



HOME! HEALTH

VET TRAINING ON HARM REDUCTION AND HOUSING FIRST TOOLS TOOLKIT

Developed by: ABD team

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Module Durations

Module 1	Module 2	Module 3	Module 4	Module 5	Module 5
Unit 1 (120 min.) Activity 1.1: 15-20 min. Activity 1.2: 45 min.	Unit 1 (180 min.) Activity 2.1: 15 min. Activity 2.2: 40 min. Activity 2.3: 30 min.	Unit 1 (120 min.) Activity 3.1: 10 min. Activity 3.2: 25 min. Activity 3.3: 25 min.	Unit 1 (170 min.) Activity 4.1: 40 min. Activity 4.2: 40 min.	Unit 1 (195 min.) Activity 5.1: 30 min. Activity 5.2: 45 min. Activity 5.3: 30 min.	Unit 1 (155 min.) Activity 6.1: 25 min. Activity 6.2: 40 min.
Unit 2 (180 min.) Activity 1.3: 30 min.	Unit 2 (90 min.) Activity 2.4: 40 min.	Unit 2 (170 min.) Activity 3.4: 40 min.	Unit 2 (180 min.) Activity 4.3: 60 min.	Unit 2 (110 min.) Activity 5.4: 50 min.	Unit 2 (265 min.) Activity 6.3: 35 min. Activity 6.4: 50 min.
Unit 3 (180 min.) Activity 1.4: 30 min. Activity 1.5: 30 min.	Unit 3 (90 min.) Activity 2.5: 30 min.	Unit 3 (160 min.) Activity 3.5: 30 min. Activity 3.6: 40 min.	Unit 3 (60 min.)		
	Unit 4 (180 min.) Activity 2.6: 30 min.				
Total Duration: 8 hours	Total Duration: 9 hours	Total Duration: 7.5 hours	Total Duration: 7 hours	Total Duration: 5 hours	Total Duration: 7 hours

1. Introduction

This document constitutes the official Toolkit designed to support the effective implementation of the Home4Health VET Training for professionals working in homeless and drug use contexts by qualified trainers and facilitators in real-life training environments. While the toolkit has been developed with a primary focus on in-person training delivery, its structure and resources are intentionally formulated to allow for a consistent and seamless adaptation to online or blended learning modalities, thereby ensuring broad applicability across diverse training contexts.

The structure of this material follows that of the Training Program and is also fully aligned with the MOOC, ensuring consistency across all learning materials and a coherent integration between theoretical foundations and practical application in different learning formats.

By maintaining this shared structure, the Training Program, Toolkit, and MOOC together facilitate a coherent and progressive learning experience, enabling facilitators and learners to navigate each module with clarity and purpose while ensuring consistent, high-quality instruction across all formats.

Moreover, the toolkit embodies the cumulative experience, professional expertise, and lessons learned throughout the design, testing, and refinement phases of the Home4Health initiative. It integrates evidence-informed practices, pedagogical recommendations, and context-appropriate methodologies aimed at enhancing participant engagement and supporting the development of relevant competencies.

In addition to providing comprehensive guidance for session planning and delivery, the toolkit offers a wide range of practical resources—including step-by-step facilitation instructions, preparatory checklists, materials lists, discussion prompts, and activity guides—to assist trainers in implementing the Training Program with accuracy, consistency, and confidence. It aims not only to operationalize the theoretical framework of the program but also to promote a participatory, inclusive, and culturally sensitive approach to training.

Ultimately, this toolkit serves as a fundamental instrument to ensure that the objectives of the Home4Health Training Program are consistently achieved, enabling facilitators to deliver impactful learning experiences that contribute to improved knowledge, strengthened capacities, and enhanced outcomes for all participants.

2. How to use this Toolkit

Each module follows a consistent structure:

- Modules are divided into several Units.
- Each Unit is further divided into Sections.
- Each Section includes a brief summary of the theoretical concepts addressed, followed by a detailed description of the activities to be carried out.
- All activities include step-by-step instructions to support implementation and facilitation.
- Each activity specifies the required materials, estimated duration, procedural steps, and any tools needed.
- All tools referenced in the activities are provided in the Annexes of this document.
- Additional notes and guidance appear throughout the toolkit to support and enrich the implementation of the activities.

Key points to keep in mind as a trainer:

RECOMMENDED:

- ✓ Read the entire training module before the workshop begins, which is aligned with this toolkit.
- ✓ Be flexible—scheduling may shift depending on participants' needs.
- ✓ Proactively engage trainees—use a variety of teaching methods to boost engagement and maintain interest, such as asking questions and encouraging feedback.
- ✓ Invite participants to share personal knowledge and experiences relevant to the program material—show appreciation and validate contributions made by participants.
- ✓ Make sure all teaching materials, including handouts and visuals, are prepared before each session.
- ✓ Ensure that by the end of the training, a provision is made for participants to facilitate questions, exploration and sharing of experience and for the evaluation.

NOT RECOMMENDED:

- ✗ Allowing distractions such as mobile phones or side conversations between participants.
- ✗ Talking *at* participants instead of *with* them as part of an interactive discussion.
- ✗ Reading directly from PowerPoint slides (it's better to prepare well and use the slides as prompts to expand on the key points).

3. Module 1: Harm Reduction

Unit 1 - An introductory overview

Learning objectives

- Define Harm Reduction and its relevance across different intervention areas
- Explain the origins, principles, methodology, and strategies of Harm Reduction

3.1 Section 1 - Introduction to the course and participant introductions

The trainer should introduce the objectives of the course, the methodology and the materials needed, as well as clarify any possible doubts.

3.1.2 ACTIVITY 1.1

ICEBREAKER: "INTRODUCE ONE ANOTHER"

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.

PRACTICAL ASPECTS

- **Duration:** 15-25 duration.
- **Materials needed:**
 - Printed or written guiding questions (optional);
 - Timer to help keep each part moving.
- **Expected outcomes:**
 - This icebreaker will encourage the creation of bonds and shared understanding among the group.
 - Building empathy and bonds among participants, setting a tone of collaboration, listening, and respect.

INSTRUCTIONS

1. Preparation (5 minutes):

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)?
- ✓ What's one thing you do to take care of yourself outside of work?

2. Activity (10 minutes):

- Participants decide how they will form pairs (randomly, nearby seats, or intentionally mixed).
- Suggest a few guiding questions, like the ones above, to help the conversation between the participants flow.
- 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.
- After taking time to talk, then participants introduce their partner to the rest of the group by sharing a few key things they learned.

3. Wrap up (10 minutes):

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.

3.2 Section 2 - Definitions

The trainer should introduce the concepts of harm reduction as a framework approach to homelessness, trauma and use of psychoactive substances. They should include the theoretical explanation of what harm reduction is, along with its origins, history and societal impact.

The trainer should introduce and share the following harm reduction historic highlights:

- The Origins of Harm Reduction
- Early Shifts in Drug Policy: The Netherlands
- The Role of Dutch Substance Users in Policy Change

The trainer should also provide the following links for more information on the topic:

- ✓ [Correlation International resources](#)
- ✓ [Amsterdam Public Health Service resources](#)
- ✓ [European Union Drugs Agency resources](#)
- ✓ [International Network of People who use Drugs resources](#)
- ✓ [A Brief History of Cannabis Policies in Spain \(1968–2003\)](#)
- ✓ [Reframing Dutch drug policies: a new era for harm reduction](#)
- ✓ [25 years of Irish Drug Policy – Looking Back to Look Forward](#)
- ✓ [20 years of Portuguese drug policy - developments, challenges and the quest for human rights](#)
- ✓ [National Strategy on Addictions – Portugal](#)
- ✓ [Dutch culture's role in modern drug policy](#)
- ✓ [Citizens' want to improve Irish drug policy](#)
- ✓ [Drug decriminalisation in Portugal: setting the record straight](#)

Also the following video:

- ✓ [The harm reduction model of drug addiction treatment | Mark Tyndall - TED](#)

3.3 Section 3 - Applied principles

The trainer should introduce a theoretical presentation of the harm reduction approach core principles and explain the practical, non-judgmental, and inclusive strategies that focus on empowering and providing care to individuals. The trainer should also facilitate a discussion activity to learn about them.

The 4 applied principles are:

- a. Individual-Centered Care
- b. Bottom-Up Approach
- c. Low-Threshold Services
- d. Non-Judgemental Approach

3.3.1 ACTIVITY 1.2 – CASE STUDIES

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.

PRACTICAL ASPECTS

- **Duration:** 45 minutes.
- **Materials Needed:**
 - Printed or digital case studies with guiding questions (1 per group, from different countries) ([Annex 1](#))
 - Pens and paper for group notes or a shared digital document where to take notes.
- **Expected Outcomes:**

By the end of this activity, participants will be able to identify key harm reduction strategies and principles present in real-world contexts, recognize barriers to their implementation, and suggest practical improvements. Through group discussion and comparison of case studies from different countries, they will develop a deeper understanding of how harm reduction has evolved globally and strengthen their ability to think critically and collaboratively about drug policy.

INSTRUCTIONS

1. Preparation (5 minutes):

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

2. Activity (25 minutes):

- In groups, participants read and discuss their assigned case study.
- Using the guiding questions, they identify:
 - ✓ *What harm reduction strategies are present?*
 - Practical interventions that reduce risk without requiring abstinence. Examples:
 - Sheila: Securing supervised contact with her child, structured wellness program, psychological support at home
 - Peter: Grocery shopping support, beer cap tracking tool, housing stability support
 - Mary: Gradual alcohol reduction support, mental health follow-up, engagement in training/occupational activities
 - Ali: Alcohol Maintained Program, transition from THC to CBD, emotional support, harm reduction shelter.
 - ✓ *Which principles of harm reduction are reflected?*
 - Meeting the person “where they are,” respecting autonomy
 - Focusing on risk reduction rather than abstinence

- Emphasizing trust, safety, and empowerment
- Examples:
 - Flexible approaches to alcohol use (Peter, Mary Ann, IG)
 - Support for maintaining housing despite ongoing substance use
 - Emotional and practical support without judgment

✓ *What barriers are visible?*

- Systemic barriers: Delays in documentation, limited access to formal employment, fragmented services
- Personal barriers: Alcohol and substance use, trauma, mental health issues, instability in housing or relationships
- Social barriers: Loss of support networks, discrimination, limited social connections outside substance-using peers

✓ *What could be improved?*

- Better service coordination between NGOs, health services, and social support
- More accessible and flexible interventions that account for trauma and substance use
- Support for long-term goals, such as employment, education, and stable housing
- Enhanced social and community integration, including safe peer networks and mentorship
- Consistent follow-up for mental health and substance use, using non-judgmental, person-centered approaches.

3. Wrap-Up (15 minutes):

- 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

Learning objectives

- Identify Harm Reduction strategies for supporting people experiencing homelessness, complex health issues, addiction, or trauma

3.4 Section 1 - Models of intervention

Brief presentation by trainer on the main models that provide a theoretical framework for the harm reduction approach applied to substance addiction and trauma. Person-Centered Humanistic Approach; Transtheoretical Model - Stages of Change; Relapse Prevention Model.

3.5 Section 2 - Methodologies and tools of intervention

The trainer should present and explore of the main methodologies and tools for intervention:

- Motivational Interviewing;
- Integrative Harm Reduction Psychotherapy (IHRP);
- Active Listening, Reflective Listening and Communication Techniques in a Support Intervention Context.

3.5.1 ACTIVITY 1.3 CASE STUDY ROLE-PLAY

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.

PRACTICAL ASPECTS

- **Duration:** 30 minutes.
- **Materials Needed:**
 - Printed examples of case studies ([Annex 2](#)).
 - Pens and paper for reflection.
 - Timer or clock.

- **Expected Outcomes:**

By the end of this activity, participants will have practiced applying harm reduction principles and intervention tools in realistic scenarios, enhancing their confidence, empathy, and communication skills. They will gain insight into the complexities faced by people who use drugs, reflect on their own approach and biases, and identify effective strategies for building trust and offering support.

INSTRUCTIONS

Participants will engage in a guided role play where one acts as a support worker and the other as a person struggling with substance addiction. The goal is to explore a realistic scenario, where participants can apply harm reduction methodologies and tools through role-play, reinforcing practical intervention skills.

1. Preparation (5 minutes):

- Divide the participants into small groups of 3-4.
- Provide each group with a brief case study scenario ([Annex 2](#)).
- Assign roles (support worker and person being supported).

2. Activity (15 minutes):

- 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).

3. Wrap-Up (10 minutes):

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?

3.6 Section 3 - Showcase of practical communication tools

The trainer should showcase 3 examples of activities that can be used in practical interaction with the client and that can improve the relationship with the client to establish an interactive and useful communication. These activities are explained below.

The trainer can print out each activity to distribute to the trainees or project them along with the presentation.

1. “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 personal 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.



2. 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.

Actions to Charge the Battery – Recovery

HVO QUERIDO	Client	Support Worker
	What is your behavior when “things are wrong”?	Share what the support can do when “things are wrong”
	What is your day-to-day like when “things aren’t going well”?	Explain how the support worker can recognize signals when “things are not going well”
	What is your behavior like when “everything is fine”?	Tell what the support worker can do when “everything is fine”



3. What If?!

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.



Unit 3 - Good practices on homelessness, substance use and trauma

Learning objectives

- Analyse how Harm Reduction strategies can be applied in different intervention contexts

3.7 Section 1 - Peer work perspective

The trainer should introduce these 8 practices:

- One-On-One Support,
- Collaboration with Other Service Providers,
- Resource Navigation,
- Crisis Intervention,
- Life Skills Development and Access to Information,
- Group Facilitation,
- Advocacy,
- Building Self-Efficiency and Empowerment.

3.8 Section 2 - Basic living conditions: Self-care, housing, employment, and access to healthcare

The trainer should be educated on and introduce these topics:

- Self-Care,
- Housing (Housing First, Rapid Re-Housing, Diversion),
- Employment (Low Threshold Employment),
- Access to Healthcare (Decentralization of Care).

3.8.1 ACTIVITY 1.4 – VIDEO FORUM

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.

PRACTICAL ASPECTS

- **Duration:** 30 minutes.
- **Materials Needed:**
 - Links to the videos (Below)
 - Computer, projector and internet connection
- **Expected Outcomes:**

After this activity, trainees will be familiar with a range of existing programs designed to address homelessness, including approaches focused on housing, employment, and broader social integration strategies.

INSTRUCTIONS

1. Preparation:

Prepare 2 or 3 videos from the following list:

- https://www.youtube.com/watch?v=sN9Md6m_6lo
- <https://www.youtube.com/watch?v=QZdIYvSE-f8>
- <https://vimeo.com/586709594?fl=pl&fe=sh>
- <https://www.corksion.com/50-faces/jj/>
- <https://www.corksion.com/50-faces/marguerite/>
- <https://www.linkedin.com/feed/update/activity:7366877241890328577>

Also provide trainees with links to examples of **good practice programs**, such as:

- **Housing First**
[CRESCER - É UMA CASA, Lisboa Vivienda Primer proyecto](#)
- **Rapid Re Housing**
[Comunidad Simon de Cork – Proyecto de 12 semanas](#)
[CRESCER – Unidad Municipal de Empleo y Autonomía \(UMEA\)](#)
- **Diversión**
[Servicio comunitario de emergencias y desvío de pacientes de Cork Simon Community](#)
[CRESCER – Unidad Municipal de Prevención y Autonomía \(UMPA\)](#)
- **Low threshold employment**
[CRESCER – É Um Restaurante/Negocio social](#)
[Servicio Social, de Integración y Participación de la Comunidad Simon de Cork](#)

2. Activity:

Show 2–3 selected videos featuring real-world harm reduction or homelessness intervention programs. After each video, allow approximately 5 minutes for participants to discuss what they observed, reflect on the practices presented, and share their thoughts on the approach. Encourage open dialogue about the effectiveness, relevance, and transferability of these practices to other contexts.

3. Wrap-up:

Conclude the activity with a group reflection by asking questions such as:

- 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?

The trainer should encourage participants to reflect on which practices they found most inspiring or applicable to their own work. Highlight the importance of adapting best practices to local contexts and remind trainees that innovation often emerges from combining different approaches. Finally, invite them to explore the shared links in more depth after the session to continue learning independently.

3.9 Section 3 - Psychoactive substance use

The trainer should be educated on some harm reduction practices such as the following, in order to explain them:

- Needle Exchange Programs
- Low-Threshold Opioid Substitution Programs
- Drug Consumption Rooms
- Alcohol Management Programs (MAPs)
- Drug Checking Services
- Naloxone Administration and Training

3.9.1 ACTIVITY 1.5 –VIDEO FORUM

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.

PRACTICAL ASPECTS

- **Duration:** 30 minutes.
- **Materials Needed:**
 - Links to the videos (Below)
 - Computer, projector and internet connection
- **Expected Outcomes:**

Trainees will gain a deeper understanding of effective, person-centered harm reduction and homelessness interventions through real-life examples, engage in reflective discussions, and be inspired to adapt these best practices creatively to their own contexts.

INSTRUCTIONS

1. Preparation:

Choose 2 or 3 videos from the following list:

- 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>
- [Inside America's First Legal Drug Use Site - Onpoint NYC](#)
- [Boyle Street — Managed Alcohol Program](#)
- Ten Working agreements Housing First of the city of Amsterdam: https://www.youtube.com/watch?v=NLcMF04Eh_k

You can also read the following projects, as a complementary action to support the videos or opt to only read these projects:

- [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](#)

2. Activity:

Show 2 selected videos featuring real-world harm reduction programs. After each video, allow approximately 5 minutes for participants to discuss what they observed, reflect on the practices presented, and share their thoughts on the approach. Encourage open dialogue about the effectiveness, relevance, and transferability of these practices to other contexts.

3. Wrap-up:

Conclude the activity with a group reflection by asking questions such as:

- 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?

The trainer should encourage participants to reflect on which practices they found most inspiring or applicable to their own work. Highlight the importance of adapting best practices to local contexts and remind trainees that innovation often emerges from combining different approaches. Finally, invite them to explore the shared links in more depth after the session to continue learning independently.

3.10 Assessment questionnaire: Module 1

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

SECTION 2: DEFINITION AND HISTORY OF HARM REDUCTION

1. What is the definition of harm reduction, and how does it differ from abstinence-based approaches? (Short answer)

2. Which of the following best defines the Harm Reduction approach?

- A legal framework to arrest people who use drugs
- A method for eliminating drug use completely

- c) A public health strategy that seeks to reduce the negative consequences of drug use
- d) A moral campaign against substance abuse

3. Name one historical event or movement that contributed to the development of harm reduction.

(Short answer)

4. Which of the following are examples of early harm reduction strategies?

(Select all correct answers)

- a) Criminalizing all drugs
- b) Needle exchange
- c) Moral approach to drugs
- d) Condoms distribution
- e) Housing
- f) Peer work
- g) Employability
- h) Health education

SECTION 3: PRINCIPLES AND APPLICATION OF HARM REDUCTION

5. Which of the following is not one of the four core principles of harm reduction introduced in this unit?

- a) Low-Threshold Services
- b) Bottom-Up Approach
- c) Abstinence-Based Recovery
- d) Judgement-Free Approach

6. Choose one of the four core principles and explain in 1–2 sentences how it applies to real-world harm reduction work. (Short answer)

7. Final Reflection (Short paragraph)

After completing this unit, how has your understanding of harm reduction changed? What is one concept you plan to apply in your own work or community?

4. Module 2: Trauma-informed care approach

Unit 1 - Understanding complex trauma

Learning objectives

- Define complex trauma and its holistic impact on individuals.
- Explain behavioural and neurobiological responses associated with trauma.

4.1 Section 1 - Introduction to the course and participant introductions

The trainer should introduce the objectives of the course, the methodology, and the materials needed. The trainer should also clarify any possible doubts.

4.1.1 ACTIVITY 2.1 – ICEBREAKER: "TWO TRUTHS AND A LIE"

OBJECTIVE

To help participants get to know each other in a light way. Allow each participant time to actively listen to each other, observe body language and have fun. Encourage people to be as creative as they like.

intervention programs. After each video, allow approximately 5 minutes for participants to discuss what they observed, reflect on the practices demonstrated, and share their thoughts on the approach. Encourage open dialogue about the effectiveness, relevance, and transferability of these practices to other contexts.

PRACTICAL ASPECTS

- **Duration:** 15 minutes
- **Materials Needed:**
 - Cards to write on
 - Pen

- **Expected Outcomes:**

- Group dynamic will have eased, and it has encouraged participation. The atmosphere will be more relaxed and engaging. People will be more comfortable interacting and collaborating.

INSTRUCTIONS

1. Preparation:

Divide the group into groups of two. Ask each person to present two truths and one lie about themselves to the other person.

2. Activity:

Allow 15 minutes for the interaction between the two people in which each participant shares the required information with each other. Each person has the opportunity to try to guess to see which fact is a lie and which are the truths.

3. Wrap up:

After the activity, invite feedback as to how the experience was and invite some participant to share their facts to allow the bigger group to participate. Allow 15 minutes for this.

4.2 Section 2 - Definitions

The trainer should describe the definition of trauma and the factors that influence the impact of trauma.

4.2.1 ACTIVITY 2.2

IF TRAUMA COULD TALK, WHAT WOULD IT SAY?

OBJECTIVE

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

PRACTICAL ASPECTS

- **Duration:** 40 minutes
- **Materials Needed:**
 - Flip chart
 - Markers

- Large paper

- **Expected Outcomes:**

Discussion on trauma and what it looks like. A sharing of knowledge and experience and a tool for learning and exploration.

INSTRUCTIONS

1. Preparation:

Divide people to go into groups of 6/7 people.

2. Activity:

Ask people to discuss the question: “If trauma could speak, what would it say?” Ask the group to nominate one person to feedback to the larger group and one person to write notes. Provide large paper and a marker. Allow 15 minutes for this activity.

One person per group should provide feedback to the bigger group. The facilitator asks each group for their feedback and writes feedback on a flip chart.

3. Wrap up:

After all the answers have been shared, the trainer asks the group what they take form the reflection and what impacts them the most, allowing for a dialogue between group members.

4.3 Section 3 - Trauma awareness and different types of trauma

The trainer should explain the key aspects of trauma awareness, why trauma awareness is important, and the different types of trauma (acute, chronic, and complex types).

The trainer should also explain Post traumatic stress disorder (PTSD), the distinction between PTSD and Complex PTSD and the symptoms of both. The trainer will also explain Trauma Informed Care (TIC) and trauma amongst women experiencing homelessness.

The trainer can recommend the following videos to watch at the convenience of the trainees, or, if there is enough time, show one or more videos in the classroom:

- Video - [What Is Developmental Trauma?](#)
- Video - [Recognizing Symptoms of Trauma with Bessel van der Kol](#)
- Video - [Trauma Informed Practice - MARAM Animation Series](#)

4.4 Section 4 - Behavioural and neurological impacts of trauma on the individual

The trainer should introduce the activity exploring the behavioural impacts of our clients and how we can help.

4.4.2 ACTIVITY 2.3 – THE TRAUMA RESPONSES IN OUR CLIENTS: OUR ROLE AS PROFESSIONALS

OBJECTIVE

To explore the trauma responses we can see in our clients. To recognise and respond to trauma in a more trauma informed way. To open discussion on this and share experiences and knowledge. To discover new ways of working with clients.

PRACTICAL ASPECTS

- **Duration:** 30 minutes
- **Materials needed:**
 - Flip chart
 - Paper for each group
 - Pens, markers
- **Expected outcomes:**

Deeper understanding of the trauma responses of our clients. A sharing of knowledge and experience amongst partners. Understanding of trauma and how it presents in our clients and gaining knowledge around recognising and responding to this. How can we support our clients? How can we manage the emotional impact on us? Create an ability to connect the theory to practice.

INSTRUCTIONS

1. **Preparation:** Divide the group to form groups of 6/7 people.
2. **Activity:**

Ask people to discuss the question: What behaviours do we see in our clients as a result of trauma and what can we do to help? Ask the group to nominate one person to give feedback to the larger group and one person to write notes. Provide large paper and a marker. Allow 15 minutes for this activity. One person per group should provide feedback to the bigger group. The facilitator asks each group for their feedback and writes feedback on a flip chart.

3. **Wrap up:**

After all the answers have been shared, the trainer asks the group what they take from the reflection and what impacts them the most, allowing for a dialogue between group members.

