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# GOOD PRACTICE GUIDANCE FOR WORKING WITH PEOPLE WHO ARE HOMELESS AND USE DRUGS

## Context

There is a lack of information about targeted interventions available across Europe for homeless people who use drugs. The European Centre for Monitoring Drugs and Drug Addiction in its 2015 report stated that

*“targeted interventions can facilitate access to treatment and ensure that the needs of different groups are met. ... Targeted programmes for homeless drug users, older drug users and lesbian, gay, bisexual and transgender drug users were less frequently available, despite many countries reporting that there was a need for this kind of provision.”<sup>1</sup>*

To deliver on this call, FEANTSA has collected some examples of good practice, which will also serve to inform its membership of useful practices in providing drug interventions.<sup>2</sup> The document will describe the underlying principles of effective drug intervention for people who are homeless and will present examples of good practice from across Europe in this area.

## Background

### What is homelessness?

A person experiences homelessness when he or she does not have somewhere to live in security, peace and dignity.<sup>3</sup> Homelessness and housing exclusion can be used to describe a wide range of living situations<sup>4</sup>: people sleeping rough and living in public spaces, people

<sup>1</sup> ECMDDA, 2015

<sup>2</sup> This document is not meant to be a full guideline on delivery of drug treatment for people who are homeless. It is developed from practical experience by the health working group of FEANTSA.

<sup>3</sup> CESCR general comment nr.4

<sup>4</sup> ETHOS categories

using homeless day or night shelters or staying in temporary accommodation, as well as people currently living in state care, hospitals, in prison without adequate housing to return to, and people living in insecure or inadequate accommodation that may be unfit for habitation, overcrowded or that may not legally be theirs. The homeless population cannot be described as a homogenous group, with research referring to a population increasingly made up of a higher number of women and young people.

## Causes of homelessness

Homelessness is caused by the interaction of structural problems, such as a lack of affordable housing; system failures, such as a lack of support in transition from state child care, inadequate discharge from prisons and mental health facilities,; and individual factors such as domestic violence, addiction etc.

## Homelessness and problematic drug use: both cause and consequence

The relationship between homelessness and problem drug use is complex. Problem drug use<sup>5</sup> can put people at an increased risk of homelessness and can also be caused and exacerbated by traumatic experiences, including homelessness. There is certainly no easy answer to the cause and consequence debate. While it is widely agreed that problem drug use has a role in homelessness, we also know that most people who are addicted to drugs never become homeless. Regardless of whether homelessness or drug use comes first, research has consistently found that the proportion of homeless people who are problematic drug users is significantly higher than in the general population.

## Drug use among homeless people

Homeless people have much higher rates of drug use than the general population and homeless drug users tend to use substances more frequently, in increased quantities and in less safe ways than their housed counterparts. Risk behavior is correlated with housing instability, with the highest levels of risk being experienced amongst rough sleepers and those in emergency accommodation.<sup>6</sup> In addition, people who use drugs and are homeless face significant barriers to accessing health care, drug treatment and support towards recovery, which further hinders their chances to being housed.

## Some of the barriers to services and key problems faced by people who are homeless and use drugs

- Mainstream services often have a high threshold.<sup>7</sup>

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<sup>5</sup> Problem drug use' is defined by the EMCDDA as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines'. This definition specifically includes regular or long-term use of prescribed opioids such as methadone but does not include their rare or irregular use or the use of ecstasy or cannabis. Alcohol remains the main substance of use among the homeless people.

<sup>6</sup> Cox and Lawless, 1999

<sup>7</sup> High threshold programmes might be contrasted with low threshold programmes that are flexible in their organization of services and eligibility requirements. The objective is treatment accessibility for the greatest number of individuals in need. Interventions are designed specifically to engage and retain some of the most

- Lack of available treatment places.
- Long waiting time for treatment.
- Strict rules of compliance and attendance.
- Lack of stable address.
- Homeless people seen as too difficult.
- Lack of coordination between health services, social services and drug services.
- Limited access to support to deal with the underlying issues (e.g. mental health problems).
- Poor service responses to dual diagnosis and complex needs.<sup>8</sup>
- No stable housing post drug treatment and rehabilitation, which can result in drug users who are homeless returning to emergency accommodation or rough sleeping, often putting their recovery in jeopardy.
- Criminal justice led responses.
- Stigma.
- Lack of social support network if estranged from family and friends.
- Many treatment programs being abstinence-based, which is less effective for people who are homeless than harm reduction strategies.

## Guiding principles for effective drug services for people who are homeless

### Harm reduction

Harm reduction must be at the heart of homeless and drug service provision. There is extensive evidence that harm reduction is more effective for homeless people with high and complex needs than abstinence-based or detoxification services.<sup>9</sup> This approach is persuasive; the goal is not necessarily to stop all drug and alcohol use, but to reduce the health related harm of continued drug use, for example, by helping users to reduce the amount or frequency of their use.<sup>10</sup>

Drug use and related needs among homeless people vary greatly and it is therefore important that there is a range of options available, from 24/7 needle exchange to consumption rooms<sup>11</sup>

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marginalized and hardest to reach populations. The non-judgmental approach of low-threshold programs aims to reduce negative health outcomes while not requiring individuals to completely abstain from illicit drug use. (Lowering the Threshold, Open Society Institute,

<https://www.opensocietyfoundations.org/sites/default/files/lowering-the-threshold-20100311.pdf>)

<sup>8</sup> A person who is homeless very often has multiple needs or complex needs, such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. This makes it very difficult for people to be in contact with all the various services they may need at one time. If one issue was to be resolved, other issues would still be cause for concern (Homeless Link, 2002)

<sup>9</sup> Pleace, N. (2008) Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an International Review Edinburgh: Scottish Government <http://www.gov.scot/Resource/Doc/233172/0063910.pdf>

<sup>10</sup> Harm reduction is a manifestation of mainstream public health approaches endorsed by the United Nations and in the EU drugs strategy.

<sup>11</sup> The serious health and public order problems associated with drug use, especially drug

and opioid substitution treatment.<sup>12</sup> These programs are most effectively delivered if low-threshold in nature and access is quick, easy and adapted to the needs of clients. A genuine harm reduction policy means providing various options for users to choose from at different stages of recovery and in a non-judgmental way.

### Housing as part of the treatment and recovery process

Stable housing is central to achieve treatment goals. Improving access to the right drug treatment at the right time is important, but it has to be emphasised that secure housing should be a fundamental part of treatment. Discharging people from treatment back into environments where other users are present, as well as the risk factors that produce substance use in the first place (violence and poverty etc.) can make it very difficult to stay 'clean.' Moving from treatment back to homelessness may lead to preventable relapses. People must have accommodation to go on to completion of treatment.<sup>13</sup>

The impact of housing on health and substance use cannot be stressed enough. Housing First involves supporting homeless people with complex needs to move quickly into permanent housing and then providing the additional services and support as required. The key characteristic of Housing First is that the offer of housing is not conditional on access to treatment or abstinence.<sup>14</sup> The outcomes of Housing first projects across Europe show high housing retention, but also improvements in health and reduction in drug use.

Housing First emphasizes housing as a human right, promoting service user choice and a harm reduction approach by offering the separation of housing and treatment. However, having appropriate housing, a place to call home, provides individuals with a greater sense of safety and stability, increased control over their lives and an environment which allows the individual to critically reflect on their drug and/or alcohol use. If treatment is desired, a referral pathway is in place. It is also important that support is in place to prevent people who use drugs from losing their accommodation.

### Addressing underlying risk factors, causes or motivations of problematic substance use

Problem drug use cannot be treated or dealt with in isolation; it has to be understood in relation to a person's other support needs, characteristics and behaviour. A holistic (whole person) approach should address all the causes and consequences of drug and alcohol use in the context of the person's environment.

Homelessness and drug use are often symptoms of other problems, for instance, mental health problems, or result from an institutionalized background like state care or prison. We know

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injecting in public places, have led in recent years to the establishment of drug consumption rooms in several countries. Consumption rooms are protected places for the hygienic consumption of preobtained drugs in a non-judgemental environment and under the supervision of trained staff

<sup>12</sup> Opioid substitution therapy supplies illicit drug users with a replacement drug, a prescribed medicine such as methadone or buprenorphine, which is usually administered orally in a supervised clinical setting. These therapy programmes are effective in substantially reducing illicit opiate use, HIV risk behaviours, death from overdose and criminal activity, and financial and other stresses on drug users and their families.

<sup>13</sup> Discharging people from institutional settings e.g. hospital/prison/care system into homelessness remains an issue. Discharge protocols must be published, implemented and resourced.

<sup>14</sup> <http://www.housingfirstguide.eu/website/wp-content/uploads/2016/HFG/Chapter2.pdf>

that homeless people often have a wide range of support needs that reinforce each other. For example, for many homeless people, substance use co-occurs with mental health issues, yet, many programs for homeless people with mental health issues do not accept people with substance use and many programs for homeless drug users do not treat people with mental health issues. In addition to this, people often receive services from two or more systems simultaneously, such as health care at one site and treatment for substance use at another. When coordination between services is poor, clients might receive confusing messages or important issues may remain unaddressed. It is therefore critical that treatment is broadly defined, not as an intervention with a single focus, but that care is delivered in an integrated multi-sectorial approach. It should be seen as directly linked to health and mental health treatment and to the provision of social services and other support needs.

There should be a strong focus on delivering effective drug services for people who are homeless, but it is important to address the underlying risk factors that might have caused drug use in the first place, for instance poverty, violence or trauma. It is important to work with health and support services to ensure other support needs are met in order for drug treatment to be successful.

Trauma informed care is a good example of a multi-focused approach to treatment, as it recognizes how central the experience of trauma can be to many people who use drugs and are homeless, and is thus responsive to this reality.

### Client-centered approach: emphasis on choice

Treatments should be client-centered and client-driven. Treatment goals should be set collaboratively with clients based on what they need and want and where they are at in their recovery, not predefined by the program's benchmarks for client outcomes. The power differential between service provider and client should be minimized. The primary role of the service provider is to listen to the client, help them identify achievable goals and facilitate steps that that client wants and is ready to take.<sup>15</sup> Clients should be the real drivers of their own recovery.

### Relapse as part of recovery

Relapse, when somebody returns to problematic drug use, is very common. It should be considered part of the recovery process and not a failure (see Wheel of Change model<sup>16</sup>). Treatments should accept and tolerate relapse and help people to learn from it in order to make changes that can prevent another relapse, encourage them to stay engaged in treatment and move forward in their recovery process.

### Drug treatment tailored to individual needs

Effective services for homeless drug users are low-threshold and are tailored to the different support needs homeless people might have. For instance, young homeless people may use

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<sup>15</sup> One method of client-centered care is motivational interviewing which uses reflective listening as a primary skill to understand clients, their readiness to change, and to create within them the motivation to take a next step. ( Miller WR and Rollnick, S, 2002: Motivational Interviewing: Preparing people for Change) This approach is said to be far more effective than the use of confrontational methods.

<sup>16</sup> <http://www.fsn.ie/resources/process-of-addiction/>

different drugs than older homeless people, who might have concurrent problematic alcohol use. Women's experiences of homelessness and substance use are often different from men's and therefore have different support needs to address them. Many homeless women have experienced violence in their lives and it is important to provide support in dealing with the trauma resulting from violence. Women who are mothers have been found reluctant to seek help with drug problems because they are afraid that their children might be taken into care.

## User involvement

Health and social care services are increasingly taking into account service users' experience, unique skills and abilities that enable them to provide 'expert advice'. User involvement can happen in four different forms<sup>17</sup>:

- a, It can happen on the individual level, when the service user is involved in their own care and treatment plan.
- b, Users can also be involved in the planning and delivery of services, for instance by pointing out how to make services more accessible. Evidence shows that services are more effective if they are developed and delivered with the direct involvement of the people who use them.
- c, User involvement can also happen in the form of peer support, which is "based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations."<sup>18</sup> It can be a peer advocate who helps the clients, for instance to attend an appointment or a peer who delivers training, for example, training current users and carers on the use of naloxone in the event of opiate overdose.<sup>19</sup>
- d, User involvement can take place in the form of user-led organisations, where the people the organisation represents or provides a service to are in control, and accountable for service users.

Peer engagement, for instance in the planning and implementation of overdose programmes, also has additional benefits in reducing stigma and discrimination – it allows professionals to appreciate the skills and commitment that peers bring, while informing a deeper understanding within the wider community.<sup>20</sup>

## Community integration

Drug treatment alone cannot address the complex needs of problematic drug users and prevent further social exclusion of already marginalised individuals. It is important that community integration measures such as housing support or vocational training is part of the

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<sup>17</sup> <http://www.nta.nhs.uk/uploads/service-user-involvement-a-guide-for-drug-and-alcohol-commissioners-providers-and-service-users.pdf>

<sup>18</sup> 1 Peer support among adults with serious mental illness: a report from the field by Davidson, Chinman, Sells and Rowe, 2006

<sup>19</sup> <http://www.feantsa.org/en/feantsa-position/2015/10/03/feantsa-position-peer-support-a-tool-for-recovery-in-homelessness-services?bcParent=27>

<sup>20</sup> [http://www.eurohrn.eu/images/stories/pdf/publications/models\\_of\\_community\\_report.pdf](http://www.eurohrn.eu/images/stories/pdf/publications/models_of_community_report.pdf)

recovery process from a very early stage. Community integration refers to ‘any social intervention with the aim of integration of former or current problem drug users into the community’<sup>21</sup> and should address the multiple barriers that problematic drug users face. Abstinence should not be a condition of community integration support. There should be a focus on education, training and employment.

## De-stigmatisation

People who are homeless and use drugs face multiple stigmas; they have been long stigmatized and blamed for their situation. There is a huge amount of addiction-related stigma as well; which means that people who are homeless and use drugs face stigmatization from society in addition to the difficulties they face in their lives.<sup>22</sup> The day-to-day manifestations of stigma harm and undermine people who are homeless and use drugs, and as a result, they become isolated and demoralised, and develop what Goffman calls a 'spoiled identity'.<sup>23</sup> This is the case when stigma becomes internalised and this self-stigma has a profound impact on the ability of the person to exit homelessness and recover from addiction. Street-based harm reduction services often emphasize the importance of a trusting relationship with clients and working in an empowering environment to reduce stigma and to increase referrals and access to other health, housing and social services.

## Move away from criminal justice led responses

Many drug users seeking treatment have a criminal record resulting from their involvement in the drugs scene. Clients consistently report that old charges (up to five years old) are brought forward after they have begun treatment and/or moved in to recovery. This puts an undue strain on a sometimes precarious recovery process and can impede residential treatment, as the client has to leave the treatment venue to go to court or has a lot of stress to face in the early days post-recovery. Engagement in treatment and treatment effectiveness can be fostered by linking such engagement to measures aimed at expunging criminal records for minor property crime. Consideration should be given to measures such as the following: outstanding drug charges being consolidated before an offender enters drug treatment and historical charges not brought forward under this consolidation being expunged; all non-victim crimes (begging, possession for personal use) should be quashed upon completion of residential treatment programs. These are small crimes that are addiction-driven. They do not have any direct victim and cause a strain on the legal system and tax payer (legal aid, court and police time) and create a huge relapse trigger in the anxiety and fear they create to clients, compromising recovery. Further exploration of the decriminalisation of drug use must be explored. Policing emphasis should shift from small scale personal use to large scale supply.

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<sup>21</sup> EMCDDA definition, Insights report

<sup>22</sup> The Stigma of Homelessness: The Impact of the Label "Homeless" on Attitudes Toward Poor Persons  
Jo Phelan, Bruce G. Link, Robert E. Moore and Ann Stueve, *Social Psychology Quarterly*. 60, No. 4 (Dec., 1997), pp. 323-337

<sup>23</sup> Notes on the Management of Spoiled Identity, Erwing Goffman

## Annex: Good practices

1. Housing First – Turning Point Scotland Glasgow
2. Mobile Health Service, Safety Net, Dublin Simon Community, Chrysalis Project - Dublin
3. Peer based Training on HCV – Swedish Drug Users’ Union
4. Naloxone guidance for homeless services and Naloxone training for homelessness staff and residents - Homeless Link
5. Consumption rooms (Copenhagen)
6. Norte Vida –Porto
7. Community integration NL
8. KETHEA- Greece

### **Turning Point Scotland, Housing First Glasgow**

The Housing First model represents a significant departure from traditional ‘linear’ models of provision for homeless people with complex needs by placing individuals directly into independent tenancies with no requirement to progress through transitional housing programmes. By sustaining a permanent tenancy, service users are in a better position to access community support, health care and social benefits. Individuals are not required to be abstinent and the model focuses on a harm reduction approach incorporating the individual’s recovery journey determining the issues addressed.

Housing First Glasgow provides mainstream social housing and 24/7 outreach support to individuals who are homeless, aged 18 or over, and involved in drug and alcohol misuse.

Peer support workers work with individuals on their recovery journey to encourage engagement with mainstream agencies and break down barriers and trust issues they may have previously faced. Working in a person-centred manner, focused on holistic recovery, staff will offer support to enhance or develop skills to maintain a tenancy like budgeting, food shopping, cooking etc.. The service consists of a service manager, service coordinator, assistant service co-ordinator and peer support workers.

Housing First is tailored to the needs of the individual, empowers individuals, supports individuals to develop towards their full potential, accords individuals respect, privacy and dignity. It enables individuals to become active and valued members of their local community and supports the individual on their recovery journey. It promotes the realisation of individual dreams and aspirations

More info at: <http://www.turningpointscotland.com/>



## **Mobile Health Clinic**

This is a free primary health care and harm reduction service for female sex workers and people who are homeless in the City of Dublin. A medical card is not required to access this service.

Through the work completed by Safetynet members it was identified that the service was missing a certain cohort of homeless people. To bridge this gap a clinical outreach service has been developed. While developing the service, it became clear that it would be difficult to identify and engage homeless people and female sex workers with the service and this is why the Chrysalis Community Drug Project and the Dublin Simon Community were approached to join the partnership. Their outreach workers already had a working relationship with the client group and they use this relationship to engage people with the clinic. This role is fundamental and without it we would not be able to reach these people.

The clinic is staffed by doctors, outreach workers and emergency medical staff.

The primary care service diagnoses and treats a range of general health problems. Referrals to hospitals and other health services are also provided. The clinic is currently developing a screening and vaccination service for blood-borne viruses and a screening service for sexual health.

## *Harm Reduction Service*

Firstly, the clinic identifies people who are in need of primary care services. Once identified, people are either brought to the mobile clinic or they attend pre-arranged appointments. The service also operates a drop-in system, where people can attend without an appointment. This role is fundamental and without it, it would be difficult to identify and engage homeless people and female sex workers with the primary care service.

Secondly, the outreach workers complete a range of harm reduction interventions with patients. The RST targets rough sleepers and homeless people. Some of their harm reduction interventions include: safer drug use and health promotion advice and information, and needle and syringe-exchange services.

More info at: <http://www.primarycaresafetynet.ie/>

## **Peer based Training on HCV – Swedish Drug Users’ Union**

This peer-training for hepatitis C (HCV) treatment advocates and provides information on how to conduct activities that support a reduction in hepatitis C transmission and ways to increase access to diagnosis, treatment and care for people living with and/or at risk of hepatitis C infection. It also aims to improve knowledge about and skills for hepatitis C treatment, and care for people who inject drugs (PWID) specifically. This resource aims to develop understanding of best practice in HCV prevention, treatment and care among current and former PWID. It recognises how the development of people’s skills and the capacity of peers are central in shaping the provision of effective supports, systems and services that can combine to reduce the impact of HCV among affected communities.

The peer to peer approach to train those who have been infected with HCV provides a new level of raising awareness. Individuals who have completed HCV treatment are ideal candidates to complete this training and go on to becoming peer-to-peer trainers. This training provides information to help others to understand hepatitis c virus, to know the risk of HCV, to learn how to access diagnosis and treatment, to become aware of stigma and HCV, to support others with HCV and show their peers how to become advocates for HCV awareness.

## **Guidance for managers on how homeless services can use naloxone**

This guidance is designed to give managers in accommodation-based homelessness services a framework to implement good practice around using naloxone as part of a wider harm reduction approach.

It is expected that this will reduce the number of lives unnecessarily lost to heroin and other opioid overdose. This is especially relevant given that homelessness is understood to increase the risk of opioid use.

Provision of naloxone is an evidence-based intervention that can save lives. Incorporating naloxone into homelessness services encourages drug users to engage with treatment services and helps to keep them alive until they are in recovery. It is important to remember that the intervention is not just about providing naloxone: training people to recognise the signs of overdose and how to respond appropriately are key steps in reducing drug-related deaths. More info:

<http://www.homeless.org.uk/sites/default/files/Homeless%20Link%20-%20Naloxone%20Guidance.pdf>

## **Naloxone training for homelessness staff and residents – Homeless Link**

The supply of naloxone alone is not sufficient to prevent drug-related deaths. Training residents, peers, volunteers and staff in how to recognise and respond appropriately to a suspected opioid overdose is just as important.

Training clarifies the causes of overdose and dispels myths about how to respond when someone overdoses, and leaves people more willing to intervene. There are four key aspects to the training:

- Risk factors for opioid overdose
- How to recognise the signs and symptoms of opioid overdose
- How to respond on discovering a suspected opioid overdose, including practical instruction in the assembly of the naloxone product and injection
- The recovery position

Naloxone training is often provided by the local drug service and takes approximately 30 minutes. It may take place in a one-to-one setting or be delivered to a group.

It is important that all staff working with opioid users know how to administer naloxone in the event of an emergency.

Nominated staff could receive ‘train the trainer’ training to be able to cascade information to others, including those not engaged with drug treatment.

Local service user group or peer volunteers, are encouraged to be involved as peer trainers. This can be particularly effective in sharing information among residents.

Basic first aid training should also be made available to all hostel residents and staff. This will complement the naloxone training and give the appropriate information needed to react in an emergency situation.

More info at: <http://www.homeless.org.uk/our-work/resources/naloxone-in-homelessness-services/naloxone-training-for-staff-and-residents>

### Drug Consumption Rooms

Drug consumption rooms are defined as ‘professionally supervised health care facilities where drug users can use drugs in safer and more hygienic conditions.’ People who are homeless are at particular risk of overdose and drug related death. Unsafe drug intake often involves unhygienic and incorrect injections which can cause both injury and infection. Evidence shows that DCRs have an impact on both improving health and reducing death by overdose. Besides from providing a secure environment, DCRs also facilitate access to health and social services as well as numerous harm reduction interventions. DCRs can follow two models: they can be integrated units, part of a shelter or a health clinic or a mobile unit, or as a hygienic safe place for injection. DCRs are staffed with health professionals (e.g. nurses) who work together with social workers. The primary goal of staff is to prevent overdoses by informing clients about strong drugs and by intervening in cases of intoxication. The staff convey a non-judgemental attitude and promote acceptance. While providing referrals is not the primary mission of DCRs, they can connect clients to treatment programmes.<sup>24</sup>

### Norte Vida – Porto

Norte Vida is a day center and night shelter exclusively for people with dual diagnosis and provides low threshold, 24h access services with an open door policy. The center applies a holistic approach to its interventions by looking at the needs of clients from a biopsychosocial perspective.

Services that are provided in the center include general health promotion, psychiatrist and psychologist consultations, screening tests (HIV, HEP C and B and syphilis), hospital referral and nursing care. The center also provides a wide range of harm reduction interventions including needle exchange and a low threshold methadone programme. Among the more specific health programmes it offers is a combined medication programme. It also offers community integration support.

More info at: <http://www.nortevida.org/servicos-e-projectos>

### Community integration (re-integration ) at De Regenboog Groep

De Regenboog Group offers various work activities that are easily accessible to a diverse group including homeless people, people who use drugs and alcohol and people with mental health problems, in three different kinds of facilities.

<sup>24</sup> <https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-016-0109-y>

Drop-in centre: The drop-in centre targets homeless people and is at least by 60% run by the participants of the program. Participants prepare and serve coffee, tea and food, do the laundry, do the cleaning, register the visitors etc.

Workprojects. These are small-size firms within De Regenboog Group that organize work activities around certain products or services such as carpentry, designing & printing services, working with textiles, cleaning offices, doing chores both by and for people with psychiatric problems, fixing computers etc.

Social Firms. This is usually more serious work for 'high-potential' participants and most often the last stop before making the leap to regular work and financial independence. Social Firms are commercial enterprises, they make a large percentage of their earnings in commercial activities but they do so by employing people who are furthest from regular employment.

People can choose work activities according to their specific preferences and capacities and upon consulting with work counsellors. This tailored approach is essential for the success of the work integration and contributes significantly to the empowerment of our target group. Participants start slowly, working only a few half days per week. In most cases the number of working days increases over time, as do the participants' skills and self-confidence.

## INVRA

INVRA is an Inventory of Self-reliance Skills that has a module that focusses on labor related competences. It distinguishes 38 different skills in three different categories (motoric/physical skills, working skills and attitude) that are scored on three levels (plus 'no score'), in so far as they have been (visually) recorded, so the score is based on factual repeated behavior. No score or a low score can therefore either mean somebody does not possess a skill, or has not demonstrated it. The score is then presented to the participant, which makes it easy to discuss their functioning and to pick skills to practice in the next period. What INVRA explicitly does is to mirror what people *can do* as opposed to what they cannot and it is up to them to decide which skills they want to train.

INVRA is a helpful tool that enables work coaches to give more precise feedback.

## **KETHEA EXELIXIS Low threshold programme in Greece**

This programme has been operating in Athens since 1995, and provides services to drug users who do not wish to join a therapeutic programme, or who do not have access to social services. With this goal in mind, a multifaceted network of services has been established through which groups of people who use drugs with specific needs (the homeless, prostitutes, ethnic minorities) can be approached.

- Special Center for Direct Access for drug users who cannot join a therapeutic and social reintegration programme. It provides medical and mental diagnostic services, conducts street-work interventions, and operates a day use center for drug users to spend time, cook, take a bath, etc.

- A street-work programme - 2 Mobile Units. Frequent morning, evening and midnight interventions are made into parts of downtown Athens where drug users congregate with a view to offering them support and limiting their exposure to the everyday dangers and problems linked with drug abuse. House calls are also made to provide support to drug users' families. The programme has been conducting individual and family sessions for substance abusers in the Ilion area since 2008 in collaboration with the municipality's Social Services department.

-The Off Club, which operates on week days and provides drug users with safe, substance-free surroundings in where they can spend time, cook, and attend to their personal hygiene.

-A Mobilization/Support Centre which provides information and prepares drug users to join a therapeutic community.

-A Diagnostic Centre. The Centre is equipped with full physical and mental diagnostic facilities and provides first aid, dental care and a referral service for medical examinations. It also stages information seminars on health-related issues including how to protect against HIV/AIDS and other infectious diseases, and safer substance use.