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Home- and Community-Based Work at the Margins of Welfare: Balancing between Disciplinary, Participatory, and Caring Approaches

Editors

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Editorial

Home- and Community-Based Work at the Margins of Welfare: Balancing between Disciplinary, Participatory and Caring Approaches

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Abstract

By the end of the 20th century, deinstitutionalisation had become a pervasive trend in the Western world. This thematic issue discusses how successful deinstitutionalisation has been in enabling dignified and safe living with necessary services in local communities. It contributes to an understanding of the history and phases of deinstitutionalisation and ‘home turn’ policies, and sheds light on the grassroots-level of home- and community-based work at the margins of welfare, hitherto little researched. The latter includes grassroots work to implement the Housing First approach to homelessness, commonly portrayed as a means of social inclusion, worker–client interactions during home visits and in the local community, as well as close inspections of what ‘housing support’ may actually entail in terms of care, discipline and service user participation.

Keywords

deinstitutionalisation; grassroots level; home turn; Housing First; participation; worker–client interaction

Issue

This editorial is part of the issue “Home- and Community-Based Work at the Margins of Welfare: Balancing between Disciplinary, Participatory and Caring Approaches” edited by Kirsi Juhila (Tampere University, Finland), Cecilia Hansen Löfstrand (University of Gothenburg, Sweden) and Johanna Ranta (Tampere University, Finland).

1. Introduction

Deinstitutionalisation, meaning “the complete replacement of institutions by services in the community” (Mansell, 2005, p. 26), is seen as a human rights issue and has become a pervasive trend in the Western world. Large treatment institutions have been depicted as typical examples of what Goffman refers to as “total institutions” (Goffman, 1961, p. xiii), i.e., “a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.” Institutions have been argued as being stigmatising, violating clients’ and patients’ privacy and free lives, and segregating them from what is culturally defined as ‘normal’ living in the community. Based on such arguments, different types of community services have developed over time (see Hall et al., 2021).

The first phase of deinstitutionalisation, starting approximately 40–50 years ago, included creating various group and residential homes for people who had previously lived in large total institutions. During the last decades, providing services in people’s own homes and local communities has been on the increase. This ‘home turn,’ resulting from the second phase of deinstitutionalisation, emphasises that everyone is entitled to their own affordable and safe home place in the community regardless of economic status, possible problems or support needs. However, it is not always clear what it actually means to offer welfare services in communities and homes nor the kinds of dilemmas and tensions it may include.

This thematic issue discusses how successful deinstitutionalisation has been in enabling dignified and safe living with necessary services in the community. The special focus is on grassroots level home- and community-based work at the margins of welfare. By this, we mean work targeted at adults with complex needs, suffering, for example, from mental health and substance abuse problems, and homelessness. Despite being motivated to promote human rights, this type of work can include many contradictions. In practice, the work means balancing between disciplinary, participatory and caring approaches, such as surveilling home environments and making pedagogical interventions on home lives, attempting to engage people with the wider community and prevent isolation, and ensuring people's safe and decent lives.

2. Deinstitutionalisation: Back and Forth

The article by Hall et al. (2021) is based on a literature review of research published from 1990 onwards about deinstitutionalisation and 'home turn' policies. It discusses and evaluates thoroughly the two abovementioned policy phases (phase one of group or residential homes and phase two of home-based services) regarding vulnerable adults' care in in the community. They focus especially on how these policies are argued to both promote and hamper social inclusion and, thus, community participation in the Western world. The main conclusion is that the aim of social inclusion has not yet been fulfilled, although steps taken towards 'home turn' have advanced this.

Urek (2021) continues the evaluation of the history of deinstitutionalisation by describing its process in Slovenian mental health services since the 1980s. She concentrates on services users' roles in the process. By using multiple types of data, the author demonstrates how the history includes some innovative participatory practices, but also a large gap between the declarative participation policy and lived participation experiences. Both Hall et al. (2021) and Urek (2021) importantly remark that large institutions still exist and, furthermore, that 'institution-like' practices, including a disciplinary orientation towards service users, may have been transferred to residential and group homes and even home spaces (transinstitutionalisation and reinstitutionalisation).

Using a multiple-case study design that includes five Swedish municipalities, Fjellfeldt et al. (2021) investigate efforts to find suitable locations for supported housing units for people with severe mental illness, while also shedding light on community resistance towards the establishment of group or residential homes in their communities. In their article, the authors identify three municipal strategies—using existing buildings for a new purpose, infilling new buildings in existing neighbourhoods and establishing new buildings in a new area. Taken together, however, all three strategies tend to result in residential homes being established in the outskirts (geographical margins) of local communities. Arguably, homes in the 'fringes' of local communities may hamper the goal of social inclusion.

3. Efforts towards 'Housing First'

Several of the thematic issue's articles explore the role of Housing First policy in community- and home-based service practices. Housing First emphasises everyone's right to their own apartment without any conditions, such as abstinence, and housing independent from the services provided. It thus questions the tradition of institutions, including various shelters, residential and group homes, in which housing, treatment, care and control are merged. As Housing First prioritises community-living in scattered site housing, it aligns with the premises of social inclusion and participation. Housing First can be seen as an example of 'home turn'; according to its principles, homelessness shelters, which carry many of the criticised features of institutions such as discipline and control of residents, should be shut down. Instead, homeless people should be given individual accommodation with their own rental agreements. This change also entails identity transformation and struggles among both workers and clients, as Hansen Löfstrand and Juhila (2021) show in their article. Based on a mobile ethnographic study in Sweden, the article includes both focus group interviews with workers and observations of worker–client interactions during home visits.

In Finland, Housing First is commonly implemented in congregated housing units besides in individual apartments on the regular housing market (as in Sweden). In the congregated housing units, making a distinction between housing and services is difficult, and residents may not feel that their accommodation is their own home space. Workers in the units can take a caring but sometimes a controlling or even disciplinary orientation towards residents. This becomes evident in Granfelt and Turunen (2021), when they analyse interviews with workers in one such unit. However, using another type of data consisting of interviews with women living in Housing First scattered-site rental flats, Granfelt and Turunen (2021) demonstrate the successful pathways to living in an accommodation that feels like one's home and increases participation in the community. The important element in these success stories is trust-based relationships with social and care workers in the women's past and present lives.

In Knutagård et al. (2021), transformation towards Housing First philosophy in social housing programmes is examined from the viewpoints of service user involvement and strength perspective (cf. Urek, 2021). They ask how service users participate and are encouraged to participate in the process of change in social housing programmes. Drawing on multiple data sources, their participatory action research focuses especially on participation-enabling niches in the process. An important conclusion is that enabling niches are more difficult to sustain in congregate housing units than in Housing First-oriented programmes; having one's own apartment in the community creates an enabling niche in itself. Knutagård et al. (2021) also emphasise social workers' important role in discovering and supporting 'missing heroes,' who would be willing and competent to participate in coproducing change. Trust between parties in co-producing change is also emphasised.

4. Worker–Client Interactions in Homes and Communities

Taken together, as illustrated above, meaningful and trust-based relationships between service users and social and care workers as well as service user participation as an enabling resource in home-based services are deemed important by scholars. Three of the issue's articles illuminate the characteristics of these relationships, as they analyse in detail real-life worker–client interactions in service users' homes and nearby communities. Holmberg and Räsänen (2021) disclose how floating support encounters with clients suffering from mental health and substance abuse problems include emotionally loaded conversations on being and moving in the community outside the home. It demonstrates how workers can support clients' inclusion and participation in nearby neighbourhoods and decrease their risk of isolation.

Günther (2021) reveals how intimate worker–client interactions can be during home visits. Body work includes talk not only about clients' physical health and problems, but also actions entailing direct physical contact between workers and clients, such as showering. It further illustrates that entering clients' private homes and conducting body work have both caring and disciplinary dimensions, which creates a risk of homes becoming institutionalised. However, conducting body work can also strengthen clients' participation if it is based on their own wishes and on trustful relationships between workers and clients.

Entering private home spaces is also in focus in Saario et al. (2021). They analyse how workers justify the continuation or termination of support to mental health clients defined as difficult to reach in their homes, although home visiting is scheduled and included in their care plans. The balance between disciplinary and caring actions is strongly present in their analysis, and it is connected to workers' ethical responsibilities. Ceasing to support 'hard-to-reach' clients can be interpreted as disciplinary action, but so can continuation, if the clients themselves resist home visits. However, continuing support can also be seen as a sign of caring; clients are not left on their own if they are assessed as needing help.

5. What is Community- and Home-Based Work About?

Results of the studies described above demonstrate that community- and home-based work in times of deinstitutionalisation and 'home turn' is manifold and entails balancing between disciplinary, participatory and caring approaches. Three of the remaining articles discuss the sometimes unclear and contextually changing nature of this work. Börjesson et al. (2021) draw on the concept of institutional logic to understand the variations of housing support in mental health in different municipalities in a Swedish county. The analysis of focus group interviews with care managers, managers of home- and community-based support, and housing support workers shows that the meaning of housing support is constructed through dichotomies of process and product, independence and dependence, and flexibility and structure. These dichotomies create space for professional discretion as no clear guidelines for housing support exist.

Carlsson Stylianides et al. (2021) offer another viewpoint on the contents of housing support. Based on their analysis of interviews with staff from municipal social services and the municipal housing company, they argue that the housing company has increasingly started to deny some people the right to housing. These people are then referred to social services, who thus carry the risk of possible failures in housing. This produces categorical inequality and increases the number of people whose housing is controlled by social workers via contracts and weekly inspections during home visits. This work is not based on the wishes or needs of the people in need of housing, but on the preferences and risk-minimisation strategies of municipal housing companies.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Deinstitutionalisation and ‘Home Turn’ Policies: Promoting or Hampering Social Inclusion?

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Abstract
By the end of the twentieth century, caring for vulnerable adults in the community had become a pervasive policy trend in the Western world. In this article, this policy is described in two phases: deinstitutionalisation and the ‘home turn’ that are reflected from the perspective of social inclusion. Deinstitutionalisation has meant large institutions and asylums being replaced by group homes and communal-supported housing units in the community. In the second and current phase, the ‘home turn’ emphasises well-developed community care, home-based services, everyone’s right to have their own home, and having a valued place in the community. In this semi-systematic narrative review, the widely shared incentives, premises, and criticisms of deinstitutionalisation and the ‘home turn’ are mapped from the research literature. The special focus is on the possibilities of and hindrances to social inclusion in both policy phases. The research results are mixed and conflicting concerning social inclusion, but there exists a wide consensus that small housing units and supported housing with devoted workers enhance social inclusion better than big institutions. However, the prevalent view is that deinstitutionalisation has not fulfilled its promise of social inclusion, and although the ‘home turn’ is a step in the right direction, there are still problems in strengthening service users’ involvement and creating inclusive and accepting communities.

Keywords
community care; deinstitutionalisation; home-based services; narrative literature review; social inclusion

Issue
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1. Introduction

By the end of the twentieth century, caring for vulnerable adults in the community had become a pervasive policy aim in the Western world (Chow & Priebe, 2013; Hudson, 2019; Mansell, 2005; Novella, 2010; Pedersen & Kolstad, 2009; Priebe et al., 2009; Wiker et al., 2019). This ‘community care’ policy preceded an influential criticism, starting from the 1950s, towards total institutions that were deemed to be inhuman (e.g., Goffman, 1969). In its first phase, the policy of ‘care in the community’ meant that large institutions and asylums, such as psychiatric hospitals and homelessness shelters, were largely replaced by group homes and supported housing units in neighbourhoods (Fakhoury & Priebe, 2007). In the second and current phase, the emphasis is on permanent flats and housing in ordinary residential areas with home- and community-based support services (e.g., Šiška et al., 2018; Walker & Thunus, 2021). For our purposes, we call this second policy phase the ‘home turn.’ Today, these two policy phases—deinstitutionalisation and the ‘home turn’—are overlapping, yet the ‘home turn’ is strengthening and is increasingly seen as a primary policy choice. These policy phases have had major consequences for vulnerable adults' housing conditions and support arrangements, social relationships and societal roles, even though social inclusion has not been the only driver of the policy. As Bostock et al. (2004, p. 41) argue, deinstitutionalisation has been represented as a major step towards the social inclusion of people residing in institutional care. We state that social inclusion is a demanding yet essential precondition for the wellbeing of vulnerable adults. Hence social and health care policies are necessary to evaluate especially from that point of view (see Šiška et al., 2018).

The 'care in the community' policy has decreased the number of beds in psychiatric hospitals and increased the number of supported housing, community care, and home-based services (e.g., Emerson & Hatton, 2005; Pedersen & Kolstad, 2009). This has resulted in dispersed service systems and various conceptualisations, resulting in different responses to supported living and social inclusion in the community. Lambri et al. (2012, p. 2) summarise the variety of accommodation, housing solutions and support models as follows:

> Briefly, models of supported accommodation include communal group homes and hostels with onsite support workers; therapeutic communities; independent living supported housing schemes for people with mental health problems through self-contained accommodation located in one building or site, with onsite support workers during office hours; independent tenancies in general needs housing with outreach workers or floating support visits regularly.

The ways in which community care has been organised and defined vary according to local and national contexts and times. As can be drawn from the various conceptualisations above, housing and support services are connected to each other in many ways, and what is called 'supported housing' or 'supported accommodation' can take on different forms of service provision (e.g., Bostock et al., 2004; Emerson, 2004; McPherson et al., 2018; Šiška et al., 2018; Wiker et al., 2019, p. 211).

In this semi-systematic narrative literature review article, which is based on the research literature on deinstitutionalisation and the 'home turn' from the 1990s onward, we ask: (1) What kinds of supportive and critical evaluations are presented on the 'care in the community' policy at its two phases? (2) What do the evaluations tell about reaching the aim of social inclusion?

We narrowed our considerations to services targeted at working-age adults living in vulnerable life situations and suffering from, for example, mental and substance abuse problems and being at risk of homelessness (Kuluski et al., 2017). Much of the deinstitutionalisation and community care literature concerning working-age adults analyses changes in adult psychiatric services, yet there is also research on services for people with intellectual disabilities (e.g., Emerson, 2004; Tøssebro, 2016). We are not aiming at country-specific descriptions, but instead focused on uncovering general premises and policy shifts in the care, support, and housing services targeted at adults with multiple service needs.

The article is structured as follows: First, we clarify our theoretical viewpoint on the policy of 'care in the community' and describe how we conducted the semi-systematic narrative literature review. Then we introduce the incentives, premises, and reflections as well as critics of the deinstitutionalisation phase. Second, we depict how the 'home turn' has developed in response to the shortcomings of the first phase of deinstitutionalisation and by the ambitions of recovery, self-determination, client-centredness and the 'right to home.' Throughout the narrative, while describing these two phases, we pay special attention to the social inclusion aspect. In the conclusion, we consider the limits, preconditions, and possibilities of the 'care in the community' policy to produce inclusive communities with socially integrated members.

2. Narrative Literature Review: Reaching the Aim of Social Inclusion in Two Policy Phases

Social inclusion is seen as a crucial element of human wellbeing and meaningful life. Inclusion is often presented as a key element in successful housing and living in the community. Šiška et al. (2018) define the concept as active presence in the community, contributing to the community and participating in one's own life. Possibilities to contribute to society are often referred to as having 'a valued role' (Wolfensberger, 2000). Quilgars and Pleace (2020, p. 5) adopt a broad focus and define social integration as formerly homeless people's ability "to live, work, learn, and participate in their communities to the extent that they wish to, and with as many opportunities as other community members." In summary, social inclusion can be understood as active citizenship, connectedness, and involvement in the community (see Raitakari et al., 2016). We understand social integration and social inclusion as parallel terms, but for consistency, we mainly use the term social inclusion in this article.

The 'care in the community' policy aims to provide safe and meaningful living and participation in ordinary neighbourhoods equally for everyone despite disabilities and/or vulnerable life situations and special care needs (Tøssebro, 2016; Walker & Thunus, 2021). It thus includes a promise of social inclusion, why it is crucial to reflect on whether this promise is fulfilled and, if not, what prevents its fulfilment. Research evidence concerning the issue is inconsistent and limited, as seen in the following findings section based on the literature review. Variety of the research evidence reflects the contradictory nature of deinstitutionalisation and 'home turn' in different contexts.

In mapping the supportive arguments and critical evaluations of deinstitutionalisation and 'home turn' policies, especially from the point of view of social inclusion, we have applied the basic ideas of a semi-systematic narrative literature review (Green et al., 2006; Snyder, 2019). This review type fits well when studying complex and diverse research fields, and when reviewing every single article that could be relevant to the topic is simply not possible. A narrative literature review provides a comprehensive overview and helps to place existing information into perspective (Green et al., 2006; Snyder, 2019). In a narrative literature review, as Efron and Ravid (2018, p. 21) state:

> The reviewer gathers a broad spectrum of the literature written about the topic and synthesizes it into a coherent interpretation that highlights the main issues, trends, complexities, and controversies that are at the center of it. The author may also identify a potential direction for future research, problems that need to be explored, or possible applications for practice.

The reviewing task was challenging, as there is literature starting from the 1950s concerning criticism towards large institutions and the processes of deinstitutionalisation in different contexts. However, as our interest is in a more recent time when 'care in the community' has been established as a pervasive policy trend in the Western world, we have concentrated on peer-reviewed research articles published between 1990–2021, which can be seen to continue the earlier, often rather critical research tradition on institutions, asylums, and community care (e.g., Barton, 1976/2013; Goffman, 1969; Kugel & Wolfensberger, 1969; Scull, 1977). Furthermore, to manage the large material, we used accurate search words (deinstitutionalisation, home, home AND mental health, home AND learning difficulties, home-based services) and limited databases (Andor and Google Scholar), although this may have left some relevant contributions out of the review. Our aim is not to present all research done in the field but to describe the most common supportive and critical evaluations concerning the aim of social inclusion in two policy phases (deinstitutionalisation and 'home turn'). In other words, we concentrated on the evaluations that are repeated in many studies and are thus widely shared in the academic community. The repetition is marked in the text by listing many references to back up our findings and conclusions.

3. Deinstitutionalisation Policy and Social Inclusion

Although deinstitutionalisation has been a pervasive policy trend during the last decades, it is an inconsistent process with great variation within and between Western countries (e.g., Chow & Priebe, 2013; Keet et al., 2019; Mansell, 2005, 2006). As Salisbury et al. (2016, p. 1) state, there is no consensus on how deinstitutionalisation should be defined or what its key components and ways of implementation are, which has made the evaluation and comparisons of its success difficult. Despite its fragmentary nature and the political and ideological differences of deinstitutionalisation (e.g., Cummins, 2020), some incentives, premises, and criticisms, as well as viewpoints regarding social inclusion, are common and recognisable.