The trainer can also recommend the following videos to watch at the convenience of the trainees, or, if there is enough time, show one or more videos in the classroom:

- Video - [Trauma and the Nervous System: A Polyvagal Perspective](#)

4.5 Section 5 - Peer support

The trainer should describe why peer support is important in trauma informed care and what the peer support role looks like. Reflection questions included.

Unit 2 - Intersectionality between trauma, homelessness, and drug use

Learning objectives

- Identify intersections between trauma, homelessness, drug use, and adverse childhood experiences

4.6 Section 1 - Trauma, drug use and attachment

The trainer should introduce the exploration of the contextual vulnerability, reviewing adverse childhood experiences in relation to adverse community environments and poverty. The trainer should review the maltreatment attachment cycle and its consequences.

The trainer is encouraged to show the following video for further information:

Video on trauma and addiction: <https://youtube.com/shorts/DeXEOPd03ws?si=XkaifZsALhWMwfzX>

Recognizing insecure attachment in clients

The trainer will introduce three different scenarios to practice recognizing insecure attachments in clients that include: dismissive, preoccupied, and disorganized. The trainer will further develop the ideas of trauma, homelessness and drug use and how to address the cycle. The trainer will introduce FEANSTA and ACE, the findings of ACE's study on adverse childhood experiences and the significance of these results on many different subjects. Reflection questions included.

4.7 Section 2 - Survival adaptations

The trainer should introduce the various adaptations that survivors often undertake, both healthy and unhealthy, to cope with the effects of trauma. The trainer should stress that by understanding these various survival adaptations, individuals can take steps to foster healthy coping mechanisms and promote healing and recovery. Reflection questions included.

The following video can be watched for further information:

https://youtu.be/BVg2bfqblGI?si=i80BY_ZkYZlxXh8p

4.7.1 ACTIVITY 2.4 – CASE CLINIC

OBJECTIVE

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

PRACTICAL ASPECTS

- **Duration:** 30 minutes (15 minutes group work, 15 minutes feedback)
- **Materials Needed:**
 - Case studies ([Annex 3](#))
 - Markers and paper for each group
 - Flip chart for facilitator notes
- **Expected Outcomes:**
 - Improved ability to work collaboratively in a trauma-informed way to support clients
 - Shared knowledge and experiences among participants
 - Enhanced problem-solving, teamwork, and communication skills

Increased awareness of diverse perspectives and approaches to trauma support

INSTRUCTIONS

1. 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

2. 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.

3. 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

Learning objectives

- Define post-traumatic growth and the window of tolerance associated with it.

4.8 Section 1 - Definition

The trainer should introduce post-traumatic growth as a concept relevant to fieldwork, highlighting practical strategies to support self-regulation, self-efficacy, and positive change. Key tools include psychoeducation, mindfulness, and motivational interviewing. The trainer should also cover the Window of Tolerance model and its use in promoting emotional awareness, along with pathways to building trauma-informed organizations.

4.9 Section 2 - The window of tolerance

The trainer should introduce the Window of Tolerance as a simple way to understand how people manage emotions and stress, especially after trauma. When individuals are within their window, they can think clearly and respond calmly; outside of it, they may become overwhelmed or shut down. Strategies like mindfulness, grounding, and emotional regulation can help clients stay within this range. The trainer should also emphasize the importance of building routines, self-awareness, and strong support systems to promote healing and post-traumatic growth. Trauma-informed care recognizes how trauma affects the nervous system and helps tailor support accordingly. Organizations should aim to create safe, empowering environments by training staff, respecting cultural differences, and addressing systemic trauma. Doing so leads to stronger relationships, better outcomes, and reduced staff burnout.

The following video can be watched for further information: [Window of Tolerance](#)

4.9.1 ACTIVITY 2.5 – SUPPORTING POST-TRAUMATIC GROWTH IN THE HOMELESS CONTEXT - CASE SCENARIO

OBJECTIVE

To recognize potential growth without minimising trauma. Apply post traumatic growth principles in complex, ongoing trauma environments. Balance immediate needs with longer term needs.

PRACTICAL ASPECTS

- **Duration:** 30 minutes (20 minutes group work, 10 minutes feedback)
- **Materials Needed:**
 - Paper and markers for each group
 - Flip chart for facilitator notes
 - Printed Case Study (Annex 4)
- **Expected Outcomes:**
 - 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.

INSTRUCTIONS

1. Preparation:

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

2. Activity:

- Instruct groups to look at the case scenario in terms of post traumatic growth.
- Look at the individual's strengths and how these can translate into growth if the conditions improve.
- Examine the barriers that may exist to growth.
- What interventions could staff put in place to assist the individual to move on?
- Allow 20 minutes for this part of the activity.

3. 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

Learning objectives

- Apply trauma-informed approaches to support recovery, post-traumatic growth, and mitigate secondary/vicarious trauma in caregivers and peer workers

4.10 Section 1 - Definition

The trainer should introduce the objectives of the unit that include defining vicarious trauma and exploring the relationship between compassion fatigue and secondary trauma. Additionally the trainer should look at the Vicarious trauma model. Participants should be able to identify signs of trauma and strategies to promote resilience on personal, professional, and organizational levels.

4.11 Section 2 - Burnout

The trainer should introduce the definition of burnout and factors that contribute to this phenomenon. Additionally, the trainer should reveal the numerous aspects of self-care, why self-care is important, what self-compassion is, and numerous additional self-care activities that make use of the senses.

4.12 Section 3 - Self-care

The trainer should introduce key aspects to self-care such as: Physical health, mental and emotional well-being, social well-being, spiritual well-being. Additionally, the trainer should elaborate on effective self-care through activating the vagus nerve, sensory integration strategies, emergency self-care plans, and preventative self-care plans. The trainer should explore self care strategies for professionals and give examples of grounding techniques

4.12.1 ACTIVITY 2.6

EMERGENCY AND PREVENTATIVE SELF-CARE PLAN

OBJECTIVE

To prioritise self care. To identify what is important to you and what helps to nourish and support you in difficult times. To remind ourselves that we all have trauma and also have the responsibility to manage it. To collaborate with partners on self care and its necessity in the work.

PRACTICAL ASPECTS

- **Duration:** 20 minutes
- **Materials needed:**
 - Preventative care plan and emergency care plan document for each person ([Annex 5](#))
 - Pens, markers.
- **Expected outcomes:**

An awareness of the importance of self care. A reminder of what each of us require to ensure we keep our own cups full. Thought provoking exercise. Open discussion on what we do and do not do. Tool for change.

INSTRUCTIONS

1. Preparation:

Provide a preventative care plan and an emergency care plan to each participant.

2. Activity:

Ask each participant to think about their own self care and what is essential for them in order to promote their 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. Prompt participants with the following questions/topics:
 1. Make a list of things that you can do when you are upset that will benefit you.
 2. Make a list of people you can contact if you need support.
 3. Make a list of positive things to say to yourself when you are having a difficult time.
 4. Make a list of who and what to avoid when you are going through a tough time.
 5. Listen to yourself and practice self compassion.

3. Wrap up:

Ask the group what they thought of the exercise and how they felt completing it. Allow each person to keep their plan and use it as a guide.

4.13 Assessment questionnaire: Module 2

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

Unit 1: Understanding Complex Trauma

1. What is trauma?

- a) A normal emotion
- b) A deep hurt from hard experiences
- c) A physical illness

2. Can trauma affect both the body and the mind?

- a) Yes
- b) No
- c) No, because it affects only the mind

3. Which of these is a sign of trauma?

- a) Mood swings, social withdrawal, avoidance.
- b) Intrusive thoughts, difficulty concentrating, trouble sleeping
- c) All of the above

4. Is trauma perceivable from the outside?

- a) Very much so
- b) It depends on many factors
- c) No

Unit 2: Trauma, Homelessness & Drug Use

5. Why do some people use drugs after trauma?

- a) To heal trauma
- b) To cope with pain or stress caused by trauma
- c) To enjoy life after being traumatized

6. What is “insecure attachment”?

- a) A strong, loving connection with someone else
- b) A tendency to attach to insecure people
- c) A weak or unstable emotional bond

7. Can childhood trauma affect someone as an adult?

- a) Yes, it can affect health and choices
- b) No, people forget childhood trauma
- c) Only if the trauma was physical

Unit 3: Post-Traumatic Growth

8. What does “post-traumatic growth” mean?

- a) Staying stuck in pain
- b) Becoming stronger after trauma
- c) Ignoring problems

9. What is the “Window of Tolerance”?

- a) A type of therapy
- b) An optimal zone of arousal
- c) A method for sleeping better

10. Which of these can help someone after trauma?

- a) Mindfulness and routines
- b) Yelling and pushing them to move on
- c) Avoiding all feelings

Unit 4: Vicarious Trauma

11. What is vicarious trauma?

- a) A fear of hospitals
- b) Feeling trauma from helping others in pain
- c) A type of body injury

12. What is burnout?

- a) A feeling of being tired and worn out from stress
- b) A kind of injury
- c) When someone feels too happy

13. What constitute examples of taking care of yourself?

- a) Don't give too much attention to feelings and opt for a dismissive a lighter emotional state
- b) Keep busy all the time and enjoy the good things in life
- c) Rest, connect with others, and notice warning signs

5. Module 3: Mental health

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

Learning objectives

- Explain the relationship between homelessness and mental health, including overlapping substance use issues
- Identify barriers to accessing mental health care and the effects of stigma and discrimination

5.1 Section 1 - Introduction to the course and participant introductions

The trainer should introduce the objectives of the course, the methodology, and the materials needed. The trainer should also clarify any possible doubts.

5.1.1 ACTIVITY 3.1 – ICEBREAKER: "THE CONDUCTOR AND THE DETECTIVE"

OBJECTIVE

To foster active listening, clear communication, and teamwork among participants.

PRACTICAL ASPECTS

- **Duration:** 20-25 minutes.
- **Materials Needed:**
 - Open space large enough for 20 people to stand and move around
 - Optional: A timer or stopwatch
 - Playlist of songs. The conductor will perform movements based on the music.
 - Take On Me (a-ha)
 - The Final Countdown (Europe)
 - Just Can't Get Enough (Depeche Mode)
 - Sweet Dreams (Eurythmics)
 - Eye of the Tiger (Survivor)
- **Expected Outcomes:**
 - Promote group cohesion and active engagement.

- Encourage observation, nonverbal communication, and subtle leadership.
- Provide a fun, low-pressure way to begin conversations about awareness and perception.

INSTRUCTIONS

1. 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.

Then, the 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.

2. 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.

3. Wrap up:

The trainer should ask a few reflection questions, such as:

- a. How did it feel to try and keep the Conductor hidden?
- b. What strategies helped you figure it out as the Detective?
- c. What does this say about observation, awareness, and group dynamics?

5.2 Selection 2 - Intersection between homelessness and mental health

The trainer should introduce the theoretical explanation of the relationship between homelessness and mental health and how each condition aggravates the other. They should also describe the psychological impact of homelessness as a consequence of day-to-day struggles and trauma and increased vulnerability due to factors like social segregation, exposure to violence, substance use, and lack of access to proper care and housing. Additionally, they should highlight the comorbidity of mental health and substance use.

5.2.1 ACTIVITY 3.2 – VIDEO FORUM

OBJECTIVE

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

PRACTICAL ASPECTS

- **Duration:** 25 minutes.
- **Materials Needed:**
 - Computer with internet connection
 - Projector
- **Expected Outcomes:**

Increased awareness on the relation between mental health issues and homelessness.

INSTRUCTIONS

1. Preparation:

The trainer should introduce 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](#) (Use auto-generated English subtitles)

2. Activity:

The trainer should lead a small group discussion to discuss the main ideas and then transition to a large group discussion, debating questions like:

- What stood out to them 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?

3. Wrap up:

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

Invite participants to share one action they can take in their role to support people affected by both homelessness and mental health issues.

5.3 Selection 3 - Barriers to access mental health care

The trainer should explore the three barriers to accessing mental health care for people experiencing homelessness: structural, service-based, and personal. They should also discuss identifying the specific challenges faced by harm reduction professionals when trying to refer or connect people experiencing homelessness to mental health services and the way to approach solutions to overcome barriers such as lack of access, reluctance to seek treatment, and the constant mobility of people experiencing homelessness.

5.3.2 ACTIVITY 3.3 - FACILITATORS ROLE-PLAY

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.

PRACTICAL ASPECTS

- **Duration:** 35-45 minutes
- **Materials Needed:**
 - Set of cards ([Annex 6](#))
 - Pen and paper for group notes.
 - Timer
- **Expected Outcomes:**
 - Participants will better understand the different types of barriers individuals experiencing homelessness face when accessing mental health services.
 - Participants will enhance their skills in identifying their role as facilitators in real-life situations and develop strategies to help individuals overcome challenges.
 - The activity will foster collaboration and shared learning, providing a practical framework for harm reduction professionals to apply in their work.

INSTRUCTIONS

1. 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.

2. Activity:

- 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.

- Reflexion with the whole group

Each group shares one of their situations and their proposed solutions with the larger group, which will allow for collective learning and feedback.

3. Wrap up:

Summarize the key insights shared by the groups and discuss any recurring themes across the situations. Ask participants to reflect on their own practice: How can they apply the strategies discussed in the activity to real-life situations they may encounter?

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

Learning objectives

- Explore prevalence of and key symptoms of mental health problems among people experiencing homelessness and apply the Self-Medication Theory

5.4 Selection 1 - Prevalence of mental health problems among people experiencing homelessness

The trainer should introduce an overview of the data related to mental health conditions among those who are experiencing homelessness. Specific topics include: Neurodiversity and Homelessness: Focus on ADHD, Hoarding Among People Experiencing Homelessness, and Suicide and Self-Harm Among People Experiencing Homelessness.

5.5 Section 2 - Key symptoms of common mental health problems and self-harming behaviors among people experiencing homelessness

The trainer should introduce an overview of the main symptoms related to attention deficit and hyperactive disorder, anxiety, cognitive impairment (including drug-induced cognitive impairment), complex trauma and post-traumatic stress responses, depression, hoarding, personality disorders, borderline disorder, schizophrenia, drug induced psychotic symptoms, and other psychoses, self-harm behaviors, and suicide.

5.5.1 ACTIVITY 3.4 - INFORMATION STATIONS

OBJECTIVE

To promote knowledge of basic aspects of mental health problems, focusing on: main symptoms, common risk factors / causes, how the condition may present in homelessness, links with trauma and substance use, and practical intervention tips.

PRACTICAL ASPECTS

- **Duration:** 30 minutes
- **Materials Needed:**
 - Printed Information Station Handouts (Case Study + Reflection Questions + Fact Sheet) and facilitator guide ([Annex 7](#)).
- **Expected outcomes:**
 - Increased awareness of key mental health problems, supporting a more informed intervention approach with people experiencing homelessness, particularly those with complex trauma histories, health problems, and psychoactive substance use.

INSTRUCTIONS

1. Preparation:

- Divide the room into 6 “information stations”, each focused on one mental health problem (using the Information Station Handouts).
- At each station, provide:
 - The case vignette (life story)
 - Reflection questions
 - The corresponding fact sheet

2. Activity:

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

3. Wrap up:

Facilitate a large-group reflection (10 minutes) focusing on:

- Common challenges in intervention
- How mental health problems intersect with homelessness, trauma, and substance use
- Implications for support, engagement, and service delivery

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](#)

5.6 Section 3 - The Self-Medication Theory

The trainer will give an overview of the theoretical frameworks of the self-medication theory that include different hypotheses and models.

Unit 3 - Harm reduction strategies and evidence-informed practices

Learning objectives

- Apply harm reduction and evidence-informed approaches in mental health interventions
- Analyse cultural, diversity, and intersectional factors affecting care systems for people experiencing homelessness

5.7 Section 1 - Harm reduction strategies supporting people experiencing homelessness with mental health concerns

The trainer will introduce specific and practical harm reduction strategies intended to be used by professionals and frontline staff who may not have formal mental health training, but who work with people experiencing homelessness and a mental health condition.

5.8 Section 2 - Evidence-informed actions

The trainer should share evidence-informed actions that harm reduction workers can implement to support people experiencing homelessness who have mental health concerns. Trainers will introduce practical screening considerations, key warning signs that require special attention, red flags for urgent intervention, and practical daily interventions for each mental health condition or related behavior.

5.9 Section 3 - Cultural diversity and mental health: Considerations for practice

The trainer should be familiar with practical considerations related to cultural diversity, homelessness, mental health, and/or drug use. The trainer should present these considerations and demonstrate how professionals can use culturally competent interventions to build trust, minimize harm, and promote lasting stability for clients facing complex challenges.

5.9.1 ACTIVITY 3.5 - SUCCESSFUL INTERVENTION STORIES

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 ([Annex 8](#)).

PRACTICAL ASPECTS

- **Duration:** 30-40 minutes
- **Materials Needed:**
 - Printed handouts with success stories ([Annex 8](#))
 - Printed discussion questions for each success story ([Annex 8](#))
 - Sticky notes and pens
- **Expected Outcomes:**
 - Identify key elements that contributed to successful interventions.
 - Reflect on how trust-building strategies can support engagement.
 - Recognize harm reduction approaches and their practical application.
 - Connect intervention strategies to long-term housing and social stability.
 - Transfer lessons learned to their own professional context.

INSTRUCTIONS

1. Preparation:

- Arrange trainees into small groups (4–6 participants per group).
- Distribute the success stories ([Annex 8](#)) and the discussion questions ([Annex 9](#)).
- Provide each group with sticky notes and pens.
- Assign a facilitator in each group (or plan to rotate the role during the discussion).

2. 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 ([Annex 8](#)).
- 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.

3. Wrap Up:

- Bring all participants back together.
- Each group shares **at least one main insight or practical takeaway** (1–2 minutes per group).
- The trainer collects sticky notes and highlights common themes, emphasizing strategies that can be applied across different contexts (e.g., outreach work, shelters, Housing First programs, addiction services).

5.9.2 ACTIVITY 3.6 - ROUNDTABLE

OBJECTIVE

To help participants 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.

PRACTICAL ASPECTS

- **Duration:** 30-40 minutes
- **Materials Needed:**
 - Printed discussion questions for each table/group ([Annex 9](#))
 - Flip chart or whiteboard to note key points
 - Markers or sticky notes for participant contributions
- **Expected Outcomes:**
 - Increased awareness of how cultural background shapes trauma experiences and responses
 - Identification of biases and assumptions that may hinder effective support
 - Practical ideas for adapting harm reduction strategies to diverse needs
 - Examples of culturally sensitive, trauma-informed approaches in practice

INSTRUCTIONS

1. Preparation:

Arrange participants in small groups (4–6 people) to encourage open conversation.

Provide each group with 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?

2. Activity:

- Assign a facilitator in each group (or rotate the role) to ensure everyone participates.
- Give 20 minutes for groups to discuss at least 3–4 questions, encouraging examples from personal or professional experience.
- Ask groups to write 2–3 key insights or recommendations on sticky notes or flip chart paper.

3. Wrap Up:

- Bring everyone back together. Each group shares one main insight or practical takeaway (1–2 minutes each).
- The trainer notes common themes and highlights strategies that can be applied across contexts.

5.10 Assessment questionnaire: Module 3

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

Unit 1: Mental health & homelessness

1. Which of the following is a key concept in the relationship between mental health and homelessness?

- a) Homelessness causes improved coping mechanisms
- b) Mental health issues rarely affect the homeless population
- c) Homelessness can exacerbate existing mental health problems and vice versa
- d) There is no established relationship between the two

2. People experiencing homelessness rarely have co-occurring mental health and substance use disorders.

True / False

3. What are the three main barriers to accessing mental health care for people experiencing homelessness?

- a) Physical, legal, institutional
- b) Structural, service-based, personal
- c) Emotional, political, spatial
- d) Social, familial, behavioral

Unit 2: Mental health conditions & homelessness

4. The Housing First model prioritizes:

- a) Mental health treatment before shelter
- b) Permanent housing as the first step before addressing other needs
- c) Institutionalization of individuals with severe needs
- d) Detoxification before outreach

5. Self-harm and suicide are not common concerns among the homeless population.

True / False

6. Name two common mental health-related conditions frequently observed in people experiencing homelessness.

7. According to the Self-Medication Theory, individuals use substances primarily to:

- a) Be against authority
- b) Seeking social acceptance
- c) Relieve emotional pain or untreated mental health symptoms
- d) Develop tolerance to prescription drugs

Unit 3: Harm reduction & informed practices

8. Trauma-informed care involves understanding how trauma may impact behavior and integrating this knowledge into support strategies.

True / False

9. In your own words, describe what trauma-informed care means when working with a person experiencing homelessness. (Short answer)

10. Which of the following is an example of harm reduction in practice?

- a) Immediate forced detox
- b) Punitive measures for substance use
- c) Distribution of clean syringes and overdose prevention kits
- d) Mandatory inpatient treatment

11. Culturally sensitive harm reduction approaches can improve client outcomes.

True / False

12. Explain one reason why structural barriers might prevent someone who is homeless from accessing mental health services.

(Short answer)

13. A client with a history of complex trauma and schizophrenia has recently started missing appointments and showing signs of distress. Using a trauma-informed approach, what are two steps you could take to support them?

(Scenario-based question)

14. In a role-play activity, you're paired with someone who shares a story of using drugs after childhood abuse. As the "professional," what are two supportive questions you might ask to explore their reasons for substance use?

(Scenario-based question)

6. Module 4: Psychoactive substance use

Unit 1 - Psychoactive substances

Learning objectives

- Identify categories of psychoactive substances and explain their neurobiological effects

6.1 Section 1 - Introduction to the course and participant introductions

The trainer should introduce the learning objectives and outcomes, talk about the competencies addressed, the methodology and the materials and environment that will be used to facilitate the training.

6.1.1 ACTIVITY 4.1 - ICEBREAKER: “TRUE OR FALSE?”

OBJECTIVE

To activate participants’ prior knowledge, encourage cooperative reasoning, and introduce key information about the effects of legal and illegal psychoactive substances in a dynamic, low-pressure way.

PRACTICAL ASPECTS

- **Duration:** 30-40 minutes
- **Materials Needed:**
 - True or false documents (Participant & trainer versions) ([Annex 10](#))
 - Tape or magnets for sticking cards to a board/wall
 - Whiteboard or wall space divided into two sections: “TRUE” and “FALSE”
- **Expected Outcomes:**
 - Participants will reflect on the effects of various psychoactive substances and differentiate facts from misconceptions.
 - Group discussion will surface common myths and areas where knowledge may be incomplete or inaccurate.

- Participants will feel engaged and prepared to explore substance-related topics in more detail later in the module.

INSTRUCTIONS

1. Preparation:

- The trainer should create two clearly marked columns on a wall or board: “TRUE” and “FALSE”.
- The trainer should then shuffle the Factsheet cards- with statements about the effects of legal and illegal psychoactive substances, some correct, some incorrect- and place them face down on a table.

2. Activity:

- Ask participants to form pairs.
- Each pair selects one Factsheet card from the table and reads the statement aloud.
- The pair discusses for 2–3 minutes whether the statement is true or false, using only their current knowledge.
- The pair places the card under “TRUE” or “FALSE” on the board using tape or magnets.
- Repeat until all pairs have placed their cards.

Factsheets (examples):

Facilitation Tips:

- Foster a safe and open atmosphere. Emphasize that this activity is not a test.
- Be mindful of participants with lived experience, avoid judgment or overgeneralization.
- Use humour and curiosity to defuse discomfort and invite engagement.

3. Wrap Up:

- As a group, review each card:
 - Ask the pair who placed it to share their reasoning.
 - Reveal the correct answer and explain briefly why.
 - Invite short discussion or clarifying questions if the topic is surprising or unclear.
- Highlight common misconceptions and surprising facts.
- Conclude by emphasizing that substance effects vary by context, individual factors, and use patterns—topics that will be explored further in the module.
- Offer to clarify doubts without pushing technical language.

6.2 Section 2 - Psychoactive substances

The trainer should introduce the definition of psychoactive substances and Neurobiological Interaction. This includes a brief history and the contemporary uses and applications of these products.

Additionally, the trainer should talk about the categorization of Psychoactive Substances that includes the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. Further topics include National Interpretations and Legal Diversity, Classification by Neurobiological Mechanism of Action, New Psychoactive Substances (NPS) and Understanding Use Through Function: When Substances Help to Survive.

