rent are in “core housing need,” increasing their risk of losing housing.

Discrimination based on race, gender, ethnicity, income, sexual orientation, or disability also limits access to housing, jobs, and services, leaving marginalized groups disproportionately affected.

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- **Access to financial resources** – Limited income, low-paid or precarious jobs, and gaps in social welfare make it difficult for families to maintain housing and meet basic needs.

- **Familial and social support** – Strong networks of family, friends, and community help protect against homelessness. Social isolation increases vulnerability, especially for lone mothers without childcare or emotional support.

- **Social protection systems** – Affordable housing, welfare benefits, childcare, and healthcare are critical. Gaps in these systems—long housing waitlists, insufficient income support, or fragmented services—heighten homelessness risk and reduce recovery capacity.

***FEANTSA** highlights the particular vulnerability of lone mothers and single-parent households. Women raising children alone face high risk of housing loss due to economic, social, and policy factors.*

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SECTION 3 - CAUSES OF HOMELESSNESS AND MAIN STATISTICS

Systems Failures

Even manageable risks can lead to homelessness when institutions fail to respond adequately. Homeless Hub highlights that gaps in child welfare, healthcare, mental health, and correctional systems are major contributors.

For example, young people leaving foster care often lack transitional support, increasing vulnerability. Similarly, patients discharged from hospitals, psychiatric facilities, or prisons without coordinated housing plans frequently become homeless.

Systemic gaps also affect immigrants, refugees, and internal migrants. Limited access to language, legal, or employment support raises their risk of losing stable housing.

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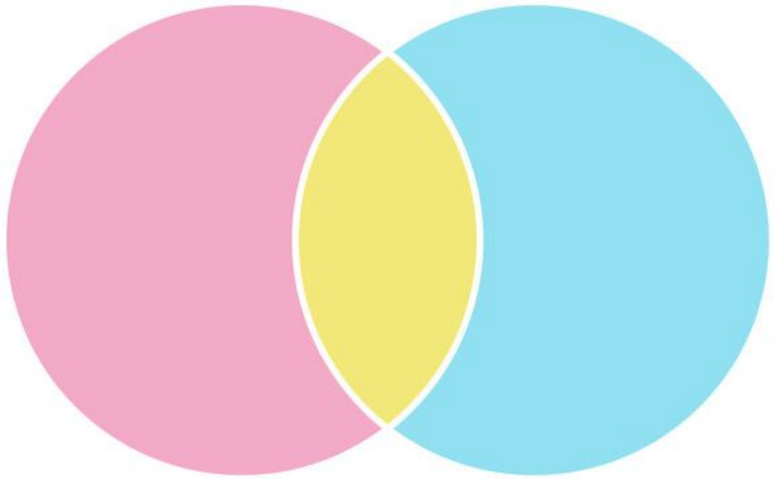
Overlapping Oppressions: Gender, Sexual Orientation and Homelessness

Homelessness often overlaps with other forms of social exclusion–such as gender inequality, migration status, health conditions, and discrimination based on sexual orientation or gender identity–intensifying housing insecurity.

Women's homelessness is increasing and often remains hidden due to factors like gender-based violence, economic dependence, and caregiving responsibilities.

Family rejection and discrimination can contribute to housing instability and homelessness among LGBTI individuals.

These patterns show that homelessness reflects broader social inequalities, highlighting the need for gender-sensitive and LGBTI-inclusion housing and support policies.



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SECTION 3 - CAUSES OF HOMELESSNESS AND MAIN STATISTICS

Personal Circumstances and Relational Problems

Individual circumstances and relationship dynamics can trigger homelessness, especially when vulnerabilities exist. Traumatic events such as job loss, death of loved ones, forced migration, family breakdown, mental health issues, and family or gender-based violence are common triggers.

Family and gender-based violence are particularly urgent causes of homelessness for women and youth, who often must leave home quickly without support or safe alternatives.

Mental health challenges and substance use disorders also increase vulnerability. Among homeless populations in high-income countries, around 76% have a current mental disorder, 44% have a substance use disorder, 19% experience major depression, and 7% have schizophrenia spectrum disorders (Gutwinski et al., 2021).

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SECTION 3 - CAUSES OF HOMELESSNESS AND MAIN STATISTICS

Intersecting Causes: A Complex Web

Homelessness rarely results from a single factor. It arises at the intersection of structural inequalities, weak social support, and inadequate safety nets. Poverty, discrimination, and job insecurity create vulnerability, while gaps in social protection and limited family support remove the safety nets that might prevent housing loss. Lone mothers are particularly affected, navigating these challenges while caring for children.

Most individuals experience multiple, overlapping factors—structural, systemic, and personal—that combine in a cascading way. Structural factors set the context, system failures remove safety nets, and personal or relational crises often tip individuals into homelessness.

UNIT 1:

SECTION 4

APPROACHES TO ADDRESSING HOMELESSNESS

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Effective responses to homelessness improve well-being, promote social cohesion, and reduce public costs in healthcare and emergency services. Homelessness intersects with unemployment, mental health issues, substance use, discrimination, and systemic inequities, making it a complex, multidimensional problem requiring coordinated, evidence-based solutions.

Approaches

To address homelessness, policymakers, service providers, and communities use multiple strategies:

- **Prevention** – reducing the risk of housing loss.
- **Crisis interventions** – responding to urgent needs.
- **Temporary and transitional housing** – providing stability and support.
- **Long-term housing solutions** – such as Housing First or permanent supportive housing, promoting sustained stability and social integration.

Each approach reduces the incidence, duration, and recurrence of homelessness while tailoring support to individuals' and families' circumstances.

