REHABILITATION AND SOCIAL INSERTION OF THE HOMELESS CHRONICALLY MENTALLY ILL

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Rehabilitation and social insertion of the homeless chronically mentally ill. Homelessness is undoubtedly the most serious and dramatic expression of all social exclusion phenomena. It affects a growing number of people suffering severe poverty, marginality and abandonment. Serious mental illness shows up within the group of homeless that survive on the streets or live in shelters. The severe mentally ill, which constitute an especially marginal group, have raised much social concern. In Spain there are precious few initiatives aimed at the care and rehabilitation of the homeless mentally ill. One particularly notable intervention took place in Madrid in 1991, the “Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill”, funded by the Health and Social Services Committee of the Madrid Regional Council, with support from the Social Services Department of the Madrid City Council. This article reviews problems of homelessness with special reference to the above-mentioned project, whose structure, organisation, main actions, intervention strategies, results and impact will be described. Finally, future perspectives and recommendations concerning the care of the homeless are discussed.

La Marginación sin Hogar es, sin duda, la expresión más grave y dramática de los fenómenos de exclusión social. Afecta a un número cada vez mayor de personas y grupos que sufren condiciones muy graves de pobreza severa, marginación y abandono. Dentro del colectivo de las “Personas sin Hogar” que malviven en las calles o son acogidas en Albergues, se ha hecho patente la presencia de trastornos graves de salud mental. Los enfermos mentales graves sin hogar constituyen un grupo especialmente marginado y han generado una importante preocupación social. Son muy escasas las iniciativas específicas que se están desarrollando en España en relación con la atención y rehabilitación de los enfermos mentales en situación de marginación sin hogar. En este sentido merece especial mención una actuación específica que se viene desarrollando en Madrid desde 1991: se trata del “Proyecto, de Rehabilitación e Inserción Social de Enfermos Mentales Crónicos Sin Hogar” que depende de la Consejería de Sanidad y Servicios Sociales de la Comunidad de Madrid y cuenta con el apoyo del área de Servicios Sociales del Ayuntamiento de Madrid. En este artículo se repasará la problemática de este colectivo y especialmente se expondrá la experiencia del “Proyecto, de Rehabilitación e Inserción Social de Enfermos Mentales Crónicos sin Hogar” Se describirán la estructura y organización del Proyecto así como sus principales acciones y estrategias de intervención, los resultados del mismo y su impacto. Para terminar sintetizaremos el balance y las perspectivas que se plantea el Proyecto y ofrecemos como conclusión algunas recomendaciones generales para mejorar la situación y atención a este colectivo.

PRESENTATION

The fundamental objective of the present article is to consider the situation of a group—the homeless chronic mentally ill—about which little is known and to which scant attention is paid, and which involves a combination of two dimensions, those of mental health and social exclusion. In addition, and especially, it aims to describe a project designed specifically to aid the rehabilitation and social reintegration of people in this situation: the “Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill”, developed initially as a “New Initiative” within the framework of the European Commission’s POVERTY 3 Programme (1990-1994), and that continued to function after the termination of Poverty 3 in 1994. This Project is the responsibility of the Health and Social Services Committee of the Madrid Regional Council, and is supported by the Social Services Department of the Madrid City Council. During its stage as a “New Initiative” of Poverty 3 it also enjoyed the support and co-funding of the then General Directorate of Social Action of the Ministry of Social Affairs, and of the European Commission.
Its essential purpose was (and continues to be) that of developing innovative strategies that aid the rehabilitation and progressive social reintegration of the homeless chronically mentally ill, a much-neglected population that has emerged over recent years as part of the complex phenomenon of “homelessness”.

We shall describe the structure and organisation of the Project, together with its principal actions and intervention strategies, its results and its impact. Finally, we shall draw some conclusions about its effectiveness and future perspectives, and offer some general recommendations for improving the situation of this community and the attention it receives.

MENTAL HEALTH AND SOCIAL EXCLUSION: The homeless chronically mentally ill

Homelessness is, without doubt, the most serious and dramatic expression of the phenomenon of social exclusion (Cáritas, 1996). It affects an ever-increasing number of persons and groups that suffer serious conditions of poverty, marginalisation and abandonment.

The term “homeless persons” refers to a group and a social problem with varied and heterogeneous characteristics, profiles and necessities, but with a series of common dimensions: severe poverty, social isolation, rootlessness, breakdown of social and family bonds, personal deterioration and lack of a place (a home) to cover needs of accommodation and social support. The phenomenon is a highly urban one, characteristic of large cities in which problems of poverty, rootlessness and isolation are exacerbated, and lead to exclusion processes (which form the basis of the problem) being expressed in the most extreme and inhuman way in situations of homelessness (Rodriguez Díaz, 1987).

Homeless persons do not constitute a homogeneous group; on the contrary, this is a group with diffuse boundaries and heterogeneous composition and characteristics. In contrast to the typical profile of the “tramp” or “vagrant” of 20 years ago (male, aged around 40, with no profession or trade, working sporadically or marginally, itinerant for reasons of seasonal employment and due to a reliance on hostels and shelters, with problems of alcoholism, etc.), today’s profile is new, differentiated and multiple (women, one-parent families, young people, long-term unemployed) and with new problems (drug-dependence, mental illness, disorders such as tuberculosis or AIDS, etc.). The phenomenon of homelessness is clearly of considerable magnitude, as evidenced by the different annual reports drawn up by the European Observatory for the Homeless and co-ordinated by FEANTSA (European Federation of Services for Homeless Persons) (Daly, 1993; Drake, 1994; Avramov, 1996). Nevertheless, it is difficult to quantify this problem due to the absence –at either national or European level– of a universal definition of “Homeless Persons” (HPs) and the extreme scarcity of epidemiological statistics or studies on the phenomenon.

