RETHINKING INTEGRATED APPROACHES TO HOMELESSNESS AND MENTAL WELLBEING:

SOLUTIONS AND GOOD PRACTICES

This article emphasises the need for a nuanced approach to mental health and homelessness, considering the complexity of needs regarding identity and access to rights. The authors propose a multidisciplinary, community-engaged, and holistic approach - citing successful experiences in smaller towns. Strategies include continuous professional training, common funds for services, and recognising informal cooperation. A bottom-up integrated service example in Udine, Italy, illustrates positive outcomes, emphasising collaboration and cultural awareness.

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MENTAL HEALTH, RIGHTS, AND IDENTITY

Mental health work is tough work. It aims to understand how social transformations affect people's well-being, the dynamics of identity, and how to take care of people who are suffering, to avoid their decline into pathology. Every era expresses a specific suffering; today, mental suffering is growing and is increasingly linked to gender identity, the social withdrawal of young people, traumatic migration experiences, addictions, and social fragility.

‘At first glance homeless people all look the same, but they are not’, says Dr Renzo Muraccini, a psychiatrist who has worked for many years in a mental health centre in Bologna. People experiencing homelessness and psychiatric problems have simultaneously complex needs and alienated identities. This is worsened by the serial denial of their rights, such as the right of residence and the right to have a general practitioner which excludes them from the social-health system.

It is necessary to work on the intervention paradigm starting from the recognition that traditional solutions to homelessness are often insufficient and inappropriate, the importance of revealing and accompanying the development of the individual’s identity, and from the idea that their rights are often denied.

HOW TO ADDRESS THE MENTAL HEALTH PROBLEMS OF PEOPLE EXPERIENCING HOMELESSNESS

Today, the dominant approach to mental health and homelessness within homeless services is based on the provision of material support for basic needs. Usually, the first contact happens on the street through mobile outreach units that guide people to specialised services (e.g., mental health departments, drug addiction services, and psychiatric communities). But the engagement with these people must be focused also on the emotional well-being of the individuals and enabling them to access their basic rights.

The approach based on knowledge and listening is less widespread among social workers and staff at the homelessness shelters, due to a lack of adequate training and resources. Listening to the person's history, learning about traumas experienced (often dating back to childhood), bereavement, identity crises, drug and alcohol addiction, and social and familial problems, are all fundamental in social and health work. People in homelessness who have mental health problems have often experienced ‘a stumble’ or a breakdown in their life course, such as not being adequately supported by solid social relationships, a decent job, or a home. This leads to a compromised identity, generates dysfunctional behaviour, and gives rise to a marginalised life. However, we cannot ignore their identities. Listening to their life stories and trying to understand what strategies they implement to cope with a hostile social context may be a tiring and complex approach for the worker, but it is crucial in helping people to break out of a blurred identity and to begin to regain an in depth understanding of their history and the course of action to recovery.

People facing homelessness and mental health problems are affected by biopsychosocial[1] suffering, which requires the social and health systems to have relevant competencies to meet people's needs and enable them to exercise their social and civil rights in a mature and informed way. At present, the issue is socially relevant, contradictory, and complex. Due to the complexity of biopsychosocial suffering, specialised services based on sectoral expertise and short-term solutions have been implemented. Over time, this logic of specialisation has created a network of services that includes primary care, drug addiction services, psychiatry, justice, public order, and social services. As Dr Muraccini pointed out, the homeless person with mental health problems 'is kept alive by many services'. A note to make here is that this approach is not an integrated service provision, i.e., each professional only acts according to what they consider their competence, without an overarching view, and thus the system fails to provide holistic responses that address the full range of people's needs.

A distinction must be made between the way in which large cities and provincial towns approach the mental health of the homeless population. Dr Muraccini's experience shows that the provincial territorial system has so far been more effective in re-integrating people facing homelessness into a social circuit. Thanks also to an act of solidarity, this system creates a link between psychiatric operators, the third sector and people with mental health problems, effectively filling the gap left by institutional responses. The metropolitan territorial system is certainly more populated by homeless people and more complex to manage. The issues are dealt with by health and social workers in a more specialised way, but this does not always mean that a long-term solution has been found.

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1 The biopsychosocial model suggests that to understand a person's medical condition it is not simply the biological factors (physiological pathologies) to consider, but also the psychological (thoughts, emotions and behaviours), and social factors (socio-economical, socio-environmental, and cultural factors) and their complex integration.

STRATEGIES TO ADDRESS A COMPLEX PHENOMENON

Integration, cooperation, and a holistic approach are the key words for effectively tackling the complex phenomenon of mental health among homeless people. Some of the strategies that have been proposed by those who, like Dr Muraccini, have been working in this field for many years are as follows:

- Encourage a multidisciplinary approach by bringing professionals closer together. Create places where psychiatrists, general practitioners, nurses, health workers and social workers can work together, sharing knowledge and skills. It is important that these places do not become stagnant, but are designed to be transitional, flexible, and collaborative.
- Be open to the community and invest in engaging the social resources and informal networks that exist in the local area. Mental health is an issue that concerns everyone, and everyone should contribute to supporting the most vulnerable.
- Establish a common fund and a common strategy for social services, psychiatry, mental health, and drug addiction services, in order to set common responsibilities, including economic ones, for the care of the most vulnerable and marginalised people.
- Promote continuous professional training that helps to build a shared vision of how different professionals can work together while maintaining their own professional identity.
- Exhibit caution, sensitivity, and patience in approaching biopsychosocial suffering, which by its very nature requires an effort of understanding that also involves the cultural sphere. This means adopting an attitude of respectful, non-judgmental listening, and offering suggestions and perspectives to the person while leaving them free to live their own identity.
- Recognising and scaling up the forms of informal cooperation and integration that spontaneously emerge between social and health professionals, as demonstrated by certain virtuous practices in small towns.
- Investing in prevention, i.e., multiplying the places where mental health issues are addressed, starting with the family, schools, and workplaces. Prevention must be seen as the basis for tackling mental health problems before they occur.

BOTTOM-UP DEFINITION OF AN INTEGRATED SERVICE: THE EXPERIENCE OF THE OPERA DIOCESANA BETANIA ASSOCIATION[2]

In the province of Udine, in Friuli Venezia Giulia region, there has long been an awareness of mental health issues, which has now led to consolidated and collaborative practices as well as a culturally informed vision of how to approach the mental health issues of those experiencing homelessness. As pointed out by Maria Luisa Pontelli, coordinator of the Opera diocesana Betania Association, the 1980s were a fertile period: the Basaglia Law (Law 180/78) led to the closure of mental hospitals, and the Alcoholics' Clubs, strongly rooted in the community, spread throughout the region.

2 http://www.caritasudine.it/opera-diocesana-betania/

Betania was born in this promising cultural framework and immediately focused on the promotion of networking with social, mental health, and addiction services. Thanks to its membership in fio.PSD (Italian Federation of Organisations for Homeless People) and in the Italian Housing First Network, Betania began to rethink extreme poverty as a complex and multidimensional phenomenon and to develop interventions specifically targeted at people experiencing homelessness, often with mental health and addiction problems, who were housed in both residential community accommodations and in independent apartments. The guiding principles of Housing First permeate the practices of the operators and guide the relationships with social and health services. Betania is committed to actively promoting the Housing First approach and raising awareness of the complexity of the homelessness phenomenon and of the need for all the actors to work together, overcoming the fragmentation and hyper-specialisation of interventions.

This work is also made possible by an institutional framework and structured practices of cooperation between services supported by regional laws (LR 41/96[3], LR 10/98[4], LR 6/2006[5]), as well as by locally defined protocols that regulate the modalities of cooperation between social and health services and third sector bodies. This framework provides instruments and mechanisms, such as the so-called Multidisciplinary Assessment Team, which allows different professionals to work together, also with the beneficiaries, to design tailor-made projects.

In 2022, *Betania* accommodated almost 200 people, 60% of whom had mental health issues, alcohol, or drug problems. A third of them were housed in residential communities, while the others were offered scattered throughout different accommodations, including more than thirty people housed in Housing First apartments. The entire network of social and health services is involved in the consultation and implementation of tailor-made projects. Evidence shows that most of the beneficiaries have achieved positive outcomes in terms of housing stability and improved quality of life.

Among the facilitating factors that make the *Betania* experience a good practice, are:

- A historical conjuncture that has promoted awareness of mental health issues, which has led to the emergence of bottom-up working practices and a common professional culture between social and health services that has been consolidated over the years, and also facilitated by regional legislation.
- A small urban context that has facilitated the development of collaboration practices, even informal ones, between social and health professionals.
- The constant maintenance of collaborative relations with the public sector and the review of practices to maintain a high focus on shared responsibility in the care of people experiencing homelessness.

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3 Regional Law on Framework law for assistance, social integration and the rights of disabled persons, N. 41 - September 25th, 1996.

4 Regional Law, Norms on health protection and social promotion of the elderly, as well as amendments to Article 15 of Regional Law 37/1995 on procedures for health and social-welfare interventions, N. 10 - May, 19th, 1998.

5 Regional Law, Integrated system of interventions and services for the promotion and protection of social citizenship rights, N. 6, March 31st, 2006.