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Challenges

Key challenges include identifying those at risk, coordinating across sectors, addressing intersecting needs (e.g., mental health or substance use), and ensuring housing solutions are affordable and accessible. Comprehensive responses require integrating policy, practice, and community engagement.

Measuring Progress

The Centre for Homelessness Impact defines ending homelessness as preventing it whenever possible, and making it rare, brief, and non-recurrent where it occurs. Progress is measured through eight core indicators, including prevalence of long-term and recurrent rough sleeping.

Centre for Homelessness Impact

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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

Retrieved from https://www.homelessnessimpact.org/ending-homelessness-framework-england

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Prevention as the first approach

Peter Mackie (Cardiff University) and Suzanne Fitzpatrick (Heriot-Watt University) developed a framework for homelessness prevention, highlighting how public policies can act at different stages of risk (Mackie et al., 2017).

Typology of Homelessness Prevention

The framework identifies five levels of prevention:

- **Universal prevention**
  Targets the general population to reduce structural and systemic risks through policies like affordable housing, subsidies, and universal housing support.

- **Targeted prevention**
  Focuses on at-risk groups, such as young people leaving care, people leaving prison, or victims of domestic violence.

- **Crisis prevention**
  Intervenes during a housing crisis to prevent eviction or family breakdown from leading to homelessness.

- **Emergency prevention**
  Supports those already sleeping rough, aiming to minimize harm and reduce time without housing through rapid rehousing programs.

- **Recovery prevention**
  Provides post-homelessness support, including psychosocial assistance, rent support, and community integration to prevent relapse and ensure long-term stability.

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Simplified Prevention Framework

Some studies (e.g., Fitzpatrick & Bramley, 2018–2020) simplify Mackie's five-level model into four levels for easier application in national systems like Wales or Scotland: **universal, at-risk, crisis, and chronic**. In this version, "emergency" merges with crisis, and "recovery" merges with chronic.

Primary Prevention

Aims to stop homelessness before risk appears by addressing structural factors and strengthening housing and welfare systems. Strategies include:

- Increasing social and public housing
- Rent controls and tenant protections
- Policies limiting speculation and promoting affordable housing
- Poverty reduction measures, minimum income guarantees, and support for survivors of gender-based violence
- Universal access to mental health, substance-use, education, and social protection services

Primary prevention is usually led by governments and reduces the number of people entering homelessness.

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Secondary Prevention

Focuses on early intervention when housing instability is detected. Methods include:

- Early identification through healthcare, schools, social services, or women's services
- Targeted support for high-risk groups: youth leaving care, people exiting institutions, migrants and refugees, women and LGBTQ+ individuals facing family rejection or violence
- Practical, short-term assistance like rent arrears support, mediation, legal advice, and emergency financial aid

Effective secondary prevention can stop evictions, stabilize families, and reduce public spending.

Tertiary Prevention

Aims to prevent recurrence for people who have already experienced homelessness. Key measures include:

- Supportive housing, such as Housing First programs
- Case management, mental health, and trauma-informed services
- Income assistance, employment pathways, and long-term tenancy support
- Specialized programs for survivors of domestic violence

Tertiary prevention recognizes that housing alone is insufficient for people with complex needs; ongoing, tailored support is essential for long-term stability.

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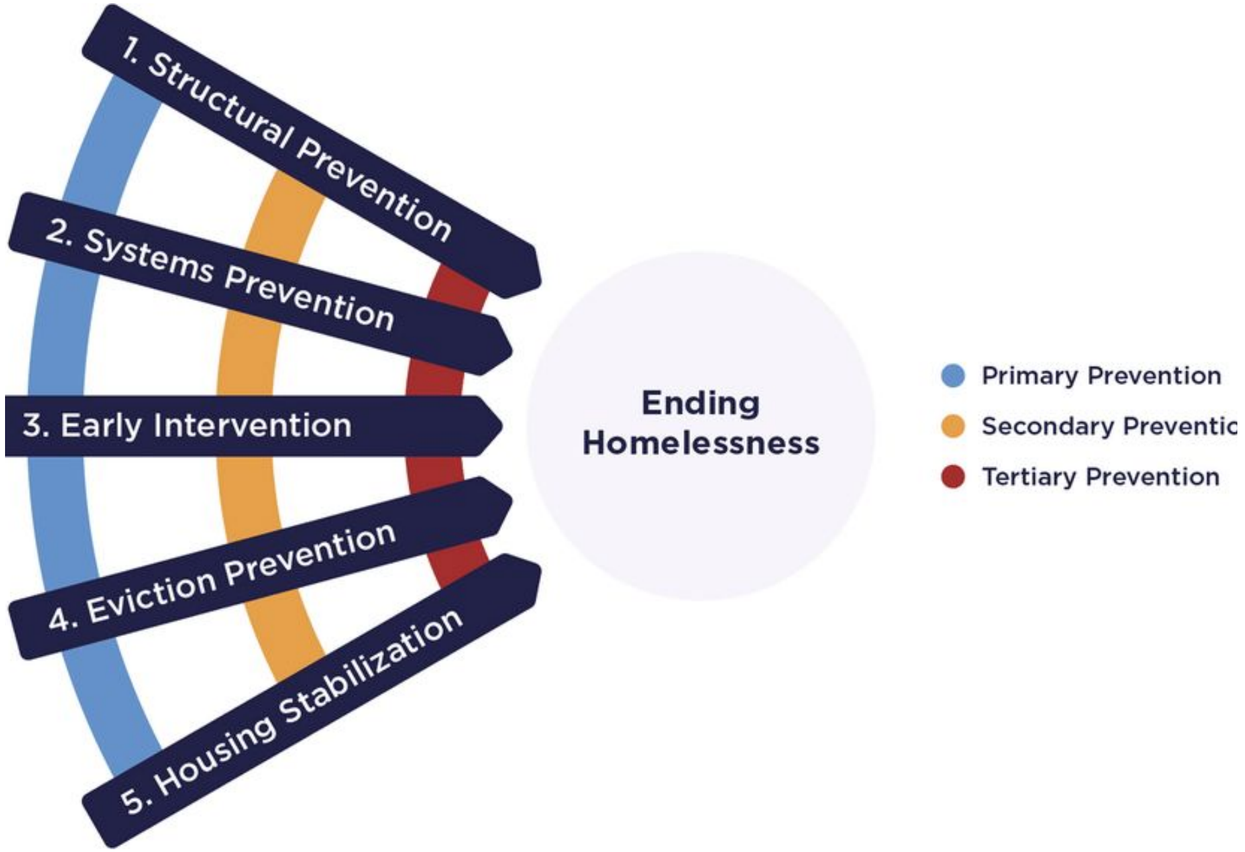
Alternative Frameworks

Other authors, such as Dej, Gaetz, & Schwan (2020), propose additional frameworks identifying multiple interrelated elements necessary for effective homelessness prevention, emphasizing integration across policy, services, and community support.

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



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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.

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Emergency Response / Crisis Intervention (1)

Emergency or crisis services provide immediate, short-term support for people experiencing homelessness, ensuring safety, dignity, and basic needs like shelter, food, and sanitation. They act as the first line of support while longer-term solutions are arranged.

In Europe, these services include 24/7 shelters, day centres, outreach teams, mobile support, and emergency accommodation provided by public authorities and civil society. While not sufficient to end homelessness alone, they reduce immediate harms and offer pathways to additional support and housing.

European networks, including FEANTSA, emphasize that emergency services should be accessible to all, regardless of administrative status, and call for more dignified, 24-hour facilities instead of “night-only” shelters, to better meet people’s holistic needs.

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Emergency Response / Crisis Intervention (2)

The Lisbon Declaration (2021) highlights that emergency accommodation is a fundamental right: no one should sleep rough due to lack of safe, accessible shelter. It also emphasizes that people should not stay in emergency or transitional housing longer than necessary, linking crisis support to longer-term pathways out of homelessness.

Emergency services across Europe aim to reduce immediate harm and coordinate care. For example, in Spain, the Red Cross operates mobile emergency units (Unidades Móviles de Emergencia Social) that provide food, blankets, hygiene products, and referrals to shelters. In 2025, 91 units across 35 provinces served over 22,000 people, ensuring rapid support during crisis periods like cold weather.

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Temporary or Transitional Housing (1)

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

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Temporary or Transitional Housing (2)

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.

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Housing First / Permanent Supportive Housing (1)

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.

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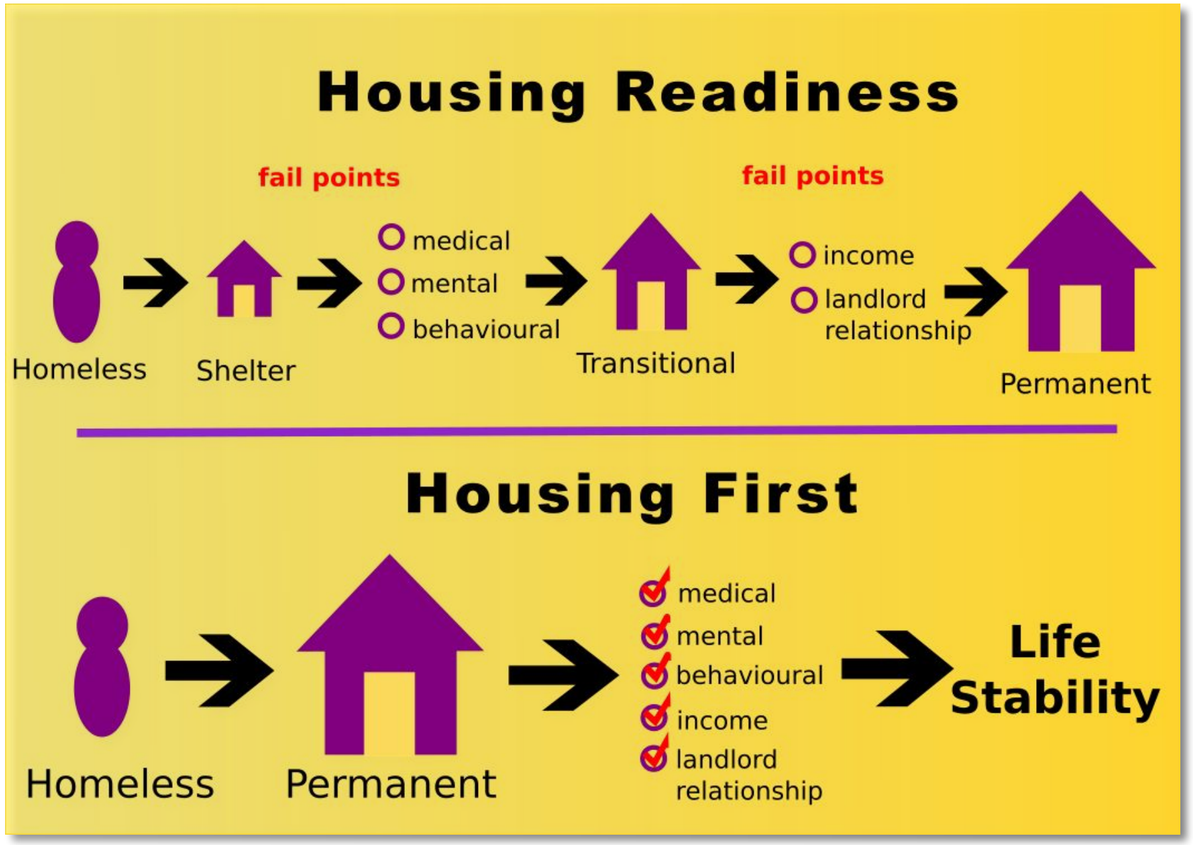
Housing First / Permanent Supportive Housing (2)

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.



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Temporary or Transitional Housing (3)

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 COMBATING HOMELESSNESS

UNIT 2:

SECTION 1

PUBLIC POLICY

UNIT 1 – UNDERSTANDING HOMELESSNESS

SECTION 4 - APPROACHES TO ADDRESSING HOMELESSNESS

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.

Lisbon Declaration on the European Platform on Combatting Homelessness (2021)

- **Commitment to end homelessness by 2030:**

  EU institutions, Member States and stakeholders agree that homelessness is unacceptable and pledge to work towards eliminating it, in line with the European Pillar of Social Rights.

- **Prevention and housing-led approaches:**

  Priority is given to preventing homelessness and promoting stable housing solutions (especially Housing First), ensuring that no one leaves institutions or emergency services into homelessness.

- **Integrated, rights-based support:**

  Homelessness should be addressed through coordinated social, health, employment and housing policies, with special attention to vulnerable groups and respect for dignity and fundamental rights.

"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 Homelessness***

UNIT 1 – UNDERSTANDING HOMELESSNESS

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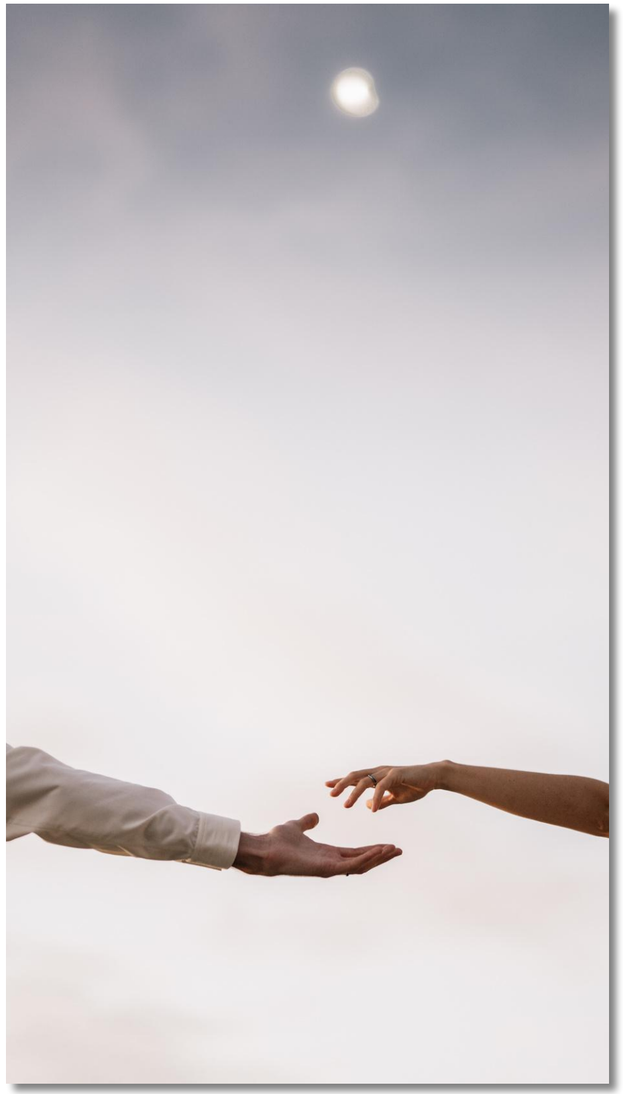
BASIC HUMANS RIGHTS AS THE BACKGROUND FOR HOMELESSNESS POLICIES

Within the EU, **national legislation often incorporates these human rights-centered 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 in general but also for vulnerable groups, including migrants, refugees, women experiencing gbv 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. → Bottom-up policies!

By framing homelessness in a legal and human rights context, practitioners and policymakers can support people now while driving systemic change and advancing social justice.



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BASIC HUMANS RIGHTS AS THE BACKGROUND FOR HOMELESSNESS POLICIES

Homelessness does not affect all populations equally → 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 must consider the ways in which **multiple social identities and structural inequalities intersect to increase vulnerability** (housing, health, and social services).

- Migrant and refugee women may face language barriers, precarious legal status, and discrimination that limit access to both housing and social services.
- Older adults experiencing homelessness often confront age-specific challenges such as limited mobility, health vulnerabilities, and social isolation → Lack of specialized resources
- People with disabilities or chronic health conditions may require tailored support (accessible housing, healthcare continuity, and adaptive social services)
- Women experiencing Gender Based Violence face additional layers of vulnerability, where housing instability may be affected by financial control, coercion, or the need to escape unsafe domestic environments.
- Etc…

This approach requires the collection of disaggregated data, coordination across sectors, and the active involvement of affected communities in policy design.

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EVALUATION AND ACCOUNTABILITY MECHANISMS ON HOMELESSNESS POLICY AND ADVOCACY

Effective policies require systematic evaluation and accountability mechanisms.

- **Policies must be monitored** to determine whether they are achieving their intended outcomes,
- **Policies must develop 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 include qualitative dimensions**

Responsiveness of interventions to the specific needs of marginalized populations. → **User experience** → **Perceived accessibility of services**

A combination of quantitative and qualitative indicators to get a complete overview of the policies being implemented

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EVALUATION AND ACCOUNTABILITY MECHANISMS ON HOMELESSNESS POLICY AND ADVOCACY

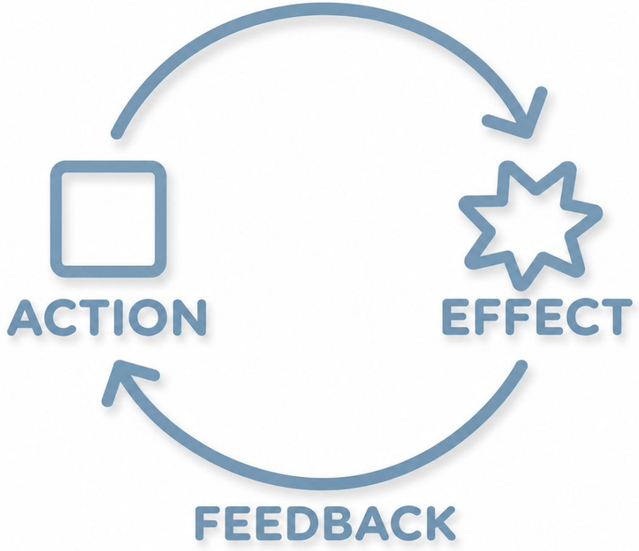
Accountability mechanisms are equally important:

- Develop **reporting structures** that allow governments, local authorities, and service providers to demonstrate progress;
- Perform **independent audits** that validate results;
- Channels for civil society and community organizations to provide feedback or highlight systemic shortcomings.

By using evaluation data and evidence-based research, **advocacy can:**

- push for policy improvements;
- identify and replicate successful models;
- ensure that commitments made at national or European levels are translated into meaningful change on the ground.

Evaluation and accountability create a **feedback loop** that strengthens interventions, supports advocacy efforts and improves outcomes for people experiencing homelessness



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Multi-Level Governance and Cross-Sector Collaboration

Grassroots organisations play a crucial role in linking lived experience to policy change.

Some examples:

- **Hungary,** the advocacy group The City is For All (A Város Mindenkié) works with people experiencing homelessness and housing poverty. Their efforts helped bring housing issues into the foreground of public debate and influence local and national policy agendas. They do this by:
  - stopping evictions;
  - providing legal support via affiliated groups ;
  - amplifying housing justice into national political conversation

- **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.

  Habita! participates in European coalitions → European Action Coalition for the Right to Housing and the City,

***City-led initiatives** also illustrate how governance at municipal and regional levels contributes to system-wide responses, fostering collaboration among public services, NGOs, and community stakeholders.*

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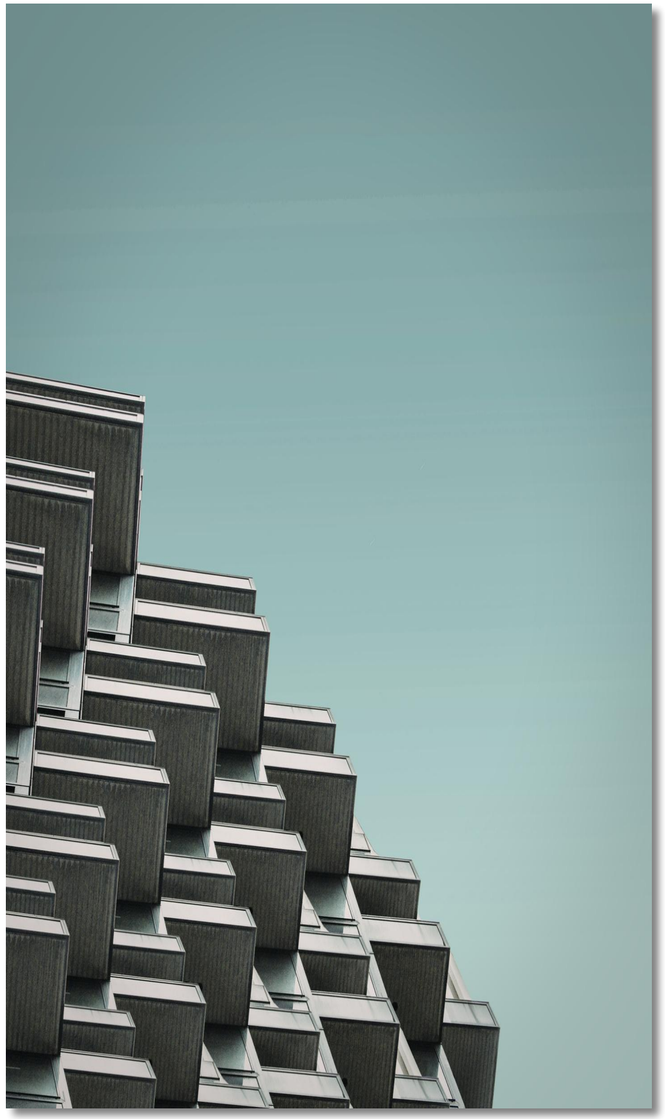
Multi -Level Governance and Cross -Sector Collaboration

> The Netherlands - Valente's project Cultuuromslag – NAD in je DNA, a project led by the HVO-Querido Centre of Expertise on behalf of Valente, 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.

Multi-level governance in homelessness is about

2. Aligning policy across institutional layers;
3. Creating spaces for dialogue, joint problem-solving, and shared accountability.
4. Ensuring that the commitments made at the European level are translated into real change on the ground.