3.1. Incentives and Premises of Deinstitutionalisation

As stated above, the core incentive for deinstitutionalisation has already been the strong criticism of institutions and asylums since the 1950s. It revealed such shortcomings in residential care as overcrowding, understaffing, underfinancing, isolating, and not taking individual needs into account, causing negative effects for inmates and patients living in institutions (Barton, 1976/2013; Kugel & Wolfensberger, 1969). Further, in more recent studies, institutions, and asylums are blamed for moving adults with vulnerabilities and complex needs to isolated areas 'outside' society, in various asylums, homelessness shelters and psychiatric hospitals. Although institutions had been established with a good intention at the time, they were later seen as poor in quality, overcrowded, and offering inhuman facilities (Cummins, 2020; Emerson & Hatton, 2005; Fakhoury & Priebe, 2007; Novella, 2010; Walker & Thunus, 2021). The segregation of vulnerable adults was partly seen as resulting from a cultural stigma connected to mental illnesses that enabled families and communities to abandon their sick members (Shen & Snowden, 2014, p. 4). Deinstitutionalisation has been associated with wider societal changes, such as progress and developments in medicine, client-centredness and recovery movements, economic incentives and political ambitions (Chow & Priebe, 2013; Hudson, 2019; Salisbury et al., 2016; Tuokkola & Katsui, 2018). Novella (2010, p. 223) depicts deinstitutionalisation as an 'expanding chain reaction' with various triggers:

> In a sort of expanding chain reaction, within two decades, all major Western countries were affected by a similar process of upheaval in their mental health systems: crisis of the old model, discussion of alternatives—often on the background of a growing social and media interest, and political involvement with new legislation or national guidelines, including variable fund provision for new model services' development.

In a large international study, Shen and Snowden (2014, p. 4) outline the power and meaningfulness of deinstitutionalisation, as well as its incentives:

> Deinstitutionalization is one of the major milestones in the care of people with mental, neurological, and substance use (MNS) disorders in the second half of the twentieth century. It is construed as an administrative apparatus that is designed to prevent chronic disability, uphold human rights, and reduce the cost of care.

Deinstitutionalisation gained strength from optimism arising from a new treatment. Antipsychotic medications introduced from the 1950s onwards made it possible to reduce institutional placements because they were able to stabilise service users' conditions (Fakhoury & Priebe, 2007; Pedersen & Kolstad, 2009; Salisbury et al., 2016; Wiker et al., 2019). However, the need to reduce treatment costs and develop alternative and more cost-effective services has spurred deinstitutionalisation (Cummins, 2020; Priebe et al., 2009; Wiker et al., 2019). In some contexts, the development of public welfare services, such as disability pensions and publicly supported housing, has increased the possibilities for adults with complex needs to live independently in the community (Keet et al., 2019; Pedersen & Kolstad, 2009). This was linked to the recognition of the lack of civil rights and opportunities for normal life in institutional care settings (Emerson & Hatton, 2008; Keet et al., 2019; Wiker et al., 2019). Overall, the protection of human rights has been a key driver of the deinstitutionalisation and development of community care services (Keet et al., 2019, p. 4). Nowadays, it is a widely shared view that community settings are more humane, offer a better quality of life, and provide more opportunities for social inclusion than long-term living in institutional care (Emerson, 2004; Newton et al., 2000; Shen & Snowden, 2014).

3.2. Critics of Deinstitutionalisation Regarding Social Inclusion

Although deinstitutionalisation has undoubtedly had many positive impacts on service users' rights and welfare, it has also created some problems (Beadle-Brown & Forrester-Jones, 2003; Cummins, 2020; Lamb, 1993; Mansell, 2005, 2006; Salisbury et al., 2017). Significant numbers of individuals with mental health problems are homeless, in prisons, and experiencing a cycle of discharge and readmission (the 'revolving door'; see Lamb, 1993). Instances of abuse and neglect can also occur in community-based settings (Salisbury et al., 2017). There is a risk that adults with severe or acute mental health problems may be forced to stay in community settings, even in situations where they are in real need of institutional care. In addition, problems of deinstitutionalisation relate to undeveloped and poor-quality supported housing and community care services, as well as to stigmatisation and isolation (Mansell, 2006).

Community care services are argued to not correspond to actual demands and needs (Kovess-Masféty et al., 2006; Lambri et al., 2012; Wiker et al., 2019); they are too limited, short term, and rigid in response to the comprehensive needs of service users, shifting from managing psychotic symptoms to managing their own affairs and relationships in the community (Kovess-Masféty et al., 2006; Kuluski et al., 2017). Hence, the main criticism is that although institutional care has been significantly reduced, community care services are fragmented and under-resourced (Cummins, 2020; Shen & Snowden, 2014). Scarcity of resources is setting the intended objectives of the policy of 'care in the community' at risk. When community care services are insufficient, there is a risk that service users, families, friends, and neighbours are obliged to take too much responsibility for managing and supporting service users' everyday lives in the communities (Kuluski et al., 2017). It has been argued that service users are often left alone without support, with too high expectations of recovery and coping. Indeed, it is an overoptimistic expectation that merely living in the community would increase wellbeing, social life, safety nets, and inclusion (Beadle-Brown et al., 2007; Stancliffe & Lakin, 2006).

Furthermore, deinstitutionalisation has often resulted in the creation of residential homes where service users are offered a flat or room in an institution-like setting. These group homes are typically targeted at people suffering from similar problems, and geographically located in remote areas in a neighbourhood and, thus, may carry stigma and create prejudice. The neighbourhoods also often resist group homes being situated nearby, which is called a NIMBY (not in my backyard) phenomenon (e.g., Lyon-Callo, 2001). Because of the institution-like surroundings and possible prejudices, moving out of these group homes and taking part in social activities is challenging, or even impossible, creating risks of isolation and loneliness. The experiences of living in group homes regarding being stigmatised as the 'other' and an 'outsider' may not be that different from the experiences of those who have lived in 'total' institutions (e.g., Bild & Gerdner, 2006). Although service users usually have regular contact with workers and fellow service users in group homes, many residents have only limited contact with other friends and family members (Ashley et al., 2019; Priebe et al., 2009).

If service users with complex service needs are now supposed to live in the community instead of institutions, but their social contacts are limited to the residents and workers of group homes, deinstitutionalisation has not been able to fulfil the promise of the social inclusion and equality of all people (e.g., Beadle-Brown et al., 2007; Davidson et al., 1996). Fakhoury and Priebe (2007, p. 314) sum up the difficulties that mental health patients face in communities and the shortcomings of deinstitutionalisation policy:

> Original expectations that community care would lead to the full social integration of people with severe mental illnesses have not been achieved. The majority of patients with severe illness are still without work, have limited social contacts, and often live in sheltered environments. Services in the community sometimes provide a new 'ghetto' for the mentally ill, where patients meet each other but have little contact with the rest of the community. It has been argued that instead of 'community psychiatry,' reforms have established a 'psychiatric community.'

It has also been questioned whether major changes have actually occurred in frontline work among service users. In many cases, institutional care has only changed location, for instance, from mental hospitals to prisons, homelessness shelters, and custodial institutions (Priebe et al., 2005). Even if institutions are closed, institutional, and coercive practices are still in use in many settings (Cummins, 2020). This permanence is called 'transinstitutionalisation' or 'reinstitutionalisation,' meaning that restrictive and oppressive institutional care just emerges in new locations in the community, such as various supported housing units (Davidson et al., 1996; Fakhoury & Priebe, 2007; Priebe et al., 2005, 2008; Shen & Snowden, 2014, p. 5). There are also conflicting views on what is seen as a marker of deinstitutionalisation and what indicates reinstitutionalisation (Salisbury et al., 2016, p. 8).

Critical and doubtful arguments seldom question the main premise or aim of deinstitutionalisation per se. Thus, the policy itself is seen as clearly worth supporting, and the criticism is mainly targeted at its unsuccessful or unfinished implementation, highlighting the problems, shortcomings, and risks in the realisation of deinstitutionalisation (see Fakhoury & Priebe, 2007; Mansell, 2006). As Shen and Snowden (2014, p. 5) conclude: "The lack of synchronicity in closing or downsizing institution-based services with scaling-up community-based services has engendered a whole host of problems." The shift from institutional care and housing to community settings has only partly been achieved (e.g., Beadle-Brown et al., 2007). The societal transformation process is perceived as incomplete because of failures, gaps, and problems with the availability, performance, and suitability of community care and supported housing. This 'failure discourse' of deinstitutionalisation points towards the second phase of 'care in the community,' which comprises extending community care, especially home-based services, and everyone's right to have their own, permanent home. We call this policy the 'home turn.'

4. The 'Home Turn' and Social Inclusion

Since the turn of the millennium, various types of home-based support services, such as mental health and substance abuse floating support and home care, have increasingly been developed to support vulnerable adults and help them live independently in their own homes (Keet et al., 2019; Magnusson et al., 2003; Sawyer et al., 2009). In homelessness policy, there has been an ongoing gradual shift from a 'treatment first' model, where service users live in fixed-term, communal settings before getting their own home, to a 'housing first' model, where directly permanent housing for homeless people is offered (Bild & Gerdner, 2006; Padgett, 2007; Tsemberis, 2010; Y-Foundation, 2017). Strong support for the 'home turn' comes from research on the 'housing first' models, which emphasise respect for choice regarding both housing and services, harm reduction, empowerment, and inclusion (e.g., Hansen Löfstrand & Juhila, 2021; McPherson et al., 2018). Studies on the 'housing first' model demonstrate consistent evidence for improvements in housing retention and stability and, where appropriate, often diminishing use of clinical services (McPherson et al., 2018). Yet these findings should be generalised with caution regarding different contexts and situations of vulnerable adults.

4.1. Triggers, Principles, and Benefits of the 'Home Turn'

The 'home turn' policy emphasises a human right to housing; here, it is believed that everyone should have their own affordable and safe place to live, regardless of economic status, life situations and care needs (Magnusson et al., 2003; Padgett, 2007). This policy also emphasises several other philosophical underpinnings, such as client-centred care, self-determination, freedom of choice and flexibility, individualisation, and voluntary-based services (Keet et al., 2019; Lydahl & Hansen Löfstrand, 2020; Magnusson et al., 2003; Wiker et al., 2019, p. 211). One premise is to advance the normality and ordinary life of people living in vulnerable and complex life situations by enabling them to have their own private space and promoting active participation in one's everyday life in and around home (Beadle-Brown et al., 2007; Magnusson et al., 2003; Padgett, 2007). Home-based services, well-resourced public services, and benefits are considered to address everyone's basic human needs and support social inclusion in the community. The 'home turn' is realised in a way where housing and support are not bundled up in one care package provided by onsite facilities. Instead, services are increasingly brought to service users' homes alongside outpatient clinical and office-based services.

The most apposite justification of the 'home turn' is that people often want to live as independently as possible in their homes (e.g., Burns et al., 2006; Davidson et al., 1996; Padgett, 2007). There is evidence that living in independent and scattered housing instead of institutions and group homes advances one's experience of autonomy, stable family contacts, belonging, and ability to use local services (De Heer-Wunderink et al., 2012; McConkey, 2007; Padgett, 2007; Stancliffe & Lakin, 2006). As McConkey and Collins (2010, p. 691) mention: "Past studies have found that people supported in more individualised housing options tend to have higher levels of community participation and wider social networks than those in other accommodation options." Having one's home, status as a tenant, and being a user of ordinary public services strengthen social inclusion in the community.

The 'home turn' is also seen to avoid hospitalisation if home-based services are well-resourced and intensive. For example, Burns et al. (2006) identify six components of effective home-based care for people with mental problems: small case loads, regularly visiting at home, a high percentage of contacts at home, responsibility for health and social care, multidisciplinary teams, and a psychiatrist integrated in the team. The ‘home turn’ has the potential to improve service accessibility, especially if workers conduct home visits. When workers enter the service users’ homes and, hence, do not need to travel for appointments or treatments, disabilities do not hinder the service uptake. It has also been argued that the home space brings a positive atmosphere for service user–worker interaction and communication (see, e.g., Juhila et al., 2020, 2021; Raitakari et al., 2018; Ranta & Juhila, 2020). The home space may equalise power relations between service users and workers, facilitating therapeutic relationships (Kuluski et al., 2017; Magnusson et al., 2003). Homes are service users’ own territories, so they also have the position of a host, not just a service user (Juhila et al., 2016, 2021).

The home space also enables discussions that are relevant to service users’ everyday lives. For instance, it can create opportunities to discuss personal issues and memories related to pets and material artefacts, such as paintings and photos, which can be brought into home visit interactions (Juhila et al., 2016, 2020). Accordingly, the home space may be more congenial than the office for sensitive discussions and troubling topics. For workers, the home space provides a lot of information related to service users’ wellbeing, strengths, and lifestyles (Juhila et al., 2020; Magnusson et al., 2003). It reveals what is meaningful, essential, and potentially difficult in their everyday lives. Thus, home visits become a vital working and information-gathering encounter. Workers entering service users’ homes are justified, among other things, by the importance of meeting service users in their own contexts and learning their abilities to function at home and in the community (Magnusson et al., 2003; Muzicant & Peled, 2018; Winter & Cree, 2016).

4.2. Doubs and Limits of the ‘Home Turn’ Regarding Social Inclusion

There are many benefits of the ‘home turn.’ However, it has also been questioned. The ‘home turn,’ such as institutionalisation and deinstitutionalisation, can mean experiences of being the stigmatised ‘other’ and an ‘outsider’ in the neighbourhood (Padgett, 2007). It is not easy to create relationships, for example, with neighbours if they are nonresponsive or even hostile. If moving out of home and taking part in social activities are challenging, there is a risk of isolation. Overall, social inclusion in the community is not possible if the community itself is not inclusive and welcoming.

There are also problems getting the necessary services outside the home. Especially, service users with complex and special needs who require integrated and intensive health and social care interventions instead of occasional service encounters tend not to find their places in the fragmented system of outpatient community services (Kuluski et al., 2017; Novella, 2010). On occasion, adults in vulnerable life situations are stuck in their homes against their own will because of the reduction of institutional care. The ‘home turn’ benefits more competent service users with less severe conditions and limited service needs. The advantage of institutional care is that it allows all-inclusive care packages in which nutrition, housing, medical, and social care, rehabilitation, and social activities are provided onsite, whereas in community care, these services are usually provided by different service providers, often in different locations (Novella, 2010).

Furthermore, there are doubts about home-based services conducted via home visits. For instance, the so-called hard-to-reach service users—who are not cooperating participants in their care and support processes and who do not let workers enter their homes or respond to calls—are not seen as benefiting from home-based support services but as in danger of drifting outside the existing, unfit service systems (see Saario et al., 2021). It is also problematic that service users need to compromise the privacy of their home spaces and the rights to govern it when workers bring along their professional tasks, working tools, and expectations to the home space (Juhila et al., 2016; Winter & Cree, 2016). Thus, in extreme cases, the ‘home turn’ can mean an intrusion of the ‘institutional’ paternalistic and controlling practices to home spaces, even though they were originally planned to be demolished in the ‘community of care’ policy (Fallow & Nissen, 2019; Hall, 2011). In every case, it is unavoidable that visiting workers will not only be guests but also professionals with responsibilities to ensure service users’ safety and support their wellbeing, always somehow weakening service users’ self-determination in their own homes (Fallow & Nissen, 2019; Muzicant & Peled, 2018). This can involve, for example, the use of normalising power (Foucault, 1982). Juhila et al. (2020, p. 13) point out workers’ power in service users’ private space:

> Observing and commenting on the clients’ home environments does not just reflect sensitive and skilful ways to interact and use ‘soft’ power; it is also highly hierarchical and coercive, involving strong cultural norms and assessments of what is considered a normal enough home and living environment and what is condemned as too deviant to be acceptable.

Home space is also recognised as a potentially risky and unsafe environment for both service users and workers (Denton et al., 2002; Kuluski et al., 2017; Pink et al., 2015; Sawyer et al., 2009). For instance, service users can fall down, or their conditions can deteriorate without anyone knowing. They can cause a fire or damage the residence in another way. For workers, home as a workplace may mean exposing themselves to unpleasant smells, dirt, messiness, and bugs (e.g., Muzicant & Peled, 2018). They cannot know what they will confront in home spaces and how home visits will proceed (Denton et al., 2002; Juhila et al., 2021): Service users may be intoxicated, agitated, sleeping, or undressed, or there can be other people present besides the service users. In the 'home turn,' workers lose their 'professional territories,' such as office rooms or wards, and take on the burden of being on the move from one home to another (Muzicant & Peled, 2018). Sawyer et al. (2009, p. 363) argue how the 'home turn' intensifies the risks of community care:

> It is also important to note that both de-institutionalization and NPM [new public management] have significantly intensified the risks community care professionals and their employers face in their daily operations. Risks were previously absorbed within the routines and procedures of state-run and charitable institutions.

5. Conclusion

In the present article, we described two phases of the 'care in the community' policy: deinstitutionalisation and the 'home turn.' Deinstitutionalisation has seen large institutions and asylums replaced by group homes and communal-supported housing units in the community (Cummins, 2020). The second phase, the 'home turn,' emphasises well-developed community care services and everyone's right to have their own home. Accordingly, care and support are brought to the service users' homes and provided in outpatient health and social care settings. Although these two policy phases—deinstitutionalisation and 'home turn'—exist side by side, the 'home turn' represents the future direction of the 'care in the community' policy. From the literature, we have mapped widely shared incentives, premises, and criticisms of deinstitutionalisation and the 'home turn.' In addition, we have reflected on the possibilities of and hindrances to social inclusion in both policy phases. There exists a wide consensus that small housing units and supported housing with devoted workers enhance social inclusion better than big institutions.

The two policy phases can be interpreted either positively or negatively. It is important to pose, for instance, the question of whether home-based support services achieve security, wellbeing, and quality of life for the service user. Although home-based services are a strengthening way of providing services, they should not be taken as a given solution for every vulnerable adult with complex needs because needs are different and individual circumstances change (e.g., Tuokkola & Katsui, 2018, p. 17). In the 'care in the community' era, there is still a place for institutional care and housing (Chow & Priebe, 2013).

Research on the 'care in the community' policy with various accommodation, care, and support solutions often displays opposing conclusions, with little unanimity, leaving workers and policy makers with little guidance as to which models work and for whom (Mansell, 2005; McPherson et al., 2018; Priebe et al., 2009; Wiker et al., 2019). Hence, it is not surprising that the discussion on deinstitutionalisation has often emphasised polarised positions, such as the expansion of hospital care or its elimination, rather than searching for an optimal balance and integration of diverse service modalities (Hudson, 2019, p. 70). 'Either or' policy does not enable, for example, service users' smooth movements back and forth between institutional care and staying at home according to changing support needs. Future research on what types of service, support, and housing models are the most helpful for particular service users is clearly needed, along with what kinds of innovations are needed to provide better care and support in the community and service users' homes (Mansell, 2005; Priebe et al., 2009, p. 814). The possibilities and limits of the 'care in the community' policy are also questions that need to be studied more from a grassroots perspective, from the service users' and workers' points of views, and the encounters between them (e.g., Davidson et al., 1995, 1996; Juhila et al., 2016; Kuluski et al., 2017).

The central question in community care is how to balance providing the necessary care and protection for service users, on the one hand, and fulfilling the aims of normalisation, choice, self-determination, and social inclusion, on the other hand (Lambri et al., 2012). Occasionally, these aims settle in a conflicting way, causing an ethical burden to workers (e.g., Magnusson et al., 2003). It seems that the biggest challenge for the 'care in the community' policy is to ensure full social inclusion of the most excluded service users. The pervasive view is that deinstitutionalisation has not fulfilled its promise of social inclusion (e.g., Ashley et al., 2019, p. 699). Although the 'home turn' is a step in the right direction, there are still problems in strengthening service users' involvement and creating inclusive and accepting communities. Social inclusion may be the Achilles heel of 'care in the community' policies. Accordingly, advancing social inclusion could be seen as the third phase, or next step, of the 'care in the community' policy. For example, in Padgett's (2007) study, in their personal lives, former homeless service users recognised the 'next step' challenge after settling down into their own homes: Traumas, adversity, societal stigma, and discrimination make engagement with others in the community demanding.

Priebe et al. (2009, p. 811) make a crucial point by stating that "the lack of social contacts outside the housing project and of regular work may be more a result of the severity of many patients' disability than of insufficient support through staff in the housing services." Service users' ability to function and engage with others is an important factor to consider when assessing and supporting social inclusion. The question of what is sufficient and wanted from the service user's viewpoint regarding social inclusion in each case also becomes crucial. Another relevant factor to take into consideration is the workers' possibilities, skills, and abilities to promote social inclusion at the frontline of care and support in the community. Better implementation of the 'care in the community' policy relies considerably on workers' possibilities, efforts, and skills to enhance social inclusion, not so much on the accommodation and care models per se (McConkey & Collins, 2010).

Advancing practices that are in line with the 'care in the community' policy require, among other things, a renewed focus on the training of and support for frontline workers (Mansell, 2005, p. 25), as well as developing leadership and resources to facilitate workers' social inclusion work. Workers' contributions and endeavours to facilitate social inclusion have received relatively little attention in research and in implementing 'care in the community' policy (McConkey & Collins, 2010, p. 691). However, research that examines the everyday practices of the 'home turn' shows the skill, creativity, commitment, and willingness to 'do good' for the service users, as well as the control and presence of power in encounters (e.g., Brodwin, 2013; Juhila et al., 2016, 2021; Kuluski et al., 2017; Lydahl & Hansen Löfstrand, 2020; Magnusson et al., 2003; Raitakari et al., 2018; Ranta & Juhila, 2020; Sawyer et al., 2009). The 'home turn' is indeed a demanding and comprehensive change process that requires major financial investments and human resources. It influences the locations, frameworks, and practices of care and support work, as well as service users' positions in the community. Thus, it requires persistent development, time, and support from all participants—policymakers, managers, service users, frontline workers, and researchers—to take the next step towards full inclusion of all members of the community.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

The Right to 'Have a Say' in the Deinstitutionalisation of Mental Health in Slovenia

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Abstract

In a time when the deinstitutionalisation of mental health services has become a global and European platform and one of the main forms of care provision, a theme such as the transition of care from large institutions down to a more personal community level care might seem outlived, but the fact is that in some European countries the discussion has revolved for almost 35 years around the most basic question concerning the closure of large, asylum-type mental health institutions. In this article, I provide a historical overview and analysis of deinstitutionalisation processes in the field of mental health in Slovenia from mid-1980s onwards, interpreted in terms of achievements and gaps in community-based care and in user participation in these processes. It demonstrates some of the innovative participatory practices and their potential to transform services. A thematic data analysis was used to analyse the data collected from various primary (a focus group) and secondary sources (autobiographies, newspaper articles, round table reports, blogs) that all bear witness to the different periods of deinstitutionalisation and the user perspective in it.

Keywords

community mental health; history of deinstitutionalisation; tokenism; social movements; user participation

Issue

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1. Introduction

In this article, a historical overview and analysis of deinstitutionalisation processes in the field of mental health in Slovenia will be presented, interpreted in terms of achievements and gaps in community-based care, all from the perspective of user participation in these processes. In the first part of the article, basic concepts and briefly presented contexts of both the European and Slovenian situations in this field are introduced. The findings are presented in the narrative form of the interrelated histories of deinstitutionalisation and embeddedness of the user perspective in its implementation. The conclusion summarises the main historical lessons learned so far in relation to the questions posed in this study.

1.1. Deinstitutionalisation in Mental Health in Europe and Its Echo in Slovenia

Perhaps the most important shift in mental health care since World War II has been the transition of care for people with long-term mental health problems from large-format mental health institutions to community providers. Deinstitutionalisation in the field of mental health usually means the closure of large, closed institutions and, subsequently the provision of community services. However, it is important to understand deinstitutionalisation in a broader context. Deinstitutionalisation is also about people gaining sovereignty in everyday life, reclaiming control over their own lives, gaining support for decision-making, and producing new ways of care that transcend the institutional patterns (Flaker, 2015; Flaker & Ramon, 2016; Ramon, 1985). By the end of the 20th century, deinstitutionalisation became a universal policy of international agencies like World Health Organisation (2005), and the right to live in the community, along with others, is an important part of the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006). It is being implemented all over the world, in some countries more and in some less successfully. The first important deinstitutionalisation process in mental health care in Europe took place in the 1970s in Italy and was pioneered by Franco Basaglia in Gorizia and Trieste. His effort resulted in Law 180, passed in 1978, that abolished the psychiatric hospitals in Italy. Early and thorough deinstitutionalisation was carried out in the Scandinavian countries, and a little later in the United Kingdom (Flaker, 2015; Ramon, 1985). Today, reforms in mental heath care have taken place in most Western European countries. In recent years, a more pronounced European platform and policy (European Expert Group on the Transition from Institutional to Community-Based Care, 2012) has been the driver to finally start the process of transition to the community in many Central and Eastern European (CEE) countries or has started anew in some of them, as is true in Slovenia.

Despite this, there are still many people interned in institutions. Even in the countries where policies have been successfully implemented there are closed units, segregation, coercion, and above all institutional practices surviving in the community, such as grouping apartments into residential compounds and targeted exclusively for people with disabilities. There are also small institutions being introduced as community-based responses (re-institutionalisation), or people from one kind of institution find themselves in another institution after closure (trans-institutionalisation; see Flaker, 2015; Flaker & Ramon, 2016; Turnpenny et al., 2018; Zaviršek, 2017). On the other hand, community living arrangements pose challenges, such as living alone or in small groups, or they may also perpetuate isolation and segregation—which are the hallmarks of institutional life. The ‘care map’ in some states may now include group homes, day centres, employment support projects, advocacy, user organisations, relatives’ groups, family respite, outreach crisis services, mobile teams, housing floating support, and many other forms that grow in the empty space of needs for different types of support in the community.

The development of community-based care and the efforts towards deinstitutionalisation in mental health in Slovenia differ from other countries in the CEE region where deinstitutionalisation processes have only recently begun. In Slovenia, these processes were strongly influenced by the unique ‘deinstitutionalisation movement’ that emerged as part of the civil society movements in the second half of the 1980s in what was then still a common socialist state of Yugoslavia and continues to this day. However, although Slovenia had a long history of deinstitutionalisation and was a pioneer of community-based mental health (including user-led) innovation in the former Yugoslavia, it still has a predominantly institutional care system. The many attempts at deinstitutionalisation, fostered firstly by the movement (which grew and expanded over the years with various disability advocacy groups, academics, users, and family members), and later other actors (the NGO sector, public sector, government bodies) created a wealth of knowledge and the technology of deinstitutionalisation along with the methods of establishing community-based care that was not followed by system-wide deinstitutionalisation reform. Although today more service users use community care than institutional care, there is still a high institutionalisation rate. For people who need more intensive support and care, it is virtually impossible to provide it in the community. In such a still double-tiered system, often ex-residents return to institutions, which has the effect of strengthening the belief in public that institutions are inevitable. But independent living is a challenge, especially in terms of affordable housing and the means to live with dignity, even for people with less intensive support needs. Slovenia still allocates the bulk of funds to finance long-term care services in an institutional setting, while the community care services remain underfunded (Flaker et al., 2015; Rafaelič et al., 2017). It seems that the new wave of deinstitutionalisation that has now come as a guideline and requirement of the European Union represents not only a new chance for real systematic reform, but also the opportunity to reflect on overlooked dimensions of the deinstitutionalisation processes in the past.

1.2. The Transition of Care into Community and User Participation

The ethical requirements that are a prerequisite for the process of transition to community care are at least the following: the abolition of any closure and no constraint (Mezzina et al., 2019), the abolition of guardianship and mental incapacity (Ramon et al., 2017), the introduction of the social model of mental distress (Beresford, 2005; Tew, 2011), and an empowerment (strengths) perspective and user participation (Flaker et al., 2007; Ryan et al., 2012).

User participation (and associated terms such as ‘involvement,’ ‘inclusion,’ ‘co-production,’ ‘service user-led,’ and ‘peer-led’) seems to be the trademark of contemporary international and European social and mental health policies (e.g., European Expert Group on the Transition from Institutional to Community-Based Care, 2012; World Health Organisation, 2010, 2015), and part of most national policies. The right of active and informed participation of everyone in decisions that affect their lives is explicitly recognised in the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006).

User involvement in mental health services can be divided into three levels: individual, operational, and strategic. Involvement at an individual level is based on the belief that people have valuable insight into their own distress and can contribute to their own care (some examples include shared-decision making, self-help, self-management, advanced directives, and others). Involvement at an operational level in the day-to-day running of services may include participation in meetings or the training of mental health professionals. Finally, involvement at the strategic level has been increasingly informed by service user involvement in research and evaluation in governing bodies, and in the production or co-production of new services (Crepaz-Keay, 2014, pp. 105–108). Research findings in some countries have shown that service users have found it difficult to influence service providers and have a real impact on decision-making across all levels of service delivery (Omeni et al., 2014). Users who participate as peer supporters and peer advocates often experience that professional self-interest dominates the discourse and decision-making within the organisations (Penney & Prescott, 2016). That's why it is inevitable that concepts such as 'inclusion' (participation, empowerment) provide tools to be given to address power practically, not just as a *buzzword*, a form of new talk in mental health used to pretend while actually preserving old attitudes and ways of relating (Flaker et al., 2007; Urek, 2017).

1.3. Thesis and Research Questions

The basic questions I present in this article are essentially three. The first is how the deinstitutionalisation movement, and in particular user-led initiatives as its vital part, have influenced deinstitutionalisation processes in mental health services in Slovenia over the last 35 years. The second is whether service users have been actively involved in the implementation of deinstitutionalisation and whether these processes have enabled them to gain more influence and contractual power, i.e., whether their autonomy and the possibility to enter into equal relationships have been increased. The last question is, is there a gap between the declarative participation policy and lived experiences of participation?

My thesis in this study is that without a simultaneous strengthening of the influence and power of users, changes in the system and services cannot really be achieved and succeed, and they only remain apparent. In the long run, they are not sustainable since they necessarily lead to the reproduction of an institutional culture and the culture of dependence. Moreover, we cannot expect user empowerment and involvement to simply come spontaneously with organisational change; this particular aspect must be provided for in deinstitutionalisation policies, concretised in action plans, taken into account in funding and continuously followed-up. In short, this is a task (and a benefit) for everyone involved in deinstitutionalisation processes, and not just a matter to be left to service user organisations to advocate for. I argue that this is a systematically neglected dimension of the deinstitutionalisation process and, to a considerable extent it is the unaccomplished part of the project of the transformation of care in Slovenia. This is why the participatory and advocatory practices (including social movements and user-led initiatives) are all the more valuable companions of this process. They are among the more dynamic, insightful, and experience-based projects of deinstitutionalisation.

In this study, I present the interrelated and interwined histories of deinstitutionalisation on the one hand, and the embeddedness of the user perspective in the transformation of mental health services in Slovenia on the other. Several studies have been conducted on the history of deinstitutionalisation in Slovenia in recent years (Flaker, 2015; Flaker et al., 2020; Rafaelič et al., 2017; Zaviršek, 2017), but so far this aspect of history has not been highlighted, which I consider the original contribution of this study.

2. Research Methods and Data

The aim of this article, however, is not an in-depth study of the history that spans nearly four decades. The main interest is to highlight the main periods and milestones that are relevant in terms of key challenges and the potential of user knowledge to impact the reform processes—as reflected in the research questions—with the movement acting as a driver and amplifier of these voices. These marginalised aspects of knowledge—which have usually been considered less important—will be integrated into the main historical narrative.

The listed main historical periods, milestones, actors leading the process and more relevant attempts to reform the system of mental health services have served as a basic matrix that also turned out relevant in terms of referencing users' projects and making sense of the role of the user perspective through time and these processes.

The criteria for placing the data of various sources in a matrix that give evidence of the development of users' voices in various periods and, the guiding principle of arranging and analysing the material were the research questions to which I kept returning. The themes that crystallised in these periods as relevant were also partly identified by means of reference literature that helped to additionally categorise and analyse various practices and place them in a social and political context. Dispersed data on various user projects and practices that had a relevant impact on their empowerment were also found in reference literature.

Various other sources that were used as secondary oral, written, and visual sources were, for instance, leaflets and photographs (of camps, actions, various events), documentary films (Markun & Švara, 2018; Muratović, 2020; Robar Dorin, 1988), literary autobiographies (i.e., Lapuh Maležič, 2016), newspaper articles from *Altra: A Newspaper for Innovation in Mental Health* (issues published between 1994 and 2000), online diaries and blogs (i.e., a blog of the friends of deinstitutionalisation by Vito Flaker), an exhibition (Museum of Madness), and other sources that bear witness to the different periods of deinstitutionalisation and user perspectives in it and were collected over a longer period of time. Furthermore, the informal stories and anecdotes, for instance of people's endeavours to get out of an institution and stay in the community, circulating as a collective memory among the people who were actively involved in the process were also documented over a longer period of time. Round tables and public tribunes organised by the local user association should also be mentioned as a source. At least two played a more important role in this article, one was held on 2nd March 2021 (on how the epidemic of Covid-19 affected the peer-support and solidarity networks) and one on 28th June 2019 (on the users' view of deinstitutionalisation). I have taken the notes which helped me to fill in the gap of the missing pieces of knowledge pertaining to the final period of the last two years.

Last, but not least, the primary data was collected through a focus group interview with three lead members of the user association *Svizci* (the Marmots), which was held on 29th April 2019. It lasted three hours and was held at the Faculty of Social Work. Some of the orientation themes for discussion involved: evaluation of the current process of deinstitutionalisation, the positive and negative aspects of community care (housing, income, work), experiences in involvement; advocacy, and other practices that empower the possibility of decision-making. The selection of this association was based on the fact that it is, to my knowledge, the only user association that is keenly interested in the processes of deinstitutionalisation.

Thematic data analysis was used on the transcribed focus group interview and various documented materials, involving both a 'data-driven' and 'inductive' approaches (in the sense that the themes identified were commensurate with the literature). In some places, only a simple chronological arrangement of the documentary material was undertaken. This was combined with a biographical approach when presenting the biographical bits of histories of both users who become emblematic of the movement and the more invisible, who can be described in terms of 'hidden activists' (Rose, 2018), as well as of my own lived experiences in these processes.

I was involved in the subject researched in this study in many roles which gave the autobiographical and autoethnographic dimension to this study. This is not meant in a strictly methodological sense, but as self-reflection upon my position as a researcher, as well as in connecting personal experience to wider social meanings (Spry, 2001). My roles include being a student at the beginning of the deinstitutionalisation process, an activist in the movement, a volunteer, an academic, and a researcher. I understand my biased and involved position as an advantage which gives me knowledge and insights that might be otherwise missing. In addition, the autobiographical stance partly affected the narrative style of representation in this article.

3. The Return of 'the Forgotten': Deinstitutionalisation in Slovenia

The foundations of the deinstitutionalisation of the mental health field in Slovenia were set in the mid 1980s, although there are many aspects of this process which had been founded even before (deinstitutionalisation of children's and youth services in the 1970s and 1980s). Deinstitutionalisation in mental health occurred in several waves that can be summarised in the period of the last nearly four decades, with different actors playing a leading role (i.e., the social movement, NGO sector, public sector, and government bodies; see Flaker et al., 2008; Flaker et al., 2015). With the changing of eras and key developments, the position of users changed significantly, along with the role of social movement as the actor in the processes of change.

3.1. 1980s–1990s: Users as Companions of the Movement for Deinstitutionalisation

I first heard of deinstitutionalisation in the second half of the 1980s, when the students of the then School for Social Workers at the University of Ljubljana (now the Faculty of Social Work) first started to pay visits to the state asylum Institution for the Mentally and Neurologically Ill, Hrastovec—Trate (in 2010 it changed its name to the Social Care Home, Hrastovec—Trate; hereinafter Hrastovec). Hrastovec, with over 600 residents, was at the time one of six large asylum-type social care homes housed in two castles in a remote and isolated area in Northeastern Slovenia. The School of Social Work organised international volunteer camps where students and residents of the asylum socialised on more equal terms. At the end of the 1980s, some activists among the students and professors, along with other supporters formed the Committee for Social Protection of Madness. Various aspects of life in the Hrastovec asylum and of events and happenings in the camps are well-documented and reflected in published diaries, reports, and papers in the publications Flaker and Urek (1988) and Urek and Zaviršek (1991), as well as in a documentary directed by Robar Dorin (1988) and in a permanent exhibition in the Museum of Madness in Trate Castle, which at that time still housed the state asylum. The group continued to organise camps, events, and public discussions. In the 1990s, it became the first mental health NGO in former Yugoslavia and started to provide community services. In 1992, it established the first group home in the whole of Eastern Europe. With the naive optimism of youth, and in the midst of the lively bubbling of a variety of other civil social movements which were opening up new social issues, it was impossible to even imagine that 35 years later we would still have to deal with the same issue of the closure of institutions.

The users were relevant companions of the movement and perhaps for the first time, they had a say, but the main initiative and articulation of demands came from the people who did not have direct 'user experience.' It seems that in the first place, the movement had only begun to open the space of options for later autonomous user-led initiatives. For all who have participated in the activities of the movement, opportunities have grown to form equal relationships and friendships with people from whom they were previously separated by social distance. This was a new and valuable experience for all, which strengthened the sense of 'alliance in the same goal.'

3.2. 1990s–2000s: User-led Alternatives as Experiments and Innovations in the Time of the Emergence of the NGO Sector

3.2.1. Development of Community Services and 'NGO-isation of Resistance'

The first community services—group homes, day centres and clubs, self-help, advocacy and user associations, carers' forums, women's crisis and counselling services, and social enterprises were introduced in the 1990s in the NGO sector which was the leading actor in the second stage of deinstitutionalisation. The major resource and the hub for these developments was the EU-funded (Tempus) international interdisciplinary postgraduate programme Community Mental Health Studies established by the leading members of the movement at the School for Social Work at University of Ljubljana. The British impact provided some solutions such as advocacy, users' run services, personal planning, direct payments, while the Italian input was in the knowledge how to organise services, and the collective way of working. These approaches were coupled with Slovenia's own tradition and knowledge, which guarantee the autonomous development of innovations (Flaker et al., 2020; Flaker & Leskošek, 1995; Ramon, 1995).

The 1990s witnessed rapid growth of the NGO sector, the process some called the NGO-isation of civil society, which was characteristic for the whole of Eastern Europe. This process had many good and some bad effects. The good ones involved the concrete steps that were taken in the direction of the organisational innovations and in providing community services and their funding. In the 1990s, the Ministry of Social Affairs funded many new social innovations in the community through tenders for projects to which NGOs applied. What was initially a good and optimistic starting point eventually proved to be an obstacle, as 'projectification' of innovation in the long term meant instability, low wages for staff, and uncertainty for users as to whether they would be able to stay in the community service. It was not uncommon for NGO staff to prefer to maintain a group home at the expense of their salary when funding was lacking. At the same time, the political sharpness of the movements softened. The members of the movement became preoccupied with the functioning of their organisations, busy with innovations, and lost their advocacy edge (Flaker et al., 2020; Rafaelič et al., 2017).

NGOs are now dependent on state funding and they have been put in a position of competing against each other for territory and funds, which often weakens solidarity. Users became 'our' and 'your' users, the users of this or that NGO. Such a 'feudal' division was not particularly helpful in encouraging users to be more connected to each other with regard to shared issues. Throughout the 1990s, users slowly turned from the 'companions in the movement' to the 'clients and users.' Within the new professional culture, the sense of 'alliances for the same goal' was less and less reflected in the contacts between users and professionals.

3.2.2. User-led Innovations and 'Hidden Activism'

In contrast, this is the period of the emergence of some pioneering and daring user-led projects, which, however, mainly did not become formalised or acquired more stable funding. Among the insightful user or mixed initiatives that were emerging and disappearing, there were different forms of peer advocacy and self-help initiatives undertaken by the people with experience in mental health and committed relatives and friends (Lamovec, 2001). An important figure in this area was Tanja Lamovec, combining her academic work with her experience as a survivor, and with her innovation work in mental health. Even now, her books (Lamovec, 1995, 1998) are still the core study literature for prospective social workers. For many years, Igor Spreizer was the legendary editor of *Altra: A Newspaper for Innovation in Mental Health* (1994–2000) that covered the most pressing issues and emerging innovations in mental health. He was also a co-organiser of the first user conference in Slovenia, which eventually brought together users from all mental health NGOs in Slovenia. In the mid-1990s, the user association Paradoks established the first—and so far, also the last—user-led crisis centre. It worked on the principle of a cooperative for mutual help. The manual of work during the crisis that they designed is still relevant today (Lamovec & Spreizer, 2001). Unfortunately, there is no quantitative or qualitative evidence of this pioneering experiment, which eventually died off. However, in personal communication with the users involved in this project which I have had on many occasions over the years, it was noticeable that users/volunteers of the crisis centre felt safer there than on the acute wards of the hospital and were supported efficiently for the most part. This is in line with studies comparing acute psychiatric wards and crisis residential alternatives (e.g., Sweeney et al., 2014).

These experiences and other alternatives which enable people to have more control and be less exposed to humiliating rituals have to a large extent remained a hidden local knowledge and part of user subcultures. This is why singular anecdotes spread by word-of-mouth and that testify about the historical perseverance and resourcefulness of people with problems in mental health, so that they can maintain their dignity and control over their lives, are so much more valuable and worthy of more systematic documentation. Such is the inspiring story about a lady in her late middle years who with the power of her will, stubbornness, and determination managed to get out from the secure and closed unit of the Hrastovec asylum, where she lived from her childhood, and finally returned to the community. For several years, she insistently wrote to and called the Slovenian Ombudsman Office, requesting to be let out from the institution, until she actually made this happen. Presently, she has lived for at least 20 years in the residential group home in Ljubljana.

Although there was no specific participation policy in mental health during this period, we are dealing with perhaps the strongest imprint of autonomous user projects on the mental health care map. They believed that people with first-person experiences had valuable insights into their own distress and could help themselves on an individual level. They participated on an operational level in running services in NGOs. Finally, they worked strategically to build alliances among users, as well as their own services based on mutual support.

When we discuss the history of deinstitutionalisation, user and movement contributions are often overlooked. As well, actors such as experts, directors, ministries, and academics are highlighted, along with the indicators, such as the number of people resettled, the number of new group homes, and so on, while people who influenced this development in numerous ways, from grassroots, are overlooked. Perhaps one could not speak of a broader user movement at the time, but the seeds had been sown, and many of the activities of people testify to what Diana Rose calls ‘hidden activism.’ As she puts it, “this [hidden] collectivity is made of ‘small groups of unrepresentative people’ who are either sicker (i.e., angrier) or more articulate than ‘normal’ patients” (Rose, 2018, p. 736).

In general, this period was important for the creation of knowledge, methods, and technologies, and thus for providing the basis for later reform of the system. But in terms of deinstitutionalisation, the development of a community provision actually did not reduce the numbers in institutions. It also took place almost exclusively in the social care sector, while psychiatry remained more or less as it was. The lesson of this period was that to actually make deinstitutionalisation happen, more is needed than establishing community services, like: the planned resettlements from institutions, the political will, the legislation, the funding, in short, the reform of the entire system (Flaker et al., 2008; Rafaelič et al., 2017).

3.3. 2000s–2010s: Opening Up of Institutions and Changing the Role of the Residents

The real deinstitutionalisation process in the public sector was initiated in the first decade of this century by the resettlement of the long-stay inmates of Hrastovec (almost 300 out of 650 residents in few years), followed also by another five long-stay institutions that also began to open their own group homes which resulted in 1,259 resettlements or more than a quarter of total capacity of long-stay institutions in Slovenia. These social care homes proved that the transformation of institutions was possible, that it was possible to change the way of work, and resettle even people with the most intensive needs. However, when deinstitutionalisation would have to become a principle guiding the whole system, the process came to a standstill. Among the reasons for these halts the managements of the institutions mentioned: a lack of political will, legislative restrictions, bureaucratic obstacles, the additional cost that residential units bring beside the cost of the maintenance of the institution, no sufficient funding, and others (Flaker et al., 2008, 2015, 2020; Rafaelič et al., 2017). Long-stay institutions also remained big employers of the local population, especially in rural areas. Many workers fear that deinstitutionalisation will cause unemployment, and that it is better to keep the existing welfare system in place (Zaviršek, 2017).

In terms of user involvement, good examples mainly include involvement practices at the operational level. For example, in Hrastovec, they employed some interesting innovative methods. The residents were invited (and were trained) to take the role of key-workers and advocates for other users who needed more support and encouragement. This experience showed that the users/key-workers became more confident and that other users accepted the support from their peers much better than the support from staff members (Strmšek, 2007). In line with the research question, we can certainly say that these processes at least gave more influence to the ‘more able’ residents, increased their autonomy, and presented the opportunity to enter into more equal relationships. However, these were not simple processes: on the contrary, they required a daily struggle with the remains of the institutionalised and patronising mentality from the staff and residents.

Studies have shown that an impact is only visible where participation truly becomes an integrated part of the philosophy of an organisation and the people who work there. If participation is seen only as an activity ‘added-on’ to services, rather than as a way of changing power relations, it can be removed as easily as it was provided (Hernandez et al., 2010, p. 717). This was the case with the innovation of ‘users as keyworkers.’ This innovation was increasingly becoming only an ‘add-on’ until it was abolished with the next management.

3.4. 2010–2020: Fourth Wave: Between Struggle for a Decent Life Outside Institution and Demands to Be Heard

3.4.1. At the Turn of the New Decade: Formalisation of Users' Participation and Users' Research

After the process came to a standstill, civic movements again started to call attention to the necessity of re-establishing the process of the transformation of the institutional form of care. At this point, in 2010, a walkout—a 700 km march from institution to institution—was staged to raise awareness and promote deinstitutionalisation. Some residents of institutions who joined the march on the way stayed and started to live in the community with the support of activists (Flaker & Rafaelič, 2012; Rafaelič & Flaker, 2012). Such was Mijo Poslek, who spent 40 years in various asylums (we met him in the first camp in Hrastovec). Under the slogan "We are All Mijo Poslak," the movement addressed direct demands to the ministries to launch concrete actions towards community care provision (Agency IN et al., 2012).

The turn of the decade was marked by the newly defined role of the users as being more explicitly participatory. The user perspective became recognised as being of key relevance, at least at the declarative level, and the user representatives were gradually introduced, but mostly just in user councils in NGOs. In the academic sphere, this was reflected in a more systematic inclusion of users in education and research (Videmšek, 2013, 2021). The *Mostovi* (Bridges) user association undertook the first autonomous user research study of the critical areas of income and work. The findings of the study pointed to a high degree of disability retirement and unemployment after the onset of mental difficulties. In order to cover their basic living expenses, and also in order to remain active, the users are often forced to work illegally and to enter risky working relationships (Cigoj-Kuzma, 2010). When users do the research, that is, when they really can make decisions about which topics to explore and which issues to raise, their research is often about poverty and basic survival, because this is something that most deeply marks their lives and requires the fastest systemic solutions. The themes that they raise are deeply social and deeply political. Although the activities carried out by the Bridges user group included peer advocacy and self-help, implying participation on the personal and organisational levels, the main achievement of this period seems to be the concrete shift of participation to the strategic level (research, going public).

3.4.2. The Gap between the Systemic Reforms and Grassroots Knowledge

Recently, a trending topic is the new 'fourth wave' of the transition to the community forms of care, which comes as a guideline and requirement of the European Union. Among the positive shifts in this context, The Resolution on the National Programme for Social Care 2013–2020 (Republic of Slovenia, 2013) should be mentioned, which announces a substantial reduction of institutional capacities (from 50% to 80% for individual categories of residents), and a large increase in services in the community. Recently, the Governmental Office for Development and European Cohesion Policy issued a grant decision for two pilot deinstitutionalisation project units, the first in a social-care home and the second in a centre for training, work, and care for people with intellectual disabilities which received European Social Fund support to make a transition of care into the community over the next few years. A project unit for deinstitutionalisation was established at the Ministry of Labour, Family, Social Affairs and Equal Opportunities to draft sectoral strategies which will allow for delivering a coordinated action in this field. In all these big, promising, and groundbreaking developments the voice of the users has not been prevalent. Big decisions about the change of the system are being adopted on policy levels and in the closed circles of the sectorial ministries and experts. On the other side of the divide, the user research generates new 'grassroots knowledge,' which, however, also does not have adequate channels to reach the decision-makers.

On the positive side, we are dealing with a very important shift at the declarative level, when also at higher levels decision-makers increasingly recognise (or are urged by the EU) the importance of user participation—but a concrete step of implementation is still too rare. While the Resolution on the National Mental Health Programme 2018–2028 (Republic of Slovenia, 2018) foresees user participation on all decision-making levels, and even the user council was set up to participate in the making of the resolution, the 'voice of the users' seems to have been only declarative (in the last moment, instead of the user representative they appointed a representative of relatives to this position). The result is two parallel, separate realities still standing apart from each other. In real life, this gap can mean numerous complications.

A decade later, it is obvious that none of the real problems that were opened up by the first user research study was not systemically solved. Today, users are working on a new study conducted in the framework of *Svizci*. This new study re-opens old problems in the areas of work, housing, and survival (Cigoj-Kuzma et al., 2019). I conducted a 3-hour interview in a focus group with its three key members, at the Faculty of Social Work (24 April 2019). The most frequent metaphor that they used, when describing their experience with the social care and mental health system was that of a 'closed door': "Big changes led by the ministry may be alright, I don't know, but only experience matters. When you have the experience, the doors are closed for you." The transitions to independent life have remained the most burning issue. The problem are rents, as the rental of a place to live is higher than a person's disability pension. Social assistance benefits do not cover other expenses, and it is becoming ever more difficult to be eligible for them. To put it simply, independent life is difficult to afford, which is why many people are destined to live in institutions or group homes or are barely getting by in their parents' homes. The problem is that systemic regulations and legislation are not written from the users' experience ("The system puts up front some strange, ideal user that does not exist"). At present, we can repeat once again, in the words of Liz Sayce (2000, p. 83), "users enjoy only the illusion of citizenship." Their wish is to encourage people to join them in resolving their shared problems: "We depend too much on institutions, and we learn too little from our own practice." In the users' public tribune (2 March 2021, via Zoom), it became clear that during the Covid-19 pandemic, of all the actors in the field of mental health, it was the users who built the human solidarity network to the greatest extent.

4. Between a Movement and a Seat on the Users' Council: A Discussion on 35 Years of Deinstitutionalisation and User Participation in Slovenia

While returning to the main questions raised at the beginning of this article, we also try to summarise the main forms and characteristics of user participation and the lessons learned in different periods. Unfortunately, I could not mention all the user groups, initiatives, or forms of participation, for instance, the support group of voice-hearers (Dekleva & Škraban, 2019) or one of the oldest user organisations for the self-help of people who had experienced depression and anxiety; or literary autobiographies that were eye-openers for me (Ažman, 2007; Lapuh Maležič, 2016).

The review of the periods reveals that historical development was not always linear and did not necessarily proceed from a bad state of affairs to a better one. Some levels of involvement were more forward in one period and less in another, but we have been able to identify all levels (Crepaz-Keay, 2014).

Looking back on the independent user alternatives of the second wave and from today's perspective, what surprises us is their autonomy, and their self-confidence in establishing independent services in areas—which even now are firmly anchored in psychiatry (such as user-led crisis centre). They aspired to work with other users and professionals to organise support for themselves, and to have control in helping relationships. They were aware of the importance of writing and finding their own language to reclaim an autonomy to describe their distress and what was helpful. They were important for the creation of knowledge and methods, and thus for providing the basis for later reform. The lesson from this period is that permanent funding and training are crucial for sustainability of innovations, so much the more for user-led projects.

In a different context, after the year 2000, the beginning of the reform of the social care homes highlighted the reflection about the ways of strengthening the influence of people who had lived for decades in the passive and mortifying roles of inmates in closed and secure units. Movement and user-led projects were in the background during this period. But the innovations that developed in this period were directly inspired by previously acquired experience and knowledge (international studies, user projects, camps, NGOs). Probably the most valuable message of this period is that it is important—when talking about user involvement in deinstitutionalisation processes—not to overlook the users who are the most seldom heard and least vocal about their needs. The first barrier to overcome is the staff belief that people with severe mental health problems are not able to contribute, when in fact they are if they are supported, encouraged, and trained (Hernandez et al., 2010).

The United Nations Convention on the Rights of Persons with Disabilities mainly brought the requirements for the necessity of formal user representative participation. This formal participatory mechanism is of key importance and big achievement, but it will not be able to become the tool of change if the awareness about rights and the need to take action will not involve a larger number of users. At the moment, there is still a large gap between the declarative participation policy and the lived participation experiences. Although we have primarily highlighted tokenistic practices, there are also good ones when users manage to use formal mechanisms to influence something more than just confirming the decisions of others. However, that gap is worth remembering while it exists. In the meantime—this is the good news—the autonomy and self-confidence of users' voices is visibly increasing. Nevertheless, genuine and routine channels for dialog must be established so that users' experiences and their proposals (i.e., from user research studies) find their way to decision-makers. In the movement, from its beginning in the mid of 1980s, users might participate more directly. Yet, the agenda is still mainly led by activists who, while solidarising with users, do not give up their position of the 'Others'; in other words, they are not ready to "transcend the traditional division of roles into allies on the one hand and those who need allies on the other" (Russo et al., 2018, p. 1).

However, it should also be noted that even as we write this article, some positive changes are taking place. Not only positive moves towards genuine deinstitutionalisation through a stronger political will than ever before, but there are also some signs of direct visible effects of the messages that have been sent out all these years. One of the two institutions that are now undergoing a transition, has set the empowerment of residents as one of the priority goals. They are trying to achieve it through regular assemblies of residents and staff on the wards, through the board of users, through residents' self-advocacy groups, and by working closely with the

Svizci user group which provides training for residents to help them set up an advocacy group (and they are paid for this). At the same time, extensive trainings for staff who will eventually also ‘resettle’ from institutions is taking a place—an important theme which we barely touch in this article.

I see this as two achievements, firstly the mainstream institution has recognised the normally marginalised user knowledge as necessary to its work, and secondly, it has recognised user empowerment and participation as a necessary dimension of the processes of deinstitutionalisation. In relation to the research questions, users (at least some of them) here are involved in the deinstitutionalisation process (while the *Svizci* user group directly influences it), and they are gradually gaining more contractual power. A gap between the declarative participation policy and the lived experiences of participation here finally seems less wide here. The lesson learned here is that user empowerment and participation will not just spontaneously accompany organisational change; it must be foreseen in deinstitutionalisation policies, put in action plans, taken into account in funding, and monitored.

Although we criticise that the users’ role within the systems of help is not relevant enough, their role can also get caught up in contradictions. The neoliberal framework of social policy presents a challenge for participatory practices. User participation, yes, sure, but in what? In the responsibilisation of impoverished users for their own well-being? The secure units packed with people do not lead the reflection towards the improvement of approaches to work in the community but look for funds to build new closed structures. Shall users participate in decisions legitimising such new buildings? Similar doubts can be raised at the fact that institutions opposing deinstitutionalisation are at the same time introducing progressive emancipatory methods, such as self-advocacy, peer support, or users’ council in the units. In such circumstances, the user participation seems a perverse concept and paradoxically contributes to further strengthening the arguments for the existence of institutions. User participation is, in my view, inevitably linked to deinstitutionalisation, and vice versa. It is inevitable to understand participation not as a ‘true’ but rather as a ‘contested’ term, terrain of political debate (Ferguson, 2011, p. 57). By failing to recognise the conflicting agendas in debates about it, there is a risk to limit its liberatory potential.

5. Conclusion

Although deinstitutionalisation sometimes seems like a matter of reorganisation, it has always been linked with social movements. In today’s strange times, in which on the one hand deinstitutionalisation has become a global platform, and on the other, the renewed demands for closing and coercion have entered areas where they did not exist before, applying to ‘non-normative’ groups at the new social margins, we need a broader coalition of deinstitutionalisation, alliances rather than allies (Russo et al., 2018, p. 1), to resist these trends. Perhaps we can start by reminding ourselves again that its real purpose is above all to open up society. But in doing so, the first step is—to conclude with Diana Rose (2018, p. 738): “To get rid of every last vestige of charitable but patronising approaches and be ready to face anger, suspicion, and dark, sometimes shocking, humour.”

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Article

Fringe or Not Fringe? Strategies for Localizing Supported Accommodation in a Post-Deinstitutional Era

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Abstract

Finding suitable locations for supported accommodations is crucial both for the wellbeing of individuals with psychiatric disabilities (PD) and to achieve the objectives of the mental health care reform in order to create opportunities for social inclusion. This article explores municipal strategies for localizing supported accommodations for people with PD. In a multiple case study, interviews with 20 municipal civil servants from social services and urban planning were conducted. Three strategies were identified and further analyzed with a public location theory approach: (1) re-use, i.e., using existing facilities for a new purpose, (2) fill-in, i.e., infilling new purpose-built facilities in existing neighborhoods, and (3) insert, i.e., inserting new premises or facilities as part of a new development. The article shows that the "re-use" strategy was employed primarily for pragmatic reasons, but also because re-using former care facilities was found to cause less conflicts, as residents were supposedly used to neighbors with special needs. When the "fill-in" and "insert" strategies were employed, new accommodations were more often located on the outskirts of neighborhoods. This was a way to balance potential conflicts between residents in ordinary housing and residents in supported accommodations, but also to meet alleged viewpoints of service users' need for a quiet and secluded accommodation. Furthermore, ideas associated with social services' view of social inclusion and urban planning's notion of "tricky" tenants significantly influenced localization strategies. Finally, this article is also a call for more empirical research on the decision-making processes, use of strategies (intended or not) and spatial outcomes, when localizing supported accommodation for people with PD and other groups in need of support and service.

Keywords

municipal localization strategies; psychiatric disabilities; public facility location; social inclusion; supported accommodation

Issue

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1. Introduction

Mental health care and support provision, in a Global North context, is characterized by a history of treatment, care, management and particular institutional spatial arrangements, often characterized by isolated and relatively sizable asylums facilities (Högström, 2012). Following heavy criticism, a paradigm of protracted deinstitutionalization process in psychiatry began in the later part of the 20th century (Kritsotaki et al., 2016). Instead of providing asylum-based care in isolated settings, the new paradigm advocates care and support in community-based settings (Fakhoury & Priebe, 2007) and, if needed, inpatient care at psychiatric clinics, often located in general hospitals instead of in specialized mental health hospitals (Högström, 2012). In the Swedish context, one policy objective of the mental health care reform was to create preconditions for people with psychiatric disabilities (PD) to have the ability to "participate in society and live like everyone else" (Ministry of Health and Social Affairs, 2001, Chapter 5, Section 7), and to create opportunities for recovery (Government Offices of Sweden, 2012; cf. Slade, 2009). This new mental health care provision paradigm and the contemporary mental health services is to a great extent framed by a "freedom of choice" paradigm (Fjellfeldt, 2017). These emerging trends are referred to as the "post-deinstitutionalization era" (Markström & Lindqvist, 2015; Rosenberg, 2009). The concept of the post-deinstitutionalization era draws attention to and characterizes the challenges attributed to the "second generation" of community-based mental health services and interconnected spatial arrangements. Here it is generally argued that mental health care systems are slow to change, as they are closely interlinked to local traditions and customs. Services tend to still be delivered in closed settings, and the service delivery organizations struggle to meet the needs of a new generation of users. Swedish policies for a recovery approach to mental health care appear consequently difficult to implement on the local level.

Mental health services in community settings in Sweden are largely organized through two forms of housing and interconnected forms of support depending on need: supported and ordinary housing with outreach services. Approximately one third of people with PD in Sweden live in supported accommodations, making it the cornerstone of Swedish mental health service provision (Tjörnstrand et al., 2020). Although we know a great deal about the characteristics of individual buildings and the perceived quality of service provision from the users and carers perspectives (Eklund et al., 2017; McPherson et al., 2018), we know surprisingly little about the processes of localizing the accommodations in the wider societal context, and whether the locations are supporting the intention of the mental health care reform of creating opportunities for people with PD "to live like everyone else" (Ministry of Health and Social Affairs, 2001). Here we recognize that location and the wider living environment matter for the group's health and wellbeing (Fossey et al., 2020). Therefore, they are a key for successfully implementing the mental health care reform of community-based services, as the location of supported accommodation may operate to support or hinder social integration and social inclusion (Government Offices of Sweden, 2006). By social inclusion we refer to "a desired goal that requires equality of opportunity and participation in the rudimentary and fundamental functions of society" (Rimmerman, 2013, p. 35), whilst recognizing that social inclusion also operates as a moral imperative for which those diagnosed with PD become targets (Barlott et al., 2020). Such a moral imperative is understood as having both empowering and controlling forces. Striving for inclusion demands adjusting to a majority culture (i.e., the norm), while the mental health service and the spatial arrangements of the supported accommodations simultaneously work to uphold a minority culture of people with PD as "minor" and other than the norm.

There is little research on the processes of locating supported accommodations for people with PD, and the consequences the localization strategies have for goals of social inclusion. A majority of the studies focusing on localization processes were made in the first wave of research on deinstitutionalized mental health care, from the mid-70s to the early 90s, with its home base in the geographical sub-field mental health geography (Wolch & Philo, 2000). The focus was on spatial-distributional questions, aiming at tracing the shift from large-scale asylums into community-based care, and also, onto the street. For example, Wolpert et al. (1975, p. 24) discussed the mental health center as a "noxious facility," needed in neighborhoods but not desired by the residents, and pointed to the fact that there were no specific outlined guidelines for where to locate them. They identified, however, two strategies concerning the actual "siting" of the facilities used to counteract the residents' resistance: (1) a low-profile approach in which communities are educated and coerced into accepting a facility before it was introduced and (2) a "fly-by-night strategy" entailing setting up a facility secretly in the hope that it would not be noticed until its operation could demonstrably be proven to be harmless. Dear (1978) added a third strategy: (3) a risk aversion strategy involving seeking out locations where no community opposition was anticipated or where controversial, "noxious" facilities would go unnoticed, most often in less affluent communities making ideals of social inclusion difficult to achieve. The stigmatization of people with PD is raised as a central component, often called the NIMBY (Not In My Backyard) phenomenon, making it difficult to locate supportive accommodations (Piat, 2000). Dear and Wolch (1987) examined the emergence of "service-dependent ghettos" in the North American context, i.e., the agglomeration of socially dependent people in inner-city areas, which was another unexpected "solution" to the problem of developing community-based care for a variety of groups in the early days of deinstitutionalization. More recent research on the topic has reworked the localization of mental health services arguments into wider arguments about the spatial preferences of neoliberal restructurings (cf. DeVerteuil, 2000; Högström, 2018; Lowe & DeVerteuil, 2020), privatization of medical/care spaces (cf. Hossler, 2012) but also highlighting the benefits of a central location, proximity to nature, transportation, shops and restaurants, according to the service-user themselves (Brolin et al., 2018).

These examples from earlier work around deinstitutionalization makes us curious about the challenges for localizing supported accommodations today.

Are there stigmatization processes at play when localizing supported accommodations in the Nordic post-deinstitutional landscape? Is the notion of "service dependent ghettos" and "noxious facilities" applicable in the Nordic context, and if so, still valid? Do the strategies for locating the accommodations support social inclusion? These rhetorical questions point to the urgency of moving away from analyzing individual housing in isolation from the context they are situated in (cf. McPherson et al., 2018; Tjörnstrand et al., 2020) and instead emphasizing the overarching strategies for localizing supported accommodations to achieve policy objectives. Our interest is congruent with what Philo (1997, p. 78) described as "the complex maneuverings involved as administrators, planners, politicians, community leaders, mental health professionals and facility users argue their way through locational conflicts which are commonly resolved… in favor of powerful and 'respectable' suburban interests."

This article aims to develop a better understanding of municipal strategies for localizing supported accommodations, and whether they support the objectives of social inclusion. A common definition of strategy is a plan, which entails some sort of conscious, intentional course of action to manage a situation (Mintzberg, 1987). However, some strategies appear without preconception, rather they emerge as patterns in a stream of action, as a response to external forces. In this study, we follow Mintzberg's definition and approach strategies as (emergent) patterns. The results stemming from the study have the potential to be directly relevant for policy makers and planning decision-making when planning new supported accommodations. The following research questions organize the study: What municipal strategies characterize processes of localizing supported accommodations for people with PD? What assumptions about people with PD underpin the strategies?

To clarify, the aim of the study is *not* to examine whether individuals that live in supported accommodations de facto are included in society, but whether the localizing strategies could be understood as supporting the underlying aims of social inclusion. This study is part of a larger research project with the overarching objective of developing knowledge aimed to support socially inclusive living environments for people with PD. The user perspective of the wider living environment of the supported accommodation is subject to analysis in a forthcoming study.

This article is organized in five sections. Following this introduction, which has set out the general research problem, aims and research question, the next section outlines the analytical framework. In the third section, we present the overarching method, procedure for analysis and empirical material. This is followed by a fourth section, an analysis where we identify three different location strategies for supported accommodations: "re-use,'' "fill-in," and "insert." In the conclusion, we argue that "fill-in" and "insert" strategies may result in "fringe localizations," in which the facilities can be said to be integrated in the neighborhoods but in a fringe position. We, furthermore, argue that such "fringe localization" seems to be the result of compromising and negotiating values in planning decision-making, but is not necessarily ideal for creating opportunities for social inclusion for people with PD.

2. Theoretical Framework

Public facilities are here understood as "those units whose primary function is to deliver goods and services which fall wholly or partly within the domain of government" (Dear, 1978, p. 94). We adopt this definition by incorporating supported accommodations for people with PD. Our theoretical framework is based on the three dimensions of localizing public facilities outlined in Dear (1978): as access, externalities, and social context, which builds on previous work on public facilities location theory (DeVerteuil, 2000). We agree with Dear's (1978, p. 98) argument that "analysis of the spatial expression of public intervention insists upon a theory of society as well as a theory of space." We would, however, push this towards a clearer relational understanding of the nexus society-space. Here, "space" is not understood as "a container in which things happen, but as a complex mixture of nodes and networks, places and flows, in which multiple relations, activities and values co-exist, interact, combine, conflicts, oppress and generate creative synergy" (Healey, 2007, p. 1). When Dear (1978, p. 98) claims that there is "a direct correlation between social policy and spatial outcome," we would see this in a relational perspective, as even though the spatial aspects are in many respects "outcomes" of social processes, social conditions will also emerge out of spatial arrangements.

In analyzing the strategies for localization with help of the three dimensions mentioned above, we approach "localization" as producing different forms of (1) access—as availability of services, social encounters, cultural experiences, etc., but also as the enabling factor public transportation or other mobility measures have for accessing those—and (2) externality—the impact or external effects on the "users" (i.e., the mental health service users) and "non-users" (i.e., neighbors) produced by the localization process. These are divided into user-associated externalities and neighborhood-associated externalities in the host community, and could be tangible (e.g., more traffic) or intangible (e.g., fear). The third approach as outlined by Dear (1978) refers to localization decisions in the context of the wider socio-economic and political formation which place mental health services and spatial considerations right into the socio-political context. A wide range of factors act in relation to each other, for example, ideas of independence and civil liberty, planning and land-use policies, fiscal values and cost savings, welfare state restructuring, as well as conceptions molded throughout history (e.g., stigma and other exclusionary discourses related to people with PD). We define this third approach as (3) the social context, including spatial circumstances, socio-political considerations and other conditions underpinning localization decision-making.

This study is situated within the post-deinstitutional era characterized by the recovery paradigm (Slade, 2009). In a recovery oriented mental health service perspective, access to areas supporting personal development, close relationships and peer-relationships, as well as areas promoting well-being, should be taken into consideration when locating an accommodation for people with PD. In the recovery perspective, access to a social environment where people can develop valued social roles, and areas where they can develop a positive identity by experiencing identity-enhancing relationships, should be considered. We will analyze the localization dimensions in light of the relevance for recovery for persons with PD, which means we will focus on the wider community mental health setting as well as the more detailed spatial arrangements.

3. Methods and Data

The research is a Swedish multiple case study (Yin, 2014) of municipal processes of localizing supported accommodations in built up areas. The objective for conducting a multiple case study was to develop a broader understanding of strategies that are employed for localizing supported accommodations across different cases, and not only from one single case. We selected the typical and average cases (cf. Flyvbjerg, 2007) for localizing supported accommodations in Sweden. These cases are not presented as particularly successful, “good” or extreme. Five cases were chosen to represent typical localization processes in Swedish municipalities of different sizes, in diverse parts of the country. Our selection is based on a national compilation (Swedish Association of Local Authorities and Regions, 2016) which divides municipalities into categories according to size and character (Table 1). We have also strived for a balanced geographical mix in the selection.

3.1. Empirical Material

In each case, key stakeholders involved in processess of localizing supported accommodations for people with PD have been interviewed. This includes urban planners, social service strategists and heads of administration. Altogether twenty (N ⍰ 20) semi structured, face-to-face interviews were conducted (cf. Brinkmann & Kvale, 2018). The interviews were carried out between February 2019 and February 2020, each interview was 30–45 minutes long, recorded and transcribed verbatim. The principles of informed content, voluntary participation and confidentiality were applied. In the interviews, we asked questions such as: How are processes of locating supported accommodations carried out? What actors are involved? Were any difficulties encountered in the process? To what extent were the users involved?

In addition to the interviews, detailed development plans and site plans, showing proposed urban development were included in three cases in which new buildings were either recently built or planned for in the near future (cases 2, 3 and 4). In one of these cases, a planning document that describes the local environment was included (case 4). In the two other cases (cases 1 and 5), new buildings were not scheduled within the timeframe of the current study period.

3.2. Empirical Context of Locating Supported Accommodations

Localizing supported accommodations is in Sweden a municipal endeavor, and engages a range of different professionals, especially urban planners, social strategists and public facilities strategists. The activities are regulated by the Swedish Planning and Building Act (Ministry of Finance, 2010) that stipulates that any planning or development should be pursued with the overarching ethic of the public interest. The activities are furthermore regulated by the Social Service Act (Ministry of Health and Social Affairs, 2001) which stipulates that the municipality should provide “adapted” accommodation in ordinary housing, or supported accommodation, to people encountering significant difficulties in their lives

Table 1. Size, character and geographical location of the municipalities of the cases.

Municipal processes of localizing supported accommodation	Character of the municipality	Population	Geographical location in Sweden
Case 1	small city	64 000	South
Case 2	commuting municipality close to a medium-sized city	11 000	Mid
Case 3	small city	57 000	Mid-north
Case 4	part of a metropolitan area	96 000	Mid
Case 5	commuting municipality close to a smaller city	15 000	South

due to mental reasons. Since the deinstitutionalization of mental health care in Sweden in the late 1980s, social inclusion of people with PD has been a guiding norm of social services provided (Ministry of Health and Social Affairs, 2001).

3.3. Analytical Procedure

The initial analytical procedures resulted in themes based on the civil servants' experiences, ideas and values concerning municipal processes for locating supported accommodations (Clarke, 2003). At this first stage, three empirical strategies that we label as "re-use,'' "fill-in,'' and "insert" were identified. Enabling an in-depth analysis in a second stage, the analytical framework of three dimensions of localizing public facilities was applied (Hsieh & Shannon, 2005). The analysis was conducted by the four authors in a collaborative manner, which included a continuous discussion across disciplinary boundaries of social work and urban planning.

4. Municipal Strategies for Localizing Supported Accommodations

This section presents the results of the analysis, with the three strategies for locating supported accommodations ("re-use," "fill-in," and "insert") and how they are reflected in our five cases and analyzed by using the lens of localization of access, externalities and social context.

4.1. Re-Use: Using Existing Buildings for New Purposes

The "re-use" strategy was prevalent in all five cases and is characterized by re-using existing buildings for new mental health services purposes. The buildings subject to re-using had previously been used as residential homes (e.g., as refugee accommodations or nursing homes). One significant consequence of this strategy is that the accommodations are not purposely designed for mental health services, rather for people needing social services generally. One social service civil servant states:

> The old accommodations were never initially intended as supported accommodations. I think it was a senior retirement home from the start, which was displaced to another location.... So, it was nothing more, a vacant space. We take it. (case 3, social services)

The existing buildings in our cases were located in neighborhoods with a long tradition of accommodating people in need of societal support. The "re-use" strategy had been used for decades and was viewed by the social service civil servants as a pragmatic solution.

In terms of access, the existing buildings, referred to in the cases, were located in established neighborhoods well serviced with public transportation. The buildings were described by the interviewees to often be centrally located in the neighborhoods, providing the residents easy access to various services, sport activities and grocery stores. Having access to public transportation was raised as an overarching concern among the social service civil servants in all cases since they recognized that the mental health service users often lacked a driver's license.

Concerning externality, the "re-use" strategy could be considered in a twofold respect. On the one hand, the social service civil servants experienced the relationship between the accommodation and the neighborhood where it was located as unproblematic. The latter was described by a social service official in case 5 as a community where human differences were understood and tolerated. On the other hand, user-associated externalities occurred, as some social service civil servants underlined the importance of ensuring resident anonymity regarding their home and ensuring the accommodation would not stand out in the neighborhood when they advocated for a "blend-in" architecture. This idea was, however, not supported by letting mental health service users move into buildings with a history as public facilities, as in case 3, a former elder care home.

When it comes to the social context, civil servants in social service in cases 1, 3 and 5 used such expressions as "you take what you get" when describing the "re-use" strategy, often referring to a general shortage of suitable housing and buildings and, as such, relating to a wider social and political context. To be able to meet the requirement to provide housing to persons belonging to the target group in the near future, this strategy was experienced by the social service civil servants as a pragmatic solution. There seemed to be no particular social ideas of inclusion and recovery, nor urban planning ideas of densification or sociable living environment space underpinning this strategy. Providing accommodations with a reasonable standard of living according to the Social Service Act appears as a difficult enough goal to accomplish.

Table 2. An overview of the incidence of the strategies in the five cases.

	Re-use strategy	Fill-in strategy	Insert strategy
Case 1	X		X
Case 2	X	X	
Case 3	X		X
Case 4	X		X
Case 5	X		

4.2. Fill-In: Purpose-Built Supported Accommodations in Existing Neighborhoods

The "fill-in" strategy that was used in one of the cases (case 2) concerned allocating land for purpose-built supported accommodations in already built-up neighborhoods. The new accommodations were planned to be located on existing park or woodlands in the outskirts of the neighborhood. This strategy is characterized by being conflictual and time consuming (e.g., years) due to the many protests during the planning process. Similar experiences of time-consuming processes led municipalities in the other cases to abandon this strategy. In case 2, in which the strategy (still) was prevalent, the municipality was confronted with a situation in which one existing supported accommodation was assessed as inadequate and inappropriate by the Health and Social Care Inspectorate as it was seen as too institutional-like. As a result, the municipality planned to localize a new purpose-built accommodation in an existing neighborhood. The accommodation was initially planned to be localized in a central part, but the municipality was forced to change the location to another neighborhood due to complaints. The social service civil servants stressed in the interviews that no final political decision about the localization for the supported accommodation has yet been made.

Concerning access, the "fill-in" strategy meant that the new supported accommodation was to be sited between two neighborhoods (case 2). This signified mental health service users were to be living in between two already established neighborhoods and set up services, such as public transportation. In a first stage of the localization process, access was fully considered by the informants when the accommodation was planned to be localized in a park area close to the city center. However, neighbors appealed the localization and the municipality had to find another site for the accommodation. The future residents' access to various services providing arenas for recovery (e.g., social environments and identity-enhancing relationships) was not prioritized when the new localization was decided. The supported accommodation will be built between two existing neighborhoods and is furthest to the center of the two (Figure 1). In the immediate vicinity of the site, a road, a park and two residential houses are located. We characterize this as an example of a "fringe localization" (i.e., accomodations located at the edge of a neighborhood, next to parks or other public facilities).

Case 2 shows clearly how dimensions of localization as externality were played out. The process of building the new supported accommodation was abruptly aborted owing to objections from neighboring property owners, forcing the municipality to continue providing supported accommodation in the inadequate and inappropriate facilities. According to the informants, the reason for objecting was that the new accommodation presented a perceived threat to the residents in the neighborhood. One informant described the complaints as "these people can be dangerous; we cannot let our children out. So, there is a lot of lack of knowledge and prejudice. I would say that it is mostly about lack of knowledge" (case 2, manager, social services).

Figure 1. Fringe localization I. This figure shows the site plan over the planned accommodation of case 2. The localization is in between two existing neighborhoods surrounded by a road, a park and two residential houses. Drawing by Andrea Gimeno Sanchez.

The social service civil servants interpreted the threat as baseless, relating it instead to ignorance and lack of knowledge. In this case, one user-associated intangible external effect was the experience of an awareness of a prejudiced context in the local community, i.e., neighbors oppose the accommodation. Another user-associated external effect associated with the “fill-in” strategy, but a tangible one, was that residents were forced to continue to live in their inadequate and inappropriate facilities for an uncertain amount of time.

In terms of social context, the case illustrates the municipal urban planning civil servants striving to balance between different public and private rights and needs. There was a conflict between on the one hand individuals with rights as residential stakeholders and, on the other hand, the society’s task to cater for those in need of societal support. The different positions adopted by the municipal urban planning and social service civil servants were set against each other. One pragmatic view was expressed by the city architect. When the planned supported accommodation was stopped, this architect’s new idea consisted of locating it in the woodlands where neighbors most likely would not object. Other social service and urban planning civil servants involved, however, did not approve of this proposal, according to the prevailing idea of integration and inclusion. Instead, the “fill-in” strategy was used again. Another neighborhood was selected for the new accommodation, and for planning and dealing with the existing residents’ opinions. An urban planning ideal of densification admittedly prevailed but was balanced with the view of mental health service users as a homogenous group with a need for privacy and shelter.

4.3. Insert: Purpose-Built Accommodations in New Developments

Planning new facilities as part of a larger new development was a long-term strategy used in cases 1, 3 and 4. This “insert” strategy involves allocating plots dedicated to the social service to suit their land allocation needs, as well as regulating land use, and cooperation between social services and urban planning was essential. However, the “insert” strategy was also a complex and time-consuming process. The process to leave the old accommodation in case 4 and move into something more appropriate had taken about 8 years. The actual move into the new facilities was expected to take place in another 3 years. When inserting supported accommodations in new developments, informants referred to the National Board of Housing, Building and Planning, advising how many residents they should include and where to locate them, to avoid an excessive number of similar accommodations in the same area.

When studying the detailed plans, the new supported accommodations were located at the edge of the new development, which we characterize as another example of a “fringe localization.” This could imply people living in the accommodation would get almost the same access to social environments, opportunities for identity-enhancing relationships and to public transportation as other residents in the neighborhood. The residents of the supported accommodation live in the neighborhood, but furthest from its center. The supported accommodation in case 3, inaugurated in 2018 as a result of the “insert” strategy is located at the very edge of the neighborhood with no residential housing next door and surrounded by walking paths, a road and a preschool (Figure 2).

Concerning externality, the social services raise the importance of regulating land use for care purposes in the early stage of the detail planning process (i.e., in the terms used in detail planning social services facilities are incorporated in the term “care”):

> It is very important, as I said, when you make a detailed plan that, from the beginning, to state the “care purpose” because then it is there. Then you [neighbors] can never oppose it—it’s, like, the point. Then maybe we do not [use all]. If we say it is in ten places, we will perhaps only construct five. But there is a possibility. And they always write housing, H or C, housing or care [in the detail plan]. But if we then say no, it is not relevant because we have no need. Then, it can be ordinary housing instead. It is important to have this flexibility, so we are included in the new ones. And it has been missing in the old, detailed plans, so there are huge problems with the old existing ones. (case 1, social strategist)

Using the “insert” strategy, location as an externality from a mental health service user perspective could differ from the user-associated perspective in the “fill-in” strategy presented in the previous section. Here, people who chose to live in this new development were possibly already aware of the planned supported accommodation. They could be expected not to oppose their future neighbors given that they were mindful in advance of the planned insertion of a public facility in the new development. When regulating land use for care purposes as in this case, it is anticipated that fewer objections from stakeholders will be made in the development phase.

The social context in which the “insert” strategy emerged was to a great extent characterized by the prevailing urban planning ideas of densification. In this case 4, the supported accommodation would comprise two floors in a planned construction of a larger residential block (Figure 3):

> It [accommodation] will be integrated into a larger property. They have sketched a house, I think, five floors high….I do not see that a detached building is needed. I mean ten apartments and common and staff spaces—it will be quite large. It makes a very large footprint on land, so I think it is an advantage that it is integrated. (case 4, social strategist)

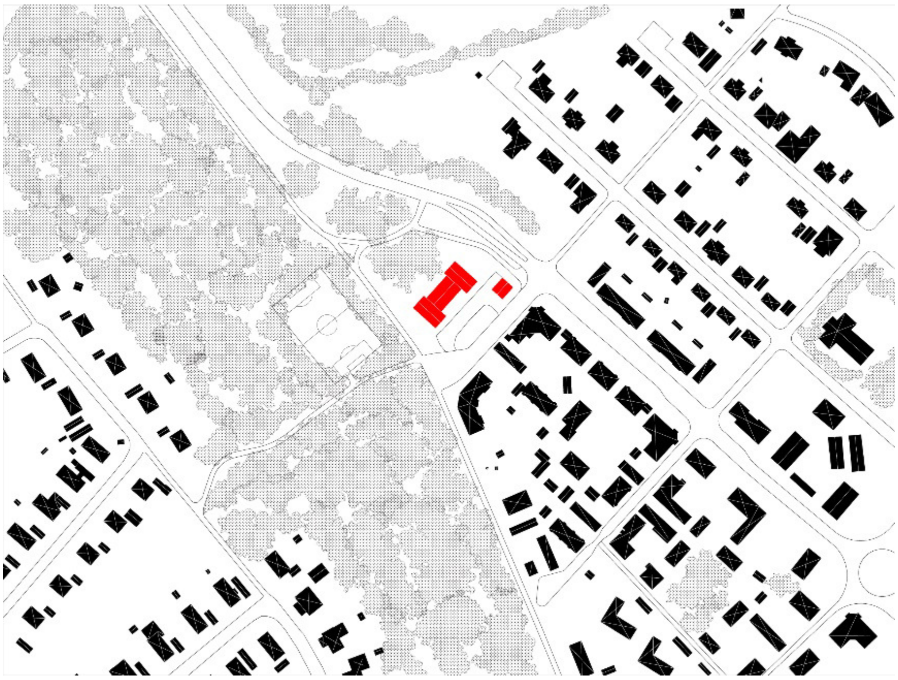

Figure 2. Fringe localization II. This figure shows the localization of the supported accommodation of case 3. Here the "insert" strategy was applied, i.e., the supported accommodation as part of a new urban development but as a free-standing construction. Drawing by Andrea Gimeno Sanchez.

The "insert" strategy was viewed by the social service as well as urban planning civil servants as an appropriate and efficient way of using land, supporting the idea of densification of sub-urban areas but also in line with ideas of localizing supported accommodations in neighborhoods as a way to support inclusion (i.e., following the ideal of community support and service). The social strategist also said: "I really work for all people, regardless of disability or age, to be together. I think that is a matter of course" (case 4, social strategist).

Figure 3. Fringe localization III. This figure shows the site plan for the new development, where the supported accommodation of case 4 will be inserted. The "insert" strategy was applied, i.e., the accommodation will form a part of the new development comprising mainly housing. The site is circumscribed by a regional motorway, a local road with quite high traffic loads, and education and sports facilities. Drawing by Andrea Gimeno Sanchez.

This quote illustrates social service civil servants' underlying assumptions, namely perceiving users as a heterogeneous group of citizens with the same rights and needs as any other person, where social inclusion and integrated living were advocated. This viewpoint is in line with the contemporary social policy of recovery, and in direct opposition to historical perceptions of people with PD to a great extent distinguished by stigmatization, prejudices and paternalistic logics. According to the social service civil servants representing this view, the localization's access to public transportation was of utmost importance (e.g., to be able to attend activities which make you feel better). Public transportation is here a measure to reach the overarching goal of social inclusion.

Another view challenged the above mentioned understanding of the group as heterogeneous. This view sees the target group as primarily vulnerable with special needs. Consequently, a localization in a more private and calm area was suggested. In case 4, in which the social service strategist advocated integration, a colleague from the urban planning department expressed another view:

> They [accommodations] can sometimes not be integrated into an ordinary housing stock but have to be a little more at the side because tenants are a little tricky. You want to give them space while also reducing potential friction with other people. And we also need to think strategically. Is it the case that we have some places we can use that are strategically located but perhaps not exactly in a large housing stock? (case 4, urban planning)

The "insert" strategy revealed a close collaboration between social services and urban planning when analyzing the spatial processes and their underlying ideas and values. In this collaboration (case 4) the different opinions and views of the target group and their living environments were subject to negotiation. For example, civil servants from social services advocated integration, whereas those from urban planning recommended privacy and shelter. The latter might be mirroring a lack of knowledge in the recovery paradigm of the importance of a wider repertoire of social relations and arenas. The negotiations between the two groups of civil servants resulted in a localization of the new accommodation in the periphery of the neighborhood, but inserted in a residential building (e.g., mental health service users were included but at the very edge). The planning document description recounts the area in which the new supported accommodation in case 4 is to be built as follows:

> The area has not been planned earlier… and is located in the eastern part of X between the highway and Z school. Today, there is an apartment complex and a social service facility belonging to the municipality, two private residential buildings, currently empty, a nature area with valuable trees, a network station and two municipal roads. The plan proposals allow for about 50 new homes on private land and about 70 new homes (rental apartments) on municipal land. Within the area of the municipal owned land, about 10 apartments will also be created for people with psychiatric disabilities. The homes [for people with PD] will be integrated into the apartment building. (case 4, planning document)

This description together with the site plan (see Figure 3) describes in text and in visuals how the accommodation is located in the fringe of the sub-urban area, and it is another example of a "fringe localization." This localization was designed to balance conflicts between residents in ordinary housing and residents in supported accommodations.

5. Discussion and Conclusions

There is a scarcity of contemporary research which focuses on the processes of localizing supported accommodations for people with PD, and the consequences the localization strategies have for goals of social inclusion. This article has looked into overarching strategies for localizing supported accommodations to achieve policy objectives, rather than analyzing individual housing, more or less in isolation from the context they are situated in (cf. McPherson et al., 2018; Tjörnstrand et al., 2020). In this article, we have sought to develop a better understanding of the ways in which municipal strategies for locating supported accommodations are composed, and whether these strategies work to support the objectives of social inclusion.

The study identified three localizing strategies—emerged as patterns out of action rather than out of preformulated intentions (Mintzberg, 1987): (1) "re-use," i.e., using existing buildings for new purposes, (2) "fill-in,'' i.e., purpose-built accommodations in existing neighborhoods, and (3) "insert," i.e., inserting purpose-built accommodations in a new urban development. We analyzed these strategies with the help of three dimensions of localizing public facilities, i.e., as access, externalities and social context. A relational space dimension was added as well as an attention to the recovery paradigm (cf. Dear, 1978; Healey, 2007; Slade, 2009).

This study demonstrates that in all of our five cases, the idea of integration in the local community seemed to prevail across the two municipal administrations of social service and urban planning. New buildings for supported accommodation and other mental health service facilities were never planned outside the built-up areas of the neighborhood, as was the predominant norm during the asylum era right up until the mid-20th century (Högström, 2012). In the post-deinstitutional era mental health service facilities in general are more often integrated in the local neighborhoods to support the idea of being part of a community. However, we have shown that at the local scale the idea of integration was compromised by actual localizations in the outskirts of neighborhoods, i.e., the spatial arrangement at the fringe impacted the social process.

The question whether identified strategies support objectives of social inclusion was, however, understood in a nuanced and multifaceted way by the informants. “Fill-in” and “insert” strategies implied community mental health service users lived in a kind of “spatial trade-off’’ in which urban planning and social services meet. Such accommodations are integrated but sheltered, with few neighbors that could negatively impact the residents living conditions. While residents are exposed to society and live as others to some extent, they are also sheltered in order not to disturb others or experience conflict with neighbors. Still, according to these two strategies, service users should also be included in society and live like others in the community. Social policies and spatial processes are related and influence each other, sometimes the latter is an outcome of the former (Dear, 1978) and sometimes more complex maneuverings take place, not only among civil servants and other agents but also in how spatial arrangements impact on the emergent strategies and on the everyday life of people with PD (Healey, 2007; Philo, 1997). Concerning social inclusion (Rimmerman, 2013), residents are both socially included and excluded, or neither socially included nor excluded, depending on the perspective taken.

Another example of the relational link between social policy and spatial processes (Dear, 1978; Healey, 2007), and of *localization as social context* was that informants referred to the National Board of Housing, Building and Planning advising how many residents a supported accommodation should have and where to locate them to avoid aggregations in the same area. Accordingly, national advisories determined how the post-deinstitutional community mental health service landscape should develop. The approach was not to have too many mental health service users in the same accommodation, nor to include too many special accommodations at the same place. This contemporary way of regulating the emergence of what Wolpert et al. (1975) in the 70s called “service-dependent ghettos” could be understood as a form of government control in the name of social inclusion, where the majority constitute the normal society in which the minority—those with PD—become targets for social inclusion (Barlott et al., 2020)

The major/minor tension was visible when using the “re-use” strategy. The history of the reused building could entail a risk for experiences, among service users as well as other residents in the neighborhood, of situations where a norm, the major, in this case “host” community meet those outside the norm, the minor, in this case supported accommodation residents (Barlott et al., 2020). At the same time, when using the “re-use’’ strategy, in terms of *localization as access*, residents could be understood as being provided with access to social environments and arenas in which they could develop valuable roles and positive identities through identity-enhancing relationships (Slade, 2009) supporting the recovery objective in national policies in another way than when using strategies “fill-in” and “insert.”

When using strategy “fill-in” and “insert,” the social services’ notion of social inclusion and urban planning’s concept of “tricky” tenants significantly impacted where new accommodations were localized. When combining these ideas, the new accommodations were often situated in the outskirts of urban areas, in between neighborhoods or at the border to woodlands, sport facilities and/or roads. We suggest this process as an example of a “fringe localization.” This type of *localization as social context* was to a great extent imposed as a pragmatic way to balance potential conflicts between residents in ordinary housing and residents in supported accommodations, and consequently as an example of what Wolpert et al. (1975) called “risk aversion.”

What social implications does the “fringe localization” phenomenon generate for the community mental health services? Previous research shows that friendly neighborhood interactions and meaningful places (i.e., places persons are attached to and important for individual wellbeing) are valuable to improve the situation and health of persons with PD (Fossey et al., 2020). The question is how these aspects are played out in “fringe localizations” and how these strategies support the access to components of a recovery oriented mental health service supply. Here, we refer to social environments where one could develop valued social roles and a positive identity, and arenas where close relationships could be established (Slade, 2009). When using the “fill-in’’ strategy from a service-user perspective, *location as an externality* implies winding up in an area where residents oppose spatial change. The appeal process entails knowledge among service users that one or more persons do not want you as a neighbor. The “re-use” strategy and “insert” strategy seemed to facilitate supporting friendly neighborhood interactions (Fossey et al., 2020) in another way than in the “fill-in” strategy, as future neighbors are more aware of each other. However, as a mental health service user, to be located in the margin, in the “fringe,” next to parks, main roads or preschools, does not seem to have the best potential to support social inclusion in the community.

The finding that access to public transport was an overriding issue across the strategies because the target group often lacked a driver’s license is related to dimensions of social inclusion highlighted in mental health research, stating that social inclusion is “a desired goal that requires equality of opportunity and participation in the rudimentary and fundamental functions of society” (Rimmerman, 2013, p. 35). Consequently, accessible public transport is a necessary condition to enable social inclusion.

To conclude, the results showed that municipalities, both large and small, seemed to face very similar challenges in the municipal localization processes. Our conclusion is that there was not a single overarching idea guiding these processes, but rather a combination of various ideas, values and conditions that municipal civil servants in urban planning and social service balanced, e.g., between an urban densification ideal, demands on maximizing land use, a recycling trend, housing shortage, as well as private (neighbors) and public (accommodations) interests. The results further suggests that in the post-deinstitutional era, the "insert" strategy can be considered as a way to preclude the NIMBY phenomenon (Piat, 2000) emerging, and the strategy could be understood as an example of the "risk aversion" approach used during the early deinstitutionalization process (Dear, 1978). The "insert" strategy includes identifying locations in which no community opposition is anticipated. Additionally, one new labelling could be added in the post-deinstitutional era, based on the "re-use'' strategy: a "familiar-with" approach, where buildings already serving and identified by the community as welfare buildings of some kind were re-used for mental health service purposes. The other two localization strategies, as captured by Wolpert et al. (1975) in the early deinstitutionalization era, the "low profile" and the "fly-by-night" strategies, were not identified in the five cases included in this study.

Finally, this study indicates the need for further research concerning mental health service users' subjective experiences of supported accommodation localization, in terms of how it impacts their lives, in what way localizations support social inclusion and personal recovery processes, but also if these accommodations could be included in its own right in urban development visions. This article is also a call for rethinking public facility location theory through more empirical research on the decision-making and participatory processes, use of strategies (intended or not) and the spatial outcomes, when localizing supported accommodation for people with PD and other groups in need of support and service. Finally, the policy of social inclusion (Government Offices of Sweden, 2006) points directly into the ardent political question of housing shortage and how to provide vulnerable and low-income groups (in which people with PD are included) affordable and appropriate dwellings (see, for example, Berglund-Snodgrass et al., 2021). This relates to broader questions concerning social sustainability (Dempsey et al., 2011), including equal access to shared resources, community resilience and to the simple but nevertheless crucial question: How do we want to live together?

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Transforming Worker–Client Identities: From Shelters to Housing First

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Abstract

The Housing First (HF) approach to counteracting homelessness, stemming from the USA, is advocated as a blueprint for homelessness policy change in Europe, including the Nordic countries. In contrast to traditional homelessness policies based on shelters as the first step towards ending homelessness, the HF policy discourse regards access to one's own housing as a basic human right that should not be conditional upon good or acceptable behaviour. Building on ethnographic research in a Swedish HF unit striving to implement the HF approach 'by the book,' which includes both focus group interviews with workers and observations of worker–client interactions during home visits, we show how the new HF policy challenges both workers and clients, who used to encounter each other in shelters but now meet in clients' own homes, transforming their identities. We demonstrate how workers account for transformations in worker–client identities by referring to how they and their clients used to think, talk and act, thus contrasting their new identities with their former selves. Moreover, in their efforts to accomplish their actual work tasks within the framework of the new HF policy discourse in the homes of formerly homeless clients, we show how workers struggle with their identities when they encounter clients in practice. In their accounts of policy change, the workers embraced their new identities with pleasure, but in practice, they were hesitant when dealing with issues of concern, such as their clients' use of tobacco, alcohol and drugs. In sum, it becomes complicated in practice.

Keywords

homelessness; Housing First; worker–client identities; discursive change; practice

Issue

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1. Introduction

The Housing First (HF) approach to counteracting homelessness, stemming from the USA (Tsemberis, 2010; Tsemberis & Eisenberg, 2000), is advocated as a blueprint for change in homelessness policies in Europe, including the Nordic countries (Hansen Löfstrand & Juhila, 2017). In European research based on data from different countries, the HF approach has been portrayed as a successful response to homelessness and can be seen to constitute a moral story of why policy change—from shelters to HF—is needed (Hansen Löfstrand & Juhila, 2017). Arguably, accounts of policy change (on what it entails and why it is needed) becomes an institutionalised discourse in country and policy contexts as well as concrete social settings (cf. Miller, 1994). The HF policy discourse claims ownership of highly respected values and principles in the welfare state that are easy to agree with and hard to resist, such as emphasising the right to housing, seeing clients as capable of making their own choices, and respecting the wishes and wants of clients to be heard and acted upon. A key to understanding accounts of the policy change from shelters to HF and the efforts made to achieve the change in practice is by recurrently drawing upon ‘contrasting comparisons’ (Hansen Löfstrand & Juhila, 2017, pp. 24–27; Smith, 1978) between the ‘old’ shelter system and the ‘new’ HF approach.

The set of fundamental assumptions that the HF policy discourse is based on is contrasted with earlier homelessness policies based on ‘rehabilitation first’ ideas, which regard shelters as the first step in ‘curing’ homelessness and one’s own apartment as a result of the rehabilitation process. Quite the opposite, in the HF policy discourse, access to housing is defined as a basic human right that should not be earned or be conditional upon good or acceptable behaviour. Access to ordinary housing is seen as the starting point (rather than an endpoint) for the subjective change the client is proclaimed to need; thus, according to the HF policy discourse, homeless clients should promptly get access to their own home, i.e., an apartment with tenant’s rights. Furthermore, housing and treatment must be offered separately; access to housing should not depend on a client’s acceptance of treatment. Additional basic principles are consumer choice and self-determination, meaning that clients are regarded as competent choice makers, who should be given the opportunity to make their own decisions. Active and engaged professional support work should be offered without coercion and should be based on each individual client’s own strengths, needs and goals. It should also be directed towards recovery, based on the principle of harm reduction. In practice, this means that staff should not, for example, demand total abstinence from alcohol and other substances, and clients should be able to decline offers of treatments without risking their access to housing and without being treated adversely by staff. Lastly, professional support work should be provided flexibly, depending on a client’s needs and wants, and as long as the client desires (Pleace, 2018; Tsemberis, 2010).

In Sweden, the introduction of the HF approach was research-driven, introduced by Lund University in 2009 (Knutagård & Kristiansen, 2013, p. 94), when the first national conference promoting the HF approach took place. Interest in the HF approach was very high, and two Swedish municipalities immediately decided to initiate HF services (Knutagård & Kristiansen, 2013, p. 95). Since then, many more Swedish municipalities have striven to implement and run small-scale HF services.

Based on a mobile ethnography of work in one Swedish HF unit, including focus group interviews with workers and observations of worker–client interactions during home visits to clients, we aim to show how the ‘new’ HF policy challenges workers and clients to transform their identities. We ask how workers account for policy change, and how they struggle with their identities when they encounter clients in practice during the home visits.

The HF policy discourse consists of fundamental assumptions and vocabularies of setting members (Miller, 1994, p. 283). However, it can also be observed in interactions between staff and clients, although such interactions are always creatively achieved in relation to the particularities of each situation (Miller, 1994, p. 283). We analyse whether and, if so, how workers in the HF setting draw on the HF policy discourse as a resource to understand and assign meaning to their work, themselves as workers and their clients, and we interpret their ‘talk about work’ as accounts of transformations in worker–client identities. In addition, we analyse workers’ practical efforts to accomplish their actual work tasks during home visits to formerly homeless clients. It is important to study the home visit as it is seen as key to the HF approach (Tsemberis, 2010). The policy change implies that the workers and clients, both of whom have experienced the ‘old’ homeless shelter environment, now need to adjust to interacting in the clients’ homes. The home thus becomes a place for professional care and support work.

Whereas international HF research on policy and national levels is abundant, research on the implementations of HF policies at the grassroots level and the challenges it involves is scarce and called for (Raitakari & Juhila, 2015). Our contribution is precisely such a frontline perspective of what the policy change from shelters to HF entails in terms of transformations of worker–client identities. We show from the workers’ perspectives how they need to create a new way of doing work under the HF policy approach to ending homelessness. To achieve our objective, a detailed ethnographic study—to study both talk about work and actual work practices—was required.

In the following, we first account for our study design, methods, materials and the analytic concepts that we draw on to make sense of our empirical materials. We then present our core findings of the detailed data analysis in two separate sections (3.1 and 3.2) and conclude with a brief discussion.

2. Method

2.1. Setting and Data

As mentioned, many Swedish municipalities currently run small-scale HF services. The setting sampled and studied to show how the ‘new’ HF policy challenges workers and clients to transform their identities is referred to throughout this article as the HF unit and it is located in the southern part of Sweden. The HF unit represents a service that has made a conscious effort to implement the HF policy ‘by the book’ or according to Tsemberis’ (2010) *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction* (or *The Housing First Manual*, as it is referred to by the staff in the unit). This makes it a particularly interesting case. For quite some time the ‘pathways HF’ approach has been internationally promoted and depicted as “the original and truest way to implement HF” (Raitakari & Juhila, 2015, p. 146) and has been adopted across the USA and in Europe, including the Nordic countries. Yet, detailed ethnographic studies of its implementation and the challenges and struggles involved in transforming worker–client identities in concrete local settings are scarce—close to non-existent.

The staff in the HF unit sampled for our study are social workers and support workers, most of whom have extensive experience working in the old shelter system. The HF unit has 12 workers divided into two teams to conduct home visits in the homes of approximately 60 clients. The clients have previously experienced lengthy periods of homelessness, shelter living and institutional treatment, and many have substance abuse and mental health problems.

For our purpose of scrutinising how the 'new' HF policy challenges workers and clients to transform their identities, we draw on a combination of empirical materials unique to the field of HF research. The first dataset was derived from two focus group interviews with workers at the unit conducted in early 2018. These interviews provided a forum for collegial discussions as joint talk among staff, whereby workers assigned meaning to their work and to themselves as workers as well as their clients. We interpret their joint talk about work in the HF unit as accounts of transformations in worker–client identities. We coded the interview data by including all talk on changes in worker–client identities and, more specifically, all instances in the interview transcripts where workers provided contrasting comparisons of 'old' and 'new' ways of accomplishing work. The interview extracts were then analysed jointly by the authors, who agreed to select two examples for this article to illustrate typical accounts of transformations in worker–client identities in an HF unit.

The second dataset was derived using the mobile ethnographic approach of shadowing (Czarniawska, 2007). In April–October 2018, we accompanied workers at the HF unit during 16 home visits, and the data were recorded by keeping a detailed research diary including fully developed field notes. Shadowing enabled us to observe actual worker–client interactions during home visits and, hence, produced data on workers' efforts to accomplish their work within the framework of the new HF policy discourse and in the homes of clients. For the purposes of this article, we coded all instances in the field notes where workers somehow struggled to accomplish their work and their new identities in relation to their clients, and we found that work tasks and interactions revolving around clients' use of alcohol or drugs were particularly challenging for the workers. The field notes also include data on staff talking about and reflecting on how they think they should accomplish work tasks in accordance with the HF method. All the coded extracts from the field notes were analysed jointly by the authors, who also agreed on which three extracts to draw on to illustrate the challenges involved in transforming worker–client identities and the approaches used to accomplish this in the practical work in an HF unit.

2.2. Analysing Worker–Client Identity Change

As theoretical tools for our analysis, we draw on the concepts of contrasting comparisons, identity categorisations and relational pairs. We apply the concept of 'contrasting comparisons' (Hansen Löfstrand & Juhila, 2017, pp. 24–27; Smith, 1978) as a tool to analyse "how setting members move from one institutional discourse to another" (Miller, 1994, p. 297) in accounts of worker–client identities and worker–client interactions during home visits. As an institutional discourse, the HF policy discourse shapes what can be said in the social setting studied (Miller, 1994, p. 286).

In studying contrasting comparisons, we pay special attention to 'old' and 'new' worker and client identities. We regard both worker and client identities as constructed in talk and text in social settings; hence, we draw on the work developed in discursive psychology (Antaki & Widdicombe, 1998a; Benwell & Stokoe, 2006; Edwards et al., 1992; Wiggins & Potter, 2008) and membership categorisation analysis (Hester & Eglin, 1997; Housley & Fitzgerald, 2002; Sacks, 1972/1990, 1992). More specifically, we draw on the concept of 'identity categorisation' in our analysis. By the concept of identity categorisation, we emphasise that identity is relational. Thus, workers construct their identities in relation to their clients, and by analysing interview talk and home visit interactions, we can understand how identities are produced (Benwell & Stokoe, 2006, p. 6). As pointed out by Antaki and Widdicombe (1998b, p. 3), producing or constructing identities involves "speaking, being spoken to, or being spoken about" and to "have an identity" means being casted "into a category with associated characteristics or features." These characteristics often have a moral dimension, especially when identity categories expressly imply rights and responsibilities (Jayyusi, 1991, p. 241). Based on these definitions of identity, the data of this study—focus group interviews with the HF unit staff members and field notes on their home visits—are seen as arenas of spoken interactions, where worker–client identity categorisations with certain characteristics and features are produced.

As mentioned, identity categorisation concerning oneself is accomplished in relation to other people. These others can either be present or absent in the interaction. The relational nature of categorisation is significant to analyse in both of our data types. In talking about their work, the HF unit workers categorise themselves in relation to their clients (focus group interviews), and in interacting with each other during the course of home visit interactions, workers and clients produce their specific roles in relation to each other (field notes). This is where the concept of 'standardised relational pairs,' originating in Sacks' (1972) influential work, becomes important. When two identity categories are paired together—as worker–client identities—their characteristics, features, rights and responsibilities are reciprocal (Psathas, 1999, p. 143) and interdependent, meaning that one identity category, e.g., the worker, cannot exist without the other, e.g., the client, and vice versa. As Mäkitalo (2014, p. 26) puts it: "If one is mentioned, the other is simultaneously made relevant without mentioning." The HF worker–client combination is clearly this kind of a relational identity pair.

Identity categorisations are contextually embedded activities. The obvious local contexts for identity categorisations in this study are joint collegial talk (in focus group interviews) and worker–client interactions during home visits. The workers concurrently produce and orient to a certain context for their talk, namely their 'old' work in shelters and their current 'new' work in the HF unit. However, we do not regard context as an external determinant for identity categorisation in the 'here and now' interactions and talk (Juhila & Abrams, 2011, pp. 280–283; cf. Miller, 1994, p. 283). Instead, as pointed out by Silverman (2000, p. 66), we assume that the workers themselves "actively produce a context for what they do," and because of this, we as researchers need to investigate "the ways in which people themselves *categorise to make sense* of people, events and actions in their local context" (Hester & Eglin, 1997, as cited in Mäkitalo, 2014, p. 26). As will be shown, workers' talk on 'old' work and the accompanying identities created a point of reference for accounts of 'new' work identities and, simultaneously, for their standardised relational pairs, 'old' and 'new' client identities.

By comparing and even contrasting 'old' and 'new' identity categories, moral judgements on which one is better and on what grounds are produced. In analysing the interview talk, we focus especially on comparing and contrasting, which is often done by presenting voices and reported speech both from the past and the present, including accounts of how they differ from each other (on voices and reported speech as interactional devices see Holt & Clift, 2007; Juhila et al., 2014). In home visit interactions, 'old' and 'new' work is not talked into being in the same way as in the interviews. However, in analysing contrasts between 'old' and 'new' in the field notes, we pay special attention to how workers struggle to accomplish the HF policy and their 'new' identities in frontline encounters with clients.

3. Findings

Our first finding on the interview data was the dominance of the HF policy discourse in the workers' accounts, whereas talk about the traditional and mainstream shelter system was oriented towards being unwanted and inappropriate. At the same time, the staff occasionally struggled to carry out their work in accordance with their 'new' worker identities as was evident from our observations of home visits.

3.1. Producing New Worker–Client Identities in Focus Group Interviews

As stated above, the repeated theme in the focus group interviews is the description of the change in work in the HF unit, compared to the shelter context. In the following, we analyse in detail two examples from the interviews to demonstrate how the workers produce the contrast between 'old' and 'new' worker–client identities. Example 1 illustrates how workers orient to their work now and how it differs in relation to their prior way of working:

1. M1: Our mission is, well, it is that they can remain in their housing, that they will succeed in handling this, yes, to live in the apartment quite simply. And then to come there and see that 'oh, it's filled with stuff from floor to ceiling and it's a sanitary nuisance'; well, then you know that the only thing to do is to fish for a change [laughter]. I think it is very good. And our method takes as its point of departure the wishes of the client, and it's a bit… because I come from an emergency shelter, where we used to have keys to go into their rooms and one hardly knocked on the door before entering the rooms. Here, we often have keys, but it's because the client wishes that we should have keys, and we do not enter with keys. I've never experienced that during my time here. I've been here a little less than a year. We knock on the door; it's up to them if they choose to open the door. It's like this: 'May we come in?' We take off our shoes and we are in their home. There's a totally different power balance.
2. F1: Yes, it is.
3. M1: So, I think the power balance is totally different, and it makes it possible for us to learn what it is that the client wants and what we, what it is that they want to do really.
4. F2: And there is no exercise of public authority.
5. M1: No.
6. F2: I think you feel that it's almost as if you become friends.
7. M1: Yes, it's very different, yes. The same clients who I have met in the shelter system that I now meet here, they are much more open. Precisely, that they talk honestly about how they live, about the criminality, about drugs and so on.
8. K2: And it's nice not to have to be condemnatory, to have that function, 'oh, now I must report this.' You don't have to do that, and that's so nice.
9. M1: Yes, it really is.

M1 talks on behalf of the whole work team in the HF unit by using pronouns "our" and "we" (turn 1). Formulations, such as "our mission" and "our method," can be interpreted as referring to *The Housing First Manual* and its committed implementation in the unit. The worker identity in the HF context is connected in this example to such characteristics as helping clients remain in their housing, fishing for a change, taking the wishes of the client as a starting point, letting the client choose to open the door, always knocking before entering clients' homes (turn 1) and learning what clients want (turn 3). These characteristics are strengthened by comparing them to the ‘old’ emergency shelter system with an opposite worker identity, comprising such activities as hardly knocking when entering clients’ rooms (turn 1), exercising public authority (turn 4) and being condemnatory (turn 8).

The difference between ‘old’ and ‘new’ identities is intensified with extreme case formulations (Pomerantz, 1986): “I’ve never experienced,” “totally different” and “very different” (turns 1, 3 and 7). Furthermore, reported speech is used in emphasising the split between ‘old’ and ‘new’ ways of working. The ‘new’ worker asks clients they may come in into their home, signalling an equal relationship, whereas the ‘old’ one responds to the client’s doings by saying “oh, now I must report this,” signalling a hierarchical relationship. The workers are very like-minded in their talk. They confirm each other’s views with short supporting responses (turns 2, 5 and 9), and smoothly complement each other’s turns of talk (turns 4, 7 and 8). They also remember the ‘old’ times in a unanimous way. A moral dimension is clearly present in the categorisation: Past, ‘bad’ shelter-related practices have been substituted with ‘good’ HF practices.

As usual in category constructing processes, the workers do their own identity categorisation in relation to other people, and in this case, especially to clients’ identities. As counterparts of the ‘new’ professional identities, ‘new’ clients—different from the old ones—are thus described as having and presenting wants and wishes, being open and talking honestly, and even becoming the workers’ friends (turns 1, 3, 6 and 7). However, sometimes clients’ identities become stuck in the ‘old’ homelessness policy discourse (example 2):

1. F1: It’s been a lot of work with many [clients]. We have gone there, we have been standing outside, nobody is home or they are at home, we know that, but they do not open the door, they do not want us there.
2. F2: So, we leave notes and send text messages.
3. F1: Yes, we try. And then, little by little, after a lot of patience. It’s insane really. Without hunting them down, instead, they should be reassured that this is of concern. We are not here to control or hunt, and all the time, we try to separate the state of the apartment; even if we do support them and can give advice as regards to how it [the apartment] should look when it’s not okay, we don’t have anything to do with it. We will not evict them.
4. F2: We are very clear when we leave notes for them [saying] that ‘we only want to know if you’re okay, how you are,’ and…
5. F1: Yes, ‘the housing organisation has been here and please just let us know that you’re okay.’
6. F2: Yes, there are no demands.
7. F1: You get worried and we can leave a note in the end [saying] that if [they] do not get in touch within a week or three days, we will use a key to enter.… But then they think it is annoying and get in touch [with us], like, they send a text message, or they are at home on the next occasion.
8. F1: We do not scold them or say ‘you have not been at home for three home visits, where have you been?’ It’s nothing like that, and I think it’s taken some time for them to get used to that, that it doesn’t work like that. Because they are used to that from staying in emergency shelters, where the staff say ‘you shall put that thing there, you cannot enter like that, and you know that…’
9. F2: ‘You have to show me what you have in your bag before I can let you inside,’ and ‘yuck, you cannot smoke in your room.’ It’s disciplining.
10. F1: It feels so good to not have to do that.
11. F2: Yes.
12. M1: Yes, indeed. That’s the best thing, I think.
13. F1: Yes, you get to be the good one all of a sudden [laughter].
14. F2: For once.

As in the previous example, the workers talk of “we” creates the sense of a shared worker identity with certain characteristics. The shared way of working is not, however, always in balance with the clients’ expectations. Although the workers try to visit the clients’ homes with caring intentions, only wanting to know that they are fine, the clients are suspicious and do not always open their doors (turns 1–5). This discrepancy between the workers’ and the clients’ identity categories (good intentions vs. suspicion) is accounted by presenting that the clients still define the workers and their characteristics according to the ‘old’ shelter system, when they were still demanding, scolding, domineering, disciplining, controlling, hunting and had the power to evict (turns 3, 8 and 9).

Again, the ‘old’ shelter discourse and the ‘new’ HF discourse and their contrasting comparisons are very clearly talked into being. In doing this, conversational remembering by using reported speech plays a big role. For example, the ‘old’ shelter worker might have said that “you have to show me what you have in your bag before I can let you inside” or “yuck, you cannot smoke in your room” (turns 8 and 9). Whereas the ‘new’ worker can, for example, write a note to the client who does not open the door that “we only want to know if you’re okay, how you are” (turn 4).

All in all, the message seems to be that the clients do not leave their ‘old’ identities as people subjected to control to create new ‘HF client identities,’ i.e., those who are cared for by workers and who have the right to make their own choices. Clients do not leave their ‘old’ identities if they do not trust that the workers have really changed their ways of working and abandoned their ‘old’ shelter identities. Thus, overcoming the discrepancy between the current workers’ and clients’ identities takes a lot of time and assuring work conducted by the workers.

3.2. Struggling between 'Old' and 'New' Policies in Worker–Client Interactions during Home Visits

As has been shown, the HF policy discourse dominates the workers' accounts in the interviews, and the 'old' shelter system as well as the workers' 'old' identities are talked about as unwanted and inappropriate. In analysing the contrasts between 'old' and 'new' in the field notes, based on observations during the workers' home visits to clients, we focus on how workers struggle to accomplish the HF policy and their 'new' identities in encounters with clients in or near their homes. We find that in these frontline encounters, they do struggle to carry out the home visit work in a way that agrees with their 'new' worker identities and the HF policy discourse talked into being during the interviews.

According to the HF policy discourse, the main mission of the worker in an HF unit is to see to it that clients can remain in their housing or, in other words, succeed in living in the apartment. In the following, we draw on three examples to illustrate the workers' efforts to accomplish home visits while simultaneously managing issues of concern: Clients' use of cigarettes, drugs and alcohol. In the 'old' shelter system, clients' use of alcohol or illicit drugs, if detected, would have led to disciplinary measures, such as reprimands, reports and even eviction as the ultimate sanction. How to manage clients' use of tobacco, alcohol and drugs, particularly during home visits, constitutes a practical challenge for support workers, since according to the HF policy discourse, all clients should be regarded as competent choice makers and are, thus, capable of making their own decisions about, for example, the use of cigarettes, alcohol and substances. Furthermore, according to the same policy, support work should be offered without coercion, based on individual clients' own needs and goals, oriented towards recovery and based on the principle of harm reduction. Therefore, workers should not demand abstinence from alcohol and other substances (Pleace, 2018; Tsemberis, 2010). At the same time, the workers are aware of the power of the property owner, who may ultimately resort to the means of eviction if the clients do not follow the rules of a normal tenancy. The workers, therefore, need to find new ways of managing their clients' use of cigarettes, alcohol and drugs. However, as illustrated below, this challenge may be approached in different ways.

In our first example, Maria and Martin (two support workers) visit the home of Timmy (a male client), who lives in one of the HF unit's apartments. Like all clients of the HF unit, Timmy has a second-hand lease of the apartment, but he will receive a first-hand lease after 18 months if no serious breaches have reached the property owner. Timmy asks the support workers if it is okay for him to smoke a cigarette during the home visit, which causes concern; how to respond to the request constitutes a challenge for the support workers in their efforts to adapt to the 'new' policy (example 1):

> Timmy asks if it is okay for him to smoke. "If you can desist, it would be good. But it is your apartment and your choice," says Maria. Timmy reaches for a box where he stores tobacco and paper, and rolls a cigarette. "Have they told you that smoking is something they can comment on when getting a first-hand lease?" Maria asks. "No," Timmy says; he has not heard about this. "No, God, now I scared you," says Maria, who continues to explain that the property office may have to clean the apartment if it smells too much of smoke. Timmy replies that he mostly smokes on the balcony and that smoking is not forbidden.

In this example, the worker begins by asking the client to desist and makes the point that whether or not Timmy chooses to do so is his choice, in accordance with the 'new' HF policy discourse. The worker then starts explaining why heavy smoking in the apartment may become a problem for the client. The property owner might object if they need to clean the apartment and smoking heavily might hinder Timmy's chances of getting a first-hand lease. She then interrupts herself and expresses great concern about what she has just said, thinking she might have scared him. This way of putting pressure on Timmy to think again regarding his decision to smoke in his home is similar to the coercive measures of the 'old' policy and, thus, also echoes the 'old' worker identity category. Timmy, however, concludes that smoking cigarettes is not forbidden, according to the rental policy or by other means:

> Once outside the house after the home visit at Timmy's, Martin says it feels like he has swallowed an ashtray. Maria agrees and explains to me [researcher] that their management has given them directives to say 'no' to clients who ask if they can smoke during a home visit. "But it's a little difficult. It is the client's home, but it is our work environment, too, and you have to find some way to balance that. We are not a controlling business," says Maria.

Aside from the harm-reduction perspective, the support workers are also concerned about their own work environment—the clients' homes. Their management's advice—to decline requests from clients' about smoking during the home visit—is difficult to accomplish within the framework of the 'new' HF policy discourse, whereby workers are no longer "in the controlling business," as expressed by Maria. The example thus illustrates that while the client seems to have adjusted to the new 'free' identity of clients in the HF unit, the workers struggle with adjusting to the principle of letting clients make their own choices.

In another example, support worker Steve visits the home of client Jenny to accompany her to the hairdresser. When invited into Jenny's apartment, her intake of alcohol (beer) during the home visit causes Steve some concern. In approaching the client with his concern, the support worker refers to "others" among the staff at the HF unit and their rules: "I have heard that staff in the HF unit usually try to say that it is good if the clients do not drink during the home visit." He, thereby, avoids positioning himself as the controlling worker carrying the 'old' worker identity:

> We [support worker and researcher] take the elevator up to Jenny's apartment and knock on the door. Jenny shouts from inside that we should come in. When we enter her apartment, Jenny sits on her bed, which consists of a spring bottom lying on the floor, full of duvets and big pillows. She has a cigarette in her mouth and drinks a 7.2% beer. In front of the bed is a coffee table. There is an ashtray and various semi-drunk glasses with juice and water, a decanter with juice, and a plate with some old meatballs. Steve enters the single room from the hallway and sits down in the only armchair. Jenny tells Steve about some friends who are "totally fucked up." She proceeds with a rather long monologue and Steve calmly answers something in the style of "no, it doesn't sound good." When Jenny goes silent, Steve says that he has heard that staff in the HF unit usually try to say that it is good if the clients do not drink during the home visit. Jenny looks sceptically at Steve. "But who's going to stop me?" she says, taking another sip of the beer. Then Steve asks her if [they] should go to the hairdresser now. Jenny gets ready by taking a few sips of beer, and then walks away with the beer can, saying she is going to put it in the fridge. Steve goes to the hallway and Jenny, too. We all leave the apartment.

Interestingly, Jenny expressly resists Steve's implicit request not to drink alcohol during the home visit, and by stating "who's going to stop me," Jenny shows she has adjusted to the 'new' HF policy discourse and identity, according to which workers should not demand or coerce clients into anything. In our third example, support worker Caroline visits Robin, and during their small talk outside afterwards, it becomes evident that Robin buys and uses prescription drugs in illegal ways (without a prescription from a medical doctor and bought on the 'black market'). In this final example, the roles are almost reversed: The client expresses concern and justifies his choices and actions, whereas the worker's attitude is non-judgmental, even supportive:

> Robin (client) and Caroline (support worker) are standing outside Robin's apartment making small talk. Robin does not seem to be in a hurry and seems to enjoy talking to Caroline. He has exercised a lot, he says. Caroline and Robin talk a little about how hot it has been the last few weeks. Meanwhile, Robin's phone rings and he answers. He happens (or is it intentional) to put on the speakerphone, so we can all hear what the person phoning Robin is saying. It is a man's voice asking if Robin wants to buy Stesolid (prescription drug) as they discussed earlier. They agree on a time to meet up. The man's voice also asks if Robin wants to buy Ritalin (another type of prescription drug), but Robin says he already has it. They hang up. Robin explains to Caroline that he needs the Stesolid "in order to go out." He could drink (alcohol) instead, but he does not like drinking. Robin says he has been to a doctor to talk about his anxiety and social phobia, but the doctor did not want to prescribe Stesolid. Thus, he buys it on the black market instead. It is like Robin wants to apologise a little, but Caroline is very non-judgmental. She just says that it is good that he finds strategies to be able to leave the house.

Taken together, the examples illustrate that what is at stake regarding the use of tobacco, alcohol and drugs among the clients at the HF unit is the workers' (and clients') struggles between 'old' and 'new' policies and identities. How to express and display concerns in accordance with the HF policy discourse constitutes a very practical challenge for the workers. Furthermore, we have shown how the implementation of the 'new' HF policy depends on the frontline support workers' practical accomplishments in interactions with their clients, i.e., their interactional competence. Finally, as illustrated, the workers do not only need to relate to each unique client and their wishes, but also—more or less implicitly—to the property owner, who they know has the ultimate power to decide if the clients can or cannot keep their apartments. This puts the workers in a tricky position, balancing between material realities and conditions on the housing market on the one hand, and the challenge to live up to the HF policy discourse in reality on the other.

4. Concluding Discussion

Our objective was to show how the policy change from shelters to HF challenges workers and clients, who have previous experiences with the homeless shelter system, to transform their identities. The specific HF setting sampled and studied to show how the 'new' HF policy challenges identities is a particularly interesting case, since the unit's goal was to implement the new HF policy 'by the book,' according to the manual presenting the 'pathways HF' model (Tsemberis, 2010). As mentioned, this approach has been widely recognised as "the original and truest way to implement HF" (Raitakari & Juhila, 2015, p. 146) for quite some time and has been adopted on both sides of the Atlantic. Yet, detailed ethnographic studies of the challenges and struggles involved in transforming worker–client identities towards 'new' ways of working are close to non-existent. Our study hence constitutes an important contribution to the HF research literature. Our study also contributes useful knowledge when planning to implement policy changes targeted at marginalised individuals, when replacing coercive and disciplining approaches with inclusion and participation, and when designing HF studies. Our study points out the usefulness of studying what goes on at the grassroots level.

We have shown that in joint talk among colleagues within the framework of focus group interviews, workers account for their new identities in line with the HF policy discourse and express how they have embraced their new identities with pleasure, e.g., it feels good to "get to be the good one," as expressed by one of the workers. Their 'old' worker identity and the traditional shelter system are depicted as obsolete and unwanted. However, in the interviews, the workers express concerns about hesitant clients, who have not yet adapted to the 'new' HF policy with the 'new' client identities, and consequently, they do not really believe or trust the changes in worker identities that workers account for in the interviews. The worker–client is, hence, a typical relational identity pair. However, workers express concerns that they do not match but build on opposite categorisations, as the workers have adapted to a 'new' worker identity, whereas the clients are still stuck in the 'old' discourse and identity.

However, in the field notes illustrating the workers' efforts to accomplish the 'new' HF policy in practice and particularly when managing issues of concern, such as their clients' use of tobacco, alcohol and drugs in their units, we find quite the opposite conflict in the worker–client relational pair and categorisations. In practice, the workers are hesitant as regards to how to deal with these issues of concern, whereas clients seem to have adjusted to the 'new' freedom endowed on them within the framework of the HF policy discourse. Hence, the transformation from the 'old' worker identity and ways of getting things done to the 'new' worker identity and practices are easily explained and vividly accounted for by way of reported speech in the interviews, but the distinction between 'old' and 'new' identities and practices are not easily upheld in the workers' practical achievement of work tasks.

In practice, when striving to accomplish work, the workers have a dilemma that they need to manage. Under the HF policy discourse, they are obliged to attend to their clients' wishes, e.g., to use tobacco, alcohol and drugs, and by no means through coercion or threats. At the same time, they are acutely aware of the perspective of the property owner as an actor on the regular housing market, who has the power to hinder the client from signing the first-hand lease and, ultimately, evict the client. The workers struggle to avoid the latter, since their overall mission is to see to it that their clients can keep their apartments while simultaneously striving to respect their clients' choices. In this way, the workers promote clients' social inclusion or at least try to avoid the risk of social exclusion.

We have provided three similar examples of managing issues of concern related to clients' intake of tobacco, alcohol and drugs. During our mobile ethnography, the workers collectively (and individually) expressed these shared concerns, though the three examples show variations among staff when dealing with these issues. Staff cannot manage issues related to alcohol and drug use the way they did in the 'old' shelter system, i.e., through reprimands and evictions, but they have no clear instructions as to how they should deal with such dilemmas. They have to rely on interactional competencies to obtain wanted outcomes—not through coercion but by motivating and encouraging their clients to consider other (preferred) choices. Thus, the main challenge for the workers is how to accomplish work when clients are free to make their own choices. It requires interactional skills and soft power measures. The workers are to make their clients "work on themselves" to "achieve responsible autonomy" (Rose, 2000, p. 334; cf. Hansen Löfstrand & Juhila, 2012; Juhila et al., 2017) but not through coercive means and disciplinary measures. This leaves workers with having to cajole and encourage clients who make sound choices and, in so doing, "appear to act out their most personal choices" (Miller & Rose, 2008, p. 214). They have to become experts in interacting with clients and applying subtle means to teach or coax them into behaving in a responsible manner (Miller & Rose, 2008). This challenge—to manage the support while controlling the balance—clearly relates to general ethical issues in social work, particularly social work with the objective of social inclusion.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Women on the Border between Home and Homelessness: Analysing Worker–Client Relationship

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Abstract
Housing First, as implemented in Finland, offers two housing options for people who are homeless or at risk of homelessness. In this context, permanent housing refers to a scattered-site rental flat or a community-based housing unit in accordance with the Housing First principle. The focus of our study was on worker–client relationship and its diverse meanings at different stages of women's housing pathways. Our data consisted of narrative thematic interviews with nine women who lived in scattered housing and three workers of a housing unit. The narratives of the housing unit workers were related to a deep concern for the women who have the most limited choices and who do not always see the housing unit as home. The workers felt frustrated with the inconsistency of care pathways in substance abuse care, psychiatric hospital care as well as gerontological services. Women in scattered housing had received sufficient support at critical stages of their housing pathway from the public service system, which is an integral part of the Finnish Housing First model. In their cases, homelessness and problems with housing had been addressed as part of a holistic effort to improve the quality of their lives either through adult social work, child protection aftercare or psychosocial services. Getting sufficient support in a vulnerable situation in a trust-based worker–client relationship was a unifying theme of this dataset of women. Our study also challenges the development of services from the perspective of women whose housing pathways are characterised by numerous losses and exclusions, and for whom many services remain out of reach.

Keywords
female homelessness; home; Housing First; housing pathway; housing unit; worker–client relationship

Issue
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1. Introduction

In 2020, there were 1,065 homeless women in Finland, 25 percent of the total number of homeless people. Of these women, 189 were experiencing long-term homelessness and make up slightly less than 20 percent of the total number of long-term homeless individuals (ARA, 2021). This data is collected with an annual homelessness survey from Finnish municipalities. It contains people who have been registered as homeless in the services and therefore does not take into account hidden homelessness.

Since 2008, Finland has been implementing the Housing First principle, which has led to a gradual decrease in homelessness year after year. Housing First principle means that unhoused people are provided with independent rental flats and adequate support instead of temporary solutions such as hostels and shelters. The Finnish Housing First model was developed independently of the Pathways Housing First model in the United States but has similar features with it (Y-Foundation, 2017). It follows the core principles of Housing First as described in the *Housing First Europe Guide* (Pleace, 2016). In the Finnish context, these can be summarised into three themes: home of your own, rental contract based on law and adequate support if needed and wanted by the resident. In Finland, the implementation of housing and support may vary. Housing can mean an individual rental flat either in scattered housing located in social housing or in flats bought from the private market or in a supported housing unit where on-site personnel is often available. In both housing options, the rental lease is permanent. This research asks: What kinds of supportive relationships exist between clients and workers at the different stages of women's housing pathways? The question is approached from two complementary perspectives both produced in thematic narrative interviews: first as a workers' narrative from workers who do their work in a supported housing unit, and second as a women's narrative from women who live in scattered-site flats. Both settings follow the Housing First principle. Our special interest is on the supportive worker–client relationship as part of homelessness intervention. As our aim was to study worker–client relationships at different stages of the housing pathways, we chose two significantly different research environments and interviewed both workers and clients.

The article proceeds in such a way that first (Section 2) we present the literature framing of our research, followed by (Section 3) the research settings, data and methods. Sections 4 and 5 are data-driven and present the research results we have generated based on our analysis. Section 6 contains the conclusions of the study.

2. Previous Literature

Several studies, starting from the pioneering study by Watson and Austerberry (1986), have shown the inadequacy, inexpedience, and attached associations of services for women (Bretherton & Mayock, 2021; Mayock & Bretherton, 2016; Mayock & Sheridan, 2020, p. 27). Research has focused on diverse aspects on women's experiences with homelessness and housing services (e.g., Averitt, 2003, pp. 79–100; Cook et al., 2002, pp. 285–316; Haahtela, 2015; Skobba, 2016, pp. 41–58). The experiences of professionals working with homeless women have been explored from the perspectives of the strain of crisis intervention and coping with work-related stress (e.g., Baker et al., 2007, pp. 465–474; Lemieux-Cumberlege & Taylor, 2019, pp. 367–378; Salem et al., 2018, pp. 665–687).

Homelessness pathway is a commonly used metaphor in homelessness studies in recent years (e.g., Clapham, 2002, pp. 57–68, 2003, pp. 119–127; Clapham et al., 2014, pp. 2016–2031; Fopp, 2009, pp. 271–291; Juhila & Kröger, 2016; May, 2000, pp. 613–638). Numerous studies of social work (e.g., Järvinen, 2015, pp. 198–226; Karttunen, 2019, pp. 117–197; Ranta, 2020, pp. 86–88; Ruch, 2018, pp. 19–35) have shown the importance of a trust-based relationship for the success of interaction work. There has been a lot of research on home support (e.g., Juhila et al., 2020; Lydahl & Hansen Löfstrand, 2020; Ranta et al., 2017) and besides research on women's homelessness has shown the importance of compassion and practical help for clients. Juhila et al. (2020) have conceptualised the unique content of home visit work into three dimensions: situationality, boundlessness, and empathy, framed by home as a context. On the other hand, Perälä and Jurvansuu (2016, pp. 532–537) have also shown the fact that the residents of a housing unit do not receive the substance abuse and mental health services they would be entitled to from the public sector. Research by Hansen Löfstrand (2015, pp. 17–38) shows the last resort shelter for the most marginalised homeless as a place of control and isolation from the rest of society. According to several studies women have perceived services as stigmatising, controlling and used only as a last resort when informal support has not been available (Bretherton & Mayock, 2021).

As stated above, we participate in a research discussion on women's pathways to housing and service experiences by focusing on the worker–client relationship, from two complementary perspectives, and using two different interview data.

3. Research Settings, Data and Methods

The context of our research focusing on the worker–client relationship is the work of implementing the Housing First principle that takes place at different settings and stages of the women's pathway to housing and home. The data contains qualitative interviews conducted in two settings.

Our first setting is a supported housing unit that operates under the Housing First principle and which is targeted to long-term homeless women. The housing unit is owned by a non-governmental organisation who also provides the support and services for the women. In this setting we interviewed the workers. Our second research setting is rental flats in ordinary blocks of flats. These flats are owned by another non-governmental organisation which also implements the Housing First principle. In this research setting we met the women in their homes at a moment when they had just got their own flats and the preceding stages of their housing pathway were still fresh in their memory. The women looked back on the support they had received in worker–client relationships along their housing pathway and evaluated its significance in a place that they felt was their home.

The data which was collected through one group interview with three workers of a housing unit centres on their relationships with women who are suffering from psychosocial burden. All workers were female, they were trained as practical nurses and their work experience varied from a few months to four years. The housing unit, the setting in which the worker–client relationships are formed, is both a workplace and a community. Group interview as a method of data collection offers group participants an opportunity to diversify and refine each other's narratives. On the other hand, a group setting may create pressure to convey a unified narrative, which can limit or even prevent the expression of differing viewpoints (Esberg, 2020, pp. 49–52; Pietilä, 2017, pp. 112–121). The power dynamics within the group will inevitably influence what and how the participants speak. In our interview, there were disparities between the participants in terms of how much they spoke: The more experienced workers spoke more. Nevertheless, the participants were respectful towards each other and supported and complemented each other's comments. The interview conveyed a shared perception of the work, which is not a surprise since the participants work as a team in the unit.

The group interview consists of the workers' time-, setting- and encounter-specific views regarding their work and the women's situations. The significance of the setting and the community is highlighted in the ways how relationships with the women are described. Furthermore, relationships are described in relation to the women's life situations and the psychosocial stress associated with them. The group interview material has been analysed with data driven content analysis. The structuring of the themes was influenced by the interview frame we used, which we had compiled on the basis of our previous research literature and our knowledge of Finnish Housing First work. We first structured the overarching theme of worker–client relationship into four main themes: place, community, sensitive topics and coping at work. As a result of a more detailed analysis, we merged the theme of coping at work and the relevance of work into the other three, as their contents seemed to largely determine the meaning of the work and, on the other hand, the workload.

Our second dataset consists of nine one-on-one interviews, which were conducted in the homes of women who had exited homelessness or the risk of homelessness. The women were recruited for the interviews through housing counsellors. The selection criteria included that the women had moved to their scattered-site flats less than a year ago and that they received support either from the municipality or from a non-governmental organisation. The women's ages ranged from 18 to 66 years old. The participants included students, pensioners and working individuals. We interviewed mothers, grandmothers and childless women. Some had been homeless for years, whereas for others, homelessness had been an anomaly on their housing pathway. Some women's life courses had been marked by the risk of homelessness, yet they had not experienced homelessness. All of the women had low income, and some were struggling to pay off their debts.

We visited the women in their homes in order to acquire narratives based on their own experiences regarding the housing pathways that led them to a home of their own. The interviews were conducted with the help of loosely structured interview frame making sure that the women had as much freedom as possible to discuss their experiences without a predetermined structure. We sought to understand the subjective meanings that the women assigned to the supportive relationships they had experienced or not along their housing pathways. Although the thematic questions guided and restricted the narratives, the women's experiences differed significantly in terms of their focus.

We analysed the women's interview material by selecting three interviews from the data corpus, two of which we built a story in which a young woman's homelessness path could have been prevented with sufficiently intensive and long-lasting support and supportive relationship in public child protection aftercare. From the two interviews, we selected extracts that describe the vulnerable life courses and, in particular, the meanings that a young woman gives to a worker she has experienced as her own. In another story, the theme is a traumatised life course in which psychosocial services with supportive relