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WORKING WITH PEOPLE EXPERIENCING HOMELESSNESS

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To my Family and my deep Love

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Abstract

This thesis starts with an analysis of attempts to define and solve the homelessness, with a focus on service delivery in Europe and the widespread transition from the Traditional Services (TS) to the Housing First model (HF) that is changing providers' work. Few studies are focused on social providers' prospective and factors affecting their work and there are not standardized instruments to analyze their working context.

Then, Study 1 aimed to understand how social providers, working in HF or TS, describe the goals and the principles of their services, considering the importance of belief system in the implementation of a new working model, such as HF. The data were collected through 29 focus group discussions involving 121 providers in eight European countries. Regardless of the kind of service they worked in, providers indicated that their main goal was to support clients with integration, basic needs (food, shower, health), housing requirements, and well-being.

Results of the Study 1 showed that providers in both types of services had the goal of clients' integration. Given the unclear meaning of the construct in the literature about it, Study 2 aimed to explore the feelings associated with 'integration' from the point of view of people experiencing homelessness. The data were collected through semi-structured interviews with 26 people in Italian homeless services. Feelings clustered in three spheres: the intrapersonal sphere refers to feelings that exist within a person, such as dignity and freedom; the interpersonal sphere includes feelings that emerge from interactions with other people, such as respect; and the societal sphere involves the sense of usefulness and responsibility.

Moreover, it seems relevant to analyze the working context of the providers to facilitate the achievement of service's goals. For this reason, Study 3 aimed to explore which

services' characteristics affect the work of social providers by examining differences between workers in HF and TS teams in a cross-national study. Data were collected through Photovoice projects with social providers. Overall, 17 Photovoice projects were conducted, involving 81 participants in eight European countries. The results showed factors influencing providers' work at three levels: systemic (e.g.: institutional attitude, structural features); organizational (e.g. support among colleagues, vision); individual (e.g.: clients' problems, balance in relationships with clients). Results for TS and HF providers were similar, however TS providers identified more obtacles.

Finally, in order to compare and measure strengths and weaknesses of homeless services, Study 4 aimed to develop a questionnaire (the SErvice PROviders' Questionnaire – SE-PRO Q) identifying organizations' profiles. The questionnaire was created basing on the qualitative results of photovoice projects (Study 3) and it was combined with providers' stress and well-being dimensions (burnout and work engagement). SE-PRO Q was administered to 569 social providers in 8 European countries. Through a Confirmatory Factor Analysis, SE PRO Q 24 version resulted; showing promising fit indexes and correlations to providers' burn-out and work engagement.

Overall, this thesis had the opportunity to 'fill in' missing pieces in our knowledge on the ecology of homelessness with a cross-national prospective and with an ecological approach. Implications of the results are discussed as suggestions to promote services facilitating work of social providers and integration of people experiencing homelessness.

Chapter 1

Homelessness: attempts to define and solve the phenomenon

1.1. What are we talking about?

A global framework for understanding and measuring homelessness

Homelessness is considered a global phenomenon affecting poorer populations in developed and developing countries. Nevertheless, research and practice have different conceptual framework and methodologies to analyze the topic. In general, the term 'homelessness' incorporate a vast array of people experiencing different conditions related to (the lack of) housing. In literature, there is a difficulty to have a standard definition of the phenomena and how the concept of homelessness should be defined. Recently, Busch-Geertsema, Culhane, and Fitzpatrick (2016) developed a 'global framework for understanding and measuring homelessness' to develop both a common language and an agreed mean of measuring the homelessness and trends, in order to help the development of successful policy and practice interventions.

Basing on the review of the literature, they proposed a global definition of homelessness as: 'lacking access to minimally adequate housing'. Housing is not related only to the physical condition of having a roof over the head, but it is connected to other dimensions. Reviewing the 'European Typology of Homelessness and Housing Exclusion' (ETHOS), developed by FEANTSA (European Federation of National Organizations Working with the Homeless) and the European Observatory on Homelessness (EOH) (Edgar et al., 2007), they defined three main 'domains of home':

- *Security domain:* refers to the possibility to stay in a home for reasonable periods that people wish to do so, providing their legal obligations;

- *Physical domain*: pertains to having an adequate dwelling which meets the household's needs in terms of both the quality of the accommodation and quantity of accommodation (not severely overcrowded);
- *Social domain*: refers to opportunities to enjoy social relations in the home, culturally appropriate and with privacy and safety from internal threats (i.e. from other occupants) to both the person and their possessions.

With this conceptual model, they envisage an operationalized *Global Homelessness Framework* containing three main categories of people who may experience homelessness, as showed in Table 1.

Table 1: Global homelessness framework (Adapted from Busch-Geertsema, Culhane, & Fitzpatrick, 2016)

Category	*Subcategory*
1- People without accommodation	People sleeping in the streets or in other open spaces (such as parks, under bridges, on pavement, etc.), public roofed spaces or buildings not intended for human habitation (such as bus and railway stations, public buildings, etc.), in their cars, open fishing boats and other forms of transport; individuals or households who live on the street in a regular spot, usually with some form of makeshift cover
2- People living in temporary or crisis accommodation	People staying in night shelters, homeless hostels and other types of temporary accommodation; women and children living in refuges for those fleeing domestic violence; people living in camps provided for 'internally displaced people' i.e. after a armed conflict, natural or human-made disasters, human rights violations, development projects, etc. but have not crossed international borders; people living in camps or reception centers/temporary accommodation for asylum seekers, refugees and other immigrants
3- People living in severely inadequate and/or insecure accommodation	People living: sharing with friends and relatives on a temporary basis; under threat of violence; in cheap hotels, bed and breakfasts and similar; squatting in conventional housing that is unfit for human habitation; in trailers, caravans and tents; in extremely overcrowded conditions; in non-conventional buildings and temporary structures, including those living in slums/informal settlements

This categorization includes various forms of housing problems, to which different needs are related to the three domains explained above. The stakeholders involved in the phenomenon can use this framework in a flexible way, and it can also be applied to countries with very different economic, housing and cultural contexts.

In fact, defining the homelessness is not only a theoretical problem, but it is related to the structure of the service delivery in order to meet the needs of the target group. It is

difficult to have customized services if the parameters of the homeless population are unclear. Consequentially, it not possible has a standard measure to count the spread of the phenomenon and therefore the amount of socio-political strategies useful for ending the homelessness.

A periodic collection of homelessness data could generate reliable trend statistics to evaluating the effectiveness of initiatives to resolve homelessness. Differences in methods and definitions across nations that have conducted counts of people experiencing homelessness have had a considerable influence on the large variations in homelessness rates (Edgar, 2012). A global estimate is not possible because the data are not comparable: they covered different periods of time (e.g. point in time counts or annual data), related to different groups of people (people living on the streets or users of homeless services), or with different local homelessness rate (e.g. in large cities) as representative for the country or region (Busch-Geertsema, Culhane, & Fitzpatrick, 2016).

For example, in Italy the Italian Ministry of Labour and Social Policy – in association with the national statistics office (Istat) and in collaboration with the Federazione Italiana Organismi per le Persone senza dimora [Italian Federation of the Organizations for Homeless People] (fio.PSD) conducted the *National Survey on the Condition of Homeless People* in Italy in 2012 (Istat, 2012, 2015), one of the first quantitative research studies on homelessness commissioned by a national public authority. The Survey estimated that 50,724 people used a service for homelessness in 2014. This is a growing number considering that the number was 47,648 in 2011 (Istat, 2015). However, the count was conducted in only 178 Italian municipalities during one month.

The *Third Overview of Housing Exclusion in Europe* (2018) showed increases in the number of people experiencing homelessness (except for the Finland and Norway) with an increased number of women, youth, families and migrants (FEANTSA and The Foundation

Abbé Pierre, 2018). The Fourth Overview of Housing Exclusion in Europe estimates that every night, at least 700,000 people sleep in the street or in emergency accommodation in the EU (FEANTSA and The Foundation Abbé Pierre, 2018).

In USA, data on homelessness are based on annual point-in-time (PIT) counts to estimate the number of people experiencing homelessness on a given night. The latest counts are from January 2018 Point-in-Time identified 552,830 people experienced homelessness in the United States: 358,363 people (65%) stayed in sheltered locations, while 194,467 people (35%) stayed in unsheltered locations. Homelessness increased by 0.3 percent (or 1,834 people) between 2017 and 2018, with an increase in the number of unsheltered individuals (US Department of Housing and Urban Development, 2018).

The last time a global survey was conducted (by the United Nations in 2005), an estimated 100 million people were experimenting homelessness worldwide and 1.6 billion of people lacked adequate housing. Moreover, these numbers may be even higher, considering that some individuals may not have gained access to services or could have been hospitalized or in jail during the time of the surveys.

Beyond the non-comparable estimates, the number of people experiencing homelessness continues to grow worldwide and then, the rise of homelessness can have severe consequences at the systemic and individual level.

1.2. Why should we be interested about homelessness?

Causes and consequences of experimenting homelessness

The various definitions support a different view of the phenomenon of homelessness and the debate over the definition of homelessness also reflects changes in social values (Shlay & Rossi, 1992). Recently, the literature demonstrated that homelessness is the results

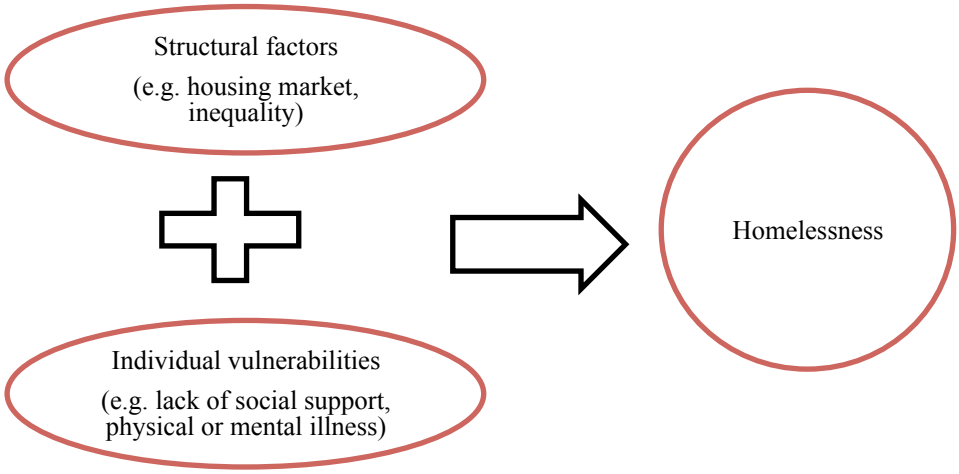
from a complex interaction of both macro (structural) and micro-level (individual) factors (Lee, Tyler, & Wright, 2010), as showed in Figure 1.

At the macro-level, factors such as housing market and reduction in public housing, changes in social policy or welfare state (Shinn, 2007), income inequality (Toro, 2007), poverty, and unemployment or financial problems (Anderson & Christian, 2003). These factors can intertwine with individual vulnerabilities, such as changes in family composition or relationship, lack of social support, stressing events, lack of education, low income, alcohol or substance abuse, and mental and physical health problems (Anderson & Christian, 2003; Shinn, 2007; Shinn, 2010; Lee et al., 2010). These vulnerabilities could be exacerbated by social exclusion and stigmatization based on income, wealth, housing and incarceration (Shinn, 2010). Without adequate support, individual vulnerabilities can intensify or be intensified by macro-level factors (Lee et al., 2010).

A recent study was conducted with 577 adults experiencing homelessness to identify self-reported causes of homelessness (Barile, Pruitt, & Parker, 2018). Findings from latent class analysis identified five distinct classes based on participants' responses to 19 potential causes that contributed to experiencing homelessness: disability or physical health issues (4%), substance abuse or mental health issues (30%), critical life changes (3%), financial crises (7%), or employment difficulties (55%). It seem that the lack/loss of job was the main cause of homelessness. Individuals of this class were very unlikely to report any other cause for their homelessness and reported fewer disabilities, better health, and lower depression scores. These results suggest that prevention and intervention should consider macro-level economic conditions. People reported to have experienced some financial difficulties prior to becoming homeless. Also, they may develop health, psychological and substance abuse problems after experiencing homelessness for the first time (Johnson & Chamberlain, 2008). In fact, the causes of homelessness could be dynamic and overlapping, changing over time

and interacting with other factors. The borders between cause and consequences could be very fleeting (Anderson & Christian, 2003).

Figure 1: Factors related to homelessness



Regarding to the consequences, two levels can be distinguished: systemic and individual. At the systemic level, homelessness is a cost for the society because of providing dedicated services to people experiencing homelessness, health care and social support through mainstream services (Hwang et al., 2013; Pleace et al., 2013; Fazel, Geddes, & Kushel, 2014), and the criminal justice system (Greenberg, & Rosenheck, 2008).

At the individual level, experiencing homelessness affect the physical and mental health of people, higher comparing to the general population. Especially, they could experiment a shorter lifespan (Nordentoft, & Wandall-Holm, 2003) and higher rates of infections, heart disease, substance abuse, mental illness, lower quality of life (Beijer, Wolf, & Fazel, 2012; deVet et al., 2013; Parker & Dykema, 2014), and self-harm and suicide (Pluck, Lee, & Parks, 2013). These problems do not only concern the person who experiences homelessness but can also influence society: homelessness should be considered as a significant problem for public health, which should be addressed.

Beyond causes and consequences, the focus should be on finding best solution to address homelessness. Different services are delivered to people experiencong homelessness; most of them are dedicated to address basic needs (shelter, food, clothes and cleaning). These services have a focus on basic needs with a risk of managing homelessness but not contributing to ending it (Busch-Geertsema & Sahlin, 2007).

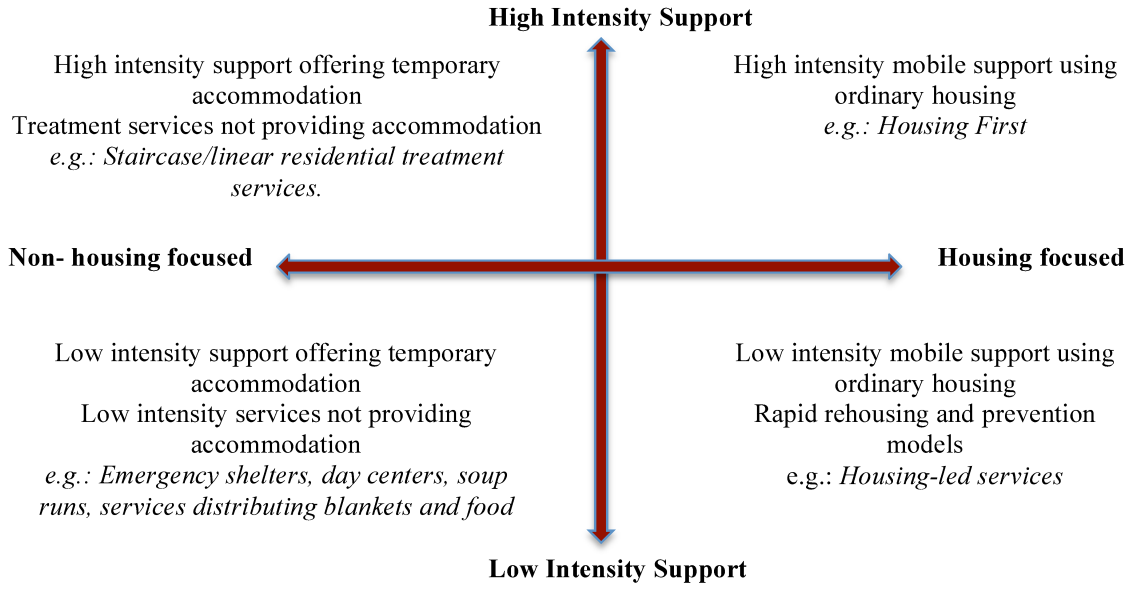
In Europe, the only two European countries (Finland and Norway) with a reduction in the number of people experiencing homelessness approached the homelessness as a housing problem and a violation of fundamental rights. They established integrated strategies that had specific, measurable and reachable targets, set in a clear time frame (FEANTSA and The Foundation Abbé Pierre, 2018). The concept of 'integrated strategies' refers to a public policy on homelessness including quantified targets for reducing homelessness and a realistic action plan. This plan is based on housing and support through interdisciplinary work and specific service delivery.

1.3. Which services are addressing this phenomenon?

A proposed typology of European homelessness services

A recently comparative research was conducted through a standardized questionnaire to experts in sixteen European countries (Denmark, France, Germany, the Netherlands, Ireland, Sweden, United Kingdom, Austria, the Czech Republic, Hungary, Poland, Romania, Slovenia, Italy, Portugal, Spain) aim to explore the homelessness services provision across Europe, starting to construct a typology of the homelessness services in Europe (Pleace et al., 2018). The proposed typology of homeless services explore two main dimensions: one dimension refers to how services are *housing focused*, i.e. using ordinary housing or making someone 'housing ready' through support and treatment; the second dimension is whether the service offers a *high level of support or a low level of support* (as showed in Figure 2).

Figure 2: A Proposed Typology of European Homelessness Services (Adapted from Pleace et al., 2018)



The classification include: emergency accommodation, temporary accommodation and two forms of non-residential homelessness services: non-housing support (e.g. daycentres, outreach, food distribution and medical services); housing-focused support services, which centers providing and sustaining housing (e.g. housing-led and Housing First services). Finally, they describe services dedicated to prevention of homelessness.

Emergency and temporary accommodation

Sometimes there is not a clear distinction between emergency and temporary accommodation. In general, emergency and temporary accommodation are provided within the same building, offering basic emergency shelter with a bed, food and access to a low support. Providers help client to access at external services or find housing. This is an example of a support focused, low intensity service. There are examples of traditional services, basic, shared emergency accommodation/shelters in almost every country, but in

some countries, (e.g. Denmark, Ireland or the United Kingdom) emergency/temporary accommodation could have high standard and offer intensive support.

Non-housing support services

Examples of non-housing focus support are: day centers, food distribution, outreach services, medical services. In general, these services provide help and assistance to people, from food, clothing and shelter during the day, to case management, medical, education, training and employment seeking services. The day centers providing food and other forms of practical support (e.g. blankets, clothing, bathrooms and washing facilities). In some cases the day centers provide access to education, training and job-seeking services. Often, outreach teams, primarily designed to connect people living rough with other services, deliver practical support. Medical services tended to be delivered in association with non-housing support services (e.g. daycentres, or mobile medical teams). Also, these kinds of services include food distribution, often delivered by voluntary, charitable, and NGO groups. In Europe, every country involved in the research has at least some form of food distribution for people sleeping on the streets in the main cities.

Housing-focused support services

Examples of housing-focused support services are: housing-led and Housing First services. They are centered on attaining and sustaining an independent home for people experiencing homelessness. An example of service with a low intensity, housing focused service is a rapid rehousing service that works with people who basically just require adequate, affordable housing but who do not require support. Instead, Housing First services offer high support and housing and represent a key role in reducing long-term and chronic homelessness associated with high and complex support needs (Tsemberis, 2010). Only some

countries, (e.g. Denmark and France) have Housing First as a part of mainstream homelessness strategy. In other countries, Housing First services are delivered by municipalities or regional authorities or by the homelessness sector itself, rather than local or national government (e.g. Italy).

Prevention/rapid re-housing

These services are delivered for vulnerable groups and individuals in financial distress, e.g. debt advice and support services with a generic function to help people in financial problems that might cause experienced of homelessness. They could have two main forms: first, the advice and mediation; second, rapid rehousing systems at the moment of eviction (see Shinn, Baumohl, & Hopper, 2001).

In most of the countries involved in the research there are more non-housing support services or emergency and temporary accommodation. In Denmark, Germany, France, Ireland, the Netherlands and the UK there was a clear emphasis on housing-led services. Nevertheless, it seems necessary using integrated homelessness strategy with equal emphasis on prevention, housing supply and an other services, to meet the different needs of people experiencing homelessness, with also an attention to welfare, health and social housing systems and the supply of adequate, affordable housing (Pleace et al., 2018).

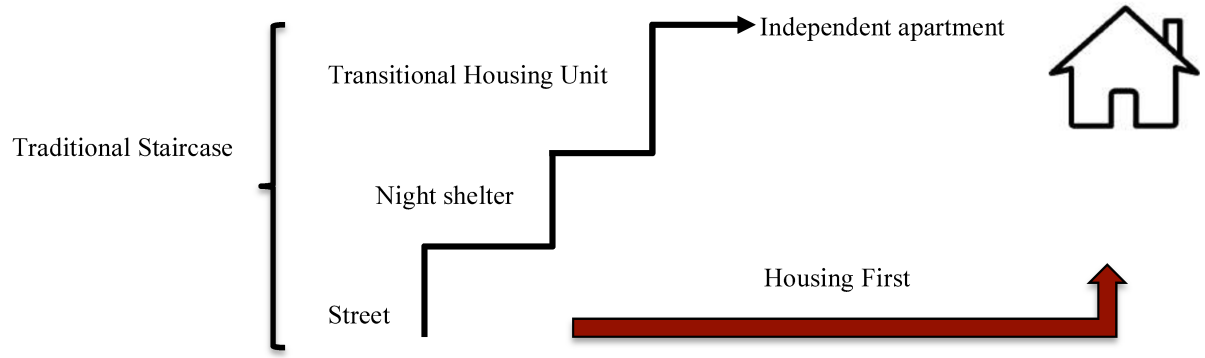
In fact, attention to the Housing First model (HF) as a potential alternative to the Traditional Staircase model (TS) is growing within the field of homeless services delivery (Lancione, Stefanizzi, & Gaboardi 2017; Busch-Geertsema, 2014; Pleace & Bretherton, 2013). These two models are the examples of intervention model that can be used to illustrate the main differences in the services delivery. Housing First is a housing focused service, using ordinary housing and offering high intensity support to clients. Traditional Staircase

services provide only temporary accommodation with on-site support staff focused services (Pleace et al., 2018).

Housing First and Traditional Staircase model

In HF, people experiencing homelessness are assisted to move directly from the street into apartments without any pre-condition to start a process of recovery (Tsemberis, 2010). Unlike HF, TS programs typically require treatment and sobriety, with the goal of stabilizing people prior to providing housing, as showed in Figure 3.

Figure 3: A comparison between Traditional Staircase and Housing First models



The HF model entails a potential paradigm shift in the service system (Nelson et al., 2019), due to radical change in basic principles guiding work with people experiencing homelessness. Tsemberis (2010) advanced the original HF model (Pathways to Housing) anchored in five key principles: a) *Housing:* immediate access to housing without conditions; b) *Choice*: participants' free choice about where and how they live; c) *Harm reduction philosophy:* separation of housing from therapeutic treatment; d) *Support:* individualized and person-centered approach that aims to support the person in his/her process of recovery; e) *Social integration*: support that seeks to integrate the people in the community where they live. Consistently, in the Housing First Europe Guide (Pleace, 2016) for the implementation

of HF in Europe, the eight principles are: housing is a human right; harm reduction; choice and control for service users; active engagement without coercion; separation of housing and treatment; person-centered planning; recovery orientation; flexible support for as long as is required. By way of contrast, TS services are based on: training people to live in their own homes; giving treatment and medication for any ongoing health problems; making sure people do not engage in behavior that might put their health, well-being and housing stability at risk; maintaining sobriety (Pleace, 2016). In the process of implementation of the model, it is important that the basic principles of the model are not lost. Research has shown that adherence to a model (and principles) helps in achieving positive outcomes (Durlak & DuPre, 2008), and adherence helps to assure that the principles of the new model are adopted. This is tricky, because the implementation process implies an adaptation of the model to the local context that could lead to modification of the principles (Lancione, Stefanizzi, & Gaboardi, 2017). For these reasons, research on HF has focused immediately on the measurement of programs' fidelity to the guiding principles of the model, as part of the implementation process (Greenwood, Stefancic, & Tsemberis, 2013). Indeed, a fidelity measure, 'Fidelity Scale', had been developed and validated for HF programs (Stefancic et al., 2013; Gilmer, Stefancic, & Sklar, 2013).

Nevertheless, several studies show the effectiveness of the HF model in helping people experiencing homelessness, especially on housing stability, health and substance abuse, recovery and general well-being, and community integration (Tsemberis, Gulcur, & Nakae, 2004; Fitzpatrick-Lewis et al., 2011; Aubry, Nelson, & Tsemberis, 2015; Woodhall-Melnik & Dunn, 2016) but less literature about services takes place in Europe (Greenwood et al., 2013; Busch-Geertsema, 2014) and fewer studies are focused on social providers, their well-being and the factors influencing their work (Mullen & Leginski, 2010; Olivet et al., 2010).

1.4. What we know and what still needs to be learned?

Since providers' well-being and their working conditions are critical for the success of the services to people experiencing homelessness and can strongly influence clients' outcomes (Henwood et al., 2013; Manning & Greenwood, 2018), it is important to include providers' perspective in research on homelessness. Service providers are responsible for addressing one of the most complex expressions of poverty in the contemporary societies, but the homeless service workforce is under-valued with little attention paid to providing the support and skills workers need to succeed (Mullen & Leginski, 2010). Beyond the model of intervention, the research needs to focus on which characteristics of services affect the work of social providers.

Considering the importance of goals and principles in the implementation and adaptation of a new working model in services for people experiencing homelessness, and the lack of studies analyzing the point of view of social providers in the field, the Study 1 aims to understand how social providers, working in HF or TS, describe and conceptualize the goals and the principles of their services.

Research question 1: *Are there any differences in the goals and principles between Hosing First and Traditional Staircase models?*

Results of the Study 1 showed that providers in both types of services had the goal of clients' integration. In literature, findings on the impact of services on community integration have been mixed and without clear differences between the two models (Quilgars & Place, 2016). Given the unclear meaning of the construct and different issues in the literature about it, the following research question will attempt to be answered in the Study 2.

Research question 2: *What people experiencing homelessness mean with integration? Which feelings are related to integration?*

Moreover, some challenges interfere in achieving the goals emerged from Study 1, with factors affecting providers' work. Few studies have analyzed the organizational characteristics affecting the wotk with people experiencing homelessness. Rather, most of the studies were focused on the factors that influence fidelity to the original principles of the HF model (Macnaughton et al., 2015; Greenwood, Bernad, Aubry, & Agha, 2018), rather than to the factors that influence professional performance. Providers can be considered as a core element for a successful implementation of the services and mediators of clients' outcomes, as showed in Figure 4.

Figure 4: Research questions

For these reasons, it is necessity to know which are the services' characteristics affecting the providers' work with this target exploring their points of view. Second, it is necessary to create standardized instruments for measuring these characteristics in order to analyze the organizations' profile. The following research questions will attempt to be answered in the Study 3 and 4.

Research question 3: *Which are the services' characteristics affecting the providers working with this target group?*

Research question 4: *Can we measure these services' characteristics?*

The hypotheses are that these services' characteristics could affect the providers' well-being, in term of burn-out and work engagement. The daily experience of working with clients in precarious circumstances may entail depression, fatigue, lack of recognition, lack of

support, and powerlessness, especially when workers have high goals and expectations, with a consequent increase in burnout risk (Fisk, Rakfeldt, & Heffernan, 1999; Mullen & Leginski, 2010). But less research is focused on which are the characteristics affecting the providers' well-being and stress. For this reason, the follow research question will attempt to be answered in the Study 4.

Research question 5: *Do services' characteristic relate to the providers' well-being and stress?*

Providers' work was analyzed in a cross-national level. Most of the research explained in this thesis was conducted in collaboration with a broad research project in Europe, HOME-EU: 'Homelessness as Unfairness'.

1.5. HOME-EU project

In Europe, the Program 'Europe 2020' emphasizes the need to develop integrated strategies to reduce social exclusion and extreme marginalization. The European Commission through a grant (H2020-SC6-REVINEQUAL-2016/ GA726997), as part of Horizon2020, finances the research project HOME-EU: 'Homelessness as Unfairness' (2016-2019) to provide a comprehensive understanding on how the Europeans perceive, tolerate, and contest homelessness, from the perspective of citizens, policy makers, people experiencing homelessness, and social providers, with a focus on the comparison between HF and TS services. The main ambition of HOME-EU is to provide an integrated perspective on long-term homelessness from the general (citizens' perspectives) to the particular (people with lived experiences of homelessness, current and past) in order to develop tools and practical guidelines for interventions and concrete initiatives to tackle homelessness, for policy and services. The current work is part of the project and analyzes the point of view of social providers.

The HOME-EU consortium is composed of 12 partners in 9 European Countries (Belgium, France, Ireland, Italy, the Netherlands, Poland, Portugal, Spain, Sweden). The University of Padova, with the DPSS research group, is the only Italian partner and leader of Providers' Study work package.

1.6. Conclusion

In conclusion, this chapter has highlighted attempts to define and solve the homelessness with a focus on service delivery in Europe. Taking into account the several consequences linked with homelessness involving clients' physical, relational, and psychosocial well-being and the relative consequences on the society, a growing number of studies in recent years have studied the best solutions (in terms of services) to end this phenomena, especially interventions to improve housing status, e.g. the HF model, as alternative to the TS model. In the literature on homelessness the focus is usually on clients, not service providers, even though they are key to effective homeless services and they are responsible for addressing one of the most complex expressions of poverty in the contemporary societies. Even the limits, this thesis represent an opportunity to explore the providers' point of view in homelessness services in a cross-national level. In the next chapter, the study analyzes how providers conceptualize the goals and principles of their services that could directly influence them, their work performance and the clients' outcomes. The studies had the opportunity to 'fill in' missing pieces in our knowledge on the ecology of homelessness with a cross-national prospective and with an ecological approach.

Chapter 2

Goals and principles of providers working with people experiencing homelessness

In Europe, the Housing First model (HF) is expanding in homeless services delivery (Lancione, Stefanizzi and Gaboardi, 2017; Busch-Geertsema, 2014) as an alternative to the Traditional Staircase model (TS), introducing a potential paradigm shift in the service system (Nelson et al., 2019), due to radical change in basic principles guiding work with people experiencing homelessness. This study focused on the goals and principles adopted by homeless services providers in HF and TS services to analyze if there are any differences between the models. The 'empowering community settings model' (Maton, 2008) guided the study and the data were collected through 29 focus group (FGs) discussions involving 121 providers in eight European countries involved in the HOME-EU project. Starting with the study's theoretical framework, the chapter explores the literature regarding goals and principles in homelessness field; the methodology used in this study, and the principal results. This study was presented in a published paper (Gaboardi et al., 2019).

2.1. Theoretical framework

Maton (2008) proposed a set of six organizational characteristics that promote organizational empowerment: a setting's group-based belief system, core activities, relational environment, opportunity role structure, leadership, and mechanisms for setting maintenance and change (i.e., the organizational mechanisms used to adapt both to internal and external changes). Each organizational characteristic is associated with psychological mediators that, in turn, are associated with higher levels of empowerment for setting members. In particular, this study is focused on the component 'belief system', which refers to the setting's ideology

and values. This study is limited to the component of 'belief system' because it is considered the basis of the other categories. Maton defines the 'belief system' as "a setting's ideology or values, and is an integral part of setting culture. These beliefs specify patterns of behavior that are intended to produce desired outcomes. A setting's belief system encompasses a view of setting members, including their needs and potential, and how they can work within the setting to achieve personal and setting goals. Belief systems help shape setting structures, norms and practices, providing opportunities for and contributing to member development and change" (Maton, 2008, p. 8). In this sense, the 'belief system' is the basis of behavior and the main component that can influence providers' work and therefore clients' outcomes.

According to the model, an empowering organization should have: a well-defined and shared belief system, i.e., the group members should have a shared vision and a larger purpose; developed to inspire change, with salient goals and clear means, and characterized by a strengths-based approach, considering the members as resources with capabilities. This kind of group belief system can contribute to empowerment by promoting higher levels of awareness and motivation among its members.

Moreover, Maton (2008) observed that, when all six sets of empowering organizational characteristics are in place, community-based settings function as vital relational communities with a triple effect on: increasing numbers of empowered citizens; empowering individual members' radiating influence; and impacting on external organizational activities. The potential impact of empowering organizations is not limited to inside the setting (members) but also on the community. For these reasons, Maton's framework has been used as a tool to assess empowering processes across ecological levels in community organizations (e.g., Monteiro et al., 2014). For the first time, this framework is used to analyze the homelessness services, considering the importance of both the individual level (increasing clients' outcomes) and the systemic level (changing of the service delivery).

2.2. Why exploring goals and principles?

Widely shared goals and principles, and well-defined work procedures, are crucial for successful program implementation, including the program's effectiveness, the quality of clients' and providers' relationships, and everyone's well-being. Findings from across several studies indicate that strong performance is associated with well-defined team goals, regular feedback on performance, and clear guidelines for coordinating the team's work (Olivet et al., 2010). These factors could be a way to promote empowerment and well-being among an organization's members (both clients and workers). Providers could experience feelings of powerlessness and fatigue without clear and realizable goals. Over time, unrealistically high goals and expectations increase disappointment and burnout (Mullen and Leginski, 2010).

Analyzing the providers' prospective in homelessness field, Henwood, Shinn, Tsemberis, and Padgett (2013) showed that the HF providers reported greater endorsement of consumer values such as the right to refuse treatment, less endorsement of systems values such as a requirement to be clean and sober prior to living independently, and greater tolerance for deviant behavior than TS providers. Manning and Greenwood (2018) studied the influence of service providers' values on service user's recovery outcomes and found that compared to interventions guided by provider-led values, interventions guided by consumer-led values (i.e., HF principles) resulted in better recovery experiences for clients.

Then, in the ongoing process of HF implementation, it is important that the basic principles of the model are not lost. This is tricky, because local adaptations of the HF model can result in modifications to main principles. Macnaughton et al. (2015) studied the factors that influence fidelity to the HF model using a mixed methods approach. Their findings highlight the importance of value congruence between staff members and the HF service, and the attention to organizational culture for program fidelity, which in turn leads to positive outcomes. In particular, staff members' commitment to the service and recognition of its

value provided a base for the growing expertise of the team, despite the difficult nature of the work. Personal values are difficult to influence through training, so building staff capacity starts with the recruitment of staff with values aligned with that of the service. More recently, a multi-country HF fidelity study was conducted in ten different HF programs (Greenwood et al., 2018). The authors indicated that important organizational facilitators of HF fidelity were regular training and team building centered on HF principles, as well as organizational and staff commitment to HF values. Also, studies have shown that the level of congruence between HF values and the personal values of the staff has an impact on program fidelity: higher fidelity when staff members' values aligned with the HF values, lower fidelity when the staff adopted a quid pro quo or transactional approach to working with clients (Gaboardi et al., 2018; Rae et al., 2018; Samosh et al., 2018).

Given the importance of goals and principles to the development and maintenance of effective organizations and promoting members' empowerment, the current research used the 'empowering community settings model' (Maton, 2008) as theoretical framework to analyze the component of 'belief system' of homeless services.

2.3. Aims

This study aimed to understand how social providers in eight European countries, working in HF or TS, describe and conceptualize the goals and the principles of their services. In particular, the specific aims are:

- Exploring the goals and principles of social providers in HF and TS services in eight European countries;
- Analyze if the component of 'belief system' in the two services is group-based as conceptualize by Maton (2008);
- Comparing HF and TS providers' goals and principles across the countries.

2.4. Method

Procedure

The data were collected through focus group (FGs) discussions during May–June 2017 in eight European countries involved in the HOME_EU project (France, Ireland, Italy, the Netherlands, Poland, Portugal, Spain, Sweden). A research protocol was shared among partners and approved by the European Ethics Committee and the Ethics Committee of each University/Research partner of the consortium.

Participants were recruited through convenience sampling within HF and TS services. At minimum, four service providers were recruited per FG, with at least six months of experience in the service. Before the FG session, consent forms were provided to each participant, adapted on the basis of the laws of their country. Local researchers in each country conducted all FGs, which were audio-recorded and lasted approximately 60–90 min.

The FGs started by researchers asking participants to describe the main aims of their program. Afterwards, specific questions inspired by the empowering community settings model (Maton, 2008) explored the six organizational characteristics (belief system, core activities, relational environment, roles, leadership, and mechanisms for setting maintenance and change). In this study, we analyzed the answers regarding goals and principles (belief system), and considered them as bases of the other organizational characteristics.

Participants

In total, 29 focus groups (15 HF, 14 TS) were conducted with 121 participants: 70 female and 59 male with at least six months of experience in the service. Two HF and two TS FGs were conducted in each country, except for Ireland, where one additional HF FG was conducted. Only two TS FGs were conducted in Poland, because there were no HF programs.

Data analysis

To analyze the responses to questions we followed two steps:

Step 1- Country analysis: all the focus groups were transcribed verbatim in the local language. Two independent coders conducted the qualitative coding in each country. Each coder independently read the data for familiarization. Next, each coder separated the sentences by connecting them to the six organizational characteristics of the empowering community settings model (Maton, 2008), eliminating potential sentences not completed or without a meaning. Each partner created a Microsoft Word document that contained listed excerpts from transcripts (translated into English) that related to the category 'belief system' of the empowering community settings model.

Step 2- Cross-national analysis: The second step involved coding the answers referred to goals and principles through a thematic analysis (Braun and Clarke, 2006). Two independent researchers developed codes regarding goals and principles and compared them to create a final coding framework (see Appendix 1). Responses were coded into the resulting categories irrespective of the type of service or the country. Categories were compared and coders discussed discrepancies until they reached agreement. Finally, we examined in which services (HF and TS) and countries each of the categories emerged.

2.5. Goals and principles in homeless services and related organizational factors

Providers talked about different aims relating to the clients. Providing support to clients is considered an important aim among providers, meaning as helping people achieving goals to improve their conditions. In their opinion, support should be fit to clients' needs, as a participant declared: *"to offer a personalized support to the person in order that everyone can set his/her objective"* (Spain, HF2). According to some providers, clients should decide their goals, while according to others, clients need providers' support to achieve goals chosen

by professionals, e.g. *"the final aim of the professionals is to provide support to the user and to her/his situation, that can be very diverse and also imply different areas"* (Spain, TS2). For example, service providers may help clients connect to local services needed for their recovery, e.g. *"another aim at the institutional level is to bring people closer to the homelessness support network"* (Spain, TS2). Also, according to providers involved in the study, the support should facilitate client autonomy, i.e., the ability to live independently in the house and in the society.

Another goal of the services delivery is community integration, as helping people to feel more integrated in the society, as citizens and with a social support, encompassing a (re)-activation of formal and informal social networks, e.g. a provider said: "*getting ties and networks in the community basically, trying to give them the support and aspects of support that they need to try and integrate back, and function in the community*" (Ireland, HF3), or another "*that people access to the normalized network (...) as any other citizen, not only of the specialized network for homeless people*" (Portugal, HF1).

Regarding clients' outcomes, another goal mentioned by providers was satisfying clients' basic needs for survival, by providing food, showers, and clothes; e.g.: "*it's actually warmth, food, a bit of company, you know? It's really that baseline*" (Ireland, HF1); or "*give him a meal, get dressed, be able to wash, that is, what they could not do before when they were on the street*" (Italy, TS1).

Providers discussed also about the aim of protecting the clients' safety by helping them finding a temporary accommodation or a house, as some participants declared: "*to guarantee a worthy housing to the person who takes part in the program, that is his/her house and that is stable housing*" (Spain, HF1); "*it is necessary to work so that they can get back a dwelling in time*" (Italy, TS1).

Further, providers aimed to help clients improve their well-being, in terms of

physical, e.g. "*health, with regard to addiction problems, which naturally also involves many risks*" (Netherlands, TS2) and psychological health, e.g. "*allow people to get off the street if they wish, and to start on a path to recovery*" (France, HF2).

Additionally, another goal mentioned is helping clients to find a job or an activity, in order to have financial resources to live independently or something to do during the day and be recognized and appreciated in society, as declared: "*bringing finances in order and having something to do during the day*" (Netherlands, TS2); "*not only the house, they need to work but the job is a bit difficult for everyone, however, it is to incorporate them into society, making them feel useful and appreciated*" (Italy, TS2).

These goals are guided by principles shared in the services. In fact, providers in HF and TS services identified principles guiding their work. They underlined the importance of respecting clients and their dignity and humanity to make them feel accepted and welcomed. They underline the importance of working with people without prejudice, giving them respect and dignity, listening to them without judgment, as participants declared: "*just treating people with respect where they might have never got it before that they will get it off us when they come in the door*" (Ireland, TS1); "*treating people with respect, dignity, (...), giving them a voice and giving people a chance to change*" (Ireland, TS1).

Another principle is helping everyone unconditionally, without constraints or access limits. Try to give everyone a chance to change, regardless of the person's problems, supporting them despite their difficult situation and what happened in their past. For example they declared: "*no matter how many problems you have, you will be helped*" (Netherlands, HF2); "*in general, the [services] always welcomes everyone, whoever arrives, without prejudices*" (Italy, HF1).

Also, providers emphasized with the importance of considering the person at the center of the support, by adopting an individualized approach and considering clients as

active agents in their projects. They try to work putting the person, her/his choices, path and aims at the center of the support, e.g.: "*the intervention is very individualized, that is, being very person-oriented and being appropriate to the person with whom we are dealing*" (Portugal, HF1), "*our actions plan is very much person-centered*" (Ireland, HF2).