Effective advocacy helps to challenge all barriers around housing by amplifying the voices of those affected, and ensuring that public policies are responsive to their needs.



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Concrete Policies: Housing, Public Health and Social Services (1)

Specific housing policy, access to secure, affordable, and adequate housing and prevention of homelessness are fundamental and provide the **stability necessary for individuals to address other life challenges.**

Strategies such as the **Housing First model**, 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 - 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.

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Concrete Policies: Housing, Public Health and Social Services (2)

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.

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Concrete Policies: Housing, Public Health and Social Services (3)

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.

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Concrete Policies: Housing, Public Health and Social Services (4)

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.*

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Concrete Policies: Housing, Public Health and Social Services (6)

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.

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Funding and Resource Allocation

All the strategies, policies, and advocacy efforts 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.

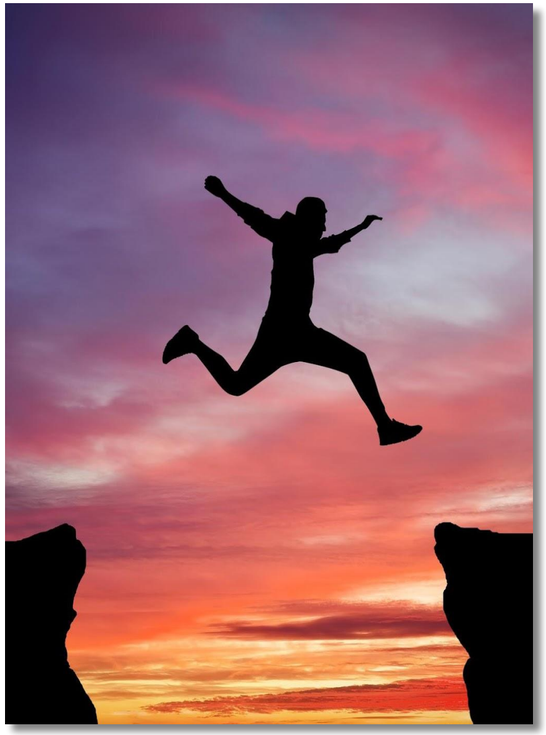
Funding ensures that evidence-based initiatives like Housing First, integrated social services, and targeted support for vulnerable groups can be scaled, monitored, and maintained over time.

Resource allocation is not just about quantity but also about strategic distribution. Resources must reach the populations most at risk, 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.

Funding also 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.



UNIT 2:

SECTION 2

DEFINITION OF ADVOCACY

UNIT 2 – SUCCESSFUL PUBLIC POLICY AND ADVOCACY IN COMBATING HOMELESSNESS

SECTION 2 - DEFINITION OF ADVOCACY

Advocacy: a process through which individuals, groups, or organizations educate the public and policymakers about the state of homelessness, its societal impacts, and potential solutions (The Institute of Global Homelessness)

Effective advocacy includes r**aising 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.

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).

Institute of Global Homelessness. (n.d.). *Global advocacy*. Institute of Global Homelessness. https://ighomelessness.org/globaladvocacy/

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, 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.

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SECTION 2 - DEFINITION OF ADVOCACY

The role of CSOs:

- Provide direct services
- Work to transform the social and policy environment that perpetuates housing insecurity.
- Combine evidence-based recommendations with public engagement and political advocacy
- Contribute to creating systemic changes that improve access to housing, healthcare, and social support
- Promote social inclusion and protecting the rights of people experiencing homelessness.

...And informal networks

Research shows that informal social support (friends or family) who provide guidance and encouragement, can play a critical role in improving outcomes for people experiencing homelessness. These personal networks often have a stronger influence on day-to-day wellbeing and resilience (Babayan, Futrell, Stover & Hagopian, 2021).

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. → 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).

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SECTION 2 - DEFINITION OF ADVOCACY

ACTIVITY 6.3 - ADVOCACY CAMPAIGN ANALYSIS

40 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Activity

Part 1: Group Campaign Analysis (20 minutes)

a. Analyze 3 advocacy campaigns from the Campaign Overviews document using the guiding questions on the Campaign Analysis Worksheet. For this material, check the toolkit
b. Prepare a short summary of your findings to present to the full group.

Part 2: Group Presentations (5–7 minutes per group)

c. Present your analysis to the larger group. There will be 1–2 minutes for clarifying questions at the
d. end of each presentation.

Part 3: Wrap-Up & Debrief

e. As a large group, we will consider key takeaways from the activity.

UNIT 2:

SECTION 3

ACTIVE ADVOCACY FOR SYSTEMIC CHANGE IN THE FIELD OF HOMELESSNESS

UNIT 2 – SUCCESSFUL PUBLIC POLICY AND ADVOCACY IN COMBATING HOMELESSNESS

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.**

ts 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.**

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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.

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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.

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.**

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SECTION 3 - ACTIVE ADVOCACY FOR SYSTEMIC CHANGE IN THE FIELD OF HOMELESSNESS

Persuasion and Lobbying

- **Direct lobbying: communicating directly with policymakers**—through meetings, briefings, or expert consultations—t**o advocate for specific policy reforms**, such as expanding social housing stock or improving access to healthcare for people experiencing homelessness.
- **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 alliances, and visible engagement in the media.

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

Focused on strengthening confidence, knowledge, and political agency among people experiencing homelessness: 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.

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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.

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 comprised of peers constitute effective mechanisms for ensuring representation and accountability.

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.

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.

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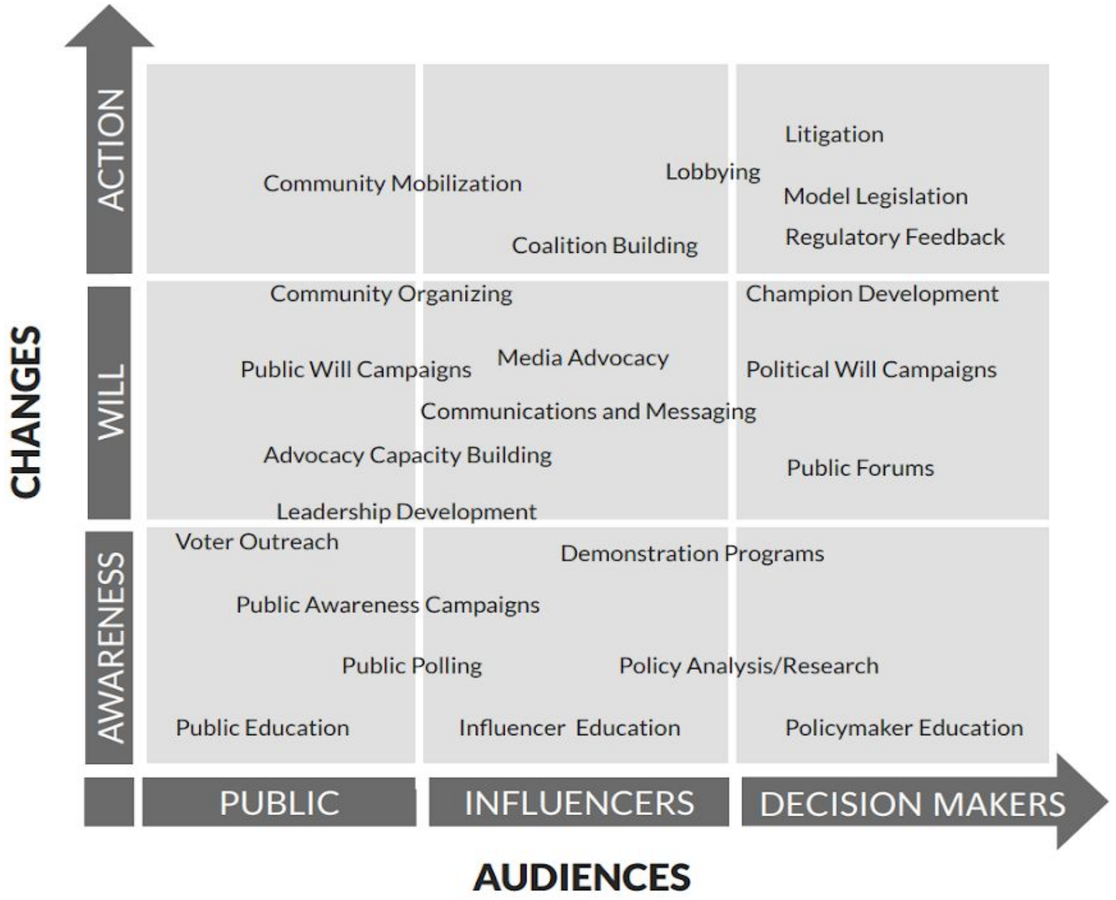
Advocacy Strategy Framework (1)

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.



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Advocacy Strategy Framework (2)

The framework is built around two key dimensions:

1. who you are trying to influence
2. 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:

1. raising awareness
2. building will
3. prompting 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 ex.: 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.

You can get to know this framework in greater depth here.

UNIT 2:

SECTION 4

LANGUAGE USED WHEN COMMUNICATING ON HOMELESSNESS

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SECTION 3 - ACTIVE ADVOCACY FOR SYSTEMIC CHANGE IN THE FIELD OF HOMELESSNESS

Language is deeply intertwined with identity and power;

How society talks about homelessness can influence:

- public attitudes
- how individuals experiencing homelessness see themselves.

Research shows that common labels such as "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), whereas the use of first person terms promotes dignity and empathy.

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).

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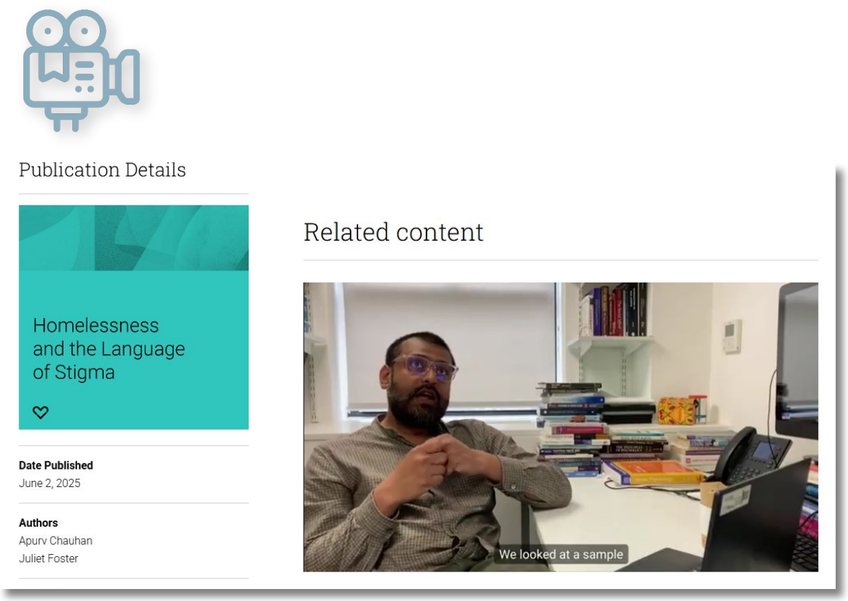
Scholars have also introduced the concept of "homeism" to describe **systemic devaluation and discrimination against people because of their housing status** (Fitzpatrick et al., 2021).

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 1) person-first phrasing, 2) avoidance of unnecessary labeling, 3) rejection of stereotypes linked to personal failure or addiction (King's College London, 2022).



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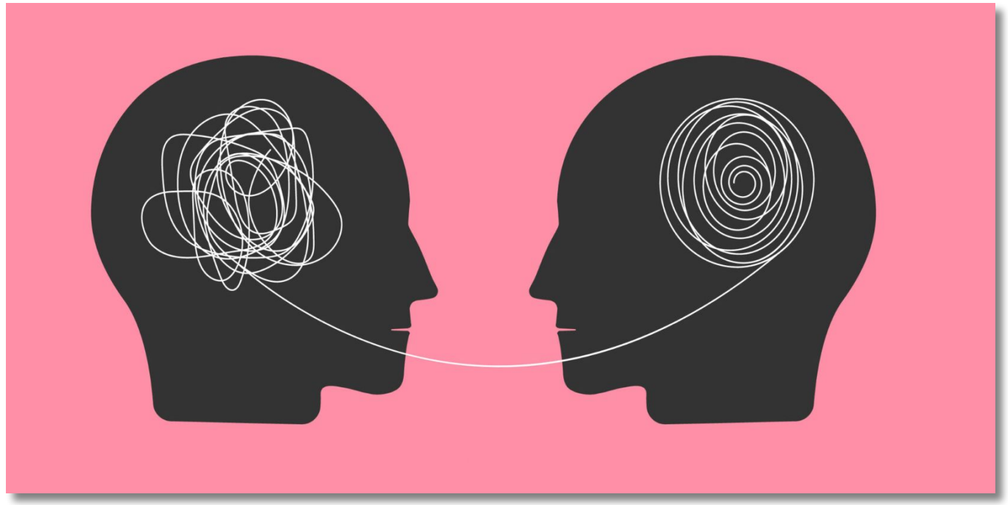
The Role of Language in Social Relations

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).
- 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.



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SECTION 3 - ACTIVE ADVOCACY FOR SYSTEMIC CHANGE IN THE FIELD OF HOMELESSNESS

Inclusive Language as a Means of Empowerment

Emphasizes the person before their condition and foster a more positive social environment.
Person-first language focuses on the individual rather than their circumstance, promoting dignity and respect.
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

Language 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.**

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.

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Good Practices in Language Use (1)		
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.

Good Practices in Language Use (2)		
Good practice	**Why?**	**Examples**
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.

UNIT 2 – SUCCESSFUL PUBLIC POLICY AND ADVOCACY IN COMBATING HOMELESSNESS

SECTION 4 - LANGUAGE USED WHEN COMMUNICATING ON HOMELESSNESS

ACTIVITY 6.4 - MAKING OUR VOICE HEARD: DESIGNING AN ADVOCACY CAMPAIGN WITH THE ADVOCACY STRATEGY FRAMEWORK (1)

30-40 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

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.

Activity

Part 1: Advocacy Topic & Primary Campaign Goal

- Each group should select one topic related to homelessness you believe requires urgent advocacy. Examples
  - Increasing availability of Housing First programs
  - Preventing evictions and improving tenant protections
  - Ensuring access to trauma-informed shelter services
  - Increasing funding for supportive housing
  - Reducing stigma and discrimination around homelessness
  - Improving access to mental health or addiction support for unhoused people
- Each group should decide what policy or systems of change they want their campaign to influence.

UNIT 2 – SUCCESSFUL PUBLIC POLICY AND ADVOCACY IN COMBATING HOMELESSNESS

SECTION 4 - LANGUAGE USED WHEN COMMUNICATING ON HOMELESSNESS

ACTIVITY 6.4 - MAKING OUR VOICE HEARD: DESIGNING AN ADVOCACY CAMPAIGN WITH THE ADVOCACY STRATEGY FRAMEWORK (2)

30-40 MINUTES

Note: activity should be done in group training sessions, not applicable for self learning

Activity

Part 2: Designing the Campaign

- With your group, design an advocacy campaign using the the core components of the Advocacy Strategy Framework, as outlined on the Designing an Advocacy Campaign document. **For the material, check the toolkit**
    - Key Audiences: Categorize specific audiences based on who you are trying to influence.
    - Desired Change: Describe what you hope to accomplish with each audience at each level.
    - Engagement Strategy: How will you reach each audience to create the desired change?
- Core Message(s): What key messages best support awareness, will, and action at each level of the selected audiences?
- Actions/Tactics: Choose actions/tactics that align with both the specific audiences and the levels of change they aim for within the table.
- Visual Representation: Using a template on Canva, design a poster/flyer/brochure/social media post, etc., visually representing your campaign. Format the template in such a way that best visually represent your campaign. Follow the QR code to access the Canva template.

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Activity

Part 3: Presentation and Feedback (10–15 minutes)

- Each group will present their advocacy campaign to the full group. Participants should respond with constructive feedback, questions, or suggestions, especially about:
  - Whether audiences were placed appropriately on the framework.
  - Whether the identified tactics align with awareness, will, or action.
  - How well the strategy connects to the overarching goal.

HOME 4 HEALTH

Coordinated by:

GROUP ABD Welfare and Development Association

In partnership with:

CRES CER (Portugal)

HVO QUERIDO (Netherlands)

Cork Simon Community (Ireland)

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