The trainer can also show this video for further insight: [What is the Drug War? With Jay-Z & Molly Crabapple](#)

6.2.1 ACTIVITY 4.2 - “FORTUNE WHEEL”

OBJECTIVE

To support participants in integrating basic knowledge about the effects and legal classification of various psychoactive substances, while beginning to reflect on the function they may serve in people's lives. This activity combines factual learning with social and ethical analysis.

PRACTICAL ASPECTS

- **Duration:** 40 minutes
- **Materials needed:**
 - Digital “[fortune wheel](#)”
 - List of psychoactive substances (10–12 examples from different categories)
 - Flipchart or board
 - Markers or post-its
 - Small paper cards with 3 categories: Effects, Legal Status, Possible Function ([Annex 11](#))
 - Optional: stickers or coloured dots for interaction
- **Expected outcomes**
 - Participants consolidate factual knowledge by correctly identifying the main effects and legal status of different psychoactive substances.
 - Participants recognize that substances can serve diverse functions in people’s lives, moving beyond stereotypes and simple harm/benefit labels.
 - Participants begin to critically reflect on the mismatch between legal status, social perceptions, and actual risks, as well as the role of social factors (e.g., poverty, gender, migration) in substance use.

INSTRUCTIONS

1. Preparation:

Explain that the group will explore psychoactive substances from three angles:

1. What effects do they have?
2. What is their current legal status in our country or internationally?
3. What role or function might they serve in real life contexts?

Encourage participants to think beyond stereotypes, and to remember that the same substance may play different roles depending on who uses it, how, where, and why.

2. Spin the Fortune Wheel:

One by one (or in pairs), participants spin the wheel, which contains different types of psychoactive substances.

After the substance is revealed, ask the participant (alone or in pairs) to:

- Describe its effects (stimulant? depressant? hallucinogen? multiple? contextual?)
- State its legal status (legal/regulated, illegal, medical use only, varies by country)
- Propose one or more possible functions (e.g., coping with trauma, staying awake, connecting emotionally, reducing anxiety, gaining control, surviving street life, enhancing pleasure...)

For each psychoactive substance revealed on the wheel, discuss with the group whether the answers given by the participant(s) are right or wrong.

3. Group discussion (15–20 minutes):

Once several substances have been analysed, open a reflective group conversation using questions like:

What surprised you about some of the functions mentioned?

- Did you notice how the legal status of a substance does not necessarily match its harm risks?
- How do power, gender, migration or poverty influence which substances are used, and how?

List of substances and brief explanation

1. Alcohol

- **Effects:** Depressant, but stimulant effects at low doses (euphoria, disinhibition, relaxation).
- **Legal status:** Legal for adults, regulated by age and sale restrictions.
- **Functions:** Social bonding, coping with stress, warmth/sleep on the street, celebration.

2. Methamphetamine

- **Effects:** Strong stimulant (increased energy, focus, euphoria, insomnia, paranoia).
- **Legal status:** Illegal in most countries (medical use very restricted).
- **Functions:** Staying awake for work or survival, enhancing performance, escape through dissociation.

3. MDMA (Ecstasy)

- **Effects:** Empathogen (increased empathy, closeness, euphoria, stimulation).
- **Legal status:** Illegal recreationally; in medical trials for PTSD/therapy.
- **Functions:** Emotional connection, sexual enhancement, partying, reducing fear.

4. Sugar

- **Effects:** Activates brain reward circuits; mood regulation, energy spikes and crashes.
- **Legal status:** Legal, widely available.
- **Functions:** Comfort, self-soothing, habit formation, coping with stress or low mood.

5. Benzodiazepines (e.g., Diazepam, Xanax)

- **Effects:** Depressant (reduces anxiety, induces sleep, relaxes muscles). Risk of dependence.
- **Legal status:** Prescription-only, controlled substances.
- **Functions:** Coping with anxiety or trauma, managing sleep, “coming down” from stimulants.

6. LSD

- **Effects:** Hallucinogen (altered perception, mood shifts, intensified emotions).
- **Legal status:** Illegal in most countries, some exceptions for research/therapy.
- **Functions:** Spiritual exploration, fun/novelty, introspection, disconnecting from reality.

7. Nicotine (Tobacco, Vaping)

- **Effects:** Stimulant (increased alertness, reduced anxiety, appetite suppression). Highly addictive.

- **Legal status:** Legal, regulated by age and packaging rules.
- **Functions:** Stress relief, habit, concentration, social bonding.

8. Synthetic Cannabinoids (“Spice” etc.)

- **Effects:** Unpredictable, can mimic or exaggerate cannabis (relaxation, paranoia, hallucinations).
- **Legal status:** Often illegal; sometimes produced to bypass laws.
- **Functions:** Alternative when cannabis unavailable (e.g., prisons, drug tests), dissociation, cost-driven choice.

9. Cocaine

- **Effects:** Stimulant (euphoria, confidence, alertness, high energy, risk of paranoia).
- **Legal status:** Illegal recreationally; restricted medical use (e.g., anesthesia).
- **Functions:** Boost self-esteem, work endurance, party drug, sexual performance, coping in sex work.

10. Heroin

- **Effects:** Depressant/opiate (pain relief, deep relaxation, numbing, high overdose risk).
- **Legal status:** Illegal recreationally; some medical morphine-based alternatives exist.
- **Functions:** Coping with trauma, emotional numbing, physical pain relief, escape.

11. Ketamine

- **Effects:** Dissociative (out-of-body feeling, sedation, hallucinations, pain relief).
- **Legal status:** Prescription-only (medical/anesthetic use), but also sold illegally.
- **Functions:** Depression treatment, dissociation, nightlife/recreation, emotional escape

4. Evaluation/closure:

The trainer can use the following closing prompt:

“What do we miss if we only talk about substances by category or legal status?

What do we now understand better about the role substances play in complex lives?”

Unit 2 - Harm reduction strategies for psychoactive substance use

Learning objectives

- Identify Harm Reduction strategies specific to psychoactive substance use cases

6.3 Section 1 - Psychoactive substances: Routes of administration

The trainer should introduce harm reduction as a public health approach that aims to minimize the negative health and social consequences of psychoactive substance use without requiring abstinence.

The trainer should discuss the methods of taking psychoactive substances and the details of each.

- **Injecting route**
 - Needle and syringe programs (NSP)
 - Opioid agonist therapy (OAT)
 - Drug consumption rooms (DCRs)
 - Overdose prevention and naloxone distribution
- **Inhaled route**
 - Safer Smoking Kits
 - Supervised Consumption Rooms (SCRs) for Inhalation
 - Preventing the Transition to Injecting
- **Sniffing route**
 - Safer Sniffing Kits
 - Nasal Hygiene and Education
 - Avoiding Risky Combinations and Dosing Practices
- **Oral route**
 - Dosing Awareness and Onset Delays
 - Encapsulating Doses for Safer Ingestion
 - Use of Droppers or Liquid Dosers
 - Safe Preparation and Measurement of Edibles and Natural Substances
 - Hydration, Temperature and Environmental Safety
 - Monitoring Interactions and Polyconsumption
 - Cultural Patterns and Shifts in Use
 - Gender, Autonomy and Invisibility

6.3.1 ACTIVITY 4.3 - VIDEO FORUM

OBJECTIVE

To deepen participants' understanding of practical harm reduction strategies for different routes of administration, build empathy by engaging with real-life experiences of people who use substances, and familiarise them with safer use materials and their functions through direct interaction.

PRACTICAL ASPECTS

- **Duration:** 60 minutes
- **Materials Needed:**
 - Projector and screen
 - Internet connection or pre-downloaded videos
 - Real samples of safer use equipment and tools (smoking pipes, for example)
 - Paper and pens for note-taking
 - Worksheet ([Annex 12](#))
- **Expected Outcomes:**
 - Participants will identify key harm reduction strategies and the risks they address.
 - Participants will reflect on challenges faced by people who use substances and possible local adaptations of interventions.
 - Participants will gain practical knowledge of safer use tools and their correct use.
 - Misconceptions and stigma related to harm reduction materials will be reduced.

INSTRUCTIONS

1. Preparation:

- Select and prepare the videos:
- **EMCDDA webinar: Drug consumption rooms in Europe**
https://www.youtube.com/watch?v=3P52cjmD_qM-

This webinar provides a comprehensive overview of Drug Consumption Rooms (DCRs) across Europe, highlighting their evolution from focusing strictly on the injectable route to incorporating specialized inhalation areas. The primary harm reduction strategy discussed is the provision of a supervised environment that transitions users from high-risk public consumption to a clinical setting where overdose deaths are virtually eliminated. By adapting facilities with high-tech ventilation for smokers, these centers successfully engage a broader demographic of people who use drugs (PWUD), offering them a bridge to social and health services.

- ***Lessons from the Field: Safer Smoking Supplies***

<https://www.youtube.com/watch?v=RuwUrtfESIA->

This video focuses on the distribution of high-quality materials for the inhalation/smoking route, such as Pyrex glass pipes and silicone mouthpieces, as a tactical alternative to injection. The core harm reduction philosophy here is "route transitioning," which encourages users to move away from the intravenous route to avoid blood-borne viruses (HIV/Hepatitis C) and skin infections like abscesses. By providing safe, heat-resistant supplies, programs prevent the use of makeshift or toxic materials that can cause pulmonary damage or severe oral burns.

- ***Ireland's First Safe Injection Rooms***

<https://www.youtube.com/watch?v=3cP1yqBzFI->

This report details the implementation of Dublin's first supervised facility, which is specifically designed to address the risks associated with the injectable route in public spaces. The harm reduction intervention is centered on immediate clinical supervision; having medical staff present allows for the instant administration of Naloxone in the event of an opioid overdose. Furthermore, it ensures that users have access to sterile needles and professional advice on vein care, which significantly reduces the health complications and public littering associated with unsupervised street injecting.

- ***Drug Consumption Rooms Around the World***

<https://www.youtube.com/watch?v=m3tZPxKoqPM->

This global survey illustrates how DCRs adapt their infrastructure based on the local routes of administration, whether that means providing individual booths for injecting or communal "smoking rooms" for substances like crack or methamphetamine. The fundamental harm reduction practice highlighted is "risk management education," where staff teach users less traumatic administration techniques. These facilities serve as non-judgmental hubs that reduce the physical toll of chronic drug use by ensuring that the equipment used—be it for smoking or injecting—is clean and safe.

- ***Safer smoking: Using aluminum foil to reduce risks***

<https://www.youtube.com/watch?v=WrhNmO5aN9o->

This technical tutorial is dedicated to the inhaled route through the practice of "chasing the dragon" (vaporizing substances on foil). The harm reduction approach is highly pragmatic: it teaches users how to prepare and use high-gauge aluminum foil to avoid inhaling toxic industrial coatings found on standard household foil. By promoting smoking over injecting, this method serves as a "step-down" strategy that eliminates the risk of needle-related injuries and provides a slower, more manageable onset of the drug's effects.

- Arrange the safer use materials for the showcase.
- Prepare a set of guiding questions for participants to take notes on:
 - What strategies are presented?
 - What risks are addressed?
 - How does harm reduction improve the lives of the people featured?
 - What challenges or gaps appear in the video?

2. Activity:

Part 1 – Introduction (10–15 min)

- Explain the aim of the activity: connecting theory with practice in harm reduction.

Part 2 – Video Screening (15–30 min)

- Show the selected videos in sequence or select a subset to fit available time.
- Encourage participants to observe practical strategies and contextual factors.

Part 3 – Group Discussion (20–30 min)

- Divide participants into small groups (3–4 people).
- Ask them to reflect on:
 - What surprised them most.
 - New strategies they learned.
 - Barriers faced by people in the videos.
 - How these ideas could be adapted locally.
- Reconvene as a whole group and share insights.
- Clarify misunderstandings and highlight recurring themes.

Part 4 – Showcase of Materials (30–40 min)

- Present safer use tools, grouped by route of administration:
 - Smoking: pipes, foil, mouthpieces
 - Snorting: personal straws, nasal spray, cards
 - Injecting: syringes, filters, cookers, ampoules, sharps containers
 - Oral: gelatin capsules, droppers, dosing spoons
- For each item, explain:
 - Its function
 - The risk it reduces
 - Safe use instructions

- Distribution and acceptance in different contexts
 - Allow participants to handle the items (if available), ask questions, and share perceptions.
 - Address myths and stigma around harm reduction materials.

Facilitation Tips:

- Create a respectful, non-judgmental atmosphere.
- Be aware of participants with lived experience; avoid generalisations or stigmatising language.
- Use curiosity and real-world examples to engage participants.
- Adapt video length and discussion depth to fit the available time.

3. Wrap Up:

- Summarise key harm reduction strategies and how they reduce risks.
- Highlight common barriers and discuss potential solutions in the local context.
- Reinforce the message that harm reduction is about practical safety, dignity, and health.
- Invite final questions and provide reliable resources for further learning.

6.4 Section 2 - More harm reduction strategies

The trainer should introduce and describe more harm reduction strategies including...

- Drug checking
- Take-home Naloxone
- Managed Alcohol Programs
- Psychoeducation and Emotional Support for Psychedelic Use
- Responding to Stimulant-Induced Psychosis
- Cannabis Social Clubs

6.5 Section 3 - Peer work perspective

The trainer should introduce peer work as essential to harm reduction and describe its importance on various levels.

1. Individual Level: Building Trust and Supporting Safer Practices
2. Community Level: Cultural Mediation and Early Risk Detection
3. Organisational Level: Service Design, Accessibility and Continuity

Unit 3 - Harm reduction strategies specific to people experiencing homelessness

Learning objectives

- Analyze intersectional factors such as homelessness, gender, sex work, and trauma in substance use and identify distinct Harm Reduction strategies for these factors
- Explain the functional use of substances in different contexts to inform supportive interventions

6.6 Section 1 - Introduction to situations of homelessness

The trainer should provide an overview on the current situation of homelessness.

6.7 Section 2 - Harm reduction in cases of homelessness

The trainer should introduce the key characteristics of harm reduction in the context of homelessness.

- Outreach teams
- Shelter inclusion and low-threshold housing models
- 24/7 service coverage
- Managed alcohol programs (MAPs)
- Mobile units in dispersed and non-urban areas
- Harm reduction and digital rights
- Hygiene, privacy and body care
- Layered stigma
- Substance Use and Extreme Temperatures in the Context of Climate Change

6.8 Assessment questionnaire: Module 4

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

Section 1: Introduction & Basic Knowledge

1. What is a psychoactive substance?

- a) A type of food
- b) A type of exercise
- c) A substance that changes how you think or feel

2. Can legal drugs like alcohol or tobacco still be harmful?

- a) Yes, they can still hurt your health
- b) No, legal drugs are always safe
- c) Only illegal drugs are dangerous

3. Do all drugs affect people the same way every time?

- a) No, it depends on the person and situation
- b) Yes, they work the same for everyone
- c) They only change based on the drug brand

Section 2: Effects, Use & Purpose

4. Why might someone use a substance like alcohol or methamphetamine?

- a) Only to have fun
- b) To stay warm, cope with stress, or feel better
- c) Because they don't know it's bad

5. Is Diazepam a psychoactive substance?

- a) Yes, it can affect the brain's reward system
- b) No
- c) Only if you eat a lot

6. Does the legal status of a drug always match how dangerous it is?

- a) Yes
- b) Not sure
- c) No

Section 3: Harm Reduction Strategies

7. What is the main goal of harm reduction?

- a) To make drug use safer and reduce harm
- b) To stop all drug use
- c) To punish people who use drugs

8. What is one tool used for safer injecting?

- a) A clean syringe
- b) A kitchen spoon
- c) A plastic straw

9. Why is it important to give out safer use kits?

- a) To help people hide drug use
- b) To reduce sickness and injury
- c) To make people stop using drugs faster

Section 4: Harm Reduction & Homelessness

10. What is a Managed Alcohol Program (MAP)?

- a) A program to give people stronger alcohol
- b) A program that helps people drink in a safer way
- c) A way to force people to stop drinking

11. Why might someone use drugs when they live on the street?

- a) To survive cold, trauma, or stress
- b) To become rich
- c) Because it's easy to access

12. What is one way outreach teams help people?

- a) By bringing safer use tools and care to where people are
- b) By giving fines
- c) By telling people to move

7. Module 5: Peer work

Unit 1 - Peer work: Roles and profile

Learning objectives

- Define Peer work and its relevance in service design and delivery
- Explain the knowledge, skills, and impact peers bring to teams and service users

7.1 Section 1 - Introduction to the course and participant introductions

The trainer should lead an introduction of the objectives of the course, the methodology, and the materials needed. They should also clarify any possible doubts.

7.1.1 ACTIVITY 5.1 – ICEBREAKER: "SOUP OF TRAITS"

OBJECTIVE

To help participants get to know each other, explore diverse backgrounds, and appreciate the variety of experiences and skills that can be valuable in a professional context. This activity encourages networking, active listening, and curiosity in a light, engaging way.

PRACTICAL ASPECTS

- **Duration:** 30 minutes
- **Materials Needed:**
 - Printed or displayed list of traits/characteristics/hobbies/experiences (e.g., speaks multiple languages, meditates, plays an instrument, has lived abroad, punctual, etc.) (Annex 13)
 - 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.

INSTRUCTIONS

1. Preparation:

- The trainer will use a printed list of 10–15 traits, 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 ([Annex 13](#)).

2. 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.
- Encourage participants to connect with as many people as possible.

3. 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.

7.2 Section 2 - What is peer work?

The trainers should begin by showing the video from the peer work HUB in Australia that introduces the key elements of peer work.

Video: [Homelessness response: the role of peers in recovery](#)

The trainer should then explain the key elements of peer work but referencing the Content document.

- Understanding peer work in homelessness support
- The role of experiential knowledge in peer work
- Recognition of peer work at the European level
- Legal and professional recognition of peer work in Europe
- What makes peer work unique?
- The core value: “Free space” in peer work
- The added value of peer work in homelessness support

7.3 Section 3 - The role of lived experience expertise in supporting people experiencing homelessness

The trainer should introduce the objectives of the course and the key components of understanding homelessness: Understanding lived experience expertise; Knowledge of survival strategies; Blending lived and theoretical knowledge. Additionally, the trainer should introduce the key competencies of a peer worker including the definition, aspects of empathy and understanding, personal insight and growth, survival strategies and real world knowledge, breaking down barriers, and advocacy and systemic change. The trainer should be educated on these topics and clarify any doubts on the subject matter.

7.3.1 ACTIVITY 5.2 - PEER WORKER COMPETENCY SIMULATION

OBJECTIVE

To help healthcare professionals understand and practice the key competencies of a Peer Worker, including empathy, personal insight, breaking down barriers, and advocacy, through an interactive role-playing exercise.

PRACTICAL ASPECTS

- **Duration:** 45 minutes
- **Materials:**
 - Printed scenario cards (detailing different situations related to homelessness, stigma, recovery, etc.) ([Annex 14](#))
 - Flipcharts or whiteboards
 - Markers
- **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.

INSTRUCTIONS

1. Preparation:

- Use the set of scenario cards from [Annex 14](#) that reflect real-life situations a peer worker might face.
- Each scenario should highlight one or more of the key competencies (Empathy, Personal Insight, Breaking Down Barriers, Advocacy).

2. Activity:

Part 1: Introduction (5 minutes)

Briefly introduce the key competencies of a Peer Worker:

- Empathy and Understanding
- Personal Insight and Growth
- Breaking Down Barriers
- Advocacy and Systemic Change

Explain that in this activity, participants will simulate real-world interactions that test these competencies.

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.

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.

3. 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.

7.4 Section 4 - Best practices for integrating lived experience into peer work

The trainer should explain the objectives of the module and the following principles and their examples that are essential to ensuring that peer workers are supported in their roles and contributions are maximized: recognizing flexibility in peer roles, supportive supervision and training, involvement in program design, and creating an inclusive and respectful environment. The trainer should be educated on these topics and clarify any doubts on the subject matter.

7.4.1 ACTIVITY 5.3 - IN THEIR WORDS: VOICES OF PEER WORKERS

OBJECTIVE

To foster empathy and deeper understanding of peer work through firsthand testimonials from peer workers.

PRACTICAL ASPECTS

- **Duration:** 30 minutes (depending on group size and number of testimonials)
- **Materials Needed:**
 - Pre-selected [audio testimonials](#) (2 clips, each 2–4 minutes)
 - Headphones or speakers
 - Reflection worksheet or printed guiding questions ([Annex 15](#))
- **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

INSTRUCTIONS

1. 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?

2. Activity:

- Play the audio testimonials for participants (individually or as a group).
- Invite participants to reflect individually for a few minutes, either in writing or mentally, using the guiding questions.

3. 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

Learning objectives

- Apply strategies for integrating peers effectively in professional settings
- Analyse challenges and opportunities in sustaining peer roles within service structures

7.5 Section 1 - Basic principles of peer institutional integration

In this section, the trainer should present the unique challenges faced by peer workers. Explore key themes that arise when integrating peer workers into support roles: Closeness vs. distance, meaning vs. meaningless and tolerating pain, strength vs. vulnerability, pride vs. shame, and new vs. existing cultural values. Additionally, the trainer should share best practices for peer workers with lived experience.

7.5.1 ACTIVITY 5.4 - EXPLORING KEY TENSIONS IN PEER WORK

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.

PRACTICAL ASPECTS

- **Duration:** 50 minutes
- **Materials needed:**
 - Printed tension cards or slides (one tension per card) ([Annex 16](#))
 - 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

INSTRUCTIONS

1. Preparation:

Explain that peer work often involves professional dilemmas and tensions rather than clear-cut answers. This activity focuses on learning how to recognise, reflect on, and discuss these tensions.

Introduce the idea that tensions are *normal* in peer work and require ongoing reflection, supervision, and dialogue.

2. Activity:

Step 1: Working with tension scenarios

Divide participants into small groups of 4–6 (mixed students and professionals if possible).

Each group receives one key tension related to peer work, for example:

- Closeness vs. distance
- Strength vs. vulnerability
- Meaning vs. meaninglessness
- Pride vs. shame
- New values vs. existing organisational culture

(You may rotate tensions if time allows.)

Ask groups to discuss the following guiding questions and note key points on flipchart paper:

- 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, team)?
- What kind of support or structure helps to manage this tension?

Encourage participants to draw on:

- real experiences (if they have them),
- examples from the text or best practices, or
- imagined but realistic situations.

Step 2: Sharing insights

Each group briefly presents their tension and key insights (2–3 minutes per group).

Encourage listeners to note:

- similarities across tensions
- recurring needs (e.g. supervision, clear boundaries, training)

3. Wrap-up:

Facilitate a plenary reflection using questions such as:

- Which tensions felt most recognisable or important?
- What do these tensions tell us about the complexity of peer work?
- What role do organisations play in supporting peer workers?
- How do supervision, reflection, and peer support help prevent overload or vicarious trauma?
- Which good practices from the examples (e.g. HVO-Querido Addendum, Crescer Peer Meetings) help address these tensions?

Conclude by emphasising that professional peer work is not about eliminating tension, but about learning to navigate it safely and reflectively.

7.6 Assessment questionnaire: Module 5

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

Unit 1: What is Peer Work?