Further, a principle mentioned by providers was that housing is a right for everybody, trying to find a housing solution first of all, e.g.: "*the house is a right and the house is where you will be, independently of how you decide to live*" (Spain, HF1); "*we wouldn't be here if we didn't have a strong belief that someone deserves a home*" (Ireland, HF2). Then, some providers discussed how the general principle of social justice guides their work, with the belief that all people deserve social improvement, regardless of their life condition: "*we all have chosen to do this job because we really think that nobody should be excluded from society*" (Netherlands, TS1); "*trying to give a chance to those who did not have it, just a sense of social justice*" (Italy, HF1).

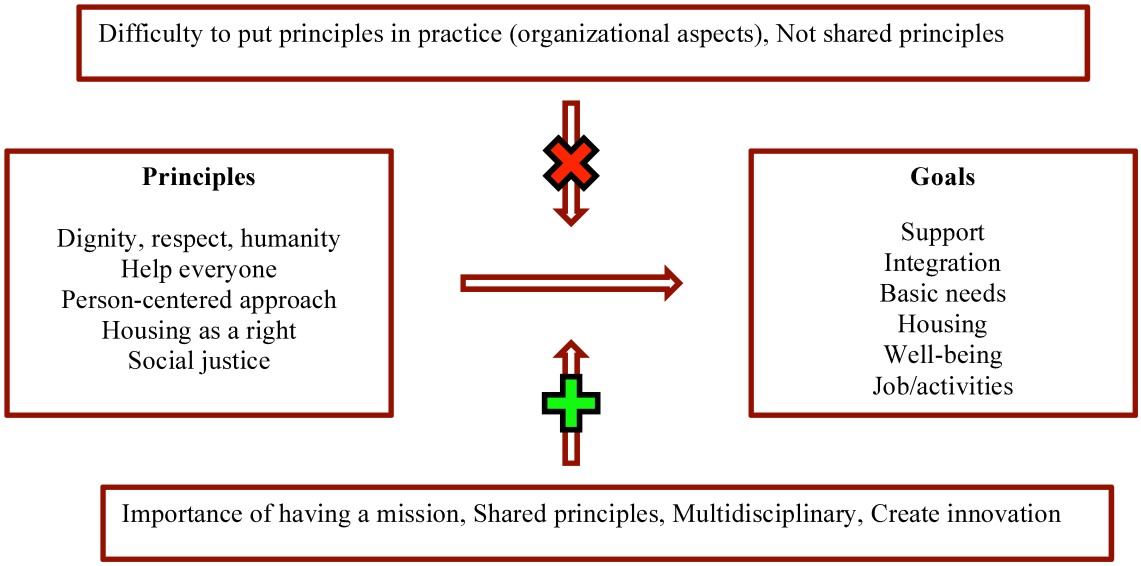
Despite these goals and principles, providers (both in HF and in TS services) also discussed spontaneously about some organizational factors that influence (hindering or facilitating) the application of them. In particular, they considered difficulty in putting the principles into practice, due to organizational limitations (e.g., lack of resources, workload, difficulty in communication). For example, they reported that their workload does not always allow enough time to nurture relationships with clients: "*when you have a 100–115 cases workload, (…), you cannot support each person as a professional as he/she deserves*" (Spain, TS2). At the same time, the providers underlined the importance of having a mission that guides their daily work, sharing values among colleagues, and having a united team: "*I think the written values facilitate the work*" (Spain, HF2); "*we can work very differently but I think our vision is always the same. We all have a common goal and a common mission*" (Sweden, HF1).

Nevertheless, sometimes the providers had difficulty sharing and adopting the organization's principles because of the lack of a good system of communication within the organization: "*it is not just sending an e-mail saying: 'these are the new values, principles or mission', but being able to work them together*" (Spain, HF1). Also, providers identified the multidisciplinary approach as a key ingredient helping put principles into practice, meaning sharing the responsibility among the staff members, with different professionals, and adopting a broader approach. In fact, this organizational aspect influences their work for two main reasons: first, having different people in the team allows them to share the responsibility of supporting people with complex needs (e.g., more providers support a client and this facilitates a person-centered approach), e.g. "*I think we are quite flexible. Like when there is a change like that, do you know, because we work well, well as team like do you know, we manage it*" (Ireland, TS1); second, having people with different professional skills and background allows the adoption of a broader approach in addressing problems: "*multi-responsibility also allows us to regulate emotional impacts*" (France, HF2).

Finally, the participants discussed about the importance of sharing the principles of the services with partners outside the team, in order to align their work with other homelessness services and to create a consistent system change in the network of services for the target group, as declared: "*linking practice and politics and trying to somehow move between how the practice of social intervention from a more innovative perspective can contribute to changing social policies*" (Portugal, HF1).

The results emerged are summarized in Figure 5.

Figure 5: Goals and principles in homelessness services and related organizational factors



Although the providers in both the services discussed seminal goals and principles, analyzing the content of the sentences emerged some differences between HF and TS services.

2.6. Results connected to Maton's theoretical framework

Relating the results with Maton's framework, some themes reflect characteristics of the 'group-based belief system' (Maton, 2008). To be empowering, services need a shared belief system that inspires change, is strengths-based, and focused beyond the self. To inspire change, the service should have salient goals and a clear means to achieve them. To be strengths-based, the service should consider members (professionals and clients) as resources: the principles of dignity, respect, and the person-centered approach are consistent with this aspect. Finally, to be focused beyond the self, the member of a service should have a shared vision and a larger purpose: shared vision and having a larger purpose (e.g., support people to get out of homelessness) were mentioned. Nevertheless, some differences between the models emerged.

2.7. Differences between Housing First and Traditional Staircase models

Each goal and principle emerged from the FGs has sub-themes that occur differentially in HF and TS. Tables 1 shows the number of services in which each goal (and sub-theme) or principle was discussed at least once.

Table 1: Service's goals, principles and relating factors emerged within HF and TS services

Goals	**Subthemes**	**n. HF (15)**	**n. TS (14)**
Support	Support individualized needs	4	8
	People decide the goals	7	1
	Connect to services	2	3
	To get out of homelessness	4	5
Integration	Autonomy	9	-
	Social network	3	2
	Community integration	6	5
Basic needs	Food, shower, clothes	4	4
	Safety	1	3
Housing	Give an house	11	1
	Find a house	-	5
	Temporary accommodation	-	6
Well-being	Health	2	7
	General well-being	4	1
Job/activities		-	5
Principles		**n. HF (15)**	**n. TS (14)**
	Dignity, respect, humanity	6	4
	Help everyone	4	7
	Person-centered approach	9	4
	Housing as a right	9	-
	Social justice	3	2
Organizational factors relating to the principles		**n. HF (15)**	**n. TS (14)**
	Difficulty to put principles in practice	6	5
	Importance of having a mission	5	2
	Shared/Not shared principles	10	5
	Multidisciplinary	3	1
	Create innovation	3	-

Discussing about the goals, HF providers emphasized client autonomy, i.e., living independently in society: "*first of all, the goal is to support them in a path of autonomy*"

(Italy, HF2); "*that thanks to us, they fly with their own wings in our society*" (France, HF1). They stressed that clients should decide their own goals: "*the person decides by him/herself, in autonomous way, what he/she wants or does not want*", "*that the person is as autonomous and independent as possible proportionally to his/her capacities*" (Spain, HF2). TS providers are still focus on individualized support, but more on clients' basic needs (food, shower, shelter) and problems as seen by the professionals. As a participant declared: "*the final aim of the professionals is to provide support to the user and to her/his situation, that can be very diverse and also imply different areas*" (Spain, TS2); "*we diagnose the problem, we diagnose specified life difficulty, such a certain range of the problem, we set a goal, the most important action and let's go, of course according to certain plan*" (Poland, TS1). Nevertheless, providers in both services pointed up the importance of clients' community integration, without any significant differences between the two services.

Participants from both HF and TS described the satisfaction of basic needs as goal, but TS providers focused especially on clients' safety, as one said: "*to offer a level of safety, because they come from the streets*" (the Netherlands, TS1); "*in the evening we try to maintain a positive and safe climate in the shelter*" (Italy, TS2). Further, the goal of housing was described differently: HF providers declared the importance of providing housing, meaning as a human right and a first step in the path to recovery: "*it is all about basic needs and fundamental rights, such as having your own home*" (Sweden, HF1); TS providers described housing as a future goal, as a final step of a process of becoming housing-ready, e.g.: "*that will hopefully lead to their own residence in the end*" (Sweden, TS2).

Regarding clients' well-being, participants in TS services more frequently referred to clients' physical health as a need, e.g., "*it is true that, initially, my work was to provide shelter, whereas now the health problems are really important*" (France, TS2). In HF, providers focused on general well-being and recovery as broader goals, as "*allow people to*

get off the street if they wish, and to start on a path to recovery" (France, HF2).

Finally, only in TS services the goal to help people to find a job or an activity was mentioned. For example, one provider mentioned "*promote and to facilitate the access to formative resources, labor training directed to facilitating the social insertion of the users*" (Spain, TS1); and another said "*not only the house, they need to work but the job is a difficult for everyone, however, it is to incorporate them into society, making them feel useful and appreciated*" (Italy, TS2).

Regarding principles, professionals in both types of services emphasized the importance of social justice, respect, and dignity. In HF, the focus was more on adopting a person-centered approach, "*the intervention is very individualized, that is, being very person-oriented and being appropriate to the person with whom we are dealing*" (Portugal, HF1); "*vision: client central and responsible. In that sense, Housing First fits*" (the Netherlands, HF1); "*it is important the involvement of the person*" (Italy, HF1). Also, the TS providers highlighted the importance of helping everyone unconditionally: "*despite everything that happened in their past, these clients are welcome here. I think that is wonderful*" (the Netherlands, TS1). HF providers emphasized unconditional acceptance: "*no matter how many problems you have, you will be helped*" (the Netherlands, HF2).

Finally, the housing as a human right was mentioned only by HF providers: "*the house is a right and the house is where you will be, independently of how you decide to live*" (Spain, HF1), "*we wouldn't be here if we didn't have a strong belief that someone deserves a home*" (Ireland, HF2).

Regarding factors that could affect goals and principles, both HF and TS providers noted that it is often difficult to put principles into practice because of organizational challenges like lack of resources, workload, and pressure from managers. As one participant noted: "*I understand that we put the persons at the center, but on the other hand it is just*

what is written. On our daily work we find some pressures that make the service leave people aside" (Spain, HF2); or "*if a client comes in and starts with Housing First, the organization ideally would like the coach/supervisor to stay with the client, but this person has no Housing First background or training*" (the Netherlands, HF1); "*the organization has a vision that they are there for everybody and that they are not selective in attracting certain clients just for financial benefit. Maybe, this is the main problem: the financial aspect. But this organization is indeed available for everybody*" (the Netherlands, TS1).

Beside that, in HF services there was a stronger emphasis on the importance a clear mission to guide their work: "*if you believe what you are doing is right, and you are supporting that service user as best you can, if you believe you're going to see it through with them, that's what gets me through*" (Ireland, HF2); of sharing values and having a united team: "*we can work very differently but I think our vision is always the same. We all have a common goal and a common mission*" (Sweden, HF1). Also, HF providers emphasized the importance of having a multidisciplinary team for putting principles into practice: "*I find that multi-referencing [flexible and multidisciplinary] is a good way to make the person central to the support that he is given*" (France, HF2). They also highlighted the importance of sharing the principles outside the team, with the local services or authorities: "*maybe other services don't have the same values, […] but if the team was all the same, if the people who provide accommodation were all on the one page, it would be different*" (Ireland, HF2). This aspect is connected to create systems change in services for people experiencing homelessness: "*linking practice and politics and trying to somehow move between how the practice of social intervention from a more innovative perspective can contribute to changing social policies*" (Portugal, HF1).

Despite the themes were analyzed all together, some goals or principles were more common to the countries, others were more discussed specifically in a context.

2.8. Recurrence across countries

As showed in Table 2, analyzing the recurrence of each goal (and sub-theme), principle or related factor across countries, some differences emerged. The idea is that more a theme is discussed across countries then it is more generalizable.

Regarding the goals, the aim of giving an house is the more common theme (seven countries), followed by: supporting people to get out to homelessness; working for providing clients' basic needs (food, shower and clothes); and helping clients to improve their health (six countries). Other aims seem be less common, e.g. support people to be connected to other services, satisfying their need of safety, and finding an house (three countries).

In relation to the principles, providers in all the countries discussed about working with a person-centered approach, resulted as main principles guiding the work with people experiencing homelessness. Only the principles of social justice seems less discussed across countries (three countries). Connected to the principles, the main organizational factors affecting the application of them is sharing the principles (seven countries), while multidisciplinary team and create innovation are less discussed (three countries).

Besides the different recurrences, in this study the organizational characteristics and contextual factors were not analyzed. In fact, the different sociopolitical context that facilitate or hinder the program implementation should be examined (Shinn, 2007). Future research could examine potential differences in goals and principles between services and across countries, for example in welfare, type of organization, number of employees, provider–client rapport, style of leadership. Better understanding of contextual variables could highlight specific differences to different types of services in different political and economic contexts.

Table 2: Service's goals, principles and relating factors emerged in eight European countries

Goals	Subthemes	Number of services per Country																n. Countries
		France		Ireland		Italy		Netherlands		Poland		Portugal		Spain		Sweden		
		HF	TS	HF	TS	HF	TS	HF	TS	HF	TS	HF	TS	HF	TS	HF	TS	
Total services involved		2	2	3	2	2	2	2	2	-	2	2	-	2	2	2	2	
Support	Support individualized needs		1	2	1	2	2				2				2			5
	People decide the goals	1	1	1		1		2						2				5
	Connect to services			1	1							1			2			3
	To get out of homelessness	1		1	1						1	1		1	2		1	6
Integration	Autonomy	2				2						1		2		2		5
	Social network			1		1	1					1					1	4
	Community integration	1	1	1			2					2		2	2			5
Basic needs	Food, shower, clothes	1		1			2					1			1	1	1	6
	Safety			1			1		2									3
Housing	Give an house	1		2		1		2	1			1		2		2		7
	Find a house						2		1								2	3
	Temporary accommodation		2		1				1		1						1	5
Well-being	Health	1	2	1			1		1						1		2	6
	General well-being	1		1			1	1								1		5
	Job/activities						1		2						1		1	4
Principles																		
Principles guiding the relationship with clients	Dignity, respect, humanity	1		2	2	1	1				1	2						5
	Help everyone			2	2	1	1	1	2		2							4
	Person-centered approach	1		2		1		1	1		1	2		1	2	1		8
	Housing as a right			3		2						2		1		1		5
	Social justice					1	1	1	1			1						3
Organizational factors relating to the principles	Difficulty to put principles in practice			2	2	1		1	2					2	1			4
	Importance of having a mission			2		1					1	1		1	1			5
	Shared/Not shared principles	2		2	1	1	1				1	1		2	2	2		7
	Multidisciplinary	2			1							1						3
	Create innovation			1		1						1						3

2.9. Discussion

This study aimed to analyze: a) how social providers, working in HF or TS services, conceptualize the goals and the principles of their services; b) if the component of 'belief system' in the two services is group-based as described by Maton (2008); and c) if there are differences between HF and TS comparing the two models in eight European countries.

From the FGs emerged common goals and principles and some differences between HF and TS services. In general, providers indicated that their main goal was to support clients with community integration, basic needs (food, shower, health), housing requirements, and well-being, regardless of the kind of service they worked in. In relation to principles, the providers in both HF and TS services emphasized the importance of a person-centered approach based on dignity, respect, and humanity. They also identified social justice and unconditional acceptance as key principles that guided their work.

However, there were some differences between HF and TS services in terms of different content on goals and principles, in line with findings by Henwood, Shinn, Tsemberis, and Padgett (2013). HF providers emphasized the importance of supporting clients' autonomy and choice over their own personal goals, with a focus on providing a house as a start on the path to recovery. Regarding the principles, the HF providers favored the person-centered approach and highlighted housing as a human right. They also emphasized all the principles of the original HF model (Tsemberis, 2010): housing, client's choice, support, integration; and the principles of the HF guide in Europe (Pleace, 2016): engagement of the clients, person-centered planning; recovery orientation; flexible support. Although harm reduction and the separation of housing and treatment were not mentioned, HF providers discussed the need to help everyone unconditionally, and so implied that there were no requirements to access the program.

The most common goal discussed is giving a house to the clients, mentioned in most

HF services. In contrast, TS providers were more focused on clients' basic needs than housing: finding a temporary accommodation, taking care of health problems, promoting safety, helping clients to find a job/activity. The implicit assumption was that clients need professionals to make decisions for them regarding their needs in order to become 'housing ready'. Their support is personalized, but clients are not involved in choosing their goals. Housing is seen as a distant goal, not as urgent, immediate or a right (Gulcur et al., 2003). This exclusive focus on basic needs put TS clients at risk of getting caught in the 'institutional circuit' of streets, homeless services, hospitals and jails (Daly, Craig and O'Sullivan, 2018), in which homelessness is managed, but not ended (Busch-Geertsema and Sahlin, 2018).

The person-centered approach was the only principle discussed by providers in both types of services, although to a greater extent by HF providers. It is possible that the main difference between the services, more so than in their basic principles, lies in the structure of the services. For example, only TS providers described the importance of finding a job or economic resources for clients, and this might be because clients need more resources outside the program to exit from homelessness (and find housing), while in HF programs housing is the starting point.

The influence of organizational factors on providers' principles was expressed by staff of both kinds of services, especially in relation to organizational aspects like workload and lack of resources. For example, providers in HF services emphasized the importance of having a multidisciplinary and flexible team, sharing values among the team, and having a clear mission. In fact, the literature showed that teams with well-defined goals (Olivet et al., 2010) perform better. Damschroeder et al. (2009) noted that, in addition to good professional skills, strong congruence between staff, and program principles is important. Congruence of principles is important for HF programs because of the profound change in values that is

required of providers who move from TS to HF. In fact, HF providers underscored the importance of sharing principles outside the team to create innovation. For this reason, Nelson et al. (2019) highlighted that dialogue among community stakeholders, during which a consensus on HF's values can be gradually solidified, should precede the implementation of HF programs.

Relating the results to Maton's framework (2008), some differences emerged between HF and TS. In HF services providers emphasized more some empowering features: the principles of dignity, respect, and the person-centered approach, considered as strengths-based characteristic of the 'belief system', and sharing a vision, considered as characteristic of setting working being beyond self.

The research has some specific limitations. First of all, the small sample size (two or three teams for each countries) and the lack of specific criteria for the selection of the teams. To address this limitation, at least four providers per FG were recruited, with at least six months of experience in the service.

Second, the researchers were different for each country and the FGs may have been influenced by the style of conducting of each one. To reduce this bias, a detailed protocol about planning (aims, recruitment, setting, role of the moderators and assistant, ethics), discussion (introduction, questions, conclusion, briefing), and content analysis were developed and shared with other HOME-EU partners. Moreover, the final results were not analyzed by the researchers that conducted the FGs but by two independent researchers of the Italian team. To reduce potential bias and to enhance the trustworthiness of the interpretation, two strategies were used (Padgett, 2011): independent coders were appointed, and group discussions took place within the research team.

Third, the discussions were translated into English, and this could have affected the meaning of the questions and contents of participants' responses. All the FG questions were

translated into native languages (seven different languages) and selected responses (from step 1 of data analysis) were then translated into English. However, the translation was necessary to allow for collaboration between partners of different countries. To reduce translation problems all partners used standardized translation/back-translation procedures (Beaton et al., 2000) and when any doubts regarding translation arose, these were discussed among the consortium.

Finally, providers in both types of services work with the goal of improving clients' community integration, without particular differences of meaning. This result is in line with the literature because results on the impact of services on community integration have been mixed and without clear differences between the two models (Quilgars and Pleace, 2016). This problem is connected to different issues, for example the research lacks a gold standard defining the construct and the consequence of having different variables and measures that hinder a comparison of the results integration may be a subjective experience that cannot be measured with objective indicators. Also, measuring integration as standard behaviors risks of 'correcting' people in a social norm that excludes the freedom of choice (Quilgars and Pleace, 2016), with a growing attention on analysis of the people experiencing homelessness' point of view about this topic (Granerud and Severinsson, 2006; Coltman et al., 2015). Next study aims to analyze this topic in order to clarify the meaning of integration from the prospective of people experiencing homelessness.

Chapter 3

Integration as service's goal:

People experiencing homelessness' point of view

From the previous study community integration emerged as one of the main goal of homelessness services (Gaboardi et al., 2019). Nevertheless, the integration of people experiencing homelessness is still a challenge both for services and for the research. In fact, results on the impact of services on integration have been mixed and without clear differences between the two models (Quilgars and Pleace, 2016). For that, the present chapter starts with an analysis of studies concerning integration and homelessness, to offer a synthesis of the main challenges in this topic. Community integration among people who experience homelessness is often measured as participation in a list of standard behaviors. This process ignores people's own feelings of integration. Then, a qualitative study explored those feelings through semi-structured interviews with 26 people experiencing homelessness in three Italian services.

3.1. Why exploring integration?

Integration and homelessness

The growing attention to the macro-level factors affecting individual vulnerabilities has resulted in a shift of the way of viewing people who are marginalized and their role in the society and then in an ongoing change in the services delivery: from de-institutionalization of people with mental illness to a staircase model where people earn independence by cooperating with services to the recent diffusion of the Housing First approach with voluntary services for people experiencing homelessness (Tsemberis, 1999; Lancione, Stefanizzi & Gaboardi, 2017). In this post-deinstitutionalization society, the importance of the provision of

housing with community support services to integrate people with mental health problems and/or experiencing homelessness is growing (Wong & Solomon, 2002; Gaboardi et al., 2019). As a consequence, research is focusing on the analysis of integration of people into the community, also defined as community integration/social inclusion/social integration. In a recent review of 307 studies about community mental health research in the field of community psychology, Townley and Terry (2018) showed that the homelessness/housing (17%) and deinstitutionalization/community integration (16%) were the second and third most frequent research topics after community mental health centers/services (20%).

In the literature, integration has been studied as a one-dimensional construct, focusing on the extent in which people participate in community activities and use community resources (Segal & Aviram, 1978). Recently, Wong and Solomon (2002) have developed a multi-dimensional construct of community integration that encompasses physical, social, and psychological dimensions, based on a synthesis of different definitions and frameworks. Physical integration refers to participation in activities of daily living in the community; social integration focuses on social contact with other community members; and psychological integration comprise an individual's sense of community and belonging (Aubry and Myner, 1999; Wong and Solomon, 2002). They also proposed a conceptual model underling the factors influencing community integration, in particular the differential configuration of housing setting and support structure in supportive independent housing. This conceptual model was focus on people with persons with psychiatric disabilities and it has been used in several studies, with people that also experiencing homelessness (Gulcur et al., 2007; Townley, Kloos, and Wright, 2009; Patterson et al., 2014; Ecker and Aubry, 2017) but the model should be extended to reflect such potential interactions among personal, program, and community characteristics.

Studies using this model have examined predictors of integration of people with

severe mental illness at the systemic level, in particular exploring housing and neighborhoods (Yanos, 2007), and at the individual level. For example, some research with people in Housing First programs showed that having independent scatter-site housing is related to a greater psychological and social integration (Yanos, Barrow and Temberis 2004; Gulcur et al., 2007; Ornelas et al., 2014). Living in independent apartments was significantly associated with greater independence (Yanos et al., 2009) and higher levels of choice (Gulcur et al., 2007), and living independently in regular neighborhoods was positively was associated with community integration (Aubry et al., 2013), in particular psychological integration (Yanos, Stefancic and Tsemberis 2011). On the other hand, formerly homeless people assigned to a Housing First program in a single building in Vancouver with private suites but common kitchens, dining, recreation, and health care facilities reported better psychological community integration than people assigned to scattered site apartments (Somers et al., 2017). After obtaining an independent apartment, people who have been homeless consider home as the place where they spend the most time (Townley, Kloos, and Wright, 2009), a place where they can experience 'ontological security' (Padgett, 2007). A number of studies have found relationships among psychological integration and housing satisfaction (Nemiroff et al., 2011) or life satisfaction (Aubry et al., 2013).

Nevertheless, people could have improvements in housing stability but remain socially isolated, with limited improvement in social integration (Tsai, Mares, and Rosenheck, 2012). For example, Patterson, Moniruzzaman, and Somers (2014) conducted a longitudinal study examining community integration among people experiencing homelessness with mental illness, living in Housing First or traditional services. They demonstrated an increase on psychological integration for participants with less severe needs living in independent apartments but no significant improvement on physical integration among any of the intervention groups. Remaining homeless predicted poorer well-being, life

satisfaction and mood but changes in social support seems to predict well-being over and above housing stability (Johnstone et al., 2016).

Safety, satisfaction, and tolerance for mental illness within the neighborhood were also related to sense of community in individuals with serious mental illness (Townley & Kloos, 2011). Physical integration, amount of time in housing, housing quality, as well as opportunities for neighbors to meet and interact in positive ways were associated with high levels of psychological integration in women experiencing homelessness (Nemiroff, Aubry, & Klodawsky, 2011). Also, people with higher levels of integration reported more positive characteristics of their housing and neighborhoods than people with lower integration (Ecker & Aubry 2016). Perceived neighborhood social cohesion was related to psychological integration, but not to physical and social integration (Yanos et al., 2009).

Other factors, such as social isolation and stigma, have been identified as obstacles to community integration (Nemiroff, Aubry, & Klodawsky, 2011; Patterson, Moniruzzaman, & Somers, 2014) while social support was connected to higher physical and psychological integration (Cherner, Aubry, and Ecker, 2017; Ecker & Aubry 2017). Distal social support from sites like grocery stores, pharmacies, and restaurants was also a predictor of community integration and recovery, especially for women and older participants (Townley, Miller, and Kloos, 2013). However, another study found no relationship between natural support (i.e., informal relationships) and mental health service use (Tsai, Desai, and Rosenheck, 2012).

Some individual factors were positively related to integration, e.g., greater social skills were related to higher physical integration (Cherner, Aubry, and Ecker, 2017). Findings about the relationship of psychological symptoms and integration are mixed among people experiencing both mental illness and homelessness are mixed. Some studies have found that having lower psychopathology was associated with higher psychological integration (Gulcur et al., 2007; Ecker & Aubry 2017); others found that social integration

was largely independent of clinical symptoms with a weak relation with life satisfaction (Tsai and Rosenheck, 2012). People with mental health problems can experience shame and fear of exclusion and a sense of loneliness in their struggle to be integrated (Granerud and Severinsson, 2006). Finally, in one study, personal mastery mediated the relationship of perceived choice to physical and psychological integration (Manning and Greenwood, 2019). Nevertheless, some challenges emerged from the analysis of the literature that hinder the comparison of the results.

Challenges in studying integration

Three interconnected issues emerge from an analysis of this literature. First, a *conceptual issue* is that the field lacks consensus on the meaning of integration. Some studies were based on Wong and Solomon's conceptual model (2002); others found additional dimensions connected to integration, e.g. 'independence/self-actualization' (Gulcur et al., 2007) or 'locus of meaningful activity' (Yanos et al., 2009) and psychological integration is often connected to a 'sense of belonging' (Cherner, Aubry, and Ecker, 2017). Tsai, Mares, and Rosenheck (2012) studied social integration as a construct with six domains: housing, work, social support, community participation, civic activity, and religious faith. In a critical review about the effectiveness of Housing First on integration, Quilgars and Pleace (2016) described four categories of integration: participation in community activities, being accepted in society, working, voting or political participation. Another study considered social integration as equitable access to economic, political, cultural, and social domains (Thulien et al., 2019). Morevoer, Ware et al. (2007) proposed the concept of social integration as a process through which people who have been psychiatrically disabled increasingly develop their capacities for connectedness (the construction and successful maintenance of reciprocal interpersonal relationships) and citizenship (the rights and responsibilities enjoyed by

members of a democratic society). The concept of integration still needs a clear and shared conceptual framework (Gulcur et al., 2007).

Second, a *methodological issue* is that different measures and target groups hinder a comparison of the results. As illustrated above, integration is measured with different methods, referring to quantity of activities carried out in a neighborhood, sense of belonging to a community, and type of social support. Most of the measures focus on behaviors of participants (activities and interactions with other people) and the feelings are confined to psychological integration, meaning as sense of community (related to a specific place/neighborhood). Also, most cited studies involved participants with mental illness. This study seeks a specific framework for people experiencing homelessness (with or without mental illness). The operationalization of the construct of integration may vary depending on people's experiences and cultural background (Tsai et al., 2012), including homelessness.

The third issue, related to the previous, is *epistemological.* Integration may be a subjective experience that cannot be measured with objective indicators. For example, the use of specific resources in the community could be related to what people enjoy (e.g. going to the cinema), as well as their resources (e.g. having money to go to the cinema). Measuring integration as participation in standard behaviors risks 'correcting' people to a social norm (movie going) that excludes the freedom of choice (Quilgars and Pleace, 2016). Only a few studies analyzed the point of view of people with mental illness who experience homelessness (Granerud, and Severinsson, 2006; Coltman et al., 2015). Coltman et al. (2015) showed the importance of studying the small interactions by which people establish relationships, feelings of self-esteem and hopefulness, and the importance of pets (not only of human interactions). They highlighted how integration and inclusion are related to themes of self-determination, independence, empowerment, based on a feeling of hope. They concluded that the research needs to acknowledge participants' individualized and non-linear paths.

Townely et al. (2009) used participatory methods that reflect the participants' unique experiences to represent activity spaces and measure geographic accessibility of places important to them and degree of mobility. As they declared: '*rather than testing what we think community integration should be, the participant is allowed to tell us what community integration and community is for them*' (Townley, Kloos, and Wright, 2009, p. 528).

3.2. Aim

The current research aims to explore the feelings associated with 'integration' from the perspective of people experiencing homelessness. In particular, we explore what made them feel integrated and why, with a focus on facilitators and obstacles which intervened in their paths of integration. Because most of the literature in this area concerns people who have mental illnesses in addition to experiences of homelessness, this study focus on people who do not.

3.3. Method

Procedure

The data were collected through semi-structured interviews during December 2017 and March 2018 in three Italian services for people experiencing homelessness (a day center, a shelter and a housing first program). Before conducting the research, the researchers explained the study's aims, methods and data analysis to the organizations' leaders to obtain their consent for their organizations to participate.

Participants who had been homeless for at least 2 months were recruited on a voluntary basis. We decided to exclude people with a psychiatric diagnosis, avoiding the potential complication of factors other than homelessness. Interviews lasted an average of one and a half hours and were audio-recorded and transcribed verbatim. The interviews

began by exploring where participants spent time and who they spent time with, and moved to more abstract questions about whether they felt integrated in these places and why, with a focus on obstacles and facilitators to integration. Before starting the data collection, we piloted the interview protocol with a person experiencing homelessness who gave feedback about the questions and style of conducting the interview. The Ethics Committee of University of Padua gave ethical approval for the study.

Participants

Overall, 26 people were involved in three different cities (BI, MIL, CES): 6 in a day center, 13 in a shelter and 9 in a housing first program. The ages of the participants ranged from 27 to 64 years, with an average of 48 years old; 5 were female, 1 trans (m-f) and 20 male; 13 were foreigners and 13 Italians. Duration of homelessness ranged from 3 months to 20 years. Three people were married and two others were in romantic relationships. Most were not employed, but three people worked part-time. The main sources of participants' economic income were disability or unemployment benefits from the Municipality (15 people), followed by part-time or occasional work (4), savings (2), panhandling (1), and help from family (1). Three participants reported no income.

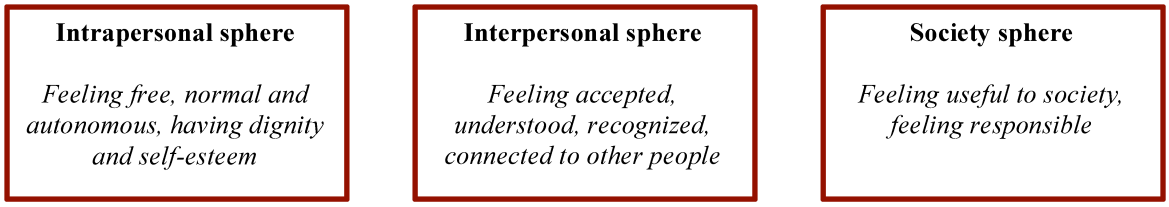
Data analysis

It was used an inductive research approach in order to remain flexible and open to theoretical discovery, and to highlight the experiences of the participants: starting with an open coding of the transcripts, and proceeding to a thematic analysis of the initial codes (Braun & Clarke, 2006). Two researchers analyzed each interview separately. Together they created the categories of codes that emerged (see Appendix 2), discussing until they reached consensus.

3.4. Feelings related to integration

Three main categories of feelings emerged, as showed in Figure 6: The intrapersonal sphere refers to feelings that exist within people, emotions regarding themselves. The interpersonal sphere encompasses feelings that emerged from their interactions with other people. The societal sphere concerns connections with the community or general society. The quotations are reported with the code of city and number of the participant.

Figure 6: Feelings related to concept of integration



Intrapersonal sphere

In relation to the intrapersonal feelings, participants discussed the importance of feeling 'a normal person,' meaning feeling the same as any others. People talked about freedom, dignity, and autonomy and referred to having a job, a private house, and good health. For example, a participant said: "*work and health are two essential things to feel like a human being in this kind of society*" (#BI01); or, in another's words: "*until I find a job, I am not me. If I find a job, I can work, come home, eat something, watch the television, work tomorrow, you are quiet, you are free, you are a person, you are someone*" (#CES09). Having choice or freedom (to do what you want) is considered an important aspect of integration: "*when I see something that I like, for example a pair of shoes, I think that I can't buy them because I don't have a job, I can't afford to spend that amount. So, I feel bad about it. I feel excluded from the freedom to choose what I want to do*" (#CES12). Talking about integration a participant declared: "*I want so much to be a normal person, to be a person like*

everyone normally lives. Having the money, a job, the family living with you, to go around, not to worry" (#CES15.) Another participant talked about the integration as a way to have self-esteem, feeling good in a society: "*feeling integrated is important, because it gives you confidence in yourself, it is quite important to [...] feel good in the society in which you live*" (#CES16) In contrast, some factors hinder these feelings, e.g., lack of economic resources or living in a shelter or group home, with rules that limit the freedom: "*there (shelter) we go to rest, to pass the time when it is cold, when you do not have nothing to do, when you are tired. We have to stay from eight in the morning to eight in the evening on the street*" (#CES1).

The cited quotes show that integration starts from feeling of freedom and dignity of the person, as described by this participant: "*Dignity holds people, respect. If you do not have this for me you are not a person*" (#CES1). Without the possibility of living a 'normal' life, with good health, housing and work, participants cannot think about other aspects of their life. As one participant summarized: "*if you have a job you are okay, because with the job you have the house, you have many things; without work you do not count as anything. If you lose your job, you lose everything; you do not have any friends. Friends stay close to you if you have work. If you lose your job you have to find other friends, tramps, who sleep at the station, then change your life, it is not like it used to be. For me it is the work that counts here in Italy. Without work, there is nothing. Because with work you do many things, you rent a house, you bring your family here, you live well, you do not wait for anyone to help you, you do not come to the shelter, you do not eat at Caritas (a charitable organization)*" (#CES14).

The cited quotes show as the integration starts from feeling of freedom and dignity of themselves, as based of life. Without the possibility to life a 'normal' life, with good health, housing and work, participants cannot think about other aspects of their life.

Interpersonal sphere

At the interpersonal level, participants discussed feeling accepted, understood, recognized by other people (and professionals in the services), and feeling connected to others. Talking about a place important for him, a participant noted: "*I feel at home [...], people call you, they want to know about you, how you are ... you feel like you are in a family because they think of you and that is important,*" (#MIL1) or as another person put it: "*to feel accepted. That is what I would like—for others to accept me with all my faults*" (#CES18).

Factors that facilitated integration included factors related to other people, and aspects of the people themselves. Facilitators included being supported and helped by the services, e.g., "*being integrated into society also means being helped if you need it, it is not possible that we are in 2018 and people have to live on the street"* (#MIL6); having people who count in one's life, e.g., "*I also need someone to talk to, but I am looking for people who understand me. People with dignity, with respect, not people to pass the time, transitory people. You are not integrated with people like that*" (#CES1); or meeting people to talk and share something: "*share with other people, know the thoughts of others, know what another can do, what another says […], integration is learning experiences as well*" (#CES6), "*because feeling integrated means that you attend to people, you know new people, you can build something, many things"* (#CES13). Starting from simple behaviors, participants can feel recognized and connected to others, as a participant declared: "*the first thing that gives me energy is when you enter (in the service) and you see a smile in the morning, you see the provider as a family*" (#MIL1). At the same time, some individual factors can facilitate these feelings, e.g., having a friendly and sociable character, as a participant noted: "*the availability to others helped me to integrate myself"* (#CES8), or knowing the local culture (and language), especially for non-Italians, e.g. "*integration is integrating with Italian culture*

[…], to be integrated at 100% into the Italian world you need to learn its language and writing" (#CES14).

In contrast, other factors that affect the likelihood of feeling accepted and respected by other people are beyond individual control, e.g. racism, indifference, and prejudice or distrust from other people, sometimes due to past life events (incarceration, bad health, family break-ups). Also living in a shelter was considered as an obstacle: "*for me the service that gave me so much trouble was the shelter; because there is no respect there, there are no rules*" (#MIL4) or "*you can not integrate here (in the shelter), first because there are times to respect, exit at 8 am and return to 8 pm. You have little time also to have a connection with the other people*" (#CES2).

These quotations illustrate an idea of integration involving respect and interaction with other people. This may involve relationships but also includes interactions and opportunities to share something with other people, starting from small acts of kindness and consideration.

Social sphere

Feelings clustered in this sphere are related to feeling useful to society and feeling responsible. In particular, participants discussed involvement in activities or having a job that facilitated the opportunity to have a role in society (or the service) and growing the feelings of usefulness and responsibility: "*I come here (at the daily center) to be busy also because we do activities, we do theater, learning English, using the computer, so in addition to not being around and maybe feeling like nothing ... it is nice to come here to feel useful, and then you can also learn*" (#MIL2); "*the thing that stimulates me the most is knowing that I have commitments, then waking up in the morning, knowing that I have a commitment and taking it forward, having responsibilities, having goals"* (#MIL2); "*it is important for me to feel*

integrated because it helps me in what I have always wanted for my life, to be me with myself as a useful person for society" (#MIL4); "*do something, also a hobby. Start doing, for example, something for everyone, there are a lot of things to do, for example, even for the home [...], leave a mark as well, if you do not leave a mark it is not community, it is nothing, it is not life"* (#CES6).

As illustrated in the above quotes, people feel integrated when they have a role, a responsibility and something to do in their daily life. They considered integration as having a role in the society.

3.5. Discussion

The research aimed to explore the feelings associated with 'integration' from the point of view of people experiencing homelessness, with a focus on facilitators and obstacles that intervened in their paths of integration. More than focusing on the behaviors related to the process of integration, respondents focused on the feelings connected to this construct. In the intrapersonal sphere participants discussed feeling 'a normal person,' freedom, dignity, self-esteem, and autonomy. At the interpersonal level, participants discussed feeling accepted, understood, recognized by other people, and feeling connected to others. In the societal sphere they described feeling useful to society and feeling responsible. Activities and behaviors were important to the extent that they gave scope for these feelings.

To capture the differences with the main theoretical model of integration and to analyze this construct beyond behaviors, the results are discussed comparing them to Wong and Solomon' (2002) multi-dimensional construct of community integration. The intrapersonal sphere can be related to psychological integration (sense of belonging) but participants discussed more about personal feeling of freedom and dignity than sense of community. In the literature, personal mastery was identified as mediator of the relationship

between perceived choice and physical and psychological integration (Manning and Greenwood, 2019). In that sense, freedom and control over one's life could be considered as important feelings to be integrated. Another study suggested incorporating identity into the conceptualization of social integration (Thulien et al., 2019). This was echoed here in the stress participants placed on feeling oneself to be 'a human being,' and someone respected by other people. The interpersonal feelings are connected to that. The interpersonal sphere could be associated with Wong and Solomon's (2002) dimension of social integration but it is not limited to the number of contacts respondents had with other people in the community. This sphere involved more the sense of recognition, the feeling of being considered, accepted and understood. The results illustrated how social stigma can be an obstacle to integration of people experiencing homelessness (Nemiroff, Aubry, & Klodawsky, 2011) and that they can experience shame and fear of exclusion in their struggle to be integrated (Granerud and Severinsson, 2006). Social support (and having people who count in own life) is indeed connected with well-being (Johnstone et al., 2016), but it is the quality of interactions, not the number or presence of people that is important. Participants declared that it is not sufficient to stay with people, but to share and interact with them. As in the study by Coltman et al. (2015), it is important to study the small interactions by which people establish both relationships and feelings of self-esteem.

Finally, the social sphere has some connections to the physical integration (Wong and Solomon, 2002). In our results participants talked about the importance of feeling useful for the society through working or be involved in activities. In this case, they did not discuss about using resources of the community but more about doing something during the day, as a potential way to feeling responsible and engaged in something of meaningful for them. It seems that they need of a social role or meaningful activities (e.g. 'locus of meaningful activity' in Yanos et al., 2009), more than only using the resources, as confirmed by other

studies showing that taking part in activities and things of interest did not always link with the participants' positive experiences of integration. When accessing public spaces in the community, some people could feel bored, unfulfilled, and lonely (Coltman et al., 2015).

Some factors seem influence the emergence of these feelings. In particular, having a job is considered an important facilitator for all the spheres emerged. Price (1985) points out that participating in the valued social role of a worker might contribute to a sense of belonging in the community or people who experience a sense of belonging and acceptance might feel more able to take on more positive social roles, such as that of a worker. The participants of this study considered the work as a base to enjoy the life: having a house, interactions, and some money to enjoy funny activities with friends and family. Lack of resources and employment made them feel neglected, as showed in another study involving people with mental illness (Granerud and Severinsson, 2006). Also in the last cited study, it was surprising that the participants of the current research placed such great importance on finding a job, especially for having a salary, companionship, daily routines, meeting people and grow their self-esteem and sense of usefulness. Also Marie Jahoda explored the psychological meaning (not only the economic one) of employment and unemployment. She explained how the unemployment negatively influences psychological well-being (Jahoda, 1982). In addiction, having an independent housing seems a base for having feelings of integration, as showed in other studies (Padgett, 2007; Gulcur et al., 2007; Ornelas et al., 2014). In contrast, living in a shelter hinder the possibility to feel the feelings emerged, due to restricted hours and lack of privacy and time to have positive interactions with other people. Moreover, participants discussed not only about external factors (work, housing, approach of other people) but also about individual factors. For example, having a friendly and open character can help the interpersonal sphere, as confirmed by another study showing that

having more social skills was related to high level of physical integration (Cherner, Aubry, and Ecker, 2017).

From the results, new insights about integration by people experiencing homelessness emerged. Participants both described their feelings of integration, and connected them to facilitators and obstacles, both external and internal to themselves. Some feelings are facilitated by some opportunities, e.g., having a job and a house. The capabilities approach (Nussbaum, 2011) provides a possible theoretical framework for the interpretation of the results. Capabilities are what people can actually do and be in everyday life, that is in turn contingent on having both competencies and opportunities. This perspective involves studying both the capacities of individuals and the opportunities in their environments. The capabilities framework was used to conceptualize homelessness from a community psychology prospective (Shinn, 2015) and to conceptualize social integration (Ware et al., 2007).

Nussbaum (2001) enumerates ten capabilities that she argues cannot be traded off, one for another, since all are essential for a life worth living, a truly human life. Yet there are two that she says "suffuse all the others" (p. 82). One of these is affiliation, being able to live in relationship to others and having the social base of self-respect and non-humiliation. The other is practical reason, or the ability to the ability to plan one's life and occupy meaningful social roles. The parallels to the intrapersonal, interpersonal, and societal aspects of integration are clear.

Although this study yielded important insights into the conceptualization of integration for people experiencing homelessness, some caution should be taken in drawing conclusions from these findings. The study is potentially limited because of small sample, which may not be representative of all people experiencing homelessness. Participants who had experienced homelessness for at least two months were selected, but excluded those with

psychiatric problems in order to exclude the possible interference of other variables in exploring participants' feeling of integration. Participants had very different stories of homelessness and different cultural backgrounds that this aspect may have affected the results. Half of the participants were foreigners and the difficulty of language may have influenced the understanding of the questions. Perhaps, in future research the use of narrative interviews might help to grasp the life paths of people, within which to analyze the construct of integration taking into account potential differences of gender, ethnic group and story of homelessness. Finally, to reduce potential bias and to enhance the trustworthiness of the interpretation, during the data analysis independent coders were appointed and group discussions took place among the researchers (Padgett, 2011).

Despite these limitations, this study could be considered an example of analyzing a complex construct such as integration from the perspective of participants. This led us to a conceptualization that encompasses not only people's behaviors and activities, but also the sentiments associated with them, and led us to conclude that integration is a subjective construct.

To define integration is not simply to specify a particular set of behaviors that measure how much a person is integrated; it is a process of feelings. In planning research and practice to foster integration, an initial inclination might be to think that people should 'correct' their behavior to fit in to a 'social norm' (Quilgars, and Pleace, 2016). However, feelings of integration arise from a combination of individual personality, and opportunities and barriers in the environment. Also, in care-relationships, the process is the result of an interaction between service users' individual challenges and social challenges (Raitakari, Haahtela, and Juhila, 2016). In this process, different factors could affect the working relationships between providers and clients, as investigate in the next study.

Chapter 4

Service characteristics affecting providers' work

As illustrated in the previous studies, the change in goals and principles of the services it is changing the way of meaning homelessness and how service providers work with people experiencing homelessness. Therefore, it seems relevant to analyze the working context of the providers, a key ingredient for policies oriented to reverse homelessness. This chapter analyzes the challenges of working with people experiencing homelessness and the possible factors related to them. Then, a study exploring which factors affect the work of social providers by examining differences between workers in Housing First (HF) and Traditional Services (TS) teams in a cross-national level is presented. Data were collected through 17 Photovoice projects in 8 European countries, involving 81 social providers. Results are discussed in three main levels of categories: systemic, organizational and individual. Also, relationship as key ingredient of these results is discussed.

4.1. Working with people experiencing homelessness

Challenges

Few studies have analyzed the service characteristics that affect working with people experiencing homelessness. Rather, most of the studies have focused on the factors that influence fidelity to the original principles of the HF model, rather than to the factors that influence professional performance as a core element for the successful implementation of the initiatives (Macnaughton et al., 2015; Greenwood et al., 2018).

In fact, service providers are responsible for addressing one of the most complex expressions of poverty in the contemporary societies, but little attention paid to providing the support and skills workers need to succeed (Mullen & Leginski, 2010). Providers work with a

population with multifaceted needs (not only the need for housing but also with physical, psychological and social problems). The daily experience of working with clients in precarious circumstances may entail fatigue and powerlessness, especially when workers have high goals and expectations, with a consequent increase in burnout risk (Fisk, Rakfeldt, & Heffernan, 1999; Mullen & Leginski, 2010; Lemieux-Cumberlege & Taylor, 2019). Moreover, homeless services are often conducted by small organizations and cooperatives without clear organization charts or defined structures with providers working in a low wage environment with high turnover. The professional roles, skills, and principles that characterize the culture of the organizations are not always clearly defined (Mullen & Leginski, 2010). Organizations rarely provide professional training (Olivet et al., 2010), especially in the TS (e.g. emergency services) where the needs of the clients are generally concrete and essential (e.g. soup kitchen, shelter) and volunteers often deliver services. Hence, professional training is deemed unnecessary (Vosburgh, 1988). Because different public and private agencies typically address specific needs (e.g.: psychiatric services, drug addiction services, and community organizations), collaboration and integration between services and agencies is important. Nevertheless, services for this target group are traditionally under-resourced and limited by rules (e.g. the access to health services required a residence).

The challenges and the difficult nature of this work can create a stressful work environment and potentially decrease the quality of care (Olivet et al., 2010). The bureaucratic system, high workload, clients' suffering and little experience of success emerged as main common demands of staff working with refugees and people experiencing homelessness. Deriving meaning from work and support among the team were identified as main common job resources. In general, the staff expressed a need of training, external

counseling and supervision (Wirth et al., 2019). Beside these challenges, the research suggests some factors that could support the work with this target group.

Facilitators of the work

Regarding the contextual factors, Rapp et al. (2010) documented the importance of developing collaboration with various local services in the community (e.g., social, health, justice, and employment agencies) and neighborhoods, in order to promote social integration of clients. Further, socioeconomic contextual factors, in particular the national GDP per capita (Gross Domestic Product), are likely to influence the organizational quality of services (Costa et al., 2014).

Factors within the organization providing services are also important. Some studies suggest that good performance is associated with teams that have well-defined goals, regular feedback on performance, administrative support, guidelines for coordinating teamwork, and supportive leadership, suggesting the importance of practices related to staffing programs in three areas: creating multidisciplinary teams, supervising and supporting staff, and training (Olivet et al., 2010). Moreover, it is important to project future needs, define competencies and skills, and develop leadership and management training (Mullen & Leginski, 2010). Then, Damschroeder et al. (2009) argued that teams should be characterized not only by good professional skills but also by strong congruence between the values of the staff and the philosophy of the program for which they work.

In Europe, a multidisciplinary team of experts involved in a cross-national study (Costa et al., 2014) defined six domains to measure the quality of services providing mental health care for marginalized groups: accessibility, supervision, multidisciplinary team, the programs provided, coordination and evaluation. But the researchers started from the experts' prospective, not using the frontline experience of social providers.

Providers are key ingredients for success of a policy oriented to end homelessness because they are directly responsible for finding housing, and helping the people experiencing homelessness (Mullen & Leginski, 2010). Given the rapid changes in the homeless service system, it seems to be useful to adopt an exploratory approach to understand the perspectives of providers.

4.2. Aims

This study aimed to understand which factors affect the work of social providers in eight European countries, working in HF or TS. In particular, the specific aims are:

- Exploring which elements influence the social providers' work in HF and TS services in eight European countries;
- Comparing HF and TS across the countries;
- Promote social change in the organizations involved.

4.3. Method

Photovoice method

The Photovoice method uses a universal language (the photography) to promote social change through the involvement of the participants (Wang, 1999). Photovoice is a method of collaborative research that captures the positive and negative aspects of a situation, in this case service programs, from the points of view of people involved (Wang, Cash, & Powers, 2000). People can identify, represent, and then improve the contexts in which they are inserted using the photographic language (Wang, & Burris, 1997), becoming active participants in the processes of analysis.

This methodology has been used in different contexts including with people experiencing homelessness (Catalani and Minkler, 2010; Cabassa et al., 2013; Seitz and

Strack, 2016; Gaboardi et al., 2018; Pruitt et al., 2018). However, literature on using photovoice to analyze work situations appears to be quite limited (Flum et al., 2010), especially in relation to homeless services.

Procedure

The data were collected through Photovoice method during May-June 2017 in 8 European countries involved in the HOME-EU project. In each country a convenience sample assembling groups of at least four workers who each had at least six months of experience in the service was used. Separate groups were formed for providers working in HF and TS programs. The participants took part in the study voluntarily without financial compensation. Participants completed consent forms adapted on the basis of the laws of their country. The European Ethics Committee and the Ethics Committee of each University/Research partner of the consortium approved the research.

The photovoice project was divided in four weekly or biweekly sessions, each lasting about 2 hours. Local researchers who were independent from the services conducted the sessions in each country, according to the following steps:

Session 1- Introduction and review of the project and training: Facilitators met with the participants to discuss the Photovoice process, underlying issues around power and ethics.

Session 2- Photographic training and assignment: Facilitators trained participants in the use of cameras (composition, lighting, contrast, and other techniques) that could help them to represent their experiences, strengths and struggles through photographs. When possible, this part should be done by a professional photographer. Participants were instructed to take pictures that responded to the following questions: *What are the aspects of the program that help your work? What are the main obstacles?*

Session 3- Sharing/discussing photos: Each photographer *selected* three to five

representative photographs. A discussion around the photographs was guided by the photovoice technique called SHOWeD (Wang, 1999). Each letter of this acronym corresponds to a question and the series of questions prompt the participants to critically analyze the content of their photographs: What do you *See* here? What is really *Happening*? How does this relate to *Our* lives? *Why* does this problem or strength *exist*? What can we *Do* about it? Then, the participants *contextualized* the photographs by telling stories about what the photographs meant to them. Finally, they *summarized* what emerged from the photographs and the discussions in main themes.

Session 4- Report: the themes that emerged were collected in a report shared with participants. Some projects have transformed the themes emerged into operational proposals to be given to the organization to improve the working environment within the service.

Participants

Overall, 17 photovoice projects (HF=8; TS=9) were conducted in 8 Countries (France, Ireland, Italy, the Netherlands, Poland, Portugal, Spain, Sweden) involving 81 participants (providers and volunteers), 41 in HF and 40 in TS. In particular, in each country one HF and one TS photovoice projects were realized (with the exception of Italy, where three HF photovoice were conducted, and Poland, where two TS photovoice took place, since there are not yet HF programs in the country).

Data analysis

Data were analyzed following two steps:

Step 1- Analysis in each country. A draft summary report was created in collaboration with the photovoice participants in each project. This document incorporates the most salient themes that emerged during the discussion of the pictures. The local research team

(facilitators) reviewed the entire photovoice collection to identify salient themes in the photos, titles, and captions. Findings from this process were combined with the participant feedback collected during the last session. The draft summary report was revised by identifying themes that overlapped between researchers' and photovoice participants' perspective. This resulted in a summary approved by the participants.

Step 2- Cross-national analysis. Facilitators translated the reports and picture captions into English for cross-national analysis. Three researchers from the Italian team independently grouped the themes that emerged in the reports of each country into categories, with disagreements resolved in discussion among the team. In total, 195 photos (HF=97, TS= 98) were analyzed.

Themes were divided into three levels: systemic, organizational, and individual (Macnaughton et al., 2015). Finally, the occurrence of categories within HF and TS and across counties was tabulated. Then, the categories were shared with all the project's partners. The follow results emerged from the step 2 of the analysis.

4.4. Factors affecting providers' work

Several themes emerged as factors that affect the work in services for people experiencing homelessness. The results include 17 major categories divided in three level of analysis: systemic (i.e., external to the service: 4 categories,), organizational (i.e., within the service: 10 categories), individual (i.e., related to providers or clients: 3 categories). These categories are also divided in facilitators and obstacles of the work, as showed in Table 3.

Table 3: Facilitators and obstacles affecting providers' work

Level	*Categories*	*Sub-categories*
	Facilitators	
Systemic	Relationships with other services:	Collaboration
Organizational	Physical environment:	Building's quality
		Tools and equipment
	Colleagues:	Support
		Communication
		Team spirit
	Roles:	Clarity
		Flexibility
		Autonomy
	Leadership	
	Vision and principles	
	Training	
	Supervision	
	Modalities to work with clients:	Strategies of working
		Importance of relationship
	Obstacles	
Systemic	Institutional arrangements	
	Relationships with other services	
	Citizens' attitude	
Organizational	Physical environment:	Geographic location
		Building's quality
		Tools and equipment
	Roles	Clarity
	Regulation	
	Contradictions	
	Workload	
	Modalities to work with clients	Obstacles to relationship
Individual	Clients' characteristics	
	Balance private/work life	
	Balance the relation with clients	

Systemic level

In relation to systemic factors, participants talked about the importance of institutional arrangements, mostly referring to the need to have economic resources to implement the services. However, having resources is not enough, providers also want that the practice of the services influencing policy change, as shown in Picture 1.

Pic. 1: *Importance of feeding the political sphere with material collected through a scientific practice* [Portugal, HF program]

Also, relating to the community, the interconnections with citizens emerged as an important element for the services. Involving the community in the services could help to integrate the clients but often the citizens have prejudice against homeless people or do not understand the homeless services, as shown in Pic. 2. The participants declared: (the necessity of) '*speaking with neighbors to learn about the situation of the homeless people and to change their perspective on them*' (Spain, TS).

Pic. 2: *General public and the politicians also seem to see homelessness as "not my problem"* [Ireland, HF program]

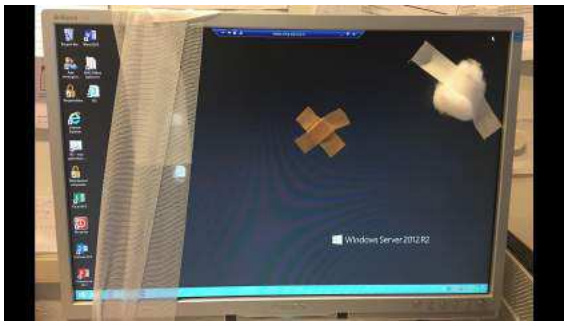
An important factor is the relationship with other services in the community; collaboration and shared work are key elements in the path of helping people experimenting homelessness with different needs, e.g. *'[name], place of meeting, it is a space that we share with other entities, both of social and of other areas'* (Spain, HF), but this collaboration is not always managed or clear and it could be an obstacle to providers' work, as a participant declared: '*let us understand what we must do, be clear and precise for everyone, and we will do it*' (Italy, TS).

Organizational level

At the organizational level, the physical environment of the services seems to affect the work in the field of homelessness. In particular, service providers underlined three elements: the geographic location of the services (e.g. Pic. 3); the quality of the services' buildings (e.g. Pic. 4); having adequate and functional tools and equipment (e.g. Pic. 5).

Pic 3: '*The location of the service is an obstacle because is too far from the city center and difficult to reach*' [Portugal, TS]

Pic. 4: '*Working in a beautiful place is beautiful*'
[Italy, HF]



Pic. 5: '*Reporting system does not work properly'*
[the Netherlands, TS]

Providers consider the relationships among colleagues as positive factor influencing the work in the service. This category involves: mutual support ('*a safe and trusted team…we can share everything with each other, we are always there for each other*', the Netherlands, HF, or as in Pic. 6); communication among the staff ('*team meetings as a fundamental factor to sharing information in order to facilitate an integrated intervention*', Portugal, HF); and the team spirit, as showed in Pic. 7 and Pic. 8.

Pic. 6: '*Share your load, it will weigh less:*
Several colleagues in the office discuss in an informal way some aspects of the cases at their work. Sharing with colleagues helps them to manage in a better way the emotional charges of working with service users'.
[Spain, HF program]

Pic. 7: *Team spirit: here we see the 'horizontality' idea, we do not distinguish the roles/duties of each other, including head managers. Everyone discusses with everyone. It's a moment of informal information sharing. The team likes these moments.*
[France, HF program]

Pic. 8: *Standing together as a team*
[the Netherlands, TS program]

The definition of roles was also important to staff, as a participant declared: '*we are social workers but sometimes we have to do the role of the nurses…and it is confusing'* (Italy, TS). Workers also spoke of autonomy (e.g. '*not be too serious, this is possible because everyone has their responsibilities*', Italy, HF) and flexibility ('*it is about multi-referencing. It is not a worker who is responsible for a case file but it is several workers who are responsible for the same file*', France, HF). Leadership emerged as a key issue for staff in

only one service: '*I am working alone at my territory, but permanently connected to my coordinator, […] I think I have a trustful relation with my coordinator*' (Spain, HF).

Some regulations also emerged as obstacles, e.g., the lack of clear rules for the clients, and difficulty in helping all the people because of rules ('*we do not accept all the people for administrative reasons*', France, TS); or as facilitators, e.g. the importance of having a working model (Portugal, HF) or the support of the volunteers (Portugal, TS).

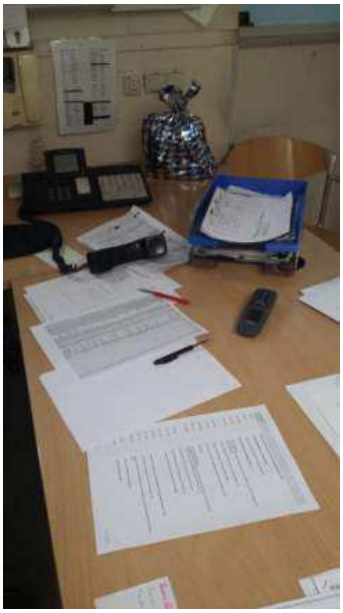
The theme of the contradictions emerged in some services. The contraposition is expressed in Pic. 9, 10, and 11.

Pic. 9: '*the good and the bad*: *the team actually has really good outcomes but there are things that when we're missing them they cause an awful lot of stress*'
[Ireland, HF]

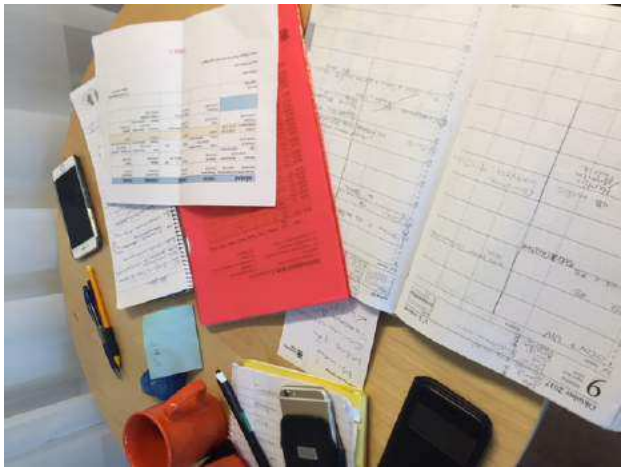
Pic. 10: *'…a contrast between trying to create a welcoming environment and…trying to protect people… trying to create the health and safety systems within the building that keep people safe'.*
[Ireland, TS]

Pic. 11: '*The reality of the system: Probably the system doesn't work as it should to promote autonomous persons, and promotes dependence to the system*'
[Spain, TS]

Sometimes the workload emerged as constraint, in particular the necessity to do more work than expected because of administrative demands. This diminishes the time dedicated to the relationship with clients, as showed in Pic. 12 and 13.



Pic. 12: *'Lots of paperwork, too much administration at the expense of the clients*'
[the Netherlands, TS program]



Pic. 13: *'Too busy*'
[Sweden, HF program]

Despite the difficulties, staff emphasized the importance of having a shared vision and mission, especially a vision of hope '*living at colors: it tells the goal of working with people experiencing homelessness: never lose the hope that the world can be lived in that way again'* (Italy, HF) or '*with new day, new opportunities are awakened*' (Poland, TS).

Professional training was also seen as key, not only in the service but also at the national level: '*the national network Housing First: research and training are two aspects that can facilitate goal attainment in daily practice'* (Portugal, HF). Psychosocial supervision was also identified as facilitator, as showed in Pic. 14.

Pic. 14: '*help the helper. A service provider who is drowning is not able to help anyone*'
[Italy, HF]

Finally, staff discussed three aspects of relationships with clients. First were obstacles in working with the clients, in particular the difficulty for creating provider-client relationships, as showed in Pic. 15.

Pic. 15: '*We are locked up with them. We share their privacy. We live together. People no longer have privacy'*
[France, TS program]

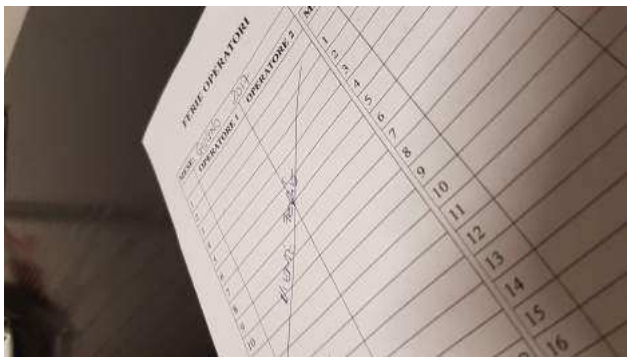
Second were strategies of supporting clients, doing something with them (e.g.: '*as part of health education [mothers' children], the children from the social care center prepared breakfasts together in order to be able to consume them in a pleasant atmosphere'*, Poland, TS), involving them in a process to improve their well-being (e.g.: '*a right, an opportunity and tool of work to rely on and to accompany the person in the process of recovery and social integration and autonomy*', Spain, TS), or using a new model (HF) to support them in their house ('*home visits*', Sweden, HF; '*home: a new step, a new challenge, a new opportunity*', Netherland, HF). Third was the way relationships between providers and users could promote change in clients' lives, e.g. '*being mindful and being present in that time with that person*' (Ireland, HF).

Individual level

Individual factors also affected work in homeless services. Staff described three important challenges. First, the difficulty in working with people who have complex and multidimensional needs. Clients' chronic problems could generate feelings of frustration and powerlessness in providers affecting their willingness to work and their attitudes towards the possibility of change, as a participant explained: '*you can get people out of the streets, but it is hard to take street life out of the people*' (Netherland, HF), and as shown in Pic. 16.

Pic. 16: '*Constant chaos: the life of the inhabitants is a constant race and new challenges that they have to face'* [Poland, TS program]

The second challenge for providers was finding a balance between private and work life. Working in a context of emergency, with no structured work hours and in multiple settings could encroach on their ability organize their own free time, as shown in Pic. 17.



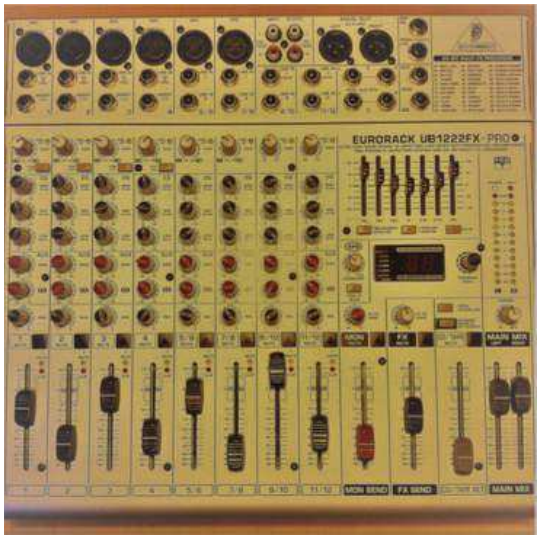
Pic.17: '*No vacation: Emergency situations at work condition the choices in my private life*'
[Italy, TS program]

A third challenge was participants' tendency to empathize with the clients, and hence difficulty in balancing their engagement with the clients, as showed in the Pic. 18.

Pic. 18: '*Finding a balance between what the professional does for the client and what the client can do*'
[the Netherlands, TS program]

For the participants it is necessary to find 'the right distance' or 'the right mix', as showed in Pic. 19 and 20.

Pic. 19: '*The right distance between provider and client'*
[Italy, HF program]



Pic. 20: '*Where do I put my hands?*
[Italy, HF program]

4.5. Differences between Housing First and Traditional Staircase models

There were fewer differences between the two models than we expected, as showed in Tables 4. The factors at the systemic level are more recurrent in HF, with a focus on the importance of institutional arrangements.

At the organizational level, the factor common to both types of service is the need for strategies to work with the clients. Workers in both two services underlined the importance of encouraging group activities with the clients (e.g. doing something with them), supporting them in a process of recovery and autonomy (e.g.: providing care, giving voice to the clients). Staff in HF programs only discussed the importance of using a new model (HF) to support clients and independent housing. Also only in a HF service providers mentioned a specific working framework, 'Recovery-Oriented Care'. Overall, in both services, staff talked about provider-client relationships irrespective of specific working tools, operating protocols or philosophy of care. Staff in both groups also discussed: difficulties in relations with other services, team spirit among the staff, workload and having a vision or guiding principles.

Table 4: recurrences of the themes within HF and TS and number of countries where they emerged

Level	*Categories*	*Sub-categories*	*HFs*	*TSs*	*TOT. Countries*
Systemic	Institutional arrangements		3	1	3
	Relationships with other services:	- Collaboration	2	1	2
		- Difficulty	2	2	2
	Citizens' attitude		2	1	3
Organizational	Physical environment:	- Geographic location	2	1	2
		- Building's quality	1	--	2
			1	1	
		- Tools and equipment	1	1	4
			--	3	
	Colleagues:	- Support	4	2	4
		- Communication	1	1	2
		- Team spirit	2	2	3
	Roles:	- Clarity	1	--	1
			--	1	
		- Flexibility	2	1	2
		- Autonomy	1	--	1
	Leadership		1	--	1
	Regulation		1	2	2
	Contradictions		2	4	4
	Workload		2	2	3
	Vision and principles		4	4	5
	Training		3	1	2
	Supervision		1	--	1
	Modalities to work with clients:	- Obstacles to relationship	3	6	6
		- Strategies of working	8	8	8
		- Importance of relationship	5	4	6
Individual	Clients		2	4	5
	Private/work life		--	1	1
	Balance the relation with clients		1	5	5

Three additional factors emerged only in HF services: the autonomy of the roles, the importance of supportive leadership and the need for staff supervision. Moreover, the support among colleagues is a themes more frequently discussed in HF programs. Contradictions and

obstacles in the modalities of working with clients, and the necessity to have working tools and equipment emerged are more recurrent in TS.

At the individual level, both frustration with the clients' problems and the need for balance in the provider-client relationship were more frequent in the TS. In particular, difficulty in balancing work and private life was described only by staff in one TS program and not in HF.

Relating the difference between the models, it is interesting to note that there were few striking differences, although in TS there was more discussion of obstacles to work including the lack of working tools and equipment, obstacles in relationships with clients, and difficulty in balancing work and private life. In HF staff more mentions the institutional arrangements, support among the staff, and the need for training more frequently.

4.6. Recurrence across countries

As showed in Table 4, analyzing the recurrence of the categories across countries, some differences emerged. The idea is that more a category is discussed across countries then it is more generalizable.

Regarding the systemic level, the categories were less discussed than others. In fact, the institutional arrangements and citizen's attitude were discussed only in three countries, followed by relationship with other services (two countries).

In relation to the organizational factors, providers in all the countries discussed about the importance of having strategies of working with clients. At the same time, obstacles to relationship and the importance of the relationship as a key ingredient with clients were discussed in the most of the countries (six countries). Some topic emerged only in one county, e.g. clarity and autonomy of roles (Italy), leadership (Spain), and supervision (Italy).

Finally, at the individual level, only the need of balancing private and work life was a

theme discussed in only one country (Italy). Nevertheless, the difficult to work with people having complex needs and the consequent need of balancing the help relationship with them were discussed in most of the countries (five countries).

In general, the organizational characteristics were the most discussed themes across countries, in line with the aim of the Photovoice projects to explore the service's factors affecting provider's work. Besides the different recurrences, in this study contextual factors (e.g. welfare system) were not analyzed. In fact, the different sociopolitical context that facilitate or hinder the program implementation should be examined (Shinn, 2007). Future research could examine potential differences between services and across countries, for example in welfare, type of organization, number of employees, provider–client rapport. Better understanding of contextual variables could highlight specific differences in different political and economic contexts.

4.7. Relationship as a key ingredient

From the analysis of the photos the role of the relationship has emerged in a relevant way (Santinello et al., 2018). Facilitators or obstacles are almost always associated with a relationship. Therefore, three major categories of relationships were identified:

First, providers attributed importance to the relationships with political institutions, but also with citizens and with other local services, external to the services. The attitude of 'others' is a factor often overlooked, but experienced as very important by the participants.

Second, the relationships experienced within the working group of the service. In the analyzed photos, the recurring themes ranged from the difficulties related to the bureaucratic aspects of the work to the importance of supporting each other. Third, providers discussed the importance of the relationship with the service clients. The recurring theme is the 'right distance' (i.e., finding a balance between involvement and detachment appears very difficult).

The relationship could be analyzed in terms of interpersonal distance. Distance/closeness are ingredients that characterizes the various relationships in which the social workers are immersed: distance in the helping relationship between social worker and client (finding the right balance is fundamental so that the accompaniment can be regarded as a success); distance in relationships within the work group (the team is the first protection network able to perform the function of support for the social workers); distance from institutions, citizens, other services (these relationships are less immediate but equally important in producing efficiency). The relationship could be considered as the main ingredient in the analysis of the services, with clients, colleagues and all the community.

4.8. Community impact

Also the potential impact of the Photovoice method at the community or organizational level (e.g. changing of the rules/procedures of the services; increase of the involvement and awareness of the community about the phenomenon; diffusion of the results) has been considered as results of the research.

According with that, the photovoice projects' results (in Italy, Poland and France) were presented to the community and local politicians through exhibitions in strategic places of the city, organized by participants and researchers. The exhibitions were visited by: citizens, social workers of community services, local politicians, and it also attracted the attention of local media. Local newspapers and TVs covered the events and published some news about the exhibition. In some places of the exhibitions, a notebook has been exposed in order to give visitors a chance to leave comments. The analysis of the comments left in the notebook showed that the citizenship reported that they have been sensitized to the problem of homelessness thanks to the findings presented in the exhibition (e.g. thanks, congratulations, appreciations of the initiative). Moreover, some selected photos of all the

projects were presented for the first time in Padua, Italy, in an exhibition (Santinello et al., 2018) hosted at the Municipality Center in June 2018, as part of the 3rd International Housing First Conference. The success and the impact that the exhibition had on social workers and citizens made other countries involved in the HOME-EU project to host it in their local contexts and promote it as an instrument of awareness and empowerment of local communities.

Finally, thanks to the gathering and sharing of photographs, each staff member was able to increase his or her awareness of the strengths, and features that can improve his/her working environment. According to participants, enabling them to share their pictures and proposal with the community and local politicians nurtured their sense of achievement and empowerment. Indeed, according with the research' aim of promoting social change, in two services involved in the research the results were translated into realistic/pragmatic proposals aimed at changing some aspects of the services. These two organizations have already modified their working methods as a consequences of the Photovoice projects: one developed new strategies to come in contact with community services (a project aim to networking with other services in the city); the other one scheduled some meetings to discuss and make the role of volunteers within the organization more effective (emphasizing their role of 'facilitators of good relationships' with the clients).

4.9. Discussion

The research aimed to explore which factors influence the social providers' work with people experiencing homelessness and analyze the differences that emerged between HF and TS across the countries involved in the research.

At the systemic level, as supported by Rapp et al. (2010), the participants underlined the importance of creating relationships with other services in the community. In some case,

these relationships are not easy and add workload. Organizing public events or meetings between organizations in the community might be useful for sharing program mission and informing the public about services. Moreover, collaboration external to the service should involve both local authorities to promote social change and the citizens to increase the awareness about homelessness and reduce stigma. According with that, the photovoice projects' results (in Italy, Poland and France) were presented to the community and local politicians through exhibitions in strategic places of the city, as illustrated above.

At the organizational level, contrary to the literature (Mullen & Leginski, 2010; Olivet et al., 2010), the necessity of training the staff, the supervision of the team and the importance of the leadership were not prevalent themes. Only the training was mentioned in a TS service, but did receive some discussion in HF services. Perhaps staff in TS services felt less need for leadership and supervision than staff embarking on the newer HF approach. Nevertheless, the nature of the relationships among the colleagues and the importance of a shared vision are common themes in different countries. Perhaps, providers value support and communication among the team in an informal way more than structured training and supervision. According with other studies, the support among the team was identified as main job resources in the work with people experiencing homelessness (Wirth et al., 2019). This is consistent with literature stressing the importance of strategies (e.g. team building) for strengthening cooperation, communication, and cohesion in the team (Weller, Boyd, & Cumin, 2014). The organization of discussion meetings with the staff could be useful to share the vision, to increase support among colleagues, and to clarify the rules or the contradiction (that emerged as obstacle).

An interesting result is the common presence in each type of program of themes related to strategies of working with clients. It seems that the providers need specific and clear strategies to facilitate the relationships with clients (e.g.: doing something together,

creating space and time to meet face-to-face). In fact, relationship is a key ingredient of the results. Balancing relationships with clients was the more prevalent topic at the individual level, along with difficulties in working with people having multiple needs. Also in other researches, maintaining professional boundaries counted both as a job demand and a coping strategy to prevent staff's mental illness (Wirth et al., 2019). For staff members, having the opportunity to talk about the emotional impact of their work to a qualified supervisor could be a helpful way to manage their well-being.

As underlined by the literature, good team performance is associated with well-defined goals, regular feedback on performance, and guidelines for coordinating team work (Olivet et al., 2010). Only in HF, providers discussed the importance of the HF model and the house as facilitating factors but did not mention specific procedures that guide helping relationships with clients. Studying how the characteristics of the services are able to help the work of providers with clients allows creation of conditions and development of strategies facilitating 'relationships that work.' This is consistent with literature that highlights the need to improve collaborative working and 'Psychologically Informed Environments' (PIES) in which workers are better supplied to manage the complex needs of people experiencing homelessness (Cornes et al., 2014; Lemieux-Cumberlege & Taylor, 2019).

Over the years, many ways of analyzing relationships have been proposed, especially when discussing helping relationships. Frequently-used frameworks include the 'therapeutic alliance' (Bordin, 1981) or the theory proposed by Li and Julian (2012), of a 'developmental relationship' based on four characteristics: power, emotional attachment, progressive complexity, and reciprocity. These ideas were echoed by providers in the field of homeless services, who focused on the quality of relationships as one of their primary aims. The design and management of a service could focus on identifying which service characteristics favor the development of relationships among staff and between provider and client.

At the individual level, providers discussed more about the difficult to work with people having complex needs and to balance the relationship with clients. This result is in line with the literature that emphasizes problems related to work with people experiencing homelessness and the need of training, external counseling and supervision for providers working with this target group (Wirth et al., 2019). Socio-psychological supervision of the staff can help providers to manage feelings of fatigue and frustration related to the relationship with the clients or to balance private and working life. This can prevent the burnout risk, which is high for this professional role (Fisk, Rakfeldt, & Heffernan, 1999).

Regarding the recurrences of the factors within HF and TS, some differences emerged: at the systemic level the importance of institutional attitudes is more frequently discussed in HF programs. Maybe, HF requires more networking in the community because of its relationship to landlords, the housing market, and other services. Or perhaps as a newer form of homeless service, it needs to explain itself and counter expectations that people experiencing homelessness need supervision and help to overcome problems defined by traditional service providers and the community.

At the organizational level, there were two main differences between the models. HF providers more often mentioned support among colleagues and needs for training, perhaps due to the innovation of the model and the need to change traditional ways of working with people (e.g. focus on clients' choice). TS providers mentioned the contradictions and obstacles in modalities of working with clients more frequently, perhaps because of the lack of clear principles and the high number of clients in the same physical structure.

Overall, there were not striking differences in the themes that emerged from providers working in the two kinds of programs. This might mean that there are more universal factors influencing providers' work regardless of the model implemented. The importance of having specific strategies to work with clients is one factor that emerged in most services (16

services, both HF and TS). Perhaps because the goals of the services are related to the clients (e.g. helping to exit from the condition of marginalization), this focus could affect also the way in which providers analyze their organization: focusing on client more than the setting.

Regarding the recurrence of the categories across nations, some factors were more common than others, particularly the strategies facilitating the work with clients, discussed in all the countries. According with the literature (Wirth et al., 2019), some factors common across States emerged as facilitators (having a vision and principles guiding the work and the support among colleagues) others as obstacles (clients' characteristics and the importance to balance the relation with clients). Unlike the literature, the organizational contradictions emerged as obstacles shared by different countries. This suggests the need of clarity (rules, working protocol, skills) in these kinds of services that could facilitate the work reducing the workload, due to the amount of paperwork. Moreover, it is possible that some factors emerged could be specific-context but others (shared by different countries) are more related to working with this target group.

The research has some limitations. First, the researchers were different for each country and individual researchers may have influenced by the style of conducting groups and translating key findings into English for cross-national analysis. The translation could have affected the meaning; also, in this study we used only the pictures selected by each team (not all the photos that they took). Probably other topics emerged in the discussion of the pictures in each project. The reports from the groups varied in length, which may have reflected differences in understanding of what should be included among the key themes or comfort with English translation.

Second, the group discussion format may have produced different insights from individual interviews. For example, it would be interesting to analyze whether talking about the relationship with clients (a frequent topic) is easier than talking about personal emotions

and experiences related to working condition. Groups might also exacerbate social desirability and self-presentation biases with respect to both colleagues and researchers, taking photos that make them or their organization look good. There are also privacy issues that could have limited their contribution (e.g., no photos showed service users).

Nevertheless, the cross-national study was informed by the continual interactions among the project's consortium members and was based on a common detailed protocol about: planning (aims, recruitment, setting, role of the moderators and assistant, ethics), process (detailed explanation of each step of the photovoice project) and content analysis.

Photovoice discussions were held in the local language, and participants chose the key themes for translation into English for the cross-site analysis. The research protocol for analysis used several strategies to reduce potential bias and to enhance the trustworthiness of the interpretation (Padgett, 2011) including having independent coders in each country, prolonged engagement with participants, and group discussions between the researchers involved in the research.

Despite the limitations, photographs represented an useful language to capture nuances of meaning that are difficult to grasp with only words and can be understand by people of different cultures and roles in homeless services. In fact, the implementation of a new model (e.g. HF) in a different context starts by informing people who should be involved, through information and research, using a language understood by all the stakeholders (Durlak & DuPre, 2008). This method represented an opportunity to analyze the organizational contexts of service provision. This research in the European context has the potential to start the debate about characteristics affecting the work in homeless services. Nevertheless, new standardized tools to analyze the services are required, as explained in the next chapter.

Chapter 5

Creation of SErvice-PROviders Questionnaire

In literature, there are not standardized instruments to analyze the working context of the service providers working with people experiencing homelessness. Moreover, the organizations working with marginalized groups do not have any tools to catch the providers' point of view about their services. This chapter presents a study to develop a questionnaire (the SErvice PROviders' Questionnaire – SE-PRO Q) aimed at creating a profile of organizations working with people experiencing homelessness, i.e., identifying the principals strengths and weaknesses of homeless services in different domains. The questionnaire was created basing on the qualitative results of photovoice projects (see Chapter 4) and it was combined with providers' well-being and stress dimensions basing on areas-of-work-life (AW) model (Leiter & Maslach, 2004; Maslach, 2017). Then, SE-PRO Q was administered to 569 social providers in eight European countries. Through a Confirmatory Factor Analysis, a SE PRO Q 24 version is resulted, showing good fit indexes. Psychometric characteristics of the instrument are presented in the following chapter.

5.1 Aim

The main aim of this study is to develop a questionnaire to understand the perspectives of service providers about their organizations working with marginalized people.

In particular, the questionnaire has the potential to: a) identify profiles of organizations working with homeless people; b) analyze provider' prospective about his/her organizations; c) compare providers' prospective in the same organizations; d) investigate the association between services' characteristics and providers' well-being and stress (in terms of burnout and work engagement).

5.2. Creation process

From Photovoice projects to the questionnaire

The qualitative analysis of pictures and captions from the cross-national Photovoice projects guided the development of a questionnaire, named SErvice PROviders' Questionnaire – SE-PRO Q. The domains included have been developed based on the factors influencing the work with people experiencing homelessness identified by service providers. The questionnaire aims to create a profile of the organizations working with people experiencing homeless. The creation process followed different steps between January and September 2018:

Step 1- Item processing: five independent researchers conducted the item generation. Each researcher has worked out 4/5 items (for each category emerged from photovoice results). Items were created basing on the captions of the pictures analyzed. A total of 564 items for 17 main categories (and related sub-categories, see Chapter 4) were created. An example of item creation is:

Picture's caption: *"A safe and trusted team. We can share everything with each other, we are always there for each other";*

Item generation: *Team members' relationships are based on trust*; *Team members encourage one another.*

Step 2- Item selection: five researchers conducted selection of the items. Each researcher reviewed the items basing on specific criteria decided by the group (e. g., syntactic form, use of the pronoun, use of specific terms related to homeless services, elimination of double sentences). Then, six group discussions among researchers are followed to select items basing on specific criteria: overlapping content, balance of item number in each category. The first version of the SE-PRO Q was created with 110 items divided into 15 categories.

Step 3- Pre-test: the first version of SE-PRO Q was administered to seven Italian social providers in order to have feedbacks about clarity and relevance. After the pre-test, 10 items were deleted and 100 items divided into 15 dimensions composed the first official version of the SE-PRO Q 100 (see Appendix 3): institutional arrangements (5), relationship with other services in the community (6), geographic location (3), building's quality (6), tools and equipment (3), relationships among the team (8: support, cohesion, trust), vision and principles (4), roles (17: clarity, autonomy, flexibility, recognition), leadership (6), workload (5), activities (15), contradiction and organizational justice (6), clients' characteristics (7), involvement of the clients (4), private/work life (5).

Measures

The first official version of SE-PRO Q 100 (see Appendix 3) was combined with other measures related to providers' well-being and stress.

Work engagement: Utrecht Work Engagement Scale, UWES-9 (Schaufeli & Bakker, 2004), a short questionnaire to measure work engagement. It refers to a positive work-related state of fulfillment that is characterized by vigor, dedication, and absorption.

Burnout: Link Burnout Questionnaire, LBQ (Santinello, Verzeletti, & Altoè, 2006), a questionnaire designed to assess four components of burnout syndrome: psycho-physical exhaustion, relational detachment, reduce sense of accomplishment, disillusionment.

In order to have services' and participants' information, an information sheet was added to investigate:

Service's information: type of service, type of clients, professional training and psycho-social supervision provided (regularity and usefulness), type of funds, and environment in which the service is located (rural, urban, semi-urban).

Participant's information: gender, age, level of education, role at the service, type of contract, formal number of working hours per week, time working in this field, time working at this service.

All the measures were translated into HOME-EU consortium partners' languages (Dutch, English, French, Polish, Portuguese, Spanish, Swedish). To reduce translation problems all partners used standardized translation-back translation procedures (Beaton, Bombardier, Guillemin, & Ferraz, 2000) and when any doubts regarding translation arose, these were discussed among the consortium.

5.3. Data collection

Procedure

The questionnaire was digitalized and uploaded on an online platform managed by Italian team (University of Padua) from July to September 2018 with eight different languages. It was possible to fill in the questionnaire through computers, tablets and smartphone, only in its online version. A link of the 'questionnaire for identifying different profiles of organizations working with homeless people' was sent to all HOME-EU consortium partners in order to reach a sample of providers in each Country. The criteria to select the sample were: organizations working with marginalized people and geographically dispersed in the Country, social providers having a work experience of at least six months in the organizations.

All the questionnaires were gathered together into a single database managed by Italian team. The online administration of the SE-PRO Q 100 in each Consortium country was conducted from September 2018 to February 2019.

Data analysis

The data analysis was conducted from March to June 2019 with software R. In order to solve the problem with missing data (i.e. "I don't know" answers), a backward elimination was conducted to find the best fit between items and subjects. Items and participants with high level of missing (i.e. "I don't know" answers) were deleted due to items not applicable to the context or not of competence of the participants (e.g. volunteers). Correlation items-subjects and confirmatory factor analysis (CFA) were conducted. Then, a correlation between SE PRO Q dimensions and stress and well-being dimensions was conducted.

Participants

Starting with a structure of 100 items with 770 subjects, a version of 33 items and 569 resulted from analysis. Table 5 shows the distribution of the sample across countries.

Table 5: Number of participants across countries

Countries	*Participants (%)*
France	65 (11,4)
Ireland	37 (6,5)
Italy	159 (27,9)
The Netherlands	93 (16,3)
Poland	122 (21,4)
Portugal	46 (8,1)
Spain	34 (6,0)
Sweden	13 (2,3)
TOT.	569 (100)

Participants were mostly female (63,1%), with a mean age of 40,15 (SD: 10,55) with a high level of education, i.e. bachelor's or master's degree, PhD, or vocational training (77,9%). Regarding their role in the service, they were: 33,2% social workers, 16,3% service coordinator, and 10,4% educator. Most of the participants had a full-time/regular contract, i.e. more than 20 hours/week (70,03%). Participants declared to work an average of 34,33 hours

at week (SD: 12,58; N. 523). They had an average experience in the field of 10,29 years (SD: 8,23; N. 493), and an average experience in the service of 6,67 years (SD: 6,3; N. 488).

Regarding the services' information, few services are HF programs (26,2%). Most of the services worked with people experiencing homelessness (82,4%), mostly with funds from local government, i.e. regional, departmental or city (64,4%) or from national governmental (36,9%), and most of them are located in an urban area (82,1%). Regarding training and supervision, most of the services receive training (87,9%) and psycho-social supervision (74,3%). Participants considered the training to be on average regular (N. 500; Range 1-5; M.: 3,24; SD: 1,16) and useful (N. 500; Range 1-5; M.: 3,85; SD: 1,10), and they considered the supervision to be on average regular (N. 421; Range 1-5; M.: 3,32; SD: 1,40) and useful (N. 423; Range 1-5; M.: 3,80; SD: 1,27).

5.4. Results

Psychometric characteristics of SE PRO Q

Basing on data analysis, a 33 items (divided into 8 dimensions, SE PRO Q 33) version of the questionnaire is resulted, with good fit indices of the factorial structure: n. par = 226, df = 467, chisq = 2350.161, cfi = 0.984 (CFI > 0.90), rmsea = 0.084 (RMSA > 0.08).

Basing on the correlation between item and factor (Std. Fact. Load. > 0.4), the items were incorporated in dimensions emerged: vision and principles (4), leadership (4), clear roles (4), support among colleagues (5), activities and procedures (4), workload (4), recognition (4), perception of clients' characteristics (4).

The version emerged was related to the theoretical framework of areas-of-work-life (AW) model (Leiter & Maslach, 2004; Maslach, 2017). This model brings together both person and job context factors in a more integrated way to analyze the burnout. Specifically, the AW model identified stressors that affect a person's level of experienced burnout, and

this level of burnout determines various individual outcomes, such as work behaviors (e.g., performance, absenteeism), social behaviors (e.g., quality of home life), and personal health. The AW model identifies six areas of stressors: workload, control, reward, community, fairness, and values. The SE PRO Q 33 was related to the AW model's dimensions, as shown in Table 6.

Table 6: AW model's dimensions (Maslach, 2017) and related SE PRO Q 33 dimensions

AW model's dimensions	*Definition*	*SE PRO Q 33 dimensions*
Workload	Little opportunity to rest, recover, and restore balance	Workload
Control	Capacity to influence decisions that affect their work, to exercise professional autonomy, and to gain access to the resources necessary to do an effective job	Autonomy of roles
Reward	Recognition and reward (whether financial, institutional, or social)	Recognition
Community	Job-related relationships are working well, there is a great deal of social support	Support among colleagues
Fairness	The extent to which decisions at work are perceived as being fair and equitable	Leadership
Values	The ideals and motivations that originally attracted people to their jobs, which goes beyond the utilitarian exchange of time for money or advancement	Values and principles

Considering that most of the SE PRO Q 33 dimensions were overlapped to AW model's six dimensions, a version with only these dimensions was tested. The results are shown in Table 7.

Table 7: Dimensions of SE PRO Q 24 and related items of SE PRO Q 100

Dimensions	*N.*	*Items of SE PRO 100*	*Items*
Workload	4	Workload_35, 56, 73, Private/work_life_22	*Work encroaches on team members' free time* *The professional workload is manageable* *The heavy professional workload often requires team members to work outside of their schedules* *Team members do not have enough time to adequately assist users*
Control	4	Autonomy_Roles_11, 31, 53, 70	*Professionals working at the service plan their work independently* *Team members manage their own coffee breaks* *Team members manage their own work schedules* *Team members discuss and agree to holiday scheduling*
Reward	4	Recognition_13, 54, 71, 86	*Team members feel appreciated by other colleagues* *The service values team members' professional qualifications* *Every team member recognizes the importance of his/her colleagues' work* *Users appreciate the work that the team does for them*

Community	4	Trust_7, Support_8, Cohesion_48, 67	*Team members counsel one another* *Team members' relationships are based on trust* *Team members feel that they are part of the same service* *Team members work well together*
Fairness	4	Trust_49, Lead_97, Organiz_Justice_91, 99	*Work is distributed equitably among team members* *The leader treats all team members the same way* *Team members respect one another* *Decisions are agreed upon among the team*
Values	4	Vis_Princ_9, 29, 68, Clarity_Roles_30	*Team members use a shared set of principles when making decisions* *Our team's work is based on clear principles* *Our team's work is consistent with our guiding principles* *Our team tends to lose sight of its goals*

The SE PRO Q 24 showed good fit indices of the factorial structure: npar = 159, df = 237, chisq = 1207.296 , cfi = 0.988 (CFI > 0.90), rmsea = 0.084 (RMSA > 0.08). Alpha and omega indexes of the dimensions are shown in Table 8.

Table 8: Alpha and Omega indexes of SE PRO Q 24

SE PRO Q 24 dimensions	*Alpha*	*Omega*
Workload	0.714	0.688
Control	0.657	0.630
Reward	0.781	0.758
Community	0.915	0.904
Fairness	0.842	0.803
Values	0.842	0.817
Total	0.932	0.934

Table 9 shows correlations among dimensions.

Table 9: Correlations among dimensions of SE PRO Q 24

	Workload	Community	Vision	Fairness	Reward	Control
Workload	1					
Community	0.281	1				
Vision	0.389	0.962	1			
Fairness	0.449	0.928	0.925	1		
Reward	0.421	0.943	0.935	0.967	1	
Control	0.171	0.627	0.628	0.672	0.700	1

Table 10 shows correlations dimensions- items with delta (extract model residuals).

Table 10: Correlations between dimensions and items of SE PRO Q 24 with delta (extract model residuals)

Dimensions	*Items of SE PRO Q 100*	*St. Fact. Load.*	*delta*
Workload	22	0.538	0.711
	35	0.936	0.125
	56	0.494	0.756
	73	0.545	0.703
Control	11	0.455	0.793
	31	0.478	0.771
	53	0.497	0.753
	70	0.807	0.348
Reward	13	0.837	0.299
	54	0.650	0.578
	71	0.811	0.342
	86	0.466	0.783
Community	7	0.899	0.191
	8	0.909	0.174
	48	0.812	0.341
	67	0.887	0.213
Fairness	49	0.867	0.249
	97	0.769	0.408
	91	0.699	0.511
	99	0.702	0.507
Values	9	0.841	0.292
	29	0.789	0.378
	68	0.848	0.281
	30	0.551	0.697

Correlations SE PRO Q and providers' well-being and stress

As expected by AW model (Maslach, 2017), a correlation between SE PRO Q 24 dimensions and providers' well-being and stress was conducted. Table 11 shows the correlations between SE PRO Q 24 dimensions and scores of burnout (psycho-physical exhaustion, reduce sense of accomplishment, relational detachment, and disillusionment) and

work engagement (vigor, dedication, absorption). According to the model, it is expected a negative correlation between positive dimensions (community, vision, fairness, reward, and control) and burnout outcomes but negative correlations with work engagement. Then, it is expected a positive correlation between workload and burnout but negative with work engagement.

Table 11: Pearson's correlations between well-being dimensions and dimensions of SE PRO Q 24 (N = 569)

Burnout and Work Engagement	M (SD)	Workload	Community	Vision	Fairness	Reward	Control
LBQ Psycho-physical exhaustion	17,79 (4,96)	.431**	-.286**	-.311**	-.316**	-.387**	-.217**
LBQ Reduce sense of accomplishment	13,58 (4,12)	.307**	-.365**	-.405**	-.329**	-.445**	-.262**
LBQ Relational detachment	16,86 (4,43)	.130**	-.197**	-.171**	-.156**	-.301**	-.149**
LBQ Disillusionment	12,94 (5,50)	.320**	-.396**	-.387**	-.389**	-.460**	-.213**
UWES Vigor	4,16 (0,95)	-.138**	.368**	.366**	.338**	.392**	.198**
UWES Dedication	4,55 (1,02)	-.183**	.417**	.377**	.341**	.439**	.207**
UWES Absorption	4,34 (1,01)	-	.345**	.316**	.243**	.312**	.193**
UWES total	4,35 (0,89)	-.127**	.421**	.393**	.343**	.425**	.222**

** *p. > 0.01*

The results showed higher positive correlations between workload and psycho-physical exhaustion, reduce sense of accomplishment and disillusionment. Community is more negatively correlated with disillusionment and positively with dedication. Vision and control have higher negative correlations with reduce sense of accomplishment while fairness and reward are more negatively correlated with disillusionment. The dimension of reward shows high negative correlations with all the dimensions of burnout and higher level of positive correlations with dedication (work engagement). Overall, work engagement is more correlated with community and reward.

5.5. Discussion

In this study a new instrument was developed to analyze the working condition of the service providers working marginalized groups. The SE PRO Q 24 version showed promising psychometric properties, in terms:

- Validity: the dimensions emerged from Study 3 (see Chapter 4) and overlapped to the six dimensions of the AW model (Leiter & Maslach, 2004; Maslach, 2017) were confirmed by the CFA. As the model is widely used in workplace literature, it is possible to extend the model to organizations that work with people experiencing homelessness.
- Construct validity: verified by the correlation coefficients of SE PRO Q 24 with burnout and work engagement in the expected directions. Moreover, there are no correlations so high as to think that the scales measured the same constructs. Moreover, to verify the degree of independence of the dimensions of the SE PRO Q 24, it was measured the correlation between dimensions. Some dimensions were too related (e.g. Community/Vision with Fairness/Reward and between Fairness and Reward). The risk is that these dimensions measure the same constructs.
- Reliability: tested with coefficients alpha and omega. Some of them were too low (<.7), probably due to the reduced number of items or their content, confirmed by some low correlations items-dimensions.

Regarding the relations between services' characteristics and providers' stress and work engagement, workload was correlated with psycho-physical exhaustion. Having good and trustworthy relationships among colleagues was correlated with lower level of disillusionment. Moreover, having clear vision, feeling appreciated and recognized by colleagues and providers and feeling to have control on own work were correlated with lower level of reduce sense of accomplishment. Not only, good relationships and feeling recognized

and appreciated were positively correlated with higher level of work engagement, in particular in the dimension of dedication. Overall, it is interesting to note that the dimension of reward presented the higher correlations with all the burnout's dimensions and with work engagement. Feeling recognized, valorized and appreciated by colleagues and providers could preserve the providers' relationships and well-being, and then, their work with clients.

Nevertheless, this study reports some limitations. First of all, the different distributions across countries did not allow conducting a cross-national validation of the instrument. Despite some limitations of sample representativeness, the present study examines for the first time the psychometric characteristics of the SE-PRO.

These are preliminary analysis of a new instrument that will be validated with a new data collection in order to confirm the structure taking also into account socio-demographic information of the participants. Moreover, it should be interesting test if burnout determines individual outcomes, such as work behaviors (e.g., performance, absenteeism) and social behaviors (e.g., quality of home life).

This research represents a first attempt to develop a standardized tool for the analysis of organizations working with people experiencing homelessness. As stated by Maslach (2017): "*all of this suggests that the six areas of work life can be used as a kind of diagnostic tool to identify important job-person mismatches, thus providing a clearer picture of what the goals of an effective intervention might be*" (p. 150). According with that, SE PRO Q 24 is a promising instrument useful to the organizations working with people experiencing homelessness in identifying strengths and weaknesses of their services.

Chapter 6

General Discussion

The present thesis provides new insight into the analysis of working with people experiencing homelessness. More specifically, in the ongoing shift from Traditional services to Housing First program, this thesis offer a contribution to the analysis of the services and the providers' work. Also, the present thesis may be an original example of organizational analysis in a cross-national level. Nevertheless, these issues leave open several other aspects that may to be addressed in further research. This chapter summarizes the main results of the present thesis, connecting them to open questions that should be addressed. In light of these results, some recommendations for research and professional practice are discussed.

6.1. What we learn from this thesis?

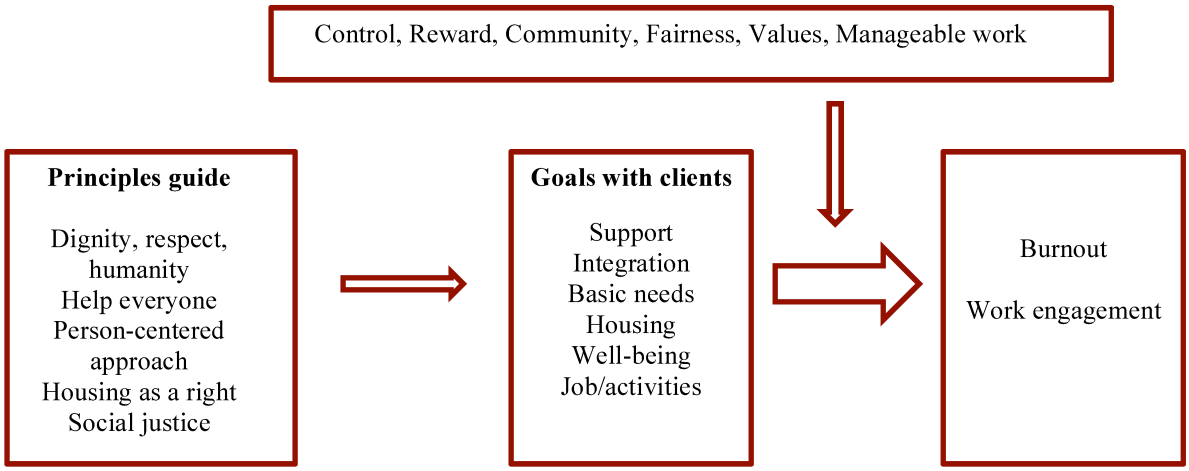
Increasing knowledge

The results of the present studies helped to increase knowledge about two main topics: providers' work with people experiencing homelessness and a new idea of integration in homelessness field.

As summarized in Figure 7, providers have high goals with clients, guided by ideal principles (Study 1) that struggle to find the possibility of being put into practice due to different factors. The factors that have emerged (Study 3) concern not only the services themselves but also the providers and the relationships, both with the outside (community services, citizens, policies) and with the clients. The main factors affecting providers and related to their stress and work engagement are: feel that they have control over their work, be recognized and appreciated, have ties of trust with colleagues and a sense of belonging to the service, fair leadership, a balanced workload, and clear and shared values. These factors

emerged from Study 3 and 4 and they were consistent with AW model (Leiter & Maslach, 2004; Maslach, 2017).

Figure 7: Main results about providers' work



From the results of Study 1, the integration emerged as one of the common services' goals. From an analysis of the literature about integration and homelessness, three interconnected issues emerged: conceptual, methodological and epistemological. The main concern is that often literature measure integration as a list of behaviors, that risks 'correcting' people to a social norm. Thus, the focus is on behaviors rather than on the feelings that the person can feel related to those behaviors. Study 2 analyzed the feelings connected to integration from clients' prospective. Activities and behaviors were important to the extent that they gave scope for these feelings of integration. For example, having a job is useful only to the extent that it allows you to feel valued as a person in society. In this sense, the capabilities approach (Nussbaum, 2011) provides a possible theoretical framework for the interpretation of the homeless services. Capabilities are what people can actually do and be in everyday life, that is in turn contingent on having both competencies and opportunities. Providers should help clients to promote these capabilities as the primary goal of their work.

Also, the originality of these studies was to start from the perspective of the participants to bring out new knowledge of little analyzed topics in a bottom-up process: with providers to bring out factors influencing their work; with clients to bring out feelings related to integration, considered one of the main services' goals. Also, the originality of Studies 1 and 3 was to conduct pioneering research in the use of qualitative methods in a cross-national level.

Using qualitative methods in a cross-national level

These studies represented first experiences of using qualitative methods in a cross-national research. Usually, the research use standardized measure to analyze differences across States. Working in collaboration with HOME-EU project had different challenges: the need of using a universal language due to the multi-languages team (eight different languages) with different backgrounds and professional skills; the presence of countries with different socio-political contexts. New topics were explored starting from providers' prospective. Photovoice method represented a useful method to reach participants' prospective through a universal language (photography) to promote social change. Also for the focus group discussions were used some strategies to overcome the inherent two main limits of a cross-national comparison.

First limit was the translation of key findings into English for cross-national analysis. The translation could have affected the meaning and reports (of photovoice projects and discussions) from the groups varied in length, which may have reflected differences in understanding of what should be included among the key themes or comfort with English translation. Seven different languages were represented in Study 1 and 3. To reduce translation problems all partners used standardized translation-back translation procedures

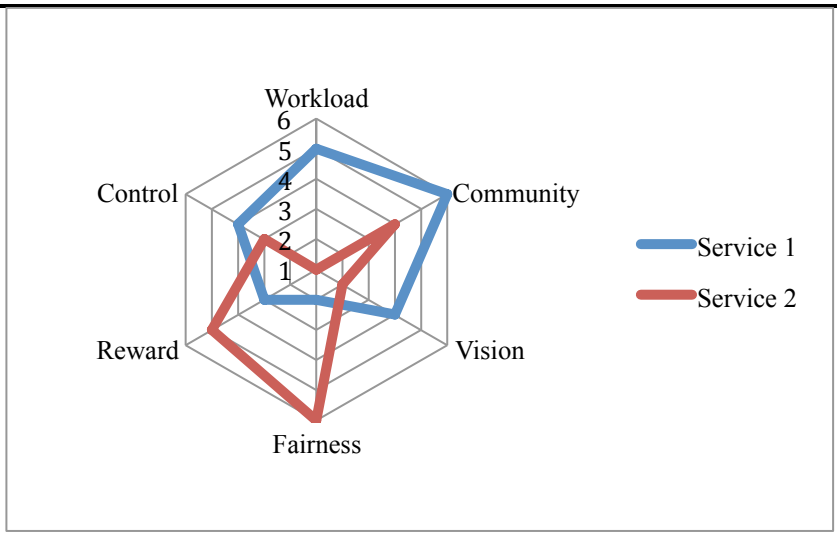
(Beaton et al., 2000) and doubts regarding translation arose were discussed among the HOME-EU Consortium.

Second, the researchers were different for each country and individual researchers may have influenced by the style of conducting groups. To reduce this bias Italian research team developed a detailed protocol about: planning (aims, recruitment, setting, role of the moderators and assistant, ethics), discussions/photovoice method (introduction, questions, conclusion, briefing) and content analysis. Moreover, the research protocol for analysis used several strategies to reduce potential bias and to enhance the trustworthiness of the interpretation (Padgett, 2011) including having two independent coders in each country, prolonged engagement with participants, and group discussions between the researchers involved in the research.

A new tool for research and professional practice

The results of the analysis in Study 4 developed the Service Providers Questionnaire (SE PRO Q 24). The SE PRO Q 24 aims to create a profile of the organizations working with people experiencing homelessness with the potential to compare services, working models and providers' prospective. This tool has the potential to fill the lack of standardized tools for organizational analysis in homelessness services. Not only, it can be a useful organizational diagnosis tool for services. Leaders and coordinators can use SE PRO Q 24 to capture the point of view of their professionals, compare their perspectives and identify the strengths and weaknesses of the organization. The analysis of the scores of the SE PRO Q 24 can be represented in a graphic form (Figure 8 shows an example of services comparison), in order to have a graphic and immediate representation of the organization.

Figure 8: Example of graphic representation of SE PRO Q 24 scores in two services



Regarding the relation emerged between SE PRO Q 24 dimensions and providers' stress and work engagement, identifying weak points allows to strengthen weak aspects of the service and therefore to prevent the providers' burnout.

6.2. What we may further learn?

About providers' work

This thesis leaves open several other aspects that may to be addressed in further research. The research should conduct new validation studies of the SE PRO Q 24, e.g. the multitrait-multimethod matrix (MTMM, Campbell and Fiske, 1959) to validate the same construct with different methods. In addition, the tool should be administered to a representative sample of providers in each country to develop normative standards that enhance the diagnostic capabilities of the tool.

Finally, using standardized instruments, further research could analyze differences among nations taking into account variables at different levels: national (e.g. welfare system); local (e.g. size of city); and organizational (e.g. type of working model) and analyzing how these factors could influence providers' and clients' outcomes. In fact, the studies presented

in this thesis did not analyze the cultural differences across organizations, policies (locals and nationals) and professional backgrounds that could have influenced the results of the studies at the cross-national level.

About integration

About integration of people experiencing homelessness, first of all future research should develop new subjective measures (and standardized tools) to investigate the feelings connected to integration, not only the behaviors. Then, research should analyze the possibilities that the people experience in relation to their proclivities and wishes, with methods that can capture participants' point of view in a participatory process (e.g. Gaboardi et al., 2018, Pruitt et al., 2018). For example researchers should ask people whether they feel recognized or valorized and eventually where or with whom they have these feelings. If they are involved in a particular activity, researchers might ask whether they feel useful doing them.

Second, future studies should analyze potential differences in the feelings of people in different countries, services or populations. Adopting the perspective of participants in research about integration involves a change in practices that starts from considering integration as an idiographic process of feelings, not a nomothetic set of activities that all should engage in. This approach may help to empower people using homeless services.

6.3. Implications for professional practice

In relation to professional practice, support in recognizing and sharing goals and principles with a psychosocial supervision would be very useful the for the teams working with people experiencing homelessness (Choy-Brown et al., 2016), not only to review key principles but also as an opportunity to share feelings of frustration related to difficulties in

reaching goals, a very common experience to service providers who support people with complex needs (Fisk, Rakfeldt and Heffernan, 1999). That could be useful also to share compliments among the team to be recognized and appreciated, increasing ties of trust with colleagues and a sense of belonging to the service.

Organizations' leaders should invest in working models that facilitate providers' work (e.g. Housing First model) and they should adopt standardized tools to analyze their organizations and providers' prospective. It is important that the leaders pay attention to providers' stress signals. Recently, the World Health Organization (WHO) has classified burnout as official medical diagnosis. Then, leaders should give a manageable work to providers with the possibility to manage it, treat providers in the same way by involving them in organizational decisions and by creating opportunities for the enhancement and recognition (financial and social) of the work done by them.

Findings about construct of 'integration' emphasize the importance of creating environments (and services) that facilitate the development of feelings connected to integration, especially fostering a set of opportunities for people where they can have active roles and responsibility. Variability in opportunities available in different settings may also reflect how well a setting cultivates the 'capacity to' be able to feel integrated (Shinn, 2015). In offering opportunities, it is important to start from participants' wishes and proclivities, with a continuous cycle of input and feedback, especially about what people feel as they carry out activities. Moreover, giving to them roles and responsibilities could be a way to make them feel valued.

Not surprisingly that one of the organizational factors most related to burnout was the reward (Study 4) and one of the factors most discussed by providers was the relationship with clients (Study 3). In Study 2 clients discussed about feeling appreciated and valorized by other people and society as one of the most important feeling of integration. Reward, in the

sense of being appreciated and valued, seems a key element of these studies. For providers, recognition is also connected to their stress and work engagement, as emerged in Study 4. How to experience reward?

First, experiencing success. Providers, as professionals, can experience success to the extent that they achieve the goals of the service. However, experiencing success with people who have complex needs can be very difficult (see Chapters 1 and 4). One solution could be to help providers in setting smaller, measurable and easily achievable goals.

Second, receiving appreciation from other professionals. Are there relationships of encouragement among the team or only discussions? Is the leader a motivator or does he/she only have a coordinating role in discussions and decisions? The same applied to clients. The first feeling of integration was feeling like a normal person and appreciated. Do providers compliment clients? Are there opportunities for clients to be valued? Can they play a significant role in the services?

Third, receiving economic and institutional recognition. Is the providers' salary adequate for their work? Are there career opportunities? These contexts hardly follow a corporate logic. Achieving goals with people is not the same as selling a product. Other rewarding methods should be envisaged in such organizations. In Table 12 are summarized the main recommendations to stakeholders of homeless services.

Table 12: Main recommendations to stakeholders

Researchers
➢ Conduct new validation studies of the SE PRO Q 24 to validate the same construct with different methods
➢ Administer SE PRO Q 24 to a representative sample of providers to develop normative standards
➢ Develop new subjective measures (and standardized tools) to analyze the possibilities that the people experience in relation to their proclivities and wishes
Providers
➢ Define smaller and measurable goals with clients
➢ Share goals and principles with the team and related feelings
➢ Promote activities that make clients experience feelings of integration
➢ Encourage and value colleagues building relationships of trust
➢ Encourage and value clients giving to them roles and responsibilities
Organizations' leaders
➢ Invest in working models that facilitate providers' work (e.g. Housing First model)
➢ Adopt standardized tools to organizational analysis
➢ Share vision and principles of the organization with social providers
➢ Give a manageable work to providers giving them the possibility to manage it
➢ Define clear roles, rules and working protocols
➢ Create opportunities for the enhancement and recognition (financial and social) of the work done by professionals
➢ Pay attention to the warning signs of providers' stress

Finally, the ongoing *paradigm shift* in homeless services, with the diffusion of the Housing First model (promoting empowerment) involves all the members of the service, not only the clients. Attention to the working conditions of providers allows workers to do their job to the best of their capacities, with the potential to improve their well-being, the quality of care and therefore clients' outcomes. The results of a service can be optimized only if the people who apply it (i.e., social providers) are enabled to work to the best of their abilities.

Appendix 1

Codes Study 1

Codes	Subthemes	Categories of Goals
• Set a goal basing on problem/difficulties of the person • Goals individualized • Support without judgment • Small individualized goals • Support in reaching the goals • Try to active the people • Care of the relationship with clients	Support individualized needs	Support
• Support people's goals • Decide goals independently • People define their goals • Support his/her project • Goals without coercion • People decide the direction of the goals • Goals decided with people	People decide the goals	
• Access to resources for homeless people • Bring people closer to homelessness support network • Collaboration between organizations to work in the same way • Recovery as engagement in the services • Linking them to support services • Support to connect people to services	Connect to services	
• To get out of homelessness (independent living) • Ending homelessness • Eliminate homelessness working with other agencies	To get out of homelessness	
• To achieve sense of autonomy (sense of control their own lives) • Gain an independent life • Live independently • Autonomy (not need of the support) • Autonomy proportionally to capabilities • Give autonomy • Believe and making them believe that they can be autonomy • Support to autonomy • Economic autonomy	Autonomy	
• Community integration as support network • Community integration as social support • Social relationships • Reactivation of social network (relationships) • Reactivate the social network (family, community) • Using community social network to help the people	Social network	Integration
• Access to normalized network as citizens (not only homeless network) • Community integration (neighbors' community)	Community integration	

• Supporting integration in own community • Personal and community adequacy (basic needs, social initiative, access to formative resources) • Integration as exit from the street and improve social and health levels • Integration into society • Take their place as citizens • Reintegration • Support people as having the energy to integrate themself in the society • Find the resources in the territory (as community)		
• Basic need (medication, food) • Basic needs (shower, food, clothes) • Basic needs (sleep, eat, shower) • Palliative orientation • Warmth • Food	Food, shower, clothes	Basic needs
• Clients safety • Safe place of residence • Safety of people in the shelter • Create a safe and positive environment in the shelter • Civil cohabitation • Rules of cohabitation	Safety	
• Fundamental rights, as having own home • Individual house • Residential solution • Worthy and own stable housing • Recovery start from having an house • Importance of having an own home • Housing first of all • House as base to a recovery process • Housing stability • Provide housing	Give an house	Housing
• Become housing-ready • Helping to find a house • Find a roof • Home is a consequence of actions to support them	Find a house	
• To provide shelter • Accommodation before a suitably accommodation • Unconditional accommodation • Immediate access to an accommodation • Help support to find an accommodation	Temporary accommodation	
• Health • Support in abstinence • Access to care • Health stabilization • Support health problems • Health (addiction problems) • Health needs	Health	Well-being
• Increasing quality of life • Recovery	General well-being	

• Client' well-being • Make them feel better	
• Employment/job • Finances to have something to do • Finances to maintain the house • Daytime activities • Labor training	Job-activities

Codes	Categories of Principles
• Human dignity • Respect privacy of clients • Provide a response that dignifies the human condition • Humanism, benevolence • No judgment • Be honest with people • Respect, listening and communication • Give dignity to people • Give respect to people • Love, warm • Create a homely environment • Welcome with kindness • Support without judgment (despite the past) • Accept people as they are	Dignity, respect, humanity
• Help each other • Helping in any case • Unconditionally help • Be available for everybody • Every client is welcome • Welcome everybody • Available without condition • Help people that someone else can't help • Vision 'nobody should be excluded from society' • Support whenever they want • Help/support everyone • Give always opportunities • Support despite the difficulties	Help everyone
• Self-identification of clients • Clients self-determination • Clients agent of the change • Clients active agents of the intervention • Person-center approach • Process of empowerment • Person at the center of the support • Client responsibility • Working strength-oriented • Give choice to people • Involve people in the project	Person-centered approach
• House as a right without conditions • Give an house without constriction • Deinstitutionalization • Give basic right to people • Independent house as a right	Housing as a right

• Work on the basis of equality • Sense of social justice	Social justice

Codes	Organizational factors related to principles
• The incoherence between beliefs and practice • Obstacles (in the organization) in the application of the principles • Workload obstacle the values • Limited resources obstacle the possibility to put the principles in practice • Difficult to be available with everyone (clients crisis) • Frustration to not be able to do everything • How we put values in practice? • Gap between principles and practice	Difficulty to put principles in practice
• Values are fundamental in the work • Need to have values written • Vision helps the work • Vision help to work despite the difficulties • Having aspiration helps to work despite the difficulties • Work with a mission	Importance of having a mission
• Shared vision • Shared value • Having a slogan • Team spirit • Be accepted in the team • Respect of own choice in the team • Having the same mind-set • Shared vision of the organization • Need of sharing values and principles • No transmission of the principles • Obstacles in the communication • Lack of information about principles • Providers have different values from organization • Lack of supervision	Shared/Not shared principles
• Having different prospective (clinical, social…) • Flexibility and professional horizontality • Multidisciplinary • Multi-referencing protects team • Flexibility in the staff	Multidisciplinary
• Difficult to transmit principles to other organizations • Difficult to share values outside the organization • Need to share principles with all the services • Share innovative principles to change the traditional system • Change the idea of homelessness • Change the method/the way to work with people • Having a new prospective • Create innovation • Vision of innovation • Need to create a change	Create innovation

Appendix 2

Codes Study 2

Codes	Spheres
• Fulfillment • Find identity • Feel like a living being • Work for satisfaction • Self-esteem • Feel like someone • Feel protagonist of one's own path • Feel normal • Be a human person • Feel comfortable • Have personal goals • Feel proud • Feel responsible for myself • Have dignity • Be proud • Feel free • Have some personal security • Have self-confidence	Interpersonal
• Have someone to discuss with • Have someone to talk to • Respect (mutual) • Be treated like a brother • Feel at home/family • Feel helped • Feel supported • Share difficulties together • Share something with others • Not to feel judged/not to feel excluded • Be treated as normal person • Have people who help and support me • Have the opportunity to meet other people • Feel like you have someone to rely on • Be treated with humanity • Feel the same as others • Building relationships • Feel accepted for the way you are	Intrapersonal
• Feel engaged in something • Feel useful • Feel responsible • Feel like a person included in the Italian society • Feel useful to society • Proud in doing a job for others	Societal

Appendix 3

SE PRO Q 100

This section contains questions about the service where you work.
Before you begin, please note the following definitions:

- Service: Where you work the majority of your time each week (e.g., a shelter or Housing First project)
- Team/Professionals: Your working group or colleagues at the service
- Users: The individuals the service aims to assist

Please indicate the type of service where you work the majority of your time:

1. □ Shelter
2. □ Housing First project
3. □ Soup Kitchen
4. □ Day center
5. □ Other: _____

Regarding **your work situation over the last 3 months,** please indicate the degree to which you agree or disagree with the following affirmations **using a scale from 1 (completely disagree) to 6 (completely agree)**.

1. There are explicit national policies (laws) that support the service.
2. Relations between this service and other local services (e.g., psychiatric services, drug addiction services, and local associations) are difficult.
3. The service is located in an outlying area that is inconvenient to users.
4. My team has access to a functional meeting room.
5. The service's computer equipment is up to date.
6. Professionals at the service share a sense of team spirit.
7. Team members' relationships are based on trust.
8. Team members counsel one another.
9. Team members use a shared set of principles when making decisions.
10. Staff members' roles are clearly defined.
11. Professionals working at the service plan their work independently.
12. Team members organize work depending on users' individual characteristics.
13. Team members feel appreciated by other colleagues.
14. The coordinator conveys the organization's values to the professionals.
15. There are too many users for the service's staff to adequately assist.
16. Team members have the opportunity to hold regular meetings.
17. Meetings are held to coordinate activities at the service.
18. The team uses instruments that facilitate its work with users (e.g., index cards, daily records, and tables).
19. The service's rules are not the same for all users.
20. It is difficult to work with a multicultural group of users.
21. Users' opinions of the service are taken into consideration before implementing new initiatives.
22. Work encroaches on team members' free time.
23. Local policy makers provide funding for the service.
24. The service shares a common vision with other local services (e.g., psychiatric services, drug addiction services, and local associations).
25. The service's location negatively affects users' social lives.
26. The service's spaces are set up to promote the privacy of its users.
27. The service's transportation resources are adequate.
28. Team members encourage one another.

29. Our team's work is based on clear principles.
30. Our team tends to lose sight of its goals.
31. Team members manage their own coffee breaks.
32. If necessary, team members perform tasks outside of their usual responsibilities.
33. The service offers economic incentives to professionals.
34. The coordinator does a good job of encouraging the team.
35. The professional workload is manageable.
36. The service's rules are clear to all users.
37. The team meets regularly to discuss cases.
38. Recreational activities are organized with/for the users.
39. The service's rules are contradictory.
40. It is difficult to work with users who speak different languages.
41. Users make choices about some aspects of the assistance they receive.
42. Emergency work situations prevent team members from organizing their private lives as they would like.
43. The service is influential in promoting changes at the political level (laws, subsidies, and rules).
44. Other local services' bureaucratic/procedural paperwork (e.g., psychiatric services, drug addiction services, and local associations) is quite long.
45. I waste too much time traveling between work locations.
46. Our office is pleasing and well cared for.
47. The service is equipped with Wi-Fi.
48. Team members feel that they are part of the same service.
49. Team members respect one another.
50. Team members maintain a good balance between what they give and what they receive.
51. The service considers and plans for the future.
52. Each team member's duties are clear.
53. Team members manage their own work schedules.
54. The service values team members' professional qualifications.
55. The coordinator listens to the team and supports us emotionally.
56. The heavy professional workload often requires team members to work outside of their schedules.
57. Team members share information among themselves in a timely fashion.
58. The service's procedures and protocols are not clear.
59. The team dedicates most of its time to managing emergencies instead of developing relationships with users.
60. The team often makes contradictory decisions.
61. It is difficult to work with users with addiction problems.
62. Users are involved in defining their objectives.
63. Working on rotating shifts prevents team members from organizing their private lives as they would like.
64. The service cultivates positive relationships with other public institutions.
65. The service shares a working protocol with other local services (e.g., psychiatric services, drug addiction services, and local associations).
66. The service has enough space to manage any emergencies that arise.
67. Team members work well together.
68. Our team's work is consistent with our guiding principles.
69. Team members perform tasks that are outside of their job responsibilities.
70. Team members discuss and agree to holiday scheduling.
71. Every team member recognizes the importance of his/her colleagues' work.
72. The coordinator supports the team by providing good practical advice.
73. Team members do not have enough time to adequately assist users.
74. The coordinator announces information to the team in a timely fashion.
75. Administrative tasks take time away from the team's work with the users.
76. The team is generally successful in managing emergencies.
77. Team members behave consistently with users.
78. It is difficult to work with users with health problems.

79. The service is organized to protect team members even if contact with users carries a number of psycho-physical risks.
80. The service is organized in such a way that users play an active, well- defined role.
81. Team members often use personal possessions (e.g., car, cell phone) for work.
82. The results of service's projects lead to new interventions.
83. This service shares a network with other organizations that work with its users.
84. Users can personalize the service's building (e.g., rooms, walls).
85. At the service, it is possible to change job positions/roles.
86. Users appreciate the work that the team does for them.
87. The service is open to ideas contributed by users.
88. Despite the heavy workload, team members find time to discuss users.
89. The service has a clear work procedure protocol.
90. Clear, achievable objectives are established with/for the users.
91. The leader treats all team members the same way.
92. It is difficult to work with users with painful histories.
93. Team members often think about users during free time.
94. The service collaborates with the local community (e.g., volunteer groups, citizens' associations, and scout groups).
95. The service's furniture is functional.
96. Users appreciate the support they receive from the team.
97. Decisions are agreed upon among the team.
98. Users are provided many opportunities to grow (e.g., training courses, workshops).
99. Work is distributed equitably among team members.
100. The users of this service are generally not motivated to change.

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