Within the community of HPs living in the streets or in hostels and shelters, cases of severe mental illness have been detected. The homeless seriously mentally ill constitute an especially marginalised group, and have given rise to considerable social concern. This situation is particularly serious in the large cities of the United States. Diverse studies carried out in that country estimate that between 25% and 50% of adult homeless suffer from severe or chronic mental illness (Lamb, 1984; Arce and Vergare, 1984; Bassuk, 1984 and 1986; U.S. GAO, 1988). However, many of the early studies presented various methodological difficulties related to sampling biases, failure to use standardised procedures, lack of a consistent definition of “mental illness”, etc., which led to overestimations of the prevalence of these disorders among the homeless population. In recent years, several studies have been carried out using improved sampling systems and more appropriate diagnoses based on structured interviews such as the DIS or the CIDI (Composite International Diagnostic Interview). These studies indicate that between 25% and 35% of HPs present some kind of serious mental disorder (such as schizophrenia, severe depression, dysthymia or cognitive deterioration), and that 30% to 50% abuse alcohol or drugs. A summary of the most relevant data found in these studies is presented in Box 1.

Until quite recently, there was scarcely any reliable data on the Spanish homeless population in general, and still less on the problem of their mental health. Some of the data was based on estimations, or on the records of centres for the homeless. For example, Solé (1994) estimated that among Barcelona’s homeless population approximately 1 in 3 suffered from some kind of mental disorder according to the DSM III-R or CIE-10, in the following proportions: 5% organic mental disorders, 10% schizophrenia or delirium, and 20% depression. Fortunately, some specific
and rigorous epidemiological studies have recently been carried out in this area. Two of these deserve special attention: that carried out in Madrid by Manuel Muñoz, Carmelo Vázquez and Juan Antonio Cruzado (1995), and that carried out in Gijón by Luis Santiago Vega (1996).

An analysis of the data from these studies clearly reveals that there is a higher incidence of schizophrenia among the homeless population than in the normal population (see data from the ECA study in Box 1); it is also clear, however, that in no way does the problem involve a majority, as some would argue, stating that “the streets are full of mentally ill people”. Depressive disorders are more frequent (as they are among the general population), which seems reasonable if we take into account the lamentable conditions in which HPs live.

In the mentioned studies from Spain, more than 50% of the interviewees presented none of the serious mental disorders assessed. The available data would therefore appear not to corroborate the hypothesis of homelessness being caused by mental illness. This should by no means, however, lead us to minimise the importance of the problem of mental health among the homeless; rather, on the basis of this type of study, appropriate measures of prevention, attention and rehabilitation should be promoted.

As we have indicated, the problem of homelessness is complex, and multidimensional in its causes, processes and results. It is therefore difficult to establish with any kind of rigour causal and temporal relationships between mental illness and homelessness. From the existing data it would not appear very likely that mental disorders constitute the main cause of homelessness, nor that severe psychiatric problems have a majority presence among homeless persons; nor can it be maintained, especially in the case of Spain, that the processes of psychiatric reform and disinstitutionalisation (Desviat, 1996) have had a decisive influence on the increased numbers of mentally ill in situations of homelessness.

Evidently, the conditions in which homeless people live and the isolation and social rejection they suffer are factors that can precipitate or facilitate the appearance of psychiatric disorders. Moreover, it should not be forgotten that the presence of serious mental illnesses may constitute an element that aggravates social exclusion situations, and helps to maintain them if the appropriate treatment and support is not provided.

Specific attention to the homeless chronically mentally ill in our country is scarce and inadequate. Networks of attention resources for the homeless (Institute of Spanish Public Opinion Studies, 1990), already limited, often

<table>
<thead>
<tr>
<th>Place and Authors</th>
<th>Sample N:</th>
<th>% Males</th>
<th>Schizophrenia</th>
<th>Affective disorders</th>
<th>SCO dementia</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Antisocial personality</th>
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<tbody>
<tr>
<td>Hostels in Baltimore (Fisher et al., 1986)</td>
<td>51</td>
<td>94%</td>
<td>2</td>
<td>14</td>
<td>8</td>
<td>--</td>
<td>20</td>
<td>16</td>
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<tr>
<td>Hostels and streets in California (Vernez et al., 1988)</td>
<td>315</td>
<td>71%</td>
<td>11</td>
<td>22</td>
<td>--</td>
<td>57</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Hostels and services in California (Koegel et al., 1988)</td>
<td>328</td>
<td>95%</td>
<td>13</td>
<td>30</td>
<td>3</td>
<td>62.9</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Hostels and streets in Buffalo (Toro and Wall, 1989)</td>
<td>76</td>
<td>79%</td>
<td>1.4</td>
<td>15</td>
<td>15</td>
<td>--</td>
<td>57</td>
<td>37</td>
</tr>
<tr>
<td>ECA Hostels (Regier et al., 1988)</td>
<td>8.571</td>
<td>41%</td>
<td>1.3</td>
<td>8.3</td>
<td>1.3</td>
<td>13.3</td>
<td>5.9</td>
<td>2.5</td>
</tr>
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(Box taken and adapted from Muñoz, Vázquez and Cruzado, 1995).
find themselves overloaded and overwhelmed due to the psychiatric and psychosocial problems of the severely and chronically mentally ill.

Given their situation and condition of severe social exclusion, many of the homeless mentally ill do not regularly use or take full advantage of mental health services—and the situation is much more serious among those living rough in the streets, who do not use hostels or support centres at all.

It is fundamental for mental health services to prioritize the development of more responsive and flexible programmes that can be adapted to the peculiarities and characteristics of this group, and can offer them the treatment and attention they need. Furthermore, the serious inadequacy of community social resources for rehabilitation, residential attention and support for the chronically mentally ill population is exacerbating and maintaining the situation of exclusion and marginalisation of many homeless mentally ill.

In sum, it is clear that attention to this community is negative and deficient. There are few specific initiatives being developed in Spain in relation to the homeless mentally ill. It is for this reason that special mention should be made of a project under way in Madrid since 1990: the “Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill”, run by the Health and Social Services Committee of the Madrid Regional Council (through the Programme of Social Services Alternative to Psychiatric Institutionalisation) and developed with the collaboration of Madrid City Council’s Social Services Department and San Isidro Shelter.

This project began in 1990, and from then until 1994 it formed part—as a “New Initiative”—of the European Commission’s POVERTY 3 Programme. It continues to function. The objective of the Project is to attend to people with serious psychiatric disorders that are using or in contact with the San Isidro Municipal Shelter, and to offer them there, through a team of specialists, individualised programmes of psychosocial rehabilitation and community support in order to increase their personal and social autonomy and improve their chances of social reintegration. The work is carried out in close collaboration with the local mental health services. The Project also has 4 supervised flats, capable of accommodating up to 18 people, which serve as back-up resources for the rehabilitation and social reintegration of those attended.

This project does not pretend to be a panacea, nor the solution for all Madrid’s homeless mentally ill; rather, it is a specific experience that has demonstrated that the homeless chronically mentally ill in situations of serious psychosocial deterioration and social exclusion can live a normal and dignified life in the community if they are offered appropriate and flexible attention and support. We have seen the success of a methodology of rehabilitation and support, based on a responsive and individualised style of attention, that has made possible the active involvement of service users, and contributed to a substantial improvement in their quality of life and increased their independence and possibilities of social reintegration. This experience might serve as a basis for improving programmes of attention, rehabilitation and reinsertion aimed at the homeless chronically mentally ill. In the following sections we shall describe the main characteristics, activities and results of the Project (for a more detailed review, see the Reports of 1988/93 and 1994/96 of the Programme of Social Services Alternative to Psychiatric Institutionalisation (PSSAPI), of which the Project forms a part).

A PSYCHOSOCIAL INTERVENTION IN THE MADRID AUTONOMOUS REGION: The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill (PRISEMI)

Antecedents and context of the project

The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill (hereinafter referred to as “the Project” or “PRISEMI”) was developed in 1989 in a context in which two factors were prominent:

a) the transformation and increase of the homeless and marginalised population, and especially the existence of a group of people with serious and chronic mental disorders in situations of homelessness.

b) The development in the Madrid Autonomous Region of a model of community attention, committed to the attention to and maintenance of the chronically mentally ill in their social environment via a set of treatment, rehabilitation and support services. The former Social Reintegration Committee (now the Health and Social Services Committee), through the Programme of Social Services Alternative to Psychiatric Institutionalisation (PSSAPI), has been working since
1988 toward favouring the rehabilitation and integration in the community of the chronically mentally ill population. For this purpose it has developed specific social resources of psychosocial rehabilitation, employment rehabilitation, residential attention and community support. The PSSAPI Programme and its different material resources (Psychosocial Rehabilitation Centres (PSRC), Employment Rehabilitation Centres (ERC), Mini-Residences, Supervised Flats and Supervised Approved Boarding Houses) function in close co-ordination and collaboration with the mental health services of the Madrid Autonomous Region.

In developing and extending community attention to the chronically mentally ill, the presence was detected of homeless people with mental disorders. During the 1980s, there was a notable increase in the homeless population of Madrid. 1988 data indicated the network of services for the homeless had attended to a total of 10,628 persons, over half of them for the first time. At the same time as this increase in numbers, a qualitative change had occurred in the composition and problems of this population. Thus, according to figures from the Madrid City Council, which estimated that 28% of people using the services of the San Isidro Municipal Shelter in 1988 suffered from serious mental health problems, an increase was recorded in the number of persons among this group with psychiatric disorders. This apparent increase of the number of mentally ill in marginal situations constitutes a new and complex social phenomenon, as yet barely known and little researched. It has arisen in recent years in a context of crisis and economic and social transformation, in which new forms of poverty and social exclusion have been generated and the number of homeless people has increased.

The appearance and apparent increase in the number of “mentally ill in the streets”, persons living in poverty and without a home, must be understood within this context of “the new poor”; these people constitute one of the groups in which homelessness and social exclusion are combined in a serious way. Marginal lifestyles, isolation, lack of family and social support, lack of economic resources, psychiatric disorders, personal and social deterioration –these are some of the elements that converge in this group, forming a vicious circle of poor conditions, marginality and exclusion. This situation is worsened by the fact that many of these people do not use the social and health services available, and tend to be reluctant to become properly involved in attention programmes.

The appearance, then, of the new phenomenon of the so-called “mentally ill in the streets”, with their special characteristics, represents an important challenge for social and health services in general, who must try to adjust to their peculiarities and respond to their needs, making possible an improvement in their quality of life and their gradual social insertion.

Given this situation, it became necessary to design specific measures oriented to this group in order to understand their problem and its extent and to develop actions designed to improve attention to them and facilitate their progressive social reintegration. Furthermore, it was (and is) fundamental to promote the development of a comprehensive network of resources for attention to, and the rehabilitation/social reinsertion of those with serious and chronic mental illnesses to prevent their becoming marginalised and facilitate the normalisation of attention to the specific treatment, rehabilitation and residential support needs of the homeless chronically mentally ill.

In this line, the Programme of Social Services Alternative to Psychiatric Institutionalisation, developed by (as it was then called) the Social Reintegration Committee of the Madrid Autonomous Region, targeted the specific social needs of the chronically mentally ill, taking advantage of the European Commission’s “Poverty 3” programme of 1990. In collaboration with the Social Services Department of the Madrid City Council, a project was designed with the aim of organising and putting into practice specific actions designed to approach this group, understand its problems and, through better attention, improve its situation.

Thus emerged the “Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill” as a “New Initiative” within the Poverty 3 programme (1990-1994). The organisational structure of the Project was framed within a model of co-operation and collaboration among various public bodies (Madrid Autonomous Region, Madrid City Council, Ministry of Social Affairs and the European Commission):

- **The Madrid Autonomous Region**, through the former Social Integration Committee (currently Health and Social Services Committee), as the body promoting the Project, was responsible for its overall management and supervision via the Programme of
Social Services Alternative to Psychiatric Institutionalisation (PSSAPI). Its duties included appointing the team of Project Co-ordinator, 2 Psychologists and 8 Instructors) and the organization and maintenance of the supervised flats. It provided most of the funding for the Project during its stage as a New Initiative within Poverty 3, and from 1994 it took on total responsibility for funding, management and co-ordination.

- The Madrid City Council, through its Social Services Department, and specifically the Section of Attention to the Homeless and the San Isidro Municipal Shelter, is the body whose collaboration and participation was essential for the planning, development and follow-up of the Project. Its collaboration was (and continues to be) particularly helpful with regard to the provision of work spaces at the San Isidro Municipal Shelter and the participation of its professionals in the development of the psychosocial rehabilitation and community support activities organised by the Project in its work with the chronically mentally ill using the Shelter.

- The Ministry of Social Affairs, through the General Directorate of Social Action, provided funding and technical support for the Project.

- The European Commission, through the administration and coordination structures of the Poverty 3 programme, gave support and technical advice, as well as the funding it provided until the end of the programme in 1994.

Although Poverty 3 concluded in June 1994, the Project continues to function, promoted, directed and funded by the General Directorate of Social Action of the Health and Social Services Committee, within its Special Programme Service via the Programme of Social Services Alternative to Psychiatric Institutionalisation, and with the support of the Madrid City Council.

The following sections are devoted to a description of its main characteristics, actions and results.

General description and principal features
The Project for the Rehabilitation and Social Insertion of the Homeless Chronically Mentally Ill emerged, then, as an attempt to develop innovative measures of social intervention with the chronically mentally ill, who had begun to become visible among the homeless population. Little was known about this new type of homeless person, and data from studies on the extent and characteristics of the problem was scarce.

Its aim was to carry out positive interventions with respect to this socially excluded group, offering them attention programmes, psychosocial rehabilitation and community support, together with housing alternatives that would help to increase their independence and quality of life and make possible their progressive social reintegration.

As already stated, the Project’s target population is that living in Madrid (permanently or temporarily), homeless, and suffering from chronic mental illness, and therefore suffering from the effects of two adverse situations and their interaction.

Those included in the category of the chronically mentally ill are characterised by the following features (Talbott, 1984; Liberman 1988/1993):
- Severe psychiatric disorders, such as schizophrenia, manic-depressive illness, recurrent serious depressive disorders, paranoid disorders and other psychoses, and organic brain syndromes.
- Psychosocial deterioration with regard to three or more aspects of everyday life, including personal hygiene, self-care, interpersonal relationships, social skills, etc., which hinders the development or maintenance of their economic self-sufficiency and their independent coping in the community.
- A history of psychiatric attention, with hospitalisation that may be long-term (one year or more in the last five years), medium-term (ninety days to a year in the last year) or short-term (less than ninety days). This feature is not common to all chronically mentally ill, some of whom may simply have attended local medical centres, or even received no type of attention at all.

To respond to this two-sided problem of homelessness and mental illness, exacerbating one another mutually, it is necessary to develop an integrated system of services that can, in a flexible and coordinated fashion, cover the different needs involved:
- Basic needs: food, lodging/housing, clothes and hygiene.
- Medical attention: this is crucial, since, due to the poor diet, hygiene and self-care conditions of this group, its mortality and morbidity rates are higher than those of the rest of the population.
- Psychiatric attention: diagnosis, psychopharmacolo-
gical treatment, crisis intervention and hospitalisation where necessary.

- Psychosocial rehabilitation: training in self-care, social skills and adaptation to the community; support for integration and maintenance in the community.
- Employment rehabilitation: prevocational, vocational and occupational training, and support for finding employment and adaptation to work.
- Residential support in the community: graded residential services according to the different levels of independence and following the principle of the least restrictive alternative.
- Economic support.

This does not imply that it is necessary to create specific services for the homeless chronically mentally ill with regard to each one of their different needs (treatment, rehabilitation, residential attention, support, etc.). In many cases the services exist, both at a general level: health centres, social services centres, hospitals, hostels, etc., and at level of specific services: mental health services, psychosocial rehabilitation centres, etc.

The problem is to create a situation whereby this group is able to accede to and benefit from these services in an appropriate way. It is therefore necessary to develop active, search-based formulas that allow us to reach this population wherever they are, to understand their problems and to put them in touch with the network of services; at the same time, there is a need to work towards improving their capacities and increasing their independence, so that they are able to take advantage of the services they need, and can gradually progress in the direction of social reintegration.

FEATURES OF THE PROJECT
With the above in mind, the Project was designed with the following characteristics or defining elements:

1) To adopt a search-based intervention style, that is, approaching the target population in situ. Given the characteristics of this group, which normally fails to use services or does so in an inadequate way, we decided, in accordance with this “search-based” style, to develop the project in the San Isidro Municipal Shelter, as a resource catering for marginalised persons, as well as working in close collaboration with the Social Emergency Mobile Units working in the streets of Madrid, detecting, assisting and advising people in situations of need.

2) To make more dynamic and strengthen coordination between the existing social/health services in order to favour integral attention to this population. This project neither should nor could pretend to cover all the multiple and varied needs of the homeless chronically mentally ill, but rather it is necessary to develop coordination among the different services already in place, especially those of mental health and general social services, with the aim of promoting their involvement in attention to the psychiatric and social needs of these people and in supporting their access to and use of these services.

3) To make accessible to the reference population programmes of psychosocial rehabilitation, aimed at increasing their independence and preparing them for integration in the community. Such programmes, which do not normally reach this group, were to be run at the San Isidro Municipal Shelter. Moreover, and with a view to creating opportunities to break away from the circuit of homelessness and marginalisation, 4 supervised flats, catering for up to 18 people, were made available.

4) To frame the project in an environment of inter-institutional collaboration (Madrid Regional Council, Madrid City Council and Ministry of Social Affairs), thus permitting access to considerable technical and financial resources, and the promotion of the Project as a measure for improving the quality of life and possibilities of social insertion of this group.

5) To design a dynamic and flexible project, capable of being readjusted as better knowledge of the realities and needs of this group and the experience and results themselves allow an assessment of the effectiveness and relevance of the actions carried out, so that the possibilities of its rehabilitation and social reintegration can be maximised. This means that the Project was conceived as a kind of “bank of tests”, allowing not only better knowledge of the problems and situation of this group, but also the type of resources, actions and programmes necessary for adapting and complementing the existing services, including the Project itself.

The Project’s aim was, therefore, to approach and work with the homeless chronically mentally ill in the context of two complementary dimensions:

- On the one hand, a Research-Assessment dimension,
which would allow, in an overall way, a fuller knowledge of the reality of this group, and enable the filling of some informational gaps with regard to its numbers, its situation, its main characteristics and its needs.

To this end, the Project proposed the development of a rigorous epidemiological study for the analysis and detection of the quantity, psychiatric and psychosocial problems and characteristics of those with serious and chronic mental disorders in situations of homelessness. Likewise, it sought to advance the study of the factors that led to their becoming homeless.

- On the other hand, an Intervention-Specific Action dimension aimed at the group of chronically mentally ill (around 60) using or in contact with Madrid City Council’s San Isidro Municipal Shelter, the principal public resource providing attention to homeless persons.

The Project aimed to offer this group active strategies of psychosocial rehabilitation and community support that would improve their level of psychosocial autonomy, promote their integration in the network of mental health, social and other community services, provide community housing (supervised flats), facilitate their leaving the Shelter and, in sum, favour their progressive normalisation, improve their quality of life and promote their gradual social reintegration.

Given the philosophy of rehabilitation underlying the Project, the participation of users in their rehabilitation process and in the control of their own lives is an objective and an instrument essential to the intervention. Thus, in a gradual but continuous way, those making up the target population of the Project were encouraged to become involved in the planning of their own process of reinsertion, and in the definition of their objectives. After all, the ultimate aim of rehabilitation is to help these people to overcome their problems and recover their capacity to make decisions and move away from exclusion and deterioration towards normalisation and integration.

For this purpose, the Project had the support of the following team:
- 1 Co-ordinator-Psychologist
- 1 Psychologist
- 6 Instructors

The Project was directed by the Committee and carried out by a company, working under contract, with expertise in the rehabilitation and support of this type of population.

Actions
In summary, the main actions and intervention strategies of the Project are:

Programmes of psychosocial rehabilitation and community support
The Project aimed, as a basic pillar of the intervention, to reach the group of homeless chronically mentally ill using the San Isidro Municipal Shelter and to offer them individualised programmes of psychosocial rehabilitation and community support (Rodríguez, 1997), with the purpose of:
- Helping them to recover the set of personal skills and abilities necessary for living as independently as possible in the community environment.
- Supporting and strengthening their links with the existing social and health services, especially with mental health services, attending to their needs for psychiatric treatment, but also with general social services and other specific services for the chronically mentally ill, as well as other socio-community resources, in order to increase their possibilities of social integration.
- Preparing, facilitating and supporting their progressive social reinsertion.

The following section offers a more detailed account of the main data on attention provided between 1990 and 1996. As a general summary of the results of this intervention strategy we can adduce the positive effects of these individualised programmes of psychosocial rehabilitation and community support: those attended have improved in terms of personal and social autonomy, their quality of life has improved during their stay at the Shelter, they have become more involved with mental health services and other community resources, psychiatric relapses and hospital admittances have decreased, and in sum, effective possibilities for reintegration in the community have been opened up.

However, in spite of these positive effects, the Project’s potential for facilitating the social reinsertion of many of the target population is limited by the insufficiency of residential alternatives and social support in the community.
**Residential alternatives in the community**

In order to facilitate leaving the San Isidro Municipal Shelter and to favour the social reintegration of the mentally ill using its services and reached by the Project, four supervised flats (18 places) were made available, to serve as housing alternatives and support, and as a context for favouring the process of rehabilitation and social reintegration.

These flats received support that was flexible and adapted to the needs of users by the Project team.

The flats have been seen to work well and constitute a positive element of the Project, as a flexible residential alternative, providing an opportunity to live in a normal community and enjoy its support, and thus as a context for moving towards social reintegration. Those benefitting form them have experienced a radical improvement in quality of life: having a home of their own has made it possible for them to recover their dignity and self-esteem, and to change their role of marginalised persons or patients for those of active, normal people. Functioning at an internal level has been interesting, with the achievement of high levels of independence and self-organisation in everyday life, as well as normalisation of the users’ current situation and perspectives for integration.

**Training**

The Project was responsible for organising various training and technical support programmes with the following personnel:
- Those working with Madrid City Council’s Social Emergency Mobile Units (UMES), in order to improve capacity for the detection of and attention to the mentally ill living on the streets.
- The auxiliary staff of the San Isidro Municipal Shelter, with the aim of increasing their knowledge of the chronically mentally ill population and providing them with strategies for improving rehabilitatory attention to chronically mentally ill persons using the Shelter.

**Research**

As already explained, the aim of the Project was to develop an epidemiological study that would provide rigorous, valid and reliable data on the number, social and demographic characteristics, and types of psychiatric problem of the homeless mentally ill, and to make progress in the analysis of the factors that have influenced their becoming marginalised.

This research was carried out by the Psychology Faculty of Madrid’s Complutense University under the direction of Manuel Muñoz, Carmelo Vázquez and Juan Antonio Cruzado, and in accordance with an agreement with the Committee. It concluded in 1994 and was published the following year, by the Regional Council of Madrid, as a book entitled: “Homeless Persons in Madrid: A Psychosocial and Epidemiological Report.”

Its main results have already been presented, and have also been summarised by Muñoz and Vázquez in other studies.

**Sumary of attention provided by the project 1990-1996**

We shall continue by offering a summary of the development of the Project and the attention provided during the period 1990-1996 (see PSSAPI reports of 88/93 and 94/96).

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The table below shows the evolution of attention in the PRISEMI Project from 1990 to 1996.

<table>
<thead>
<tr>
<th>Year</th>
<th>Beginning Attention</th>
<th>Abandonees</th>
<th>Losses to the Project</th>
<th>Positive moves</th>
<th>Receiving Attention at year’s end</th>
<th>Attended during year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>14</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>1991</td>
<td>20</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>1992</td>
<td>22</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>48</td>
<td>50</td>
</tr>
<tr>
<td>1993</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>58</td>
<td>59</td>
</tr>
<tr>
<td>1994</td>
<td>16</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>60</td>
<td>74</td>
</tr>
<tr>
<td>1995</td>
<td>14</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>1996</td>
<td>12</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>68</td>
<td>83</td>
</tr>
<tr>
<td>TOTAL</td>
<td>109</td>
<td>12</td>
<td>11</td>
<td>18</td>
<td>109*</td>
<td>109</td>
</tr>
</tbody>
</table>

*Total users attended by the Project. Not the sum of the previous figures of the column.
The following table presents the main data referring to attention provided by the project from its inception in 1990 until 31st December, 1996. During this period a total of 109 persons were attended. As can be observed in Table 1 and Graph 1, the project’s attention capacity increased continuously, reaching a maximum of 83 users, with figures of around 70 simultaneous users. The rate of new users, after reaching figu-

res of up to 22 per year in the early years, stabilised in the last three years at a mean of 14 users/year.

From the opening of the Project’s first two supervised flats, in 1992, up to the present, with 4 flats available, the team has made a considerable effort, in collaboration with the professionals at the San Isidro Municipal Shelter (SIMS), to offer users living in the SIMS more normal alternatives –not only their own flats, but also boarding houses or flats shared among several SIMS users. Supervision in these other residential alternatives has also been carried out by the Project team, and always in accordance with the circumstances of each case.

Openings for returning to the family environment continue to be limited, given the lengthy periods of separation usually involved in these cases and the mutual difficulty of adaptation, but those that have occurred have been aided by a previous stage of living in the supervised flats.

The result of the team’s work, as observed in Table 2, is that by 31st December 1996, only 48.5% of users attended by the Project were living in the SIMS. The remainder, i.e., 51.4%, were living in more normal alternative accommodation: boarding houses, shared flats and Project flats. All of those attaining these alternatives had come from the San Isidro Municipal Shelter.

The total number of places in supervised flats currently managed by the Project is 18. On 31st December 1996, 17 were occupied. The remaining place became vacant on its occupant moving to another normal housing alternative, and the place was kept free while the person’s adaptation to the new environment was assessed.

In general, as can be seen from Table 3, the level of continuity in the flats is high. Since 1992, 5 persons have left (without moving to alternative accommodation), but of these five, the team continues to help or to maintain contact with four. Only one of them has decided to separate from the Project completely.

The number of those leaving the flats for a positive alternative is also low (3). Although users’ contacts with their families increase significantly on moving to a more normalised environment, such as a supervised flat, this proximity rarely leads to a return to the family home. Other alternatives for positive moves, such as renting flats, are beyond the economic possibilities of the users, whose opportunities for integration in the world of work (with mean ages of 40 years and little training or work experience) are scarce.

<p>| TABLE 2 |
| Place of residence of Project users |</p>
<table>
<thead>
<tr>
<th><strong>SHELTER</strong></th>
<th><strong>PROJECT FLATS</strong></th>
<th><strong>BOARDING HOUSES</strong></th>
<th><strong>SHARED FLATS</strong></th>
<th><strong>LIVING BOUGH UNKNOWN</strong></th>
<th><strong>FAMILY</strong></th>
<th><strong>OTHERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A 31/12/90</strong></td>
<td>N°</td>
<td>%*</td>
<td>N°</td>
<td>%*</td>
<td>N°</td>
<td>%*</td>
</tr>
<tr>
<td>10</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>57</td>
<td>9</td>
<td>32</td>
<td>1</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>26</td>
<td>94</td>
<td>9</td>
<td>32</td>
<td>1</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>36</td>
<td>12</td>
<td>20</td>
<td>16</td>
<td>11</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>41</td>
<td>60</td>
<td>11</td>
<td>18</td>
<td>13</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>44</td>
<td>61</td>
<td>16</td>
<td>23</td>
<td>19</td>
<td>28</td>
<td>16</td>
</tr>
<tr>
<td>55</td>
<td>85</td>
<td>17</td>
<td>25</td>
<td>13</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>

With respect to total users receiving attention at year’s end.

| TABLE 3 |
| Evolution of stay in supervised project flats |
| Users in the flats at 31/12 | 9 | 12 | 11 | 16 | 17 |
| Total having occupied flats | 10 | 14 | 12 | 18 | 19 |
| LOSSES | 0 | 2 | 1 | 2 | 0 | 5/20%** |
| Total | 0 | 1 | 0 | 1 | 0 | 2 |
| Abandonment | 0 | 0 | 1 | 1 | 0 | 2 |
| Expulsion | 0 | 0 | 1 | 1 | 0 | 2 |
| Return Shelter | 0 | 1 | 0 | 0 | 0 | 1 |
| POSITIVE MOVES | 1 | 0 | 0 | 0 | 2 | 3/12%** |
| Total | 0 | 0 | 0 | 0 | 0 | 1 |
| To social services flat | 1 | 0 | 0 | 0 | 0 | 1 |
| To family | 0 | 0 | 0 | 0 | 0 | 1 |
| To sharing with partner | 0 | 0 | 0 | 0 | 0 | 1 |

* With respect to total users attended by the Project (109).
** With respect to total users having occupied flats.

| TABLE 4 |
| Evolution of Positive Moves from the Project |
| **POSITIVE MOVES** | **TO FAMILY** | **TO SHARED FLAT** | **TO BOARDING HOUSE** | **TO RESIDENTIAL SERVICES** |
| N° | %* | N° | N° | N° |
| 1990 | 1 | 3.3 | | | |
| 1991 | 1 | | | | |
| 1992 | 1 | 3.3 | | | |
| 1993 | 1 | 3.3 | | | |
| 1994 | 7 | 9.4 | | | |
| 1995 | 2 | 2.7 | | | |
| 1996 | 7 | 8.4 | | | |
| TOTAL | 18 | 16.5 | 3 | 7 | 3 | 5 |

* With respect to total users attended by the Project (109).
In total, throughout the history of the Project, 18 people have made positive moves (3 of them, as indicated, from the supervised flats). The residential destination of these 18 users is shown in Table 4:

The total number of those moving to more positive alternatives represents 16.5% of those attended, and has mainly occurred since 1993, one year after the team began to intensify its work of enabling people to leave the Municipal Shelter and move to alternative accommodation. As it can be seen, the majority of these cases (two-thirds) involved moves to shared flats or homes (Senior Citizen’s Residences or Instituto José Germain).

Table 5 shows the data on the use of other resources of the PSSAPI Programme in which the Project is included and of other community resources by users of the Project (those living in the SIMS and in other residential alternatives) between 1993 and 1996.

Despite the fact that the use of other resources of the PSSAPI is not particularly high, since the weight of rehabilitation falls mainly on the Project, considerable efforts have been made to encourage users to take advantage of community resources of all kinds. Figures for the last two years show that 70% of Project users benefit to some extent from employment and leisure services. These figures represent an increase with respect to those of previous years.

The sociodemographic data that characterises those attended by the Project are, in summary, as follows (for further details see the PSSAPI Report 1994/1996): with regard to sex, approximately 60% of those attended are women and 40% are men; mean age is 43 years; the vast majority (63%) are unmarried; schizophrenia is the most common disorder; there is a low educational level, with 53% having only elementary education and 20% education to age 15; they are unemployed and not receiving benefit (42%), or receiving a pension (55%), in the majority of cases a non-contributory disability pension; the vast majority (79%) have no criminal record; since being attended by the Project 83% have not been admitted to hospital due to psychiatric crisis.

**Summary and perspectives**

Let us consider the main conclusions reached by the Project, which form the basis of experience on which its work can be continued:

- The first and soundest conclusion reached is that it has been demonstrated that the homeless in situations of serious psychosocial deterioration and marginalisation can live in a normal and dignified way in the community if they are given the appropriate attention and flexible support.
- We have moved much closer to the problems, needs and characteristics of the homeless chronically mentally ill, and gained a much better and more comprehensive knowledge of their situation.
- A methodology of psychosocial rehabilitation and flexible community support, adapted to the needs of this population, has been successfully used. This has made possible their active involvement and contributed to an improvement in their situation and quality of life and an increase in their autonomy and possibilities of social reintegration.
- The suitability of the accommodation alternatives (supervised flats) developed by the Project has been demonstrated: these normalised and normalising alternatives have made possible a substantial improvement in the quality of life of the target group and increased their chances of social reintegration.

### TABLE 5

**Use of other socio-community resources**

<table>
<thead>
<tr>
<th></th>
<th>OTHER RESOURCES OF THE PROGRAMME</th>
<th>COMMUNITY RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ERC</td>
<td>PSRC</td>
</tr>
<tr>
<td>1993</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>1994</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>1996</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

* In number of users.

** The total of users participating in community resources is not the sum of the participation in employment and leisure resources. There are users that participate in different resources at the same time.

*** With respect to total users attended in the year.

**GRAPH 2**

Use of community resources 1993-1996

With respect to total users attended each year

- In %

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- Involvement and coordination with mental health services and other socio-community services in attending to this group have been strengthened and improved.
- A model of inter-institutional co-operation has been developed through the Project. This is an essential condition for comprehensive attention to the population in question and in general in the fight against the exclusion and in favour of the integration of the homeless.

In sum, the Project has provided a wealth of experience and practical knowledge with regard to a marginalised group about which little is known, that of the homeless chronically mentally ill. This experience should serve as the basis for improving attention to this group and their quality of life and providing more effective support for their progressive social reintegration.

CONCLUSIONS AND RECOMMENDATIONS

We should like to conclude this work by considering a series of recommendations (among many others) that we feel to be pertinent, with a view to improving the situation of the homeless mentally ill and offering them the integral attention they need:

- It is fundamental to increase the priority currently given, in general, to “homeless persons”, and specifically to the homeless chronically mentally ill, at both a political-institutional level and a social level. This necessity is evident if we consider the serious problems of social exclusion suffered by this group and the need to offer these people –citizens with full rights– the possibility of leading a dignified life as part of society.
- Given the characteristics of this population it is necessary to continue developing specific actions aimed at them that will serve as a basis for attention to them and their rehabilitation. These actions should complement the efforts of the general systems of social protection and those of specific social and health networks for giving attention to, rehabilitating and providing community support for the mentally ill.
- It is highly important to plan and develop integral programmes and projects for attending to the entire homeless chronically mentally ill population in the large cities in Spain, including not only those attended by or in contact with the various shelters and hostels, but also those living rough on the streets.
- The programmes and interventions to be developed should be based on the appropriate studies and research that permit the detection of the population to be attended and provide reliable quantitative and qualitative data on their situation, characteristics and problems.
- These interventions, although necessarily specific, should be integrated and/or coordinated in a coherent and synergetic way with general planning of attention to the homeless population, and with planning or systems of mental health and social services for community attention to the population with chronic mental illnesses.
- Measures taken should cover the different levels involved: prevention, attention, rehabilitation and social reintegration.
- From the logic of the principle of multidimensionality, all the different needs and problems of this population (detection and reach, basic needs, accommodation, psychiatric treatment and follow-up, psychosocial rehabilitation, community support, economic self-sufficiency, etc.) should be covered in a comprehensive way, with the overall objective of facilitating their integration and maintenance in the community in the best possible conditions of autonomy, quality of life and normalisation.

- Both the organisation and development of the necessary specific resources and programmes and the involvement and adjustment of the various existing networks of community services (mental health, general and specialized rehabilitation and social support, hospitals, etc.) should be taken into account in the planning of integral attention to this population, avoiding the creation of parallel networks or unnecessary duplication that may lead to marginalisation. Likewise, it is essential that the network of attention, rehabilitation and social support for the chronically mentally ill be endowed with sufficient resources to be able to include the homeless.
- As specific and priority measures to be developed with the homeless mentally ill, intensive actions should be designed –from a “search-based” perspective– that aim to detect and reach this group (specialised teams for attention and advice in the street, flexible “bridges” adapted to their characteristics –day centres, “no questions asked” accommodation, etc.–,
rehabilitation and follow-up programmes for those living rough) and aid their progressive involvement in more normalised attention programmes and resources. Also, efforts should be made by mental health services to offer, in a flexible and responsive way, the psychiatric help this population requires.

- With regard to the group of chronically mentally ill attended by or in contact with the shelters, the development of flexible and individualised programmes of psychosocial rehabilitation and community support, together with the launching of an adequate range of supervised accommodation resources in the community, should constitute one of the main pillars of the intervention.

- These programmes and interventions should be structured by promoting the involvement in planning and management, not only of health and social service administrations at their various levels (central, regional and municipal), but also of all the social bodies and organisations that work with the homeless, and whose coordinated collaboration is fundamental for the optimum and effective development of the plan and its different strategies.

REFERENCES
Desviat, M. (1996): La Reforma Psiquiátrica