1. Which of the following best defines peer work?

- a) A form of case management in clinical treatments
- b) Support that professionals provide when it comes to the lived experience of a specific issue
- c) Community volunteering
- d) Work that is based on theory or trainings

2. Why is experiential knowledge important in peer work?

- a) It is more affordable to implement than formal trainings
- b) Guarantees better clinical results
- c) Builds trust and understanding through having shared experience
- d) Replaces professional qualifications

3. Which of the following is a core value of peer work when it comes to homelessness support?

- a) A free space
- b) Confidentiality
- c) Outcome based
- d) Top down decision making

Section 3: The role of lived experience in homelessness support

4. Which of the following is NOT a key competency of a peer worker?

- a) Empathy and understanding
- b) Advocacy and systemic change
- c) Personal insight and growth
- d) Diagnosed with mental health conditions

5. Blending lived and theoretical knowledge allows peer workers to:

- a) Act only as interpreters between clients and staff
- b) Replace traditional medical roles
- c) Provide informed, relatable, and holistic support
- d) Avoid documentation and formal procedures

6. What is one barrier that peer workers can help to break down in supporting people experiencing homelessness?

- a) Academic testing requirements
- b) Personal hygiene expectations
- c) Service-user distrust of traditional professionals
- d) Housing regulations

Unit 2: Section 1: Basic principles of peer institutional integration

7. Which of the following is a recommended best practice for integrating peer workers into a service team?

- a) Assigning them isolated roles with minimal responsibility
- b) Involving them only in client intake
- c) Providing structured supervision and training
- d) Using informal, ad-hoc roles with no evaluation

8. What does meaningful integration of peer work require?

- a) Peer workers working independently of team structures
- b) Flexible roles, fair employment conditions, and supportive environments
- c) Replacing existing staff with peers

9. Which of the following is a key benefit mentioned in the Crescer Peer Meetings example?

- a) Replacing professional staff with peer mentors
- b) Creating informal, non-documented sessions
- c) Building a structured space for reflection and mutual support
- d) Avoiding feedback and accountability processes

10. Which of the following is an example of a professional tension peer workers may need to manage?

- a) Completing budget reports
- b) Closeness vs. distance in client relationships
- c) Technical system troubleshooting
- d) Time tracking and billing

11. What element made the HVO-Querido Amsterdam model a best practice?

- a) It eliminated formal contracts for peer workers
- b) It provided peer workers with structured pathways and organizational support
- c) It hired only full-time peer workers

- d) It used peer work for short-term projects only

12. Which of the following is NOT one of the principles discussed in peer institutional integration?

- a) Pride vs. shame
- b) Vulnerability vs. strength
- c) Independence vs. dependency
- d) New vs. existing cultural values

8. Module 6: European policy perspectives on homelessness and advocacy

Unit 1 - Understanding homelessness

Learning objectives

- 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.

8.1 Section 1 - Introduction to the course and participant introductions

Brief presentation by trainer on homelessness and advocacy. Topics include: Definition and Types of Homelessness, Causes of Homelessness, Approaches to Homelessness, Public Policy, Definition of Advocacy, Advocacy for Systematic Change in the Field of Homelessness, Designing an Advocacy Campaign With the Advocacy Strategy Framework, Language Used When Communicating on Homelessness.

8.1.1 ACTIVITY 6.1 – ICEBREAKER: “A DAY IN SOMEONE ELSE’S SHOES”

OBJECTIVE

To foster empathy and awareness about homelessness by exploring personal perceptions and associations with related concepts.

PRACTICAL ASPECTS

- **Duration:** 10-15 minutes (depending on group size)
- **Materials Needed:** None
- **Expected Outcomes:**
 - Increased awareness of common perceptions and stereotypes around homelessness
 - Reflection on personal assumptions and feelings regarding homelessness
 - Enhanced empathy and readiness to engage with the topic

INSTRUCTIONS

1. 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

2. 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 and have participants share their responses 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?

3. 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.

8.2 Section 2 - Definition and types of homelessness

In this section, the trainer will explain that homelessness is a complex phenomenon defined differently across European countries, making comparison difficult. To address this, FEANTSA developed the ETHOS Conceptual Framework, which broadens the definition beyond “rough sleeping” and considers housing exclusion in three key domains: the physical, the social and the legal.

8.2.1 ACTIVITY 6.2 – VIDEO FORUM

OBJECTIVE

To gain direct insights into the different types and causes of homelessness through firsthand accounts and real-life examples throughout Europe.

PRACTICAL ASPECTS

- **Duration:** 30-40 minutes (depending on group size)
- **Materials Needed:**
 - Videos to watch focusing on different types and causes of homelessness in Europe, such as the following, or others adapted to each country's reality:
 - [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](#)
 - [What are the driving factors of homelessness in Europe?](#)
- **Expected Outcomes:**
 - Increased awareness of the reality and diversity of homelessness in Europe.
 - Understanding of the main types and causes of homelessness.
 - Enhanced empathy through exposure to real-life examples and firsthand accounts.
 - Improved ability to discuss homelessness knowledgeably and sensitively.

INSTRUCTIONS

1. Preparation:

Prepare 1 or 2 videos to be watched by the group

2. Activity:

Watch the videos with the group and ask participants 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?

3. 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.

8.3 Section 3 - Causes of homelessness and main statistics

In this section, the trainer will introduce causes of homelessness by sharing some recent statistics regarding homelessness in Europe. Then, they will explain that homelessness is a complex phenomenon caused by the interaction of 1) Structural Factors, 2) System Failures, 3) Personal or Relational Issues and 4) Overlapping Oppressions. Structural factors include poverty, lack of affordable housing, and discrimination, with lone mothers and single-parent families being particularly vulnerable due to limited financial resources, weak social support, and gaps in social protection systems. System Failures might occur in areas of child welfare, healthcare, mental health services, corrections, and support services specifically for immigrants and refugees. Personal or Relational Issues such as traumatic life events, family and gender-based violence, mental health challenges and substance use disorders can trigger homelessness. Overlapping oppressions can contribute to homelessness at the intersection of various vulnerable identities such as: gender, migration status, health conditions, sexual orientation, etc.

8.4 Section 4 - Approaches to addressing homelessness

In this section, the trainer will introduce approaches to addressing homelessness highlighting Primary Prevention, Secondary Prevention, Tertiary Prevention, Emergency Response/Crisis Intervention, Temporary or Transitional Housing, and Housing First/Permanent Supportive Housing.

Unit 2 - Successful public policy and advocacy in solutions to homelessness

Learning objectives

- 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

8.5 Section 1 - Public policy

The trainer will provide an overview of current public policy related to eradicating homelessness in the EU. Topics include an introduction to the Lisbon Declaration, the European Platform on Combating Homelessness (EPOCH), and the European 2030 Strategy. In addition, this section will offer a closer look into the following topics:

- Basic Human Rights as the Background for Homelessness Policies;
- Homelessness and Intersectionality as a Basic Approach;
- Evaluation and Accountability Mechanisms on Homelessness Policy and Advocacy;
- Multi-Level Governance and Cross-Sector Collaboration;
- Concrete Policies: Housing, Public Health and Social Services;
- Funding and Resource Allocation.

8.6 Section 2 - Definition of advocacy

In this section, the trainer will have the opportunity to expand on the definition of advocacy presented by the Institute of Global Health, noting the following topics:

- Advocacy as a critical tool for civil society organizations;
- Coalition-building, grassroots mobilization, and careful communication with stakeholders;
- Combining evidence-based recommendations with public engagement and political advocacy;
- Importance of social support/connections and community.

8.6.1 ACTIVITY 6.3 – ADVOCACY CAMPAIGN ANALYSIS

OBJECTIVE

To deepen participants' understanding of harm reduction advocacy through the analysis of real-world campaigns. This activity promotes critical thinking, comparative analysis, and shared learning, while offering concrete examples of advocacy strategies from diverse contexts.

PRACTICAL ASPECTS

- **Duration:** 60-70 minutes
- **Materials Needed:**
 - Selected advocacy campaign materials (e.g., flyers, videos, social media posts, websites, reports) in Printed summary sheets (optional) ([Annex 17](#))
 - Selected advocacy campaign overviews ([Annex 17](#))
 - Analysis worksheet ([Annex 17](#))
 - Flipchart paper or presentation boards (for group summaries)
 - Markers and pens
 - Projector or screen (if showing campaign videos)
- **Expected Outcomes**
 - Greater awareness of global and local harm reduction advocacy efforts
 - Ability to identify key elements of successful advocacy campaigns
 - Insight into common challenges and tactics used in harm reduction messaging
 - Inspiration and practical ideas for designing or adapting campaigns

INSTRUCTIONS

1. Preparation:

The facilitator selects a variety of harm reduction advocacy campaigns in advance. Campaigns should represent different regions, strategies, and target groups (e.g., youth, women, people who inject drugs, rural communities). Prepare campaign materials in printed or digital form and ensure each group receives a different campaign.

Optional: Prepare an analysis worksheet to guide each group through their review (sections for goals, messages, audience, etc.).

2. Activity:

Part 1: Group Campaign Analysis (45 minutes)

Each group is assigned one advocacy campaign and asked to analyze it using the following guiding questions:

- What is the primary advocacy goal of this campaign?
- Who is the target audience?
- What are the key messages and how are they framed?
- What strategies were used? (e.g., lobbying, public demonstrations, media, partnerships)
- Who are the stakeholders and allies involved?
- What were the outcomes, successes, or challenges faced?
- How does the campaign reflect harm reduction principles?

Groups prepare a short summary of their findings to present to the full group. Encourage creativity in presentations—flipcharts, visual aids, or storytelling formats can be used.

Part 2: Group Presentations (5–7 minutes per group)

Each group presents their analysis to the larger group. After each presentation, allow 1–2 minutes for clarifying questions.

3. Wrap up & Debrief:

Facilitate a full group discussion using prompts such as:

- What strategies were most commonly used across campaigns?
- Which messages seemed most effective, and why?
- What barriers did campaigns face in promoting harm reduction?
- What lessons or tactics could be applied in your own context or country?

Summarize the learning:

There is no one-size-fits-all approach to harm reduction advocacy. By analyzing real campaigns, we can draw valuable insights into effective communication, community engagement, and policy influence. These examples serve as inspiration for building more targeted, impactful advocacy in participants' own settings.

8.7 Section 3 - Active advocacy for systemic change in the field of homelessness

In this section, the trainer will provide an overview of advocacy in the field of homelessness, introducing participants to forms of advocacy such as: Public Demonstrations, Awareness-Raising Activities, Media Engagement, Collaboration with Institutions, Scientific Research and Evidence Production, Persuasion

and Lobbying, Alliance Building and Network Development, and Community Empowerment Strategies. In addition, the trainer will also cover Recent Civil Society Insights and the Advocacy Strategy Framework.

8.8 Section 4 - Language used when communicating on homelessness

The trainer will introduce the concept of how language is deeply intertwined with identity and power and explore the following: The Role of Language in Social Relations, Stigmatizing Language and Its Consequences, Inclusive Language as a Means of Empowerment, and Practical Implications for Social Interactions. In addition, the trainer will provide tangible examples of good practices in language use, including the following:

- Person-First Language;
- Avoiding Dehumanizing Terms;
- Using Empowering Language;
- Being Mindful of Tone and Context;
- Avoiding Stereotype Reinforcement;
- Using Language as Advocacy.

8.8.1 ACTIVITY 6.4 – DESIGNING AN ADVOCACY CAMPAIGN

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.

PRACTICAL ASPECTS

- **Duration:** 40-50 minutes
- **Materials Needed:**
 - Flipchart paper or large poster paper
 - Markers
 - Advocacy Strategy Framework worksheet ([Annex 18](#))
 - Sticky notes (optional, for brainstorming or assigning roles)
- **Expected Outcomes**
 - Increased understanding of how the Advocacy Strategy Framework structures advocacy work.
 - Ability to identify, categorize, and strategically engage key stakeholders in homelessness advocacy.

- Practice in developing realistic, goal-oriented advocacy strategies.
- Enhanced collaboration, systems thinking, and clarity around how change happens.

INSTRUCTIONS

1. Preparation:

Divide participants into small groups of 3–5 people and set up each table with flipcharts and markers.

Provide a short list of homelessness-related advocacy topics to inspire or guide groups (e.g., expanding Housing First, preventing youth homelessness, improving emergency shelter conditions, increasing affordable housing stock).

2. Activity:

Part 1: Issue Selection (5 minutes)

Each group selects one homelessness issue they believe requires urgent advocacy. Examples may include:

- 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

Part 2: Advocacy Strategy Design Using the Framework (15–20 minutes)

Groups design the core components of an advocacy plan by applying the Advocacy Strategy Framework and using the activity sheet available in [Annex 18](#):

They should map out:

1. Primary goal(s):

What policy or systems change do they want to influence?

2. Key audiences:

Categorize them using the framework's three groups:

- Public (e.g., local residents, neighbourhood associations, community volunteers)
- Influencers (e.g., journalists, service providers, faith leaders, business owners)
- Decision-makers (e.g., councillors, housing committees, government departments)

3. Desired change for each audience:

Using the three levels of the framework:

- Awareness: What do they need to know?
- Will: What belief, motivation, or sense of urgency must shift?
- Action: What do you want them to do?

4. Engagement strategy:

How will the group reach each audience to create the desired shift?

Examples include: community storytelling, briefing meetings, op-eds, coalition building, lobbying, or community forums.

5. Core message(s):

What key messages best support awareness, will, or action for the selected audiences?

6. Proposed actions/tactics:

Groups choose tactics that align with both the audience type and the level of change they aim for.

Examples:

- Awareness-building: social media campaigns, info sheets, public talks
- Will-building: lived-experience panels, stakeholder meetings, opinion polling
- Action-oriented: presenting at council meetings, mobilizing supporters, drafting policy proposals

7. Roles:

Assign who in the group is responsible for drafting messages, mapping audiences, designing tactics, or presenting.

Encourage groups to reflect on complexity (e.g., allies, opposition, timing) and to consider the realistic pathways through which advocacy influences homelessness policy.

Part 3: Presentation and Feedback (10–15 minutes)

- Each group presents their advocacy plan to the full group. Encourage participants to 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

Part 4: Wrap-Up

Facilitate a brief reflection using questions such as:

- What made your strategy feel realistic or challenging?
- What insights did the Advocacy Strategy Framework give you about how change actually happens?
- Which audiences seemed most critical for influencing homelessness policy?
- How could you use this framework in your own workplace, community, or advocacy efforts?

Summarize the learning:

Advocacy is a powerful tool for systemic change. By identifying urgent needs, engaging the right stakeholders, and crafting clear messages, we can build impactful campaigns that support health, dignity, and rights for people who use drugs.

8.9 Section 5 - Language used when communicating on homelessness

In this section, the trainer will prepare participants to communicate using person-first language when discussing homelessness. Topics to be explored include: The Role of Language in Social Relations, Stigmatizing Language and Its Consequences, Inclusive Language as a Means of Empowerment, Practical Implications for Social Interactions, and Good Practices in Language Use including:

- Person-First Language,
- Avoiding Dehumanizing Terms,
- Using Empowering Language,
- Being Mindful of Tone and Context,
- Avoiding Stereotype Reinforcement,
- Using Language as Advocacy.

Assessment questionnaire: Module 6

Please answer the following questions to the best of your ability. Your responses will help us evaluate the effectiveness of this training.

Unit 1: Introduction & Basic Knowledge

1. Which of the following best describes the ETHOS framework's understanding of homelessness?

- a) It defines homelessness only as sleeping on the streets.
- b) It considers homelessness as lacking one or more of three domains: physical, social, or legal.
- c) It limits homelessness to people registered in government shelter systems.

2. What is the main purpose of ETHOS Light?

- a) To replace national laws on homelessness across Europe.
- b) To provide a simplified set of categories that countries can realistically measure.
- c) To focus exclusively on people living in inadequate housing.

3. Why is homelessness best understood as a complex phenomenon rather than the result of a single cause?

- a) Because it results from the interaction of structural factors, systems failures, and personal or relational crises.
- b) Because it is caused only by personal life choices.
- c) Because it occurs only when housing prices increase rapidly.

4. What is the primary goal of the Housing First approach to homelessness?

- a) Require individuals to complete treatment before receiving housing.
- b) Provide immediate permanent housing first, followed by tailored support services.
- c) Focus only on temporary shelters as long-term solutions.

5. Which type of prevention aims to stop homelessness before any risk appears by addressing structural factors such as housing supply and income supports?

- a) Crisis prevention
- b) Emergency prevention
- c) Primary prevention

Unit 2: Public Policy & Advocacy

6. What is one main goal of the European 2030 Strategy on homelessness?

- a) To eliminate all social services related to housing
- b) To ensure that no one must live on the streets due to lack of adequate housing
- c) To replace national housing policies with a single EU law

7. Why is an intersectional approach important in homelessness policy?

- a) Because homelessness affects everyone in exactly the same way
- b) Because it focuses only on economic factors
- c) Because different social identities and inequalities can combine to increase vulnerability

8. According to research presented in Module 6, what type of support can strongly improve outcomes for people experiencing homelessness?

- a) Informal support from friends or family
- b) Only government financial aid
- c) Strict shelter rules without social contact

9. According to the Advocacy Strategy Framework, what is the purpose of the “will” stage in advocacy?

- a) To ensure people already take action immediately
- b) To help people care about an issue, feel urgency, and believe they can act
- c) To replace awareness campaigns with legal action

10. Why is person-first language recommended when communicating about homelessness?

- a) It reduces stigma by emphasizing the individual rather than defining them by their situation
- b) It makes communication more technical and formal
- c) It allows professionals to categorize people more easily

9. Assessment questionnaires answers

9.1 Module 1

Q: 1. What is the definition of harm reduction, and how does it differ from abstinence-based approaches? (Short answer)

A: Harm reduction is a pragmatic, humanistic approach that focuses on reducing the negative consequences of risky or addictive behaviours—especially substance use—for individuals and society, without requiring that people stop those behaviours entirely. It emphasizes practical strategies, health, dignity, and support.

It differs from abstinence-based approaches because those prioritize complete cessation of substance use as the primary goal, whereas harm reduction accepts that some people may continue using substances and instead aims to minimize the harms associated with that use rather than insisting on total abstinence.

Q: 2. Which of the following best defines the Harm Reduction approach?

A: c) A public health strategy that seeks to reduce the negative consequences of drug use

Q: 3. Name one historical event or movement that contributed to the development of harm reduction. (Short answer)

A: One example is the creation of the **Junkiebond in Rotterdam (1980)**, a union of people who use drugs that distributed sterile needles and advocated for needle-exchange programs to reduce HIV transmission (Answers may vary).

Q: 4. Which of the following are examples of early harm reduction strategies?

(Multiple correct answers)

A: b) needle exchange, d) condoms distribution, f) peer work, h) health education. (Note: Housing is an important intervention, but it is not historically an early harm reduction strategy. Employability is also important, but not part of early harm reduction origins).

Q: 5. Which of the following is not one of the four core principles of harm reduction introduced in this unit?

A: c) abstinence-based recovery

Q: 6. Choose one of the four core principles and explain in 1–2 sentences how it applies to real-world harm reduction work. (Short answer)

A: Low-Threshold Services – This principle means services should be easy to access, with minimal barriers such as strict rules, long waitlists, or abstinence requirements. In real-world practice, this looks like walk-in clinics, same-day treatment access, outreach services, and flexible appointment policies so people can receive support whenever they are ready.

Bottom-Up Approach – Harm reduction values the leadership and expertise of people with lived experience, involving them in program and policy design. In practice, organizations collaborate with service users, hire peer workers, and build programs based on community input to ensure services actually meet real needs.

Individual-Centered Care – This principle prioritizes each person's goals, needs, and pace of change rather than imposing a single standard outcome. Real-world workers apply it by tailoring care plans, supporting

different goals (from safer use to abstinence), and meeting people where they are physically and emotionally.

Judgement-Free Approach – Harm reduction rejects stigma and moralizing attitudes, treating substance use as a health and social issue rather than a moral failing. In practice, staff use respectful language, create safe spaces, and build trust so people feel comfortable seeking help without fear of shame or punishment.

Q: 7. Final Reflection (Short paragraph)

After completing this unit, how has your understanding of harm reduction changed? What is one concept you plan to apply in your own work or community?

A: *Answers will vary.*

9.2 Module 2

Q: 1. What is trauma?

A: *b) A deep hurt from hard experiences*

Q: 2. Can trauma affect both the body and the mind?

A: *a) Yes*

Q: 3. Which of these is a sign of trauma?

A: *c) All of the above*

Q: 4. Is trauma perceivable from the outside?

A: *b) It depends on many factors*

Q: 5. Why do some people use drugs after trauma?

A: *b) To cope with pain or stress caused by trauma*

Q: 6. What is “insecure attachment”?

A: *c) A weak or unstable emotional bond*

Q: 7. Can childhood trauma affect someone as an adult?

A: *a) Yes, it can affect health and choices*

Q: 8. What does “post-traumatic growth” mean?

A: *b) Becoming stronger after trauma*

Q: 9. What is the “Window of Tolerance”?

A: *b) An optimal zone of arousal*

Q: 10. Which of these can help someone after trauma?

A: *a) Mindfulness and routines*

Q: 11. What is vicarious trauma?

A: *b) Feeling trauma from helping others in pain*

Q: 12. What is burnout?

A: *a) A feeling of being tired and worn out from stress*

Q: 13. What constitute examples of taking care of yourself?

A: *c) Rest, connect with others, and notice warning signs*

9.3 Module 3

Q: 1. Which of the following is a key concept in the relationship between mental health and homelessness?

A: *c) Homelessness can exacerbate existing mental health problems and vice versa*

Q: 2. People experiencing homelessness rarely have co-occurring mental health and substance use disorders.

A: *False*

Q: 3. What are the three main barriers to accessing mental health care for people experiencing homelessness?

A: *b) Structural, service-based, personal*

Q: 4. The Housing First model prioritizes:

A: *b) Permanent housing as the first step before addressing other needs*

Q: 5. Self-harm and suicide are not common concerns among the homeless population.

A: *False*

Q: 6. Name two common mental health-related conditions frequently observed in people experiencing homelessness. (Short answer)

A: *Any of the following: Attention-deficit/hyperactivity (ADHD), anxiety disorders, cognitive impairment (and/or drug-induced cognitive impairment), complex trauma, post-traumatic stress, depressive disorders, hoarding disorder/behaviors, personality disorders (including borderline personality disorder), psychotic disorders (including schizophrenia, substance-induced psychosis, and other psychotic presentations), self-harm behaviors, and suicidal thoughts/behaviors.*

Q: 7. According to the Self-Medication Theory, individuals use substances primarily to:

A: *c) Relieve emotional pain or untreated mental health problems*

Q: 8. Trauma-informed care involves understanding how trauma may impact behavior and integrating this knowledge into support strategies.

A: *True*

Q: 9. In your own words, describe what trauma-informed care means when working with a person experiencing homelessness. (Short answer)

A: *Answers will vary. Key-phrases related to trauma-informed care when working with a person experiencing homelessness include: Noticing early signs, providing a safe space to talk, validating feelings without judgement, assessing immediate safety, supporting access to mental health services, keeping regular contact when possible, coordinating with mobile or crisis teams, supporting provision of medication, promoting health literacy and understanding prescribed medications, compensating for difficulties with physical or cognitive skills, supporting communication with healthcare professionals, reducing isolation and risk through consistent care, supporting basic needs as an entry point to mental health care, structuring routines and predictability, advocating for clients within systems, strengthening motivation and readiness for care, crisis de-escalation and emotional regulation support, recognizing and responding to trauma triggers, documenting observations and information safely, collaborating across sectors.*

Q: 10. Which of the following is an example of harm reduction in practice?

A: *c) Distribution of clean syringes and overdose prevention kits*

Q: 11. Culturally sensitive harm reduction approaches can improve client outcomes.

A: *True*

Q: 12. Explain one reason why structural barriers might prevent someone who is homeless from accessing mental health services. (Short answer)

A: *Answers will vary. Key-phrases related to structural barriers that might prevent someone experiencing homelessness from accessing mental health services include: undocumented migration status, lack of culturally competent providers, and inflexible treatment models, racism, globalization, loss of traditional support systems, rapid social change, among many others.*

Additionally, answers should provide an explanation such as the following: Structural barriers, such as inflexible treatment models, fail to consider the broader contexts that affect the health, well-being, and engagement in care of someone who is experiencing homelessness, thus preventing them from accessing care.

Q: 13. A client with a history of complex trauma and schizophrenia has recently started missing appointments and showing signs of distress. Using a trauma-informed approach, what are two steps you could take to support them? (Scenario-based question)

A: *Answers will vary, but may include key phrases such as: encourage attendance at appointments with reminders or accompaniment, support engagement with mental health or peer support services, coordinate with occupational therapy, mental health teams, social workers, and other relevant*

professionals to support the person holistically, avoid punitive or forced questioning unless you notice an immediate life-threatening risk- use calm, clear, and simple language.

Q: 14. In a role-play activity, you're paired with someone who shares a story of using drugs after childhood abuse. As the "professional," what are two supportive questions you might ask to explore their reasons for substance use? (Scenario-based question)

A: *Answers may vary. Answers should reflect a respectful, assumption-avoiding questioning approach that aims to better understand the person's experiences. Additionally, key words regarding ways of supportive questioning include: conversational questions, open questions, empathetic questions, respectful questions, non-clinical questions, non-intrusive questions, non-judgemental questions, gentle questions, and culturally sensitive questions, among others.*

9.4 Module 4

Q: 1. What is a psychoactive substance?

A: *c) A substance that changes how you think or feel*

Q: 2. Can legal drugs like alcohol or tobacco still be harmful?

A: *a) Yes, they can still hurt your health*

Q: 3. Do all drugs affect people the same way every time?

A: *a) No, it depends on the person and situation*

Q: 4. Why might someone use a substance like alcohol or methamphetamine?

A: *b) To stay warm, cope with stress, or feel better*

Q: 5. Is Diazepam a psychoactive substance?

A: *a) Yes, it can affect the brain's reward system*

Q: 6. Does the legal status of a drug always match how dangerous it is?

A: *c) No*

Q: 7. What is the main goal of harm reduction?

A: *a) To make drug use safer and reduce harm*

Q: 8. What is one tool used for safer injecting?

A: *a) A clean syringe*

Q: 9. Why is it important to give out safer use kits?

A: *b) To reduce sickness and injury*

Q: 10. What is a Managed Alcohol Program (MAP)?

A: *b) A program that helps people drink in a safer way*

Q: 11. Why might someone use drugs when they live on the street?

A: *a) To survive cold, trauma, or stress*

Q: 12. What is one way outreach teams help people?

A: *a) By bringing safer use tools and care to where people are*

9.5 Module 5

Q: 1. Which of the following best defines peer work?

A: *b) Support that professionals provide when it comes to the lived experience of a specific issue*

Q: 2. Why is experiential knowledge important in peer work?

A: *c) Builds trust and understanding through having shared experience*

Q: 3. Which of the following is a core value of peer work when it comes to homelessness support?

A: *a) A free space*

Q: 4. Which of the following is NOT a key competency of a peer worker?

A: *d) Diagnosed with mental health conditions*

Q: 5. Blending lived and theoretical knowledge allows peer workers to:

A: *c) Provide informed, relatable, and holistic support*

Q: 6. What is one barrier that peer workers can help to break down in supporting people experiencing homelessness?

A: *c) Service-user distrust of traditional professionals*

Q: 7. Which of the following is a recommended best practice for integrating peer workers into a service team?

A: *c) Providing structured supervision and training*

Q: 8. What does meaningful integration of peer work require?

A: *b) Flexible roles, fair employment conditions, and supportive environments*

Q: 9. Which of the following is a key benefit mentioned in the Crescer Peer Meetings example?

A: *c) Building a structured space for reflection and mutual support*

Q: 10. Which of the following is an example of a professional tension peer workers may need to manage?

A: *b) Closeness vs. distance in client relationships*

Q: 11. What element made the HVO-Querido Amsterdam model a best practice?

A: *b) It provided peer workers with structured pathways and organizational support*

Q: 12. Which of the following is NOT one of the principles discussed in peer institutional integration?

A: *c) Independence vs. dependency*

9.6 Module 6

Q: 1. Which of the following best describes the ETHOS framework's understanding of homelessness?

A: b) *It considers homelessness as lacking one or more of three domains: physical, social, or legal.*

Q: 2. What is the main purpose of ETHOS Light?

A: b) *To provide a simplified set of categories that countries can realistically measure.*

Q: 3. Why is homelessness best understood as a complex phenomenon rather than the result of a single cause?

A: a) *Because it results from the interaction of structural factors, systems failures, and personal or relational crises*

Q: 4. What is the primary goal of the Housing First approach to homelessness?

A: b) *Provide immediate permanent housing first, followed by tailored support services.*

Q: 5. Which type of prevention aims to stop homelessness before any risk appears by addressing structural factors such as housing supply and income supports

A: c) *Crisis prevention*

Q: 6. What is one main goal of the European 2030 Strategy on homelessness?

A: b) *To ensure that no one must live on the streets due to lack of adequate housing*

Q: 7. Why is an intersectional approach important in homelessness policy?

A: c) *Because different social identities and inequalities can combine to increase vulnerability*

Q: 8. According to research presented in Module 6, what type of support can strongly improve outcomes for people experiencing homelessness?

A: a) *Informal support from friends or family*

Q: 9. According to the Advocacy Strategy Framework, what is the purpose of the “will” stage in advocacy?

A: a) *To help people care about an issue, feel urgency, and believe they can act*

Q: 10. Why is person-first language recommended when communicating about homelessness

A: a) *It reduces stigma by emphasizing the individual rather than defining them by their situation*

10. Annexes

10.1 Annex 1: Activity 1.2 - Case studies

Module 1 Activity 1.2 - Case studies: IG

1. Sociodemographic data

Alias: IG		
Sex: Female	Gender: Non-binary	Date of Birth: 1988
Nationality: Spanish		Legal status: Native
Time as homeless:		
Brief life story: At 16, IG left home to live with friends and joined Barcelona's squatter movement, gaining independent housing and a supportive social network. By age 25, her parents - both with histories of alcohol and cocaine use - separated, leaving her mother homeless. At 28, IG experienced unstable living conditions, alternating between the streets, staying with her mother, and performing sex work at clients' homes. During the COVID-19 emergency, she and her mother entered a residential service with a no-substance policy; IG was expelled for violent behavior while intoxicated and subsequently referred to CRI Galena hostel, a harm reduction-oriented shelter.		

2. Health situation

Physical health
Chronic illnesses: None reported.
Regular medication: None.
Substance abuse: IG uses multiple substances, including inhaled cocaine (~0.5g/day), inhaled methamphetamine, inhaled cannabis, alcohol, and GHB.
Doctor follow-up: She has no ongoing link with drug treatment services and accesses healthcare only through hospital emergency services.

Mental health
Chronic illnesses: Anxiety; history of undiagnosed psychotic episodes.
Regular medication: Quetiapine and non-benzodiazepines, prescribed to reduce risk of misuse.
Doctor follow-up: No structured or ongoing follow-up.

3. Social situation

Close relationships - Primary social support comes from her homeless mother - Other connections mainly include sex work clients and substance-using peers with housing - No friendships outside of substance use
NGOs and public services intervening on the case Linked to Metzineres - a harm reduction service for women and gender-diverse individuals. Initial case coordination highlighted challenges: - Episodes of violence - Possible manic episodes related to substance use - Difficulty with group living - Manipulative behavior toward staff
Economic aspects Does not receive any financial benefits Income comes entirely from sex work and small-scale buying/selling of substances in street and squatted locations

4. Case description

DATE	EVENT/DEMAND/ACTION	RESPONSE AND OUTCOMES
April 2020	Requested shelter during COVID-19 context	Referred to CRI Galena hostel, a harm reduction-oriented shelter
May 2020	Episodes of agitation have been observed in the context of alcohol and stimulant intoxication	Start of Alcohol Maintained Program Referred to psychiatrist through CRI Galena Support from social worker Reference educator assigned for ongoing follow-up
January 2022	IG expressed a desire to start a work itinerary to structure her daily life and enhance motivation	Processing of financial subsidy (RG) CV preparation and email distribution for job seeking Accompaniment in transition from THC cannabis to CBD cannabis Participation in home CBD plant gardening workshop
August 2022	Started first job in a supermarket	Support in frustration management related to assigned tasks Support in managing relationship with her supervisor Support in savings plan for a new home
October 2022	Started living in a shared apartment	Received moving support Access to emotional telephone support Referral to Treatment Center for ongoing care

5. Activity

Please identify:

- ✓ What harm reduction strategies are present?
- ✓ Which principles of harm reduction are reflected?
- ✓ What barriers are visible?
- ✓ What could be improved?

Module 1

Activity 1.2 - Case studies: Mary Ann

1. Sociodemographic data

Alias: Mary Ann		
Sex: Female	Sex: Female	Sex: Female
Nationality: Angolan		Nationality: Angolan
Time as homeless: 3 years		
Brief life story: Mary Ann grew up in Angola in a family facing socioeconomic hardship and worked in various sectors from adolescence. She moved to Portugal in 1999 with her partner seeking better living conditions, returning temporarily to Angola in 2010 due to her father's illness and housing loss in Lisbon. Her relationships have often been marked by conflict and financial exploitation. Since 2016, Mary Ann has faced multiple challenges including sexual assault, economic hardship, housing instability, and alcohol use. She lost savings attempting to start a restaurant, experienced further abuse, and entered municipal emergency shelters. Lack of legal documentation has limited employment opportunities and increased vulnerability. Mary Ann was referred to the Housing First project during the COVID-19 pandemic, where she developed strong connections with staff and community supports. She maintains contact with her mother and sister in Angola. Despite progress, ongoing challenges with mental health, alcohol use, and documentation have disrupted housing stability, leading to multiple relocations and impacting her ability to maintain a support network.		

2. Health situation

Physical health
Chronic illnesses: Hypothyroidism; dry eye; features indicating high vascular risk; under evaluation for potential gastroenterology, gynecology, otorhinolaryngology, and stomatology issues.
Regular medication: Levothyroxine
Substance abuse: Mary Ann has a history of heavy alcohol use, often exceeding 2 liters of wine per day. She uses alcohol to cope with emotions and trauma. While she engaged in previous treatment, she discontinued pharmacological support. Since joining the Housing First project, the team focuses on supporting her mental health and helping her gradually reduce alcohol use, and she is becoming more open to addressing these issues.
Doctor follow-up: General medicine, ophthalmology, gastroenterology, gynecology, otorhinolaryngology, and stomatology.

Mental health

Chronic illnesses: Mary Ann shows signs of an anxious-depressive syndrome and possible undiagnosed hypomania/bipolar disorder. She has a history of complex trauma, including sexual violence, which she identifies as a major turning point in her life, shaping how she relates to herself and others.

Regular medication: None

Doctor follow-up: She maintains a good relationship with her general medicine assistant and attends regular check-ups. She remains ambivalent about psychiatric and alcohol-related follow-up, showing inconsistent adherence.

3. Social situation

Close relationships

Mary Ann maintains several meaningful connections that support her well-being:

- Church group: Regular attendance provides social connection, spiritual support, and a sense of strength.
- Friendship: She has an important, empowering relationship with a friend living outside Lisbon, which boosts her self-esteem during periods of low confidence.
- Family: She keeps regular phone contact with her mother, providing support when possible. Despite challenges, this relationship is nurturing and empowering.
- Project team: Mary Ann often refers to the CRESCER team as her “Portuguese family,” highlighting the trust and sense of belonging she experiences there.

NGOs and public services intervening on the case

- Early support network:
 - Neighbors, local commerce, parish social and food services, community NGOs
 - Many supports were lost due to disruptions from alcohol use, trauma, and mental health challenges
- Current challenges in food support:
 - Local parish refused support due to protocol issues
 - Local NGO cut her from food support after absenteeism
- Employment and occupational support:
 - Supported by Porta Aberta Employability Agency for training and job seeking
 - Lack of legal documentation remains a major barrier
- Documentation support:
 - Project team connected her with the Angola Consulate and migrant support structures
 - Systemic delays and previous alcohol-related disruptions complicated the process
 - Mary Ann is awaiting reissue of her passport but is discouraged and reluctant to pursue further follow-up

Economic aspects

- Current financial situation: Highly vulnerable due to lack of documentation and irregular residency in Portugal
- Income sources:
 - Occasional monthly social aid from Lisbon Social Emergency Unit for People Experiencing Homelessness: €180
 - On-call, temporary, informal work as an intern carer for an elderly acquaintance from her church group

4. Case description

DATE	EVENT/DEMAND/ACTION	RESPONSE AND OUTCOMES
2020/ 2023	Documentation milestones & support • Referred to the Angola Consulate to renew her passport • Referred to the National Centre of Migrants' Integration Support (CNAIM) juridic support department • Referral made to CEPAC – a service providing social support and follow-up to all immigrants • Passport lost; referral made again to Angola Consulate	• 2021 – Angola Consulate: Passport successfully obtained • National Centre of Migrants' Integration Support (CNAIM): Guided and supported through residency regularisation process • CEPAC: Case manager assigned to support Mary Ann with residency regularisation Residency pathways: 1. Via employment contract 2. Via health support needs Follow-up was temporarily paused due to systemic delays, process complexity, and personal challenges (alcohol use, mental health, trauma). Later, Mary Ann became open to resuming the residency regularisation process. A medical report was issued to support her need to remain in Portugal • 2023 – Angola Consulate: Passport lost; currently attending passport delivery
N/A	Employment and occupational support • Mary Ann has identified seeking job or training opportunities as a key goal • She sees these activities as a way to enhance her sense of purpose, increase motivation, and support management of her alcohol use	• No formal job contract yet • Previous opportunity via Porta Aberta • Employability Agency was not pursued • Emotional and mental health challenges, along with alcohol use, have limited progress toward formal employment Mary Ann has engaged in occupational activities and informal training of interest (e.g., social network skills), supported by the project team and her formal/informal support network

5. Activity

Please identify:

- ✓ What harm reduction strategies are present?
- ✓ Which principles of harm reduction are reflected?
- ✓ What barriers are visible?
- ✓ What could be improved?

Module 1

Activity 1.2 - Case studies: Peter

1. Sociodemographic data

Alias: Peter		
Sex: Male	Sex: Male	Sex: Male
Nationality: Dutch citizen (born in Suriname)		Nationality: Dutch citizen (born in Suriname)
Time as homeless: 15 years		
Brief life story: Peter is a 52-year-old man who migrated from Suriname to the Netherlands during adolescence. His early years in the Netherlands were marked by social exclusion and discrimination related to his family background, contributing to feelings of marginalisation and a lack of belonging. During his teenage years, Peter began using substances, initially as a way of coping with emotional distress. Over time, his substance use escalated, contributing to long-term dependency and a gradual loss of family relationships, community connection, and financial stability. Peter experienced chronic homelessness for approximately 15 years, moving between shelters, street homelessness, temporary accommodation, and short stays with acquaintances. He later completed a mandatory two-year residential treatment programme and was subsequently offered supported housing through HVO-Querido. Although now housed, Peter continues to face significant challenges related to ongoing alcohol and cocaine use. He reports feeling misunderstood or insufficiently supported by healthcare professionals, despite maintaining regular formal contact with services.		

2. Health situation

Physical health
Chronic illnesses: None reported
Regular medication: None
Substance abuse: Heavy and long-term alcohol use; regular cocaine use
Doctor follow-up: Peter meets with his therapist once a month and occasionally attends appointments with a general practitioner.
Mental health
Chronic illnesses: Borderline Personality Disorder (BPD)
Regular medication: None; no pharmacological treatment currently in place

Doctor follow-up: Peter does not have structured, continuous mental health care beyond occasional therapy sessions.

3. Social situation

Close relationships

Peter does not have stable personal or family relationships that provide support in his daily life. His most consistent connections are with professionals, including:

- Housing support workers
- Therapist from GGZ-InGeest
- Probation officer
- General practitioner

These relationships primarily serve monitoring, treatment, or supervision purposes rather than offering emotional or social support.

NGOs and public services intervening on the case

Peter's formal support network includes:

- HVO-Querido: Provides supported housing and case management
- GGZ-InGeest: Offers low-frequency mental health therapy sessions
- Probation Services: Provides legal supervision and behavioural monitoring
- General Practitioner: Offers basic medical care
- Salvation Army: Provides cleaning assistance and limited support with daily living

Although Peter is connected to multiple agencies, coordination between them appears limited.

Economic aspects

Peter relies entirely on public financial assistance, including:

- Social welfare benefits from the Municipality of Amsterdam
- Additional national government subsidies
- Occupational Therapy Allowance (~€10 per day)

His limited financial resources, combined with ongoing alcohol dependence, often result in funds being depleted early in the month.

4. Case description

DATE	EVENT/DEMAND/ACTION	RESPONSE AND OUTCOMES
N/A	Budgeting and priorities Peter struggles significantly with managing his finances. He often spends the majority of his food allowance on alcohol within a short period. During episodes of intoxication, he may become	To stabilise Peter's access to food and reduce the risk of legal problems, the support team implemented the following strategies: 1. A social worker accompanies him during grocery shopping, or

	disoriented and forget that he has money, sometimes leading to impulsive shoplifting of groceries. These incidents carry legal risks, strain his relationships with local shops, and threaten his supported housing arrangement. Primary request expressed by Peter: He wants to maintain his current housing.	2. Staff purchase groceries on his behalf These approaches help ensure that Peter's basic nutritional needs are met while minimising risk.
N/A	Substance use goals Peter is not currently interested in abstinence but does want support in managing and reducing his alcohol consumption. He expresses a desire for "more control" over his drinking, while opting out of traditional abstinence-based treatment programmes.	One potential strategy for Peter is the use of a Beer Calendar / Intake Awareness Tool. He collects beer bottle caps in a visible container to track his daily and weekly consumption. This method helps him gain insight into his drinking patterns and supports gradual reduction, empowering him to increase control over his alcohol use without requiring abstinence.

5. Activity

Please identify:

- ✓ What harm reduction strategies are present?
- ✓ Which principles of harm reduction are reflected?
- ✓ What barriers are visible?
- ✓ What could be improved?

Module 1

Activity 1.2 - Case studies: Sheila

1. Sociodemographic data

Alias: Sheila		
Sex: Female	Sex: Female	Sex: Female
Nationality: Irish		Nationality: Irish
Time as homeless: 2.5 years in emergency accommodation prior to referral to Housing First service		
Brief life story: Sheila experienced significant trauma in early childhood, including periods of institutional care and multiple adverse childhood experiences (ACEs). During her teenage years, she became pregnant and later described her relationship with her former partner - the father of her five children - as abusive. One of her children died in infancy, an event that had a profound impact on her mental health and her ability to cope with parenting responsibilities. Her youngest daughter was born with Spina Bifida, which added further emotional and practical pressures. In 2016, Sheila lost a sibling to suicide. She reports that her sibling had experienced abuse, which has contributed to ongoing grief and distress. Over the years, Sheila has experienced mental health difficulties and has received different diagnoses, which she has at times felt did not reflect her lived experience. She has also relied on substances at different points as a way to cope with emotional distress and ongoing challenges. Following a motorbike accident in 2023, Sheila experiences chronic pain and possible brain injury. She reports increased distress and greater reliance on substances to manage pain and emotional overwhelm.		

2. Health situation

Physical health
Chronic illnesses: Serious accident in 2023 resulted in permanent mobility issues/injury to her left foot, and recurring episodes of pneumonia
Regular medication: Opiate painkillers
Substance abuse: Misuse of prescribed medication at times, and additional benzodiazepines
Doctor follow-up: Attended community outpatient (primary care) appointments

Mental health
Chronic illnesses: Diagnosed with Emotionally Unstable Personality Disorder
Regular medication: Prescribed mood stabilizers, diazepam
Doctor follow-up: Attend community mental health team

3. Social situation

Close relationships Sheila found it difficult to maintain close relationships and often experienced instability in her social connections. It could be said that her most consistent and supportive relationships were with Housing First staff. Sheila described feeling a strong sense of safety and trust within these relationships, and at times referred to the psychologist as “like a sister” to her. Her strongest emotional bond was with her youngest daughter, towards whom she showed significant love and devotion. Supervised access visits provided Sheila with an important opportunity to express this care and to strengthen their connection. Sheila had also begun to rebuild a relationship with her mother. However, this relationship remained complicated, as her mother often appeared to prioritise her own needs, which sometimes left Sheila feeling unsupported.
NGOs and public services intervening on the case Sheila received intensive, multidisciplinary support through the Housing First team, including input from a psychologist, nurse, key worker, occupational therapist, and social worker. She was also supported by the National Learning Network through a year-long day programme. In addition, Sheila engaged with community-based primary care and specialist services, including fracture and plastics clinics, as well as the Community Mental Health Team.
Economic aspects Sheila received state welfare support, including Disability Allowance. When she moved into her tenancy through Cork Simon as part of the Housing First programme, she also received grants to support setting up and furnishing her home.

4. Case description

DATE	EVENT/DEMAND/ACTION	RESPONSE AND OUTCOMES
Summer 2021	Sheila considered independent accommodation through the Housing First programme to be her main priority, reflecting her own expressed needs and preferences.	December 2021: Sheila was supported in moving into independent accommodation through the Housing First programme
Dec 2021	Sheila prioritised psychological support, expressing a preference for sessions delivered in her home or within the community.	December 2021: psychological support commenced. Sheila engaged on a weekly basis and maintained regular phone contact with the psychologist.
March 2022	Sheila was supported to secure access to her youngest child. This involved attending Family Law Court appointments with Sheila over the course of a year, alongside the Housing First psychologist and key worker, in order to obtain supervised access through the court process.	The psychologist and key worker accompanied Sheila to court, provided emotional and practical support, liaised with her solicitor, and prepared reports for the court when requested.
August 2022	Sheila expressed a desire for more structure in her life and agreed to attend a structured community-based wellness and mental health programme for one year.	A place on the programme was secured by the Housing First team's Occupational Therapist.

5. Activity

Please identify:

- ✓ What harm reduction strategies are present?
- ✓ Which principles of harm reduction are reflected?
- ✓ What barriers are visible?
- ✓ What could be improved?

:

10.2 Annex 2: Activity 1.3 - Case study role-play

Module 1 Activity 1.3 - Case study role-play: IG

Using the case of IG discussed in Unit 1, please read carefully the instructions for the role-play of Activity 1.3.

Roles:

- **Case worker:** The meeting with IG will take place in a safe space in the community, where the support professional is working with IG to assess needs and plan support.
- **IG:** A non-binary person with complex substance use, mental health, housing, and social challenges.

Goal:

Build trust, explore IG's current needs, and identify potential support pathways.

Questions

Questions for the case worker and leads for the service user to answer

1. **“What is the biggest challenge you’re facing right now?”**
Clue: IG might mention substance use, unstable housing, or managing relationships at work.
2. **“How are you feeling about your mental health and medication?”**
Clue: May express anxiety, struggles with side effects, or ambivalence about treatment.
3. **“Can you tell me about your current living situation?”**
Clue: Living in a shared apartment, maybe feeling frustrated or stressed by group living.
4. **“What kind of support or help would make a difference for you now?”**
Clue: Could want help with work frustration, housing stability, or managing substance use.
5. **“Who do you rely on when things get difficult?”**
Clue: Mentions mutual support with mother, sex work clients, limited social circle mostly linked to substance use.
6. **“What are your goals or hopes for the next few months?”**
Clue: Working steadily, saving for a home, stabilizing emotions, reducing substance use.

Bear in mind

Bear in Mind: For the Case Worker Role

- Listen actively and without judgment, especially around substance use and mental health.
- Acknowledge the complexity of IG's situation and respect their identity and experiences.
- Build trust by showing empathy and validating IG's feelings.
- Keep questions open and supportive, avoid pushing too hard on sensitive topics.
- Focus on strengths and small achievable goals to encourage motivation.
- Speak in clear, simple language and adapt communication to IG's emotional state.

Bear in Mind: For the IG Role

- Be honest about challenges but also share strengths and what's going well.
- Communicate feelings about medication and mental health openly.
- Express needs clearly but feel free to show frustration or doubts—it's realistic.
- Highlight important relationships and how they impact wellbeing.
- Think about your goals and what support you want to accept or refuse.

Module 1

Activity 1.3 - Case study role-play: Mary Ann

Using the case of Mary Ann discussed in Unit 1, please read carefully the instructions for the role-play of Activity 1.3.

Roles:

- **Case worker (e.g., psychologist, housing support):** The meeting takes place at Mary Ann's home. The Case Worker is supporting Mary Ann with her challenges related to housing (the landlord issued a warning about disruptive behaviours when she drinks), health, trauma, alcohol use, and documentation.
- **Mary Ann:** A woman experiencing housing instability, health and mental health challenges, trauma, alcohol use, and difficulties with residency/documentation.

Goal:

Builds rapport, listens, identifies urgent needs, and explores realistic support options for Mary Ann.

Questions

Questions for the case worker and leads for the service user to answer

1. **"Can you tell me what is your biggest challenge right now?"**
Clue: Mary Ann may mention housing problems with neighbours and/or landlord, or lack of documentation.
2. **"How is your current housing situation?"**
Clue: She might say she has unstable housing, is worried because she has been forced to move twice in the past, and does not want that to happen again.
3. **"Why do you think this situation is happening?"**
Clue: She may explore feeling judged or misunderstood by neighbours and/or landlord, for example due to loud noise at night, listening to music, or bringing people home.
4. **"How can I support you right now to avoid losing your housing like in the past?"**
Clue: She might want help with emotional/mental health support, documentation, or activities that distract her and help manage alcohol use.
5. **"What do you think about getting medical or mental health support to help you deal with this current situation?"**
Clue: She may say she has some follow-up but struggles with adherence to mental health care and shows ambivalence about treatment.
6. **"What kind of work or activities would you like to do in the future?"**
Clue: She may express interest in returning to work or training but feels blocked by lack of documents and low confidence.

Bear in mind**Bear in Mind: For the Case Worker Role**

- Listen actively and patiently - give Mary Ann space to express herself without interrupting.
- Show empathy and avoid judgment, especially regarding trauma, alcohol use, and setbacks.
- Use open-ended questions to encourage honest sharing.
- Focus on building trust and rapport, rather than rushing to fix everything.
- Acknowledge the complexity of Mary Ann's situation: it's okay to say you don't have all the answers right away.
- Summarize what you hear to show understanding and check for accuracy.
- Encourage hope and autonomy: ask what Mary Ann feels she can do or wants to do next.
- Speak in clear, simple, non-technical language, adapted to her stress and cognitive load.

Bear in Mind: For the Mary Ann Role

- Talk openly about challenges and feelings, but stay realistic about what you can and want to share in the moment (alcohol use is not a topic you are able to approach right away).
- Show the impact of housing instability as a retraumatization.
- Express your ambivalence regarding mental health treatment.
- Highlight your strengths and sources of hope (e.g., faith, friendships, small wins).
- Be open to suggestions but also communicate doubts or fears.
- Remember this is a safe space to practice asking for help and exploring options.
- Take your time to express yourself and ask for clarification if something isn't clear.

Module 1

Activity 1.3 - case study role-play: Peter

Using the case of Peter discussed in Unit 1, please read carefully the instructions for the role-play of Activity 1.3.

Roles:

- **Case worker (e.g., psychologist, housing support):** The meeting takes place at Peter's home. The Case Worker is helping Peter manage alcohol use, finances, and housing stability.
- **Peter:** 52-year-old man with a long history of homelessness, currently living in supported housing, who uses drugs, including alcohol.

Goal:

Build rapport, explore Peter's needs, and identify realistic harm reduction and stability strategies.

Questions:

Questions for the case worker and leads for the service user to answer

1. **"Peter, what's the most important thing you need help with right now?"**
Clue: Likely to say keeping his current housing, managing money better, or controlling alcohol use.
2. **"How do you feel your drinking is affecting your daily life?"**
Clue: Might mention spending all food money on alcohol, memory lapses, missing appointments, or getting into trouble when drunk.
3. **"Can you tell me about your current living situation and how it's going for you?"**
Clue: May say housing is good and he wants to keep it, but admits alcohol use makes daily routines and responsibilities harder.
4. **"What strategies have you tried to manage your drinking before?"**
Clue: Could say he hasn't tried much, or mention harm reduction strategies he's experimented with, like the beer calendar.
5. **"Who do you feel you can count on for support?"**
Clue: May mention healthcare professionals, probation officer, cleaning assistance from the Salvation Army, but could say he feels limited emotional support from friends or family.
6. **"What would you like to see change in your life over the next few months?"**
Clue: Could say keeping housing, drinking less, having more control over money, avoiding trouble with the law, or feeling safer and more stable in daily life.

Bear in mind**Bear in Mind: For the Case Worker Role**

- Stay non-judgmental about alcohol use; focus on harm reduction and stability.
- Speak in clear, simple, non-technical language.
- Acknowledge successes (e.g., maintaining housing) while addressing ongoing risks.
- Use simple, concrete strategies rather than abstract goals.
- Suggest or explore harm reduction strategies (beer calendar, grocery support) without forcing interventions.
- Keep the conversation realistic: Peter does not want full sobriety, but maintaining housing requires minimal investment in hygiene, daily chores, and basic budget management.
- Allow time for Peter to reflect and speak freely; validate his feelings and perspective.
- Support autonomy and respect Peter's pace.

Bear in Mind: For the Peter Role

- Be clear about challenges, but also share strengths and what's going well.
- Communicate feelings about medication and mental health openly.
- Express needs, but feel free to show frustration or doubts - it's realistic.
- Highlight important relationships and how they impact wellbeing.
- Think about your goals and what support you want to accept or refuse.
- Take your time to express yourself and ask for clarification if needed.

Module 1

Activity 1.3 - Case study role-play: Sheila

Using the case of Sheila discussed in Unit 1, please read carefully the instructions for the role-play of Activity 1.3.

Roles:

- **Case worker (e.g., psychologist, housing support):** The meeting with Sheila will take place in a safe community space for a routine check-up to assess her wellbeing and current needs.
- **Sheila:** A woman with a history of trauma, chronic pain from a recent accident, mental health challenges, and a strong emotional connection to her youngest child.

Goal:

Build rapport, assess wellbeing, explore current needs (e.g. stability, connection, structure), and support Sheila in identifying achievable goals.

Questions

Questions for the case worker and leads for the service user to answer

1. **“Sheila, how have you been feeling since our last meeting?”**
Clue: May talk about chronic pain from her accident, emotional struggles (stress, anxiety, sadness), and moments of loneliness or isolation.
2. **“How are things going with your housing and daily routines?”**
Clue: Could say she feels safe in her accommodation but struggles to keep daily structure without support.
3. **“Can you tell me about your visits with your daughter? How are they going?”**
Clue: Likely to share that these visits give her purpose and joy, but also sadness when apart.
4. **“What has been helping you cope with your pain and mental health lately?”**
Clue: Might mention medication, speaking with Housing First staff, or activities from her wellness/mental health program.
5. **“Are there things you would like more support with, or changes you’d like in your daily routine?”**
Clue: Could ask about pain management strategies, express concern about medication use, or show interest in alternative therapies or structured activities.
6. **“What goals feel most important to you right now? And for the next few months?”**
Clue: Might want more structure, better health, stronger family contact, or to continue her program.

Bear in mind**Bear in Mind: For the Case Worker Role**

- Be empathetic and warm, non-judgmental.
- Validate Sheila's physical pain and emotional struggles.
- Preserve and build trust: Sheila values feeling heard and safe.
- Use open-ended questions to explore feelings, challenges, and goals.
- Speak in clear, simple, non-technical language, adapting communication to her traumatic brain injury condition.
- Avoid rushing; allow Sheila time to respond and reflect.
- Gently explore both strengths (love for her daughter, engagement with wellness program) and risks/concerns (medication misuse, social isolation).
- Check for immediate needs: physical health, mental health, housing, social support.
- Offer small, realistic steps rather than overwhelming change.
- Suggest or explore harm reduction strategies without forcing interventions.
- Support autonomy and respect Sheila's pace.
- Recognize both challenges and achievements, reinforcing empowerment.
- Be consistent and reliable - trust is hard-won and must be preserved.

Bear in Mind: For the Sheila Role

- Be open about your pain, mental health, and challenges in daily life.
- Take your time to express yourself and ask if you are unsure about something or need clarification.
- Share your feelings about your daughter and what those visits mean to you.
- Express what's helping and what isn't in your current support.
- Mention any concerns about your medication or health follow-up.
- Show both your hopes and your fears for the future.

10.3 Annex 3: Activity 2.4 - Case clinic

Module 1 Activity 2.3 - Case clinic

Case 1 - Sam

Sam grew up in a supportive family, did well at school, and had many friends. While at university, Sam experienced a physical assault at a party, which required a hospital admission. Since then, Sam has become anxious and feels threatened around other people. Sam no longer attends university and is unable to find work.

Sam experiences flashbacks and is constantly vigilant when away from home. He has not shared these feelings with anyone due to shame and self-blame. His parents report that he has become moody, irritable, and appears lazy.

Recently, Sam has started experimenting with drugs and enjoys the effects. At a party, someone offered him heroin to smoke, which he found pleasurable. He is now contemplating injecting heroin, as peers have suggested it is “better.” Sam was offered a syringe but refused because he does not know how to inject. One of his new friends, John, has agreed to show him how to inject at the weekend, and Sam is excited about this.

Sam has started socializing with an older group who regularly use drugs and have unstable housing.

Case 2 - Charley

Charley grew up in a violent household, where arguments between his parents were frequent and sometimes turned physical. At school, he had some friends but struggled to concentrate in lessons, was often labeled disruptive by teachers, and did not finish school.

Currently, Charley is in a verbally abusive relationship, where insults and swearing are the main form of communication. He has a history of trouble with the law related to violent behavior and is described by some as an angry person.

More recently, Charley has been incarcerated, having lost his previous accommodation and is no longer in a relationship with his girlfriend.

Case 3 - Bobby

Bobby grew up in an abusive household, where his parents would hit him and sometimes lock him in a cupboard at random. He was sexually abused by an uncle, but never disclosed it to anyone.

From a young age, Bobby began avoiding school and has struggled to form meaningful relationships with others. Bobby has no siblings and no friends. He began experimenting with drugs, which he finds help to numb his emotional pain.

Bobby's parents have asked him to leave home because he has been stealing money and other valuable items. Bobby is now accessing homeless services, but he rarely gets a bed due to his violent and aggressive behavior. Bobby feels very angry, isolated and alone. He is contemplating suicide.

10.4 Annex 4: Activity 2.5 - Case scenario

Module 2 Activity 2.5 - Case scenario

Gerry

Gerry is a 45-year-old male who has experienced intermittent homelessness over the past five years. His housing situation has been unstable, with periods of rough sleeping interspersed with temporary or short-term accommodations. This pattern reflects ongoing challenges in maintaining consistent housing rather than a single acute episode of homelessness.

Gerry reports a history of significant childhood trauma, as well as additional traumatic experiences in adulthood. These experiences appear to have had a lasting impact on his interpersonal functioning and engagement with support systems. In particular, Gerry identifies difficulty trusting others, including professionals and service providers, which has affected his willingness and ability to consistently access available support.

He demonstrates a high level of self-reliance and has developed practical survival skills that have enabled him to manage in unstable and, at times, high-risk environments. Gerry is able to identify his own resilience and acknowledges his capacity to endure challenging circumstances. However, this reliance on self-sufficiency may also contribute to his reluctance to engage with structured support services.

At present, Gerry reports feeling “stuck” and uncertain about how to move forward. While he expresses some awareness that change is possible, he has difficulty identifying clear goals or the steps required to achieve greater stability. Overall, Gerry presents with strengths in resilience and adaptability, alongside ongoing challenges related to trust, engagement, and future planning.

10.5 Annex 5: Activity 2.6 - Emergency and preventative self-care plan

Module 2

Activity 2.6 - Emergency and preventative self-care plan

Activity

1. Emergency/reactive self care

Emergency Self-Care Plan	
Activities That Ground Me: (...when I'm 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)

2. Preventative self care

List some of the actions you can take to best support your well-being in everyday life.

Self-Care Plan	
Everyday Self-Care:	My Non-Negotiables:
	(1.)
	(2.)
	(3.)

What Activities Fill My Cup?	
Nourish My Relationships:	Nourish My Body:
Nourish My Mind:	Treat Myself:

10.6 Annex 6: Activity 3.3 - Facilitators role-play

Module 3 Activity 3.3 - Facilitators role-play: Jamal

1. Client information

Client Name: Jamal	Age: 34
Description: Returning veteran navigating chronic pain and opioid use	
Setting: Community health center/drop-in support clinic	

Background

Overview:

Jamal returned from service three years ago. He was injured during deployment and lives with chronic lower back and right leg pain. Initially prescribed oxycodone after surgery, he has continued using opioids, both prescribed and unprescribed, to manage the persistent pain and emotional distress-PTSD.

Current Status:

Jamal has difficulty sleeping and has been isolating himself. He occasionally drinks alcohol to “take the edge off” and reports mood swings and irritability. He has started missing appointments and has withdrawn from a veterans’ support group he used to attend regularly.

Additional Information:

Jamal does not identify as someone with a “drug problem,” but admits he feels “off” when he doesn’t take something. His sister, who recently moved in with him, has expressed concern and encouraged him to speak to someone. He has agreed to come in for a one-time consultation, but is visibly guarded and skeptical about treatment.

Key Client Beliefs/Statements

- “I’m not some addict—I’m just trying to get through the day.”
- “The VA just gave me some pills and then left me hanging.”
- “Nobody understands what it is like living with this pain.”
- “I’ve already given everything. Now I just want some peace.”
- “If I stop, I won’t be able to function.”

2. Support worker goals

1. Build a relationship through respect for Jamal’s service and validation of his pain and trauma.
2. Use motivational interviewing to explore his substance use habits.
3. Apply harm reduction tools without pushing abstinence or a major change.
4. Offer non-judgemental support and foster a sense of control.
5. Help identify safer strategies for pain and emotional management.

3. Role-play

Two individuals should assume the roles of client and support worker.

Support Framework	
1.	Warm Introduction - Greet: show curiosity & kindness
2.	Open Exploration - Check-In: explore general well-being
3.	Explore Substance Abuse - Discover: identify use
4.	Building Insight - Discuss: examine motivation of use
5.	Harm Reduction Conversation - Support: provide harm reduction tools
6.	Closing and Next Steps - Offer: reassure support without pressure

4. Debrief prompts/questions

- ✓ How did the support worker show respect and build trust?
- ✓ In what ways did Jamal reveal ambivalence or openness to change?
- ✓ What specific harm reduction tools were offered and how were they used?
- ✓ What emotions or challenges came up during the role play?
- ✓ What could have been done differently to improve rapport or motivation?

Module 3

Activity 3.3 - Facilitators role-play: Juan Carlo

1. Client information

Client Name: Juan Carlo	Age: 21
Description: Student navigating anxiety, sleep problems, and opioid use	
Setting: Student support and harm reduction center	

Background

Overview:

Juan Carlo is a 21 year old attending the University of Barcelona. He recently began going to the Espai Viriat where he gets free snacks, has access to mental health resources, and where harm reduction materials are accessible. Usually he is very laid back and calm but on one particular day he is very agitated. Juan Carlo asks if there are any fentanyl test strips and quickly takes back the question changing the subject and mentions how he wants to “cut back,” but never specifies on what.

Current Status:

Juan Carlo has recently initiated contact with a support worker at the Espai Viriat. He has made brief comments that suggest he may be contemplating or preparing for change, though he has not openly disclosed specific concerns. He appears cautious about sharing personal information, and it is important to allow him space to explore his feelings and goals without pressure or judgement.

Additional Information:

Juan Carlo has been using OxyContin pills regularly and has recently noticed that his tolerance has increased. He’s become worried that something bad might happen as a result. Although he hasn’t told anyone about his issue, he feels it would be safer to talk to someone at the student center. He’s not ready to stop completely because the medication helps him sleep and manage his anxiety, but he’s concerned about overdosing. Out of fear of getting in trouble, he wants to subtly express his worries about openly sharing or saying it aloud.

Key Client Beliefs/Statements

- “I’m not ready to stop completely, it still helps me manage.”
- “I don’t want to overdose to get hurt.”
- “I don’t anyone to think I’m ‘one of those people.’”
- “I’m just curious, I’m not really doing anything dangerous.”

2. Support worker goals

1. Build trust and validate Juan Carlo's concerns without pressuring disclosure.
2. Respond to his question about fentanyl test strips and use it as an opportunity for a conversation about harm reduction.
3. Normalize mixed feelings about substance use and acknowledge the role substances may currently play.
4. Offer tools that match his stage of change (like contemplation).
5. Reinforce that it's okay to take small steps and explore support on his own terms.

3. Role-play

Two individuals should assume the roles of client and support worker.

Support Framework	
1.	Warm Introduction - Greet: show curiosity & kindness
2.	Open Exploration - Check-In: explore general well-being
3.	Explore Substance Abuse - Discover: identify use
4.	Building Insight - Discuss: examine motivation of use
5.	Harm Reduction Conversation - Support: provide harm reduction tools
6.	Closing and Next Steps - Offer: reassure support without pressure

4. Debrief prompts/questions

- ✓ How did the support worker show respect and build trust?
- ✓ What language helped avoid shame or pressure?
- ✓ What specific harm reduction tools were offered and how were they used?
- ✓ What emotions or challenges came up during the role play?
- ✓ What could have been done differently to improve rapport or motivation?

Module 3

Activity 3.3 - Facilitators role-play: Gabriella

1. Client information

Client Name: Gabriella	Age: 24
Description: Single mother navigating lack of childcare and opioid use	
Setting: Community harm reduction clinic	

Background

Overview:

Gabriella is a 24-year-old single mother of five. She recently began an opioid use treatment program for methadone/suboxone use, but following the treatment plan has been challenging for her.

Current Status:

Gabriella recently started treatment and missed the last three appointments because she is struggling to find childcare, which makes it difficult to get to the clinic on time. She is hesitant to ask for support, fearing that staff may see her as unreliable or non-compliant. One day, she stopped by the clinic to pick up more supplies for safer use, aiming to be quick and avoid drawing attention, yet she seemed to be grappling with a strong need to ask for help. She looked visibly tired and different than usual. On her way out, she mentioned that her childcare support had fallen through again.

Additional Information:

The program that Gabriella is in has a strict attendance policy, so missing any program meetings and doses will heavily impact her treatment program. From an integrative harm reduction psychotherapy approach, and considering the relapse prevention model, placing pressure or shame on Gabriella would damage the communication and relationship in place. Gabriella needs support, a listening ear, and validation of her experience while exploring ways of continued support and how to keep her connected to the care she needs. The support she needs now may be different than the support she needed when she began the program.

Key Client Beliefs/Statements

- “I want to keep going, but life is getting in the way.”
- “I’m afraid they think I’m just not trying.”
- “I’m not ready to talk about everything, I just need my supplies.”
- “I don’t want to lose this program.”

2. Support worker goals

1. Approach with empathy and curiosity while avoiding shame or pressure.
2. Acknowledge how hard it can be to stay engaged when daily life is unstable.
3. Validate her efforts without judgement.
4. Offer other flexible options for staying connected and in treatment.
5. Explore creative solutions around childcare, transportation, or alternative appointments.

3. Role-play

Two individuals should assume the roles of client and support worker.

Support Framework	
1.	Warm Introduction - Greet: show curiosity & kindness
2.	Open Exploration - Check-In: explore general well-being
3.	Building Insight - Discuss: normalize setbacks
4.	Harm Reduction Conversation - Support: provide harm reduction tools
5.	Closing and Next Steps - Offer: reassure support without pressure

4. Debrief prompts/questions

- ✓ How did the support worker validate Gabriella's experience without minimizing her struggles?
- ✓ What small openings did Gabriella give that hinted at a desire for continued support?
- ✓ How did the support worker balance program policy with a harm reduction mindset?
- ✓ What creative or flexible approaches were offered?
- ✓ What could have been done differently to improve rapport or motivation?

Module 3

Activity 3.3 - Facilitators role-play: Daniel

1. Client information

Client Name: Daniel	Age: 33
Description: New father navigating recovery	
Setting: Community health center/drop-in counseling services	

Background

Overview:

Daniel recently became a father and is trying to stay sober after years of heroin and fentanyl use. He was in a residential treatment program six months ago and has been living in transitional housing. Since his child was born, he's been trying to rebuild his relationships with his partner and focus on parenting. However, he recently relapsed after an argument with his partner, and now feels ashamed and afraid of losing custody or trust.

Current Status:

He's returned to the health center voluntarily, asking to speak with someone. He admits he used it again for two days and has since stopped, but he's scared that "everything is falling apart." He's also dealing with chronic back pain and says that physical pain is a trigger for him.

Additional Information:

Daniel wants to stay clean for his child but feels stuck and overwhelmed. He's hesitant to go back into inpatient care and says he doesn't want to "start over" again.

Key Client Beliefs/Statements

- "I can't go back to zero again."
- "I already failed my family."
- "I don't have time for treatment again - I have to be a dad."
- "I was doing everything right until I messed up."
- "The pain makes it impossible not to use sometimes."

2. Support worker goals

1. Show compassion and avoid framing the relapse as a failure.
2. Validate the difficulty of chronic pain and parenting stress.
3. Normalize relapse as part of the recovery process.
4. Explore strategies for preventing future use without requiring total abstinence right away.
5. Support Daniel in setting short-term, realistic goals.

3. Role-play

Two individuals should assume the roles of client and support worker.

Support Framework	
1.	Warm Introduction - Greet: show curiosity & kindness
2.	Open Exploration - Check-In: explore general well-being
3.	Explore Substance Abuse - Discover: identify use
4.	Building Insight - Discuss: examine motivation of use
5.	Harm Reduction Conversation - Support: provide harm reduction tools
6.	Closing and Next Steps - Offer: reassure support without pressure

4. Debrief prompts/questions

- ✓ How did the support worker respond to the relapse?
- ✓ What were the signs of Daniel's motivation or ambivalence?
- ✓ What specific harm reduction tools were offered and how were they used?
- ✓ What made the conversation feel supportive or difficult?
- ✓ What could have been done differently to improve rapport or motivation?

Module 3

Activity 3.3 - Facilitators role-play: Vanessa

1. Client information

Client Name: Vanessa	Age: 28
Description: Young mother in a cycle of use	
Setting: Women's drop-in center with childcare services	

Background

Overview:

Vanessa is a single mother of two young children. She has been using methamphetamines off and on for the past five years, mostly during times of high stress. She grew up in the foster care system and has limited family support. Vanesa works part-time cleaning houses but struggles with unstable housing and inconsistent childcare.

Current Status:

Recently, a social worker from child protective services (CPS) conducted a welfare check after a neighbor reported loud arguments and suspected drug use. While no action was taken, Vanessa is scared of losing her kids and feels deeply judged. She is now at the drop-in center asking for help but is defensive and unsure what kind of support she wants.

Additional Information:

She says meth helps her stay awake, clean, work, and manage her kids alone. She doesn't want to go to rehab because she doesn't know who would take care of her children, and she doesn't trust the system.

Key Client Beliefs/Statements

- "I don't have the luxury of falling apart."
- "Meth keeps me going - I can't afford to be tired."
- "If CPS gets involved again, I'll lose everything."
- "I don't trust rehab or shelters; I've seen people come out worse "
- "I just need a break, but I can't get one."

2. Support worker goals

1. Build trust by validating her experiences and strength.
2. Avoid judgement and show understanding of her daily survival strategies.
3. Explore harm reduction tools that are realistic in her situation.
4. Empower her to identify one or two things that could help her feel more stable or supported.
5. Provide information about low-barrier services (e.g., childcare support, outpatient help, legal aid, etc.)

3. Role-play

Two individuals should assume the roles of client and support worker.

Support Framework	
1.	Warm Introduction - Greet: show curiosity & kindness
2.	Open Exploration - Check-In: explore general well-being
3.	Explore Substance Abuse - Discover: identify use
4.	Building Insight - Discuss: examine motivation of use
5.	Harm Reduction Conversation - Support: provide harm reduction tools
6.	Closing and Next Steps - Offer: reassure support without pressure

4. Ebrief prompts/questions

- ✓ How did the support worker approach Vanessa's fears and defensiveness?
- ✓ What tools were used to reduce shame and build trust?
- ✓ What harm reduction strategies felt most realistic?
- ✓ What was difficult about staying client-centered in this scenario?
- ✓ What could have been done differently to improve rapport or motivation?

10.7 Annex 7: Activity 3.4 - Information stations

Module 3

Activity 3.4 - Information stations: Maria

STATION 1: Hoarding Disorder – Maria (Housing First)

Name: María, 52

Background: Grew up in a family where letting go of possessions was discouraged. Experienced repeated domestic violence and lost multiple homes due to eviction.

Current situation: Maria has been recently rehoused through a Housing First program. She struggles to adjust because she has brought most of her belongings with her, including items of very low value (bags, newspapers, old containers). Her apartment is cluttered, and she feels intense anxiety at the thought of discarding anything.

Behavior / challenges:

- Avoids letting staff touch her items; may refuse cleaning support.
- Anxiety escalates if asked to organize or reduce possessions.
- Conflicts with caseworkers can arise when safety or space becomes an issue.
- Emotional attachment to objects is strong—they provide a sense of identity and safety.

FACT SHEET

What it is: A condition involving persistent difficulty discarding possessions, leading to severe clutter and impaired functioning.

Main symptoms

- Difficulty discarding items regardless of value
- Strong emotional attachment to possessions
- Excessive accumulation of objects
- Living areas become unusable or unsafe
- Distress when attempting to throw things away
- Avoidance of visitors due to shame

Common risk factors / causes

- Trauma and significant loss
- Anxiety and depression
- Obsessive-Compulsive Disorder (OCD)-related traits (but not the same as OCD)
- Cognitive difficulties (decision-making problems, attention deficits)
- Social isolation

How it may present in homelessness

- Carrying many bags/carts constantly
- Refusal of shelters/housing if belongings cannot come
- Conflict with services due to storage limits
- Increased eviction risk after rehousing due to clutter

Trauma & substance use link

- Hoarding may function as emotional safety/control after trauma
- Substance use can worsen disorganization and judgment

Practical intervention tips

- ✓ Use respectful, non-judgmental language
- ✓ Focus on safety first (fire exits, hygiene, pests)
- ✓ Go slowly: small steps and shared decisions
- ✓ Offer harm reduction solutions (storage support, prioritizing essentials)
- X Avoid forced clean-outs (can be traumatic and ineffective)
- X Avoid shaming (“this is disgusting”)

Myths

Myth: Hoarding is laziness or poor hygiene.

Reality: It is linked to anxiety, trauma, attachment, and cognitive difficulties.

Red flags / referral

- Severe health hazard, blocked exits, infestation
- Severe self-neglect or inability to live safely

Key teaching point:

- Hoarding often serves as a coping strategy for control and emotional security.
- Interventions in Housing First should focus on gradual, collaborative approaches, prioritizing safety (fire exits, walkways) and empowering Maria to make decisions about her possessions.
- Forced clean-outs or judgmental approaches are counterproductive; incremental goals and emotional support are far more effective.

Reflection Questions:

1. What challenges might Maria face in maintaining her housing despite being in a Housing First program?
2. How might her emotional attachment to objects affect her interactions with staff and support workers?
3. What strategies could help Maria feel safe while gradually reducing clutter?
4. How could you recognize when her hoarding becomes a safety risk?
5. What are some ways to validate her feelings without forcing change?

Module 3

Activity 3.4 - Information stations: David

STATION 2: Psychosis / Schizophrenia Spectrum Disorders – David (Street)

Name: David, 28

Background: Experienced abuse and neglect in childhood. Started using cannabis at age 16 to cope with social anxiety.

Current situation: Homeless for 2 years, mostly isolated. Reports hearing voices commenting on his actions and believes people on the streets want to harm him. Refuses shelters due to fear of being controlled or tricked.

Behavior / challenges: Difficult to engage with services, poor hygiene, communication often disorganized, may become defensive when challenged about perceptions.

FACT SHEET

What it is:

Conditions affecting perception and thinking, sometimes involving hallucinations and delusions.

Main symptoms

- Hallucinations (hearing/seeing things)
- Delusions (paranoia, persecution beliefs)
- Disorganized thinking/speech
- Disorganized behavior
- Negative symptoms (withdrawal, flat affect, lack of motivation)

Common risk factors / causes

- Genetic vulnerability
- Stress and trauma
- Substance use (can trigger or worsen)
- Early adversity

How it may present in homelessness

- Vulnerability to exploitation and violence
- Difficulty managing hygiene, routines, appointments
- Refusal of services due to paranoia

Trauma & substance use link

- Stimulants can cause or worsen psychosis
- Trauma increases paranoia and dissociation

Practical intervention tips

- ✓ Speak calmly, use short sentences
- ✓ Focus on safety and basic needs
- ✓ Don't argue about delusions ("I understand you feel unsafe")
- ✗ Avoid confrontation or sudden movements

Myths

- **Myth:** People with schizophrenia are always violent
- **Reality:** Most are not; they are more often victims than perpetrators

Red flags / referral

- Voices commanding harm, inability to care for self, severe agitation

Key teaching point:

Interventions require calm, validation, and safety-focused approaches, not confrontation of delusions

Reflection Questions:

1. How might David's experiences of trauma and street life contribute to his psychotic symptoms?
2. What signs indicate that he might be at risk for harm to himself or others?
3. How could you build trust with someone who is suspicious of services?
4. What are safe ways to approach someone experiencing hallucinations or delusions?
5. What role could substance use play in his current mental state?

Module 3

Activity 3.4 - Information stations: Sofia

STATION 3: Borderline Personality Disorder – Sofia (Shelter)

Name: Sofia, 34

Background: Experienced emotional abuse in childhood and lost family contact. Developed unstable relationships and intense fear of rejection.

Current situation: Lives in temporary shelters, moving frequently between programs. Often has emotional crises and threats of self-harm when she perceives “abandonment” by caregivers. Alternates between trust and rapid rejection of professionals.

Behavior / challenges: Impulsive, occasional alcohol and drug use, mild self-harm, emotional outbursts followed by remorse and apologies.

FACT SHEET

What it is: A pattern of emotional instability, impulsivity, and unstable relationships.

Main symptoms

- Intense fear of abandonment
- Strong emotional reactions
- Unstable relationships (idealization/devaluation)
- Impulsivity (substance use, risky behavior)
- Self-harm or suicidal behavior (common)
- Chronic emptiness
- Dissociation under stress

Common risk factors / causes

- Trauma (especially childhood trauma)
- Emotional neglect
- Invalidating environments
- Genetic vulnerability

How it may present in homelessness

- Frequent crises and emergency use
- Conflict with services or staff
- Rapid changes in engagement (“all in” then disappearing)
- Self-harm or threats during distress

Practical intervention tips

- ✓ Combine empathy with consistent boundaries
- ✓ Avoid “rescuer” dynamics
- ✓ Validate feelings while reinforcing safe behavior

- ✓ Take some time to regulate yourself before and after the intervention
- ✗ Avoid punitive reactions or abandonment

Myths

- **Myths:** Borderline Personality Disorder is manipulation.
- **Reality:** Behaviors are often desperate attempts to regulate overwhelming emotions.

Red flags / referral

- Active self-harm, suicide attempts, severe emotional crisis

Key teaching point: Relationships should be consistent, empathetic, and clearly bounded; validate emotions without reinforcing harmful behavior.

Reflection Questions:

1. What patterns in Sofia's behavior suggest emotional instability or fear of abandonment?
2. How could staff respond to her emotional outbursts without escalating conflict?
3. What strategies could help Sofia feel supported while maintaining boundaries?
4. How might her impulsivity or substance use impact her housing stability?
5. What would be important to consider before offering her a new program or service?

Module 3

Activity 3.4 - Information stations: Marco

STATION 4: Antisocial Personality Disorder – Marco (Abandoned House)

Name: Marco, 40

Background: Childhood of neglect and violence. Involved in petty crime and running away from home since adolescence.

Current situation: Living in an abandoned building after being evicted from shelters and losing rented housing. Often lies or manipulates for food, shelter, or money. Can be aggressive if threatened.

Behavior / challenges: Conflicts with shelters, difficulty following rules, high risk of aggressive behavior, although rarely initiates violence without provocation.

FACT SHEET

What it is: A pattern of disregard for rules and the rights of others, often involving impulsivity and aggression.

Main characteristics

- Repeated lying or manipulation
- Impulsivity and irresponsibility
- Aggression and conflict
- Rule-breaking behavior
- Lack of remorse (may appear emotionally detached)

Common risk factors / causes

- Early trauma and neglect
- Childhood conduct problems
- Substance use
- Environmental instability

How it may present in homelessness

- Conflict with shelters or outreach teams
- Legal problems and unsafe behaviors
- Difficulty following program rules
- Increased risk of violence

Practical intervention tips

- ✓ Clear rules and predictable consequences
- ✓ Prioritize staff safety and boundaries
- ✓ Keep communication factual and brief
- ✗ Avoid power struggles or emotional escalation

Myths

Myths: Antisocial Personality Disorder means the person cannot change.

Reality: Some change is possible, especially with stable support and accountability.

Red flags / referral

- Threats or violence, weapon carrying, repeated serious aggression

Key teaching point: Interventions need clear rules, consistency, and safety focus, without moralizing. Trauma effects must be distinguished from antisocial patterns.

Reflection Questions:

1. How might Marco's past trauma contribute to his current behavior?
2. What strategies can be used to maintain safety for both Marco and staff?
3. How could outreach workers distinguish between antisocial behavior and trauma responses?
4. How might repeated conflicts with services affect his chances of rehousing?
5. What approaches might increase his engagement without reinforcing manipulation?

Module 3

Activity 3.4 - Information stations: Leila

STATION 5: Generalized Anxiety Disorder – Leila (Rented Room)

Name: Leila, 29

Background: Grew up in a violent neighborhood with frequent school changes and parental neglect.

Current situation: Lives in a rented room, after a period in shelters. Constantly worries about safety, finances, health, and future. Struggles to sleep or eat properly due to fear of assault or losing belongings.

Behavior / challenges: Hypervigilant, avoids social services due to fear or judgment; may have anxiety crises triggered by unexpected changes or loud noises.

FACT SHEET

What it is: Persistent and excessive worry that is difficult to control.

Main symptoms

- Constant worrying about multiple topics
- Restlessness, tension
- Irritability
- Sleep difficulties
- Physical symptoms (headaches, stomach issues, racing heart)

Common risk factors / causes

- Trauma and prolonged insecurity
- Unsafe environments
- Chronic stress and instability
- Stimulant use (cocaine, amphetamines)

How it may present in homelessness

- Hypervigilance and mistrust
- Difficulty relaxing or focusing
- Avoidance of services due to fear or uncertainty

Trauma & substance use link

- Trauma increases chronic anxiety
- Drug use can worsen anxiety symptoms

Practical intervention tips

- ✓ Communicate clearly and maintain predictability (respect schedules and appointments)
- ✓ Offer choices to increase control
- ✓ Teach simple grounding/breathing

- ✕ Avoid minimizing or rushing the person

Myths

Myths: Anxiety is just “overthinking.”

Reality: It has real physical and psychological effects.

Red flags / referral

- Severe impairments, inability to function, frequent crisis states

Key teaching point: People with Generalized Anxiety Disorder may appear hyper-alert or irritable; interventions should be predictable, offer choices, and include simple grounding techniques.

Reflection Questions:

1. How does Leila’s past trauma contribute to her current anxiety?
2. How might hypervigilance interfere with her ability to engage in services or maintain housing?
3. What simple strategies could help Leila feel more in control and safe in her environment?
4. How can staff identify when her anxiety becomes overwhelming or unsafe?
5. How might her constant worry affect relationships with neighbors, landlords, or support staff?

Module 3

Activity 3.4 - Information stations: Tomás

STATION 6: Major Depressive Disorder with Suicidal Ideation – Tomás (Street → Shelter)

Name: Tomás, 36

Background: Lost job and housing after alcoholism problems; history of family abandonment and bullying in adolescence.

Current situation Homeless on the street for 6 months; recently moved into a temporary shelter. Feels hopeless and worthless; often talks about wanting to “disappear” or end life. Poor hygiene, little interest in social interactions.

Behavior / challenges: Passive, unmotivated, low engagement with programs. May express suicidal thoughts directly or indirectly.

FACT SHEET

What it is: A mental health condition involving persistent low mood and loss of interest, affecting energy, thinking, and daily functioning.

Main symptoms

- Persistent sadness or emptiness
- Loss of interest or pleasure
- Fatigue and low motivation
- Sleep and appetite changes
- Feelings of guilt or worthlessness
- Difficulty concentrating
- Suicidal thoughts (sometimes)

Common risk factors / causes

- Trauma and grief
- Chronic stress and poverty
- Social isolation
- Physical illness or chronic pain
- Substance use

How it may present in homelessness

- Withdrawal, “giving up”, reduced engagement
- Poor self-care and hygiene
- Irritability or anger instead of sadness

Trauma & substance use link

- Depression is common after trauma exposure
- Substances may be used to cope or numb pain

Practical intervention tips

- ✓ Use empathy and validation
- ✓ Encourage small achievable goals
- ✓ Support access to healthcare and routines
- ✗ Avoid blaming language (“you just need to try harder”)

Myths

Myth: Depression is just laziness.

Reality: It is a serious condition affecting motivation, cognition, and energy.

Red flags / referral

- Suicidal ideation, severe self-neglect, refusal to eat/drink → urgent referral

Key teaching point: Requires urgent, empathetic intervention with risk assessment and referral. Validating suffering and setting small achievable goals helps reduce isolation.

Reflection Questions:

1. What are the warning signs that Tomás might be at immediate risk of suicide?
2. How might his past experiences of trauma and homelessness affect his mental state?
3. What strategies could help him engage with services even when feeling hopeless?
4. How could small achievable goals improve his daily functioning or hope?
5. How would you prioritize empathy, safety, and risk assessment in this situation?

Module 3

Activity 3.4 - Information stations

Facilitator Answer Sheet

1) HOARDING DISORDER / MARIA (HOUSING FIRST)

1. What challenges might Maria face in maintaining her housing despite being in a Housing First program?

She may risk housing instability due to clutter becoming a health and safety hazard (blocked exits, fire risk, pests). She may also have conflict with landlords, neighbors, or staff if the home becomes unsafe or unsanitary. Shame and avoidance can lead to disengagement from support.

2. How might her emotional attachment to objects affect her interactions with staff and support workers?

She may experience staff involvement as a threat. Even supportive suggestions can feel like an attempt to take away her identity, control, or safety. This can result in mistrust, refusal of home visits, anger, or withdrawal.

3. What strategies could help Maria feel safe while gradually reducing clutter?

A harm-reduction approach: focus on walkways, kitchen access, bathroom access, and emergency exits first. Use collaborative goal-setting ("Which area would you like to make safer first?"). Provide storage solutions and sorting systems, and reinforce her autonomy. Progress should be slow and consistent.

4. How could you recognize when her hoarding becomes a safety risk?

Red flags include blocked doors/windows, inability to use stove or bathroom, fire hazards, strong odors, infestation, mold, falls risk, and inability for emergency services to enter. Also: neighbors complaining or landlord warning letters.

5. What are some ways to validate her feelings without forcing change?

Acknowledge the meaning: "These items feel important to you."

Reflect emotions: "It sounds scary to think of losing them."

Then shift gently: "Let's work together to make the space safer while keeping what matters most."

2) PSYCHOSIS / SCHIZOPHRENIA SPECTRUM / DAVID (STREET)

1. How might David's experiences of trauma and street life contribute to his psychotic symptoms?

Street life reinforces hypervigilance and paranoia because danger is often real. Trauma can increase dissociation, mistrust, and stress sensitivity. Chronic sleep deprivation, hunger, and violence exposure can intensify hallucinations and delusional beliefs.

2. What signs indicate that he might be at risk for harm to himself or others?

Warning signs: extreme agitation, confusion, command hallucinations (“voices telling him to hurt himself/others”), carrying weapons, inability to care for himself, severe insomnia, escalating fear of being attacked, or threats of retaliation.

3. How could you build trust with someone who is suspicious of services?

Consistency is key: show up regularly, keep promises, avoid sudden changes. Use respectful language, avoid arguing about beliefs, and offer practical help (food, hygiene kits, medical support). Trust often develops through small repeated safe interactions.

4. What are safe ways to approach someone experiencing hallucinations or delusions?

Stay calm, speak slowly, give space, and avoid rapid movements. Focus on feelings rather than content: “That sounds frightening. How can we help you feel safer right now?”
Ask about needs and safety, not “proof” of delusions.

5. What role could substance use play in his current mental state?

Cannabis or stimulants can trigger or worsen psychosis. Withdrawal or intoxication can mimic psychiatric symptoms. Substance use may also be self-medication for anxiety or trauma. Both psychosis and addiction may reinforce each other.

3) BORDERLINE PERSONALITY DISORDER / SOFIA (SHELTER)

1. What patterns in Sofia’s behavior suggest emotional instability or fear of abandonment?

She reacts strongly to perceived rejection, has sudden shifts between closeness and anger, and threatens self-harm when she feels unsupported. The “push-pull” pattern (seeking connection then rejecting staff) suggests attachment insecurity.

2. How could staff respond to her emotional outbursts without escalating conflict?

Stay calm and grounded. Avoid matching intensity. Use short validating statements:
“I see you’re overwhelmed. We can talk when you feel safer.”
Offer time-outs and predictable steps, not arguments or punishment.

3. What strategies could help Sofia feel supported while maintaining boundaries?

Clear structure: regular check-ins, consistent rules, one main contact person, and predictable responses to crises. Boundaries should be firm but non-rejecting:
“I can’t stay after hours, but we will meet tomorrow at 10.”

4. How might her impulsivity or substance use impact her housing stability?

It may lead to conflicts, rule-breaking, risky relationships, missed appointments, or unsafe behaviors that increase eviction risk. Substance use may also intensify emotional swings and increase the risk of self-harm and exposure to dangerous situations.

5. What would be important to consider before offering her a new program or service?

The program must be stable and trauma-informed, with staff trained in boundaries. Sudden transitions may trigger abandonment fears. Planning should include a safety plan, crisis contacts, and clear expectations to reduce relational rupture.

4) ANTISOCIAL PERSONALITY DISORDER / MARCO (ABANDONED HOUSE)**1. How might Marco's past trauma contribute to his current behavior?**

Early violence and neglect can shape survival-based behaviors: mistrust, emotional detachment, aggression as self-protection, and learning that manipulation is necessary to survive. Trauma may also reduce empathy development.

2. What strategies can be used to maintain safety for both Marco and staff?

Meet in public/safe spaces, use two-worker visits when needed, set firm boundaries, avoid bringing valuables, and maintain clear exit strategies. Keep communication short, respectful, and factual. Avoid escalating conflict.

3. How could outreach workers distinguish between antisocial behavior and trauma responses?

Trauma responses often show fear-based reactivity and shame underneath. ASPD patterns show repeated rule-breaking, exploitation, and lack of accountability over time. In practice, the distinction is hard — but safety planning remains essential regardless.

4. How might repeated conflicts with services affect his chances of rehousing?

He may be excluded from shelters, lose opportunities due to behavior, and become “blacklisted.” This reinforces distrust and increases chronic homelessness. Systems may unintentionally push him further away.

5. What approaches might increase his engagement without reinforcing manipulation?

Use consistent consequences and clear agreements. Focus on practical goals (documents, health care, income) rather than emotional bonding. Reinforce positive cooperation immediately, and don't negotiate rules during conflict.

5) GENERALIZED ANXIETY DISORDER / LEILA (RENTED ROOM)**1. How does Leila's past trauma contribute to her current anxiety?**

Trauma can keep the nervous system in “survival mode.” Her brain expects danger, so worry becomes constant and protective. Past instability teaches her that safety is temporary, making her anticipate worst-case outcomes.

2. How might hypervigilance interfere with her ability to engage in services or maintain housing?

She may avoid appointments, distrust professionals, misinterpret neutral situations as threats, and struggle with sleep and decision-making. Anxiety can make daily tasks overwhelming, increasing risk of rent issues or conflict with housemates/landlords.

3. What simple strategies could help Leila feel more in control and safe?

Predictable routines, written plans, reminders, breathing exercises, grounding (5-4-3-2-1), reducing caffeine/stimulants, and practical safety planning (locks, safe contacts). Also: reassurance through clear communication.

4. How can staff identify when her anxiety becomes overwhelming or unsafe?

If she cannot sleep for days, stops eating, becomes unable to leave the room, experiences panic attacks, uses substances to cope, or shows paranoid thinking. Also if she starts expressing hopelessness or suicidal thoughts.

5. How might her constant worry affect relationships with neighbors, landlords, or support staff?

She may appear demanding, suspicious, or “difficult,” ask repeated reassurance questions, complain frequently, or misread boundaries. This can lead to conflict and reduce support if not understood as anxiety-driven behavior.

6) MAJOR DEPRESSIVE DISORDER + SUICIDAL IDEATION / TOMÁS (STREET → SHELTER)

1. What are the warning signs that Tomás might be at immediate risk of suicide?

Direct statements (“I want to die”), giving away belongings, saying goodbye, recent losses, severe hopelessness, intoxication, access to means, withdrawal, previous attempts, or sudden calmness after agitation.

2. How might his past experiences of trauma and homelessness affect his mental state?

Homelessness reinforces shame, isolation, exhaustion, and hopelessness. Trauma increases emotional pain and reduces trust in others. Bullying and abandonment may create a strong belief that he is “worthless” and that help will not last.

3. What strategies could help him engage with services even when feeling hopeless?

Start with basic needs: food, hygiene, rest, medical check. Use small relational steps: consistent presence, listening, no pressure. Set micro-goals (“Let’s do one form today”). Avoid overwhelming plans.

4. How could small achievable goals improve his daily functioning or hope?

They restore a sense of control and success. Even tiny actions (shower, appointment, meal) can interrupt helplessness. Repeated success builds momentum and trust.

5. How would you prioritize empathy, safety, and risk assessment in this situation?

- First: ensure immediate safety (ask directly about suicide plan/means).
- Second: reduce isolation (stay with him, involve crisis team if needed).
- Third: validate suffering and offer hope through practical next steps. Referral should be urgent but done with respect and support.

10.8 Annex 8: Activity 3.5 - Successful intervention stories

Module 3

Activity 3.6 - Successful intervention stories

1. Sofia - Amsterdam

“Sofia,” a 36-year-old woman with a long history of heroin use, trauma, and anxiety disorders, entered supported housing after many years of unstable living situations. When she arrived, she rarely attended appointments, experienced frequent panic attacks, and used heroin daily to manage emotional distress.

The team focused on creating a safe and predictable relationship. Instead of pressuring her to stop using, they concentrated on reducing risks and strengthening her sense of safety. Staff members made short daily check-ins, offered a calm space to talk, and respected her pace. This helped Sofia feel less judged and more willing to accept support.

Together they introduced small harm reduction steps. The team helped her create a personal “anxiety plan” that included grounding exercises, a warm transfer to mental health services, and a quiet room she could use when overwhelmed. Staff also supported her with practical tasks such as organizing mail, attending medical appointments, and securing regular meals.

Over several months, Sofia began using fewer times per day and shifted from street-involved use to a supervised consumption setting. Her panic attacks became less frequent, and she began attending therapy sessions consistently for the first time in years. She started planning activities for her days, including art workshops and volunteer work in the housing project.

Sofia later shared with her support worker, “I didn’t know I could feel safe without getting clean first. You helped me see I can take things one step at a time.”

This success story shows how meeting someone where they are, reducing daily risks, and providing steady emotional and practical support can lead to meaningful improvements long before full recovery is possible.

2. Marta - Barcelona

“Marta,” in her early forties, arrived in Barcelona three years ago after losing her job, housing, and much of her social network. Living on the street, she faced unstable conditions and occasionally stayed in shelters, which she often left because they felt unsafe. During this time, her use of base cocaine increased to stay awake, cope with anxiety, and protect herself.

Her mental health deteriorated, with panic attacks, insomnia, and feelings of isolation. Her only contact with professionals was through a mobile outreach team. Initially, Marta refused more help, driven by fear and past negative experiences with institutions. Thus, building trust was crucial. The outreach team approached her gradually and over weeks she recognized them and felt calmer around them. Importantly, they didn’t ask her to stop using drugs before supporting her, which helped her open up.

Finally, after an especially difficult night, Marta accepted an invitation to visit a harm-reduction center. There, she found a space to shower, store belongings, rest safely, and speak with trauma-informed professionals. Over months, several harm-reduction strategies helped her stabilize. She received tailored safer-use counseling, attended regular health check-ups, and developed a crisis-response plan.

Small steps led to lasting change. After six months, her substance use decreased significantly, not through pressure, but as her stability improved. With ongoing support, she entered a Housing First program, gaining immediate access to a small flat, which reduced her anxiety and helped her sleep regularly. Continued follow-up and psychological support enabled her to reconnect with her sister and participate in a basic skills workshop. Her substance use became safer, less frequent, and no longer overshadowed her life. Reflecting on her progress, she said, “Leaving the street made it easier to take care of myself. Having support made it possible to keep going.”

3. Anna - Cork

Anna, 33 years old, has endured over a decade of homelessness, spending most of that time in emergency accommodations. Her primary dependencies have been alcohol and benzodiazepines, with ongoing poly-substance use. Her life has been marked by emotional volatility, which at times led to physical and verbal aggression towards others, including her now ex-partner.

Her involvement with the justice system has been significant, with multiple offenses related to her addiction. Anna's early life was marred by trauma—she experienced care system placements during childhood due to her parents' substance dependency, suffered childhood sexual abuse, and lost her mother at a young age. These traumatic experiences were compounded by her children being placed into care and enduring domestic violence and physical assault in adult relationships.

Despite these profound challenges, Anna's journey began to change when she was supported into independent accommodation after her release from prison in 2021. Her most recent tenancy was secured in January 2024, following a 12-month prison sentence. Throughout this period, Anna received daily, intensive support from the harm-reduction team, including psychological therapy, case management, nursing, and social work—provided through both face-to-face meetings and phone contact.

Even during crises and periods of increased substance use in 2022 and 2023—prior to her imprisonment—the team remained steadfast, never discharging her support. During her recent incarceration, psychologists and her case manager delivered targeted, intensive support, fostering her mental health recovery. They worked closely with Anna to build trust, enhance her insight, and help her to understand her patterns of thoughts, feelings, and behaviors.

This support enabled Anna to gradually feel safer and develop healthier coping strategies. She made notable progress in her sense of self-worth and her ability to recognize internal fears. Instead of reacting impulsively with substances or aggression, Anna now seeks support when she feels overwhelmed or fearful. Her focus has shifted toward addiction recovery, with her current goal of abstinence—an aim influenced by her pregnancy. Previously, she was supported through harm reduction strategies, which helped stabilize her substance use.

Furthermore, Anna has been supported to engage with the social services department to explore options for her children who are in care, with the hope of reconnecting and rebuilding her family life. Her ongoing journey reflects resilience and a commitment to change, supported by a dedicated team that has stood by her through her struggles.

Today, Anna continues to work towards her goals, demonstrating increased self-awareness, stability, and hope for her future.

4. Tim - Cork

Tim, 44 years old, experienced approximately five years of rough sleeping, during which he faced significant mental health and interpersonal challenges. Diagnosed with Emotionally Unstable Personality Disorder (EUPD), Tim's life was marked by emotional volatility, impulsivity, and difficulty managing relationships. His early life was shaped by adversity and trauma, contributing to his struggles later in life.

For over 18 years, Tim battled alcohol dependency, which compounded his mental health difficulties and contributed to his involvement with the criminal justice system. He often grappled with feelings of shame, a critical inner voice, self-hatred, and an overwhelming sense of guilt. Estranged from his only surviving family member, Tim had a tendency to push others away when feeling fearful of abandonment or being hurt, making trusting relationships especially challenging.

Despite these hardships, Tim has made significant progress. He has been living independently in his own home for the past three years and has been managing his tenancy well. His engagement with the harm-reduction team has been consistent, with bi-weekly contacts and ongoing phone support through texts and calls, providing him with stability and reassurance.

Over the past three years, Tim's involvement with the criminal justice system has decreased markedly. The support he received from staff played a crucial role in helping him attend court appearances and navigate legal processes, contributing to a significant reduction in offending behavior. His approach to alcohol use has also evolved, with a focus on harm reduction strategies that have led to more controlled consumption.

Tim's mental health journey has seen notable positive changes. Through ongoing support, he has developed increased self-awareness and acceptance. He now has a better ability to see situations from others' perspectives and relies less on hostile responses to feel safe. Importantly, Tim has learned to recognize and respond to his inner critic, reducing self-judgment and fostering greater self-compassion.

Today, Tim continues to build on his progress, demonstrating resilience and a growing sense of stability. His journey reflects his dedication to change, supported by a compassionate team that has helped him navigate his challenges and embrace a more hopeful future.

5. Manuel - Lisbon

Manuel, a 52-year-old Portuguese man, grew up in an unstable household marked by poverty and family conflict. He experienced 18 years of homelessness and a complete breakdown of family relationships due to substance use. During this time, he had very heavy cocaine use and also used other psychoactive substances. He lived on the streets, either alone or with occasional partners, and consistently refused engagement with support teams, sometimes reacting aggressively. Professionals described him as aggressive. Manuel often expressed frustration with social services, saying he was tired of them, did not want to go to shelters, and felt there was nothing to discuss because that was all the teams could offer.

For several months, he refused any contact until he was approached by the Housing First (HF) team for project integration. The initial conversation took place while he was sleeping on the street. A team member asked him, “How can we help you?” He replied, “I want a home.” The team member responded, “Then we will get you a home.” After some reflection, Manuel said, “I will trust you.” From that moment, he began accepting support from the HF team on the streets and eventually transitioned into stable housing. He has now been part of the Housing First programme for eleven years.

Since his integration, Manuel describes the most significant moment as the first time he was able to provide a home address when engaging with social services. Initially resistant, he gradually engaged with health services and strengthened his connections with social services. He developed positive relationships with neighbors and local shop owners, began working at a local parish council, where he has been employed for seven years, and received dental treatment, having lost nearly all his teeth while living on the streets. During this process, an oncological issue was identified and successfully treated. Manuel also reconnected with his siblings, visiting them during holidays, started taking vacations and going to the beach, and took out his first loan two years ago to purchase a television and a mobile phone.

Manuel’s journey illustrates the transformative impact of stable housing and consistent, person-centered support. After 18 years of homelessness, heavy substance use, and social isolation, his engagement with the Housing First programme allowed him to rebuild his life. He established connections with health and social services, developed positive relationships in his community, regained family ties, secured employment, addressed health issues, and achieved everyday milestones like taking vacations and making personal purchases. His story shows that even long-term homelessness and complex challenges can be overcome with trust, stability, and tailored support.

5. Alex - Lisbon

Alex, a 50-year-old male migrant, has lived in Portugal for 25 years. He previously worked in construction until a workplace accident left him unable to continue working. He experienced approximately 14 years of homelessness.

His first contact with services was through the outreach team, who found him sleeping on the streets. At that time, he presented heavy alcohol use and occasional hashish use, disorganised and delusional speech, and severe spatial and temporal disorientation. He had completely withdrawn from personal hygiene and showed extreme neglect of the space he occupied. He was undocumented, living irregularly in the country, disconnected from all social and health support structures, with no financial benefits, and surviving through begging and scavenging from rubbish bins.

His mental state made communication extremely difficult. He claimed he communicated through computers and his speech was evasive and fragmented, often expressed in an incomprehensible language. He wore multiple layers of clothing throughout the year, regardless of the season. The case was signalled by the municipality due to a lack of alternatives, and the municipal team was already in a desperate situation due to strong community complaints and the inability to integrate him into any of the existing responses available.

He was integrated into the Housing First programme, where he has now been for eight years. At the time of entry, he did not engage with any services, did not adhere to the support team, and also did not adhere to the housing itself. He would spend several days without going to the apartment until the team located him and accompanied him back home. He refused support with personal hygiene and house cleaning, and the neighbours and landlord frequently complained about strong odours. He continued wearing multiple layers of clothing all year round and did not allow any intervention inside the house. He also refused, and did not allow, any support with cutting his hair or trimming his nails. This was a highly sensitive and gradual process and, when he eventually began accepting this support, he kept everything that was cut (hair and nails), storing it carefully in boxes.

Over the following years, with consistent and patient support from the Housing First team, he gradually engaged with health and social services and started medication after being diagnosed with schizophrenia. He began receiving a disability pension (83% incapacity) and became documented. He now attends medical appointments independently and manages his daily medication autonomously. He gradually accepted support with personal hygiene and house cleaning and eventually allowed the team to cut his hair. Later, he purchased an electric shaver and became able to manage his beard and nail care with little support. He now dresses according to the seasons and participates in physical activity with the support of a volunteer.

This story illustrates how severe long-term homelessness combined with untreated mental illness and extreme isolation can improve significantly when stable housing is paired with long-term, flexible, and person-centred support, enabling recovery, dignity, and increasing autonomy.

Module 3

Activity 3.5 - Successful intervention stories

Discussion questions:

- What were the client's main needs and risks at the start of the story?
- What were the main barriers to engagement (mental health, trauma, substance use, system issues)?
- What did professionals do to build trust and keep the relationship going?
- What harm reduction strategies were used (or could have been used)?
- What were the key turning points that led to progress?
- What role did teamwork or multi-agency coordination play in the outcome?
- What is one practical lesson from this story that could be applied in your daily work?

Group reflections/key takeaways

10.9 Annex 9: Activity 3.6 - Roundtable

Module 3 Activity 3.7 - Roundtable

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?

10.10 Annex 10: Activity 4.1 - Icebreaker: “True or false?”

Module 4 Activity 4.1 - Icebreaker: “True or false?”

Participants:

1. **True or False:** There are 3 categories of psychoactive drugs.
2. **True or False:** If a drug is legalized or is given as a prescription, you cannot get addicted to it.
3. **True or False:** Opioids include compounds that are extracted from the poppy plant and hallucinogenic effects, one of the main reasons they are taken for non-medical reasons.
4. **True or False:** Worldwide in 2024, an estimated 64 million people suffered from drug use disorders.
5. **True or False:** You have to use drugs for a significant amount of time before they start to affect you negatively.
6. **True or False:** Long after the effects of the drug stop being felt, the drug can still be in the body.

Trainers:

1. *True or False: There are 3 categories of psychoactive drugs. (FALSE)*

False: There are at least 6 types of psychoactive drugs. They include depressants, opioids, stimulants, hallucinogens, designer drugs, and cannabinoids. Some of these include alcohol, nicotine, marijuana, LSD, cocaine, and heroin.

2. *True or False: If a drug is legalized or is given as a prescription, you cannot get addicted to it. (FALSE)*

False: There is always the possibility of becoming addicted to drugs or alcohol regardless of the legality; their effects do not change based on the method of which they are obtained. You should always follow medical advice when taking prescription medication and please seek support if you are concerned you are becoming or could become addicted.

3. *True or False: Opioids include compounds that are extracted from the poppy plant and hallucinogenic effects, one of the main reasons they are taken for non-medical reasons. (FALSE)*

False: False- While it is true that opioids derive from the poppy plant, they do not cause hallucinations. Opioids have analgesic and sedative effects and can cause euphoria.

4. True or False: Worldwide in 2024, an estimated 64 million people suffered from drug use disorders. (TRUE)

True: According to the United Nations Office on Drugs and Crime World Drug Report 2024. Only 1 in 11 of these 64 million people is in treatment. Additionally, women receive less access to treatment than men, with only one in 18 women in treatment versus one in 7 men.

5. True or False: You have to use drugs for a significant amount of time before they start to affect you negatively. (FALSE)

False: Drugs can cause the brain to send harmful signals to the body. Drugs can cause a person's breathing/respiration to significantly slow down. This can potentially happen the first time a person ever uses drugs, especially with first time users.

6. True or False: Long after the effects of the drug stop being felt, the drug can still be in the body. (TRUE)

True: Many drugs can still be found in the body for up to weeks or months after the last use. Cocaine can be found up to one week after and marijuana up to 3 months after a single use. Individuals could fail a drug test for work or any other organization even if they had stopped using the drug after a period of time had lapsed. It is important to think about the long term consequences of taking drugs, even if it is only once.

10.11 Annex 11: Activity 4.2 - “Fortune wheel”

Module 4 Activity 4.2 - “Fortune wheel”

Substances worksheet:

1. ALCOHOL

Effects:	Legal Status:	Possible Functions:

2. METHAMPHETAMINE

Effects:	Legal Status:	Possible Functions:

3. MDMA (ECSTASY)

Effects:	Legal Status:	Possible Functions:

4. SUGAR

Effects:	Legal Status:	Possible Functions:

5. BENZODIAZEPHINES (E.G. DIAZEPAM, XANAX)

Effects:	Legal Status:	Possible Functions:

6. LSD

Effects:	Legal Status:	Possible Functions:

7. NICOTINE (TOBACCO, VAPING)

Effects:	Legal Status:	Possible Functions:

8. SYNTHETIC CANNABINOIDS (“SPICE,” ETC.)

Effects:	Legal Status:	Possible Functions:

9. COCAINE

Effects:	Legal Status:	Possible Functions:

10. HEROIN

Effects:	Legal Status:	Possible Functions:

11. KETAMINE

Effects:	Legal Status:	Possible Functions:

Module 4

Activity 4.3 - Video forum

The aim of this activity is to connect theory with practice in harm reduction. During the video screening, observe practical strategies and contextual factors while considering the following questions:

1. What strategies are presented?
2. What risks are addressed?
3. How does harm reduction improve the lives of people featured?
4. What challenges or gaps appear in the videos?

10.13 Annex 13: Activity 5.1 - Icebreaker: “Soup of traits”

Module 5 Activity 5.1 - Icebreaker: “Soup of traits”

Find someone who...

1. Speaks more than two languages:
2. Has lived in another country for more than six months:
3. Has worked night shifts:
4. Plays a musical instrument:
5. Has attended a harm reduction training before:
6. Knows how to cook a dish from another culture:
7. Has volunteered with a community or health organisation:
8. Enjoys hiking or outdoor activities:
9. Has completed a first aid course:
10. Has worked in a job completely different from their current role:
11. Practices meditation, yoga, or another form of mindfulness:
12. Has experience working with culturally diverse communities:
13. Can remember an inspiring quote or saying in another language:
14. Has been part of a theatre, music, or art project:
15. Knows a practical tip for staying healthy during night or rotating shifts:

10.14 Annex 14: Activity 5.2 - Peer worker competency simulation

Module 5

Activity 5.2 - Peer worker competency simulation

**Before delivering the training session, the trainer should print this sheet and cut out each individual card to provide to groups of participants during the activity.*

1. “Reluctant to Access Services”

Scenario: A client experiencing homelessness is hesitant to access healthcare services due to previous negative experiences with providers who treated them disrespectfully.	
Competencia principal: Empathy & Breaking Down Barriers	
Peer Worker Instructions: Use active listening and empathy to understand the client's concerns. Explore ways to rebuild trust in the system and support the client in trying again.	Client & Supporting Role Instructions: Act as the client and a skeptical family member.

2. “Struggling With Relapse”

Scenario: A client in recovery has relapsed and feels ashamed, thinking they've let everyone down. They're afraid to talk to support services.	
Primary Competency: Personal Insight & Empathy	
Peer Worker Instructions: Share personal experience (real or simulated) with relapse to show understanding. Support the client in understanding that recovery is not linear.	Client & Supporting Role Instructions: Role-play the client and a critical service provider professional.

3. “Language and Cultural Barriers”

Scenario: A migrant client facing homelessness struggles to communicate due to language barriers and doesn't trust the system.	
Primary Competency: Advocacy and Breaking Down Barriers	
Peer Worker Instructions: Identify ways to advocate for better communication (e.g., interpreters, simplified language). Explore how to empower the client despite the cultural gap.	Client & Supporting Role Instructions: Act as the client and a social worker unfamiliar with their needs.

4. “Discrimination in Shelters”

Scenario: A transgender client reports being discriminated against in a local shelter and feels unsafe returning.	
Primary Competency: Advocacy & Empathy	
Peer Worker Instructions: Listen without judgment and validate the client's experience. Discuss possible safe alternatives and help advocate for inclusive services.	Client & Supporting Role Instructions: Play the client and a resistant shelter staff member.

5. “Burnout and Boundaries”

Scenario: A peer worker feels overwhelmed by the emotional weight of their work and is starting to neglect self-care.	
Primary Competency: Personal Insight & Self-Care	
Peer Worker Instructions: Reflect on your own boundaries and identify healthy strategies to cope.	Client & Supporting Role Instructions: Role-play a colleague or supervisor providing support and feedback.

10.15 Annex 15: Activity 5.3 - In their words: Voices of peer workers

Module 5

Activity 5.3 - In their words: Voices of peer workers

Reflection guide

Reflect on the following questions in relation to the audio testimonials of Heleen and Nuno:

1. What stood out to you most in what you heard?

2. How does the speaker's lived experience enhance their professional role?

3. What feelings or insights did the testimonials evoke in you?

10.16 Annex 16: Activity 5.4 - Exploring tensions in peer work

Module 5

Activity 5.4 - Exploring tensions in peer work

Tension cards

1. CLOSENESS VS. DISTANCE

What is the tension? Peer workers build trust by being close to clients and sharing lived experience. At the same time, they must keep professional boundaries to protect themselves and the client.	Why is this challenging? → Emotional involvement can become overwhelming → Boundaries may feel unclear or shift over time → Former peers or friends may expect special treatment
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2. STRENGTH VS. VULNERABILITY

What is the tension? Lived experience is a strength, but it also brings vulnerability. Peer workers must decide how much of themselves to share and when.	Why is this challenging? → Vulnerability can be misunderstood as weakness → Over-sharing may create emotional risk → Hiding vulnerability can lead to isolation or burnout
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3. MEANING VS. MEANINGLESS

What is the tension? Peer work often involves offering hope, but progress can be slow or interrupted by relapse, crisis, or chronic hardship.	Why is this challenging? → Peer workers may feel powerless or frustrated → There is a risk of trying to “fix” the situation → Setbacks can feel like personal failure
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4. PRIDE VS. SHAME

What is the tension? Peer workers may feel proud of using their lived experience, while also feeling shame linked to stigma, trauma, or past experiences.	Why is this challenging? → Sharing personal stories can feel exposing → Stigma may be internalised → Recognition and discrimination can coexist
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5. NEW VALUES VS. EXISTING ORGANIZATIONAL CULTURE

What is the tension?	Why is this challenging? → Too much flexibility can blur boundaries → Too much structure can limit authenticity
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Clear roles protect peer workers, but flexibility allows peer work to stay human and responsive.	→ Expectations may differ between team members
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6. ROLE CLARITY VS. FLEXIBILITY

What is the tension? Clear roles protect peer workers, but flexibility allows peer work to stay human and responsive.	Why is this challenging? → Too much flexibility can blur boundaries → Too much structure can limit authenticity → Expectations may differ between team members
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10.17 Annex 17: Activity 6.3 - Advocacy campaign analysis

Module 6 Activity 6.3 - Advocacy campaign analysis

Advocacy campaign analysis materials

1. “Harm Reduction Must Go On!” - European Harm Reduction Networks

- [Campaign Webpage](#)
- [Promotional Material](#)
- [Read: Shared Experiences](#)



2. “EVAWUD” (Elimination of Violence Against Women Who Use Drugs)

- [2025 Global Action Report](#)
- [EVAWUD Campaign Toolkit](#)
- [Previous Campaigns](#)
- [Article](#)



3. “Support. Don’t Punish” - Metzineres

- [Campaign Blog 2024](#)
- [Campaign Blog 2023](#)
- [Campaign Video 2020](#) (use English subtitles)
- [Campaign Manifesto](#) (AI translated to English)
- [Campaign Instagram Post](#)



4. “European End Street Homelessness Campaign” - World Habitat

- [Campaign Information](#)
- [Campaign Video](#)
- [Blog Post - Campaign Impact](#)



5. “Harm Reduction Works!” - European Union Drugs Agency (EUDA)

- [Campaign Webpage](#)
- [Policy Paper: A call to invest in a European health-based drug policy](#)
- [Communication Package and Advocacy Toolkit](#)



Module 6

Activity 6.3 - Advocacy campaign analysis

Advocacy campaign overviews



1. “HARM REDUCTION MUST GO ON!” - EUROPEAN HARM REDUCTION NETWORKS

Harm Reduction Must Go On!—a campaign for the continuity of harm reduction services was enacted during the COVID-19 pandemic in response to the heightened systematic discrimination faced by People Who Use Drugs (PWUDs). Partners for this campaign included Correlation - European Harm Reduction Network, Eurasian Harm Reduction Association, and the Rights Reporter Foundation. The campaign carried out a number of advocacy strategies, such as a manifesto/call to action, social media presence, and a blog sharing the lived experiences of people working with individuals affected by this crisis. Harm Reduction Must Go On! not only called for the continuity of harm reduction and other low-threshold services for PWUDs, but also called for specific guidelines and regulations acknowledging the role of these services in combating the COVID-19 pandemic within the communities they serve.



2. “EVAWUD” - (ELIMINATION OF VIOLENCE AGAINST WOMEN WHO USE DRUGS)

EVAWUD (Elimination of Violence Against Women Who Use Drugs) is a global, feminist harm reduction campaign that works to eliminate violence against women and gender-diverse people who use substances around the world. Coordinated by WHIRN and AIVL, in collaboration with partners such as YouthRISE and EuroNPUD, the campaign mobilizes international activism through its annual 16 Days of Action. EVAWUD uses art, storytelling, media advocacy, public action, webinars, and policy engagement to challenge stigma, expose systemic violence, and amplify the voices and rights of women and gender-diverse people who use substances.



3. “SUPPORT. DON’T PUNISH” - METZINERES

“Support. Don’t Punish” is a global advocacy campaign calling for drug policies rooted in health, well-being, and human rights, and for an end to prohibitionist laws that fuel stigma and the criminalization of people who use drugs. Each June, Metzineres joins thousands of individuals and organizations worldwide in mobilizing to build sustainable alternatives to the war on drugs. Metzineres is a womxn-focused harm reduction cooperative in Barcelona that provides a safe and inclusive space for women and gender non-binary people who use drugs, particularly those who have experienced violence. The organization marks “Support. Don’t Punish” through multi-day, community-centered actions that blend protest, education, and celebration, centering care, dignity, and collective empowerment.



4. “THE EUROPEAN END STREET HOMELESSNESS CAMPAIGN” - WORLD HABITAT

The European End Street Homelessness Campaign was a collaborative advocacy initiative led by World Habitat that united organizations across Europe in the shared goal of ending street homelessness and ensuring access to safe, permanent housing for everyone. The campaign promoted Housing First, thus emphasizing support for people experiencing homelessness without preconditions. The campaign was organized through multi-stakeholder mobilization and strategic public engagement that centered human rights, long-term housing solutions, and collective action to end homelessness on Europe’s streets.



5. “HARM REDUCTION WORKS!” - EUROPEAN UNION DRUGS AGENCY (EUDA)

Harm Reduction Works! is a campaign established by the European Union Drugs Agency (EUDA) that advocates for a health-focused, rights-based approach to drug policies within the new EU Drug Strategy (2026-2030). The campaign demands increased investment, drug decriminalisation, and improved access to harm reduction services with specific initiatives for people who use drugs and experience homelessness. Organized by the Correlation - European Harm Reduction Network (C-EHRN) in collaboration with EHRA, IDPC, and HFHR, the campaign provides a dedicated toolkit for partners. This initiative aims to move beyond punitive measures and ensure that the rights and well being of people who use drugs are centered in European drug policy.

Módulo 6

Activity 6.3 - Advocacy campaign analysis

Advocacy campaign analysis worksheet

	Campaign n.º 1:	Campaign n.º 2:	Campaign n.º 3:
<i>What is the primary advocacy goal of this campaign?</i>			
<i>Who is the target audience?</i>			
<i>What are the key messages and how are they framed?</i>			
<i>What strategies were used? (e.g., lobbying, public demonstrations, media, partnerships)</i>			

	Campaign n.º 1:	Campaign n.º 2:	Campaign n.º 3:
<i>What stakeholders, allies, organizations, institutions, governmental bodies, etc. are involved?*</i>			
<i>How does the campaign reflect harm reduction principles?</i>			

Module 6

Activity 6.4 - Designing an advocacy campaign

10.18 Annex 18: Activity 6.4 - Designing an advocacy campaign

You are expected to develop the core ideas for an advocacy campaign focusing on the H4H main topics, namely homelessness, drug use and solutions from a trauma informed perspective.

1. ADVOCACY TOPIC / PRIMARY CAMPAIGN GOAL:

2. DESIRED CHANGE / ENGAGEMENT STRATEGY FOR EACH AUDIENCE:

Audience / Level of Change	Awareness (What do they need to know?)	Will (What beliefs or motivation must shift?)	Action (What action do you want them to take?)
Public			
Public Engagement Strategy			
Influencers			
Influencers Engagement Strategy			
Decision-makers			
Decision-makers Engagement Strategy			

3. CORE MESSAGES / KEY IDEAS:

4. ACTIONS / TACTICS / STRATEGIES:

5. VISUAL REPRESENTATION:

(How do you imagine the visual representation of your campaign?)

The **Home4Health** VET Training for professionals working in homeless and drug use contexts project was completed in the summer of 2026.

This project was coordinated by:



Project partners:



HOME4 HEALTH



Coordinated by:



In partnership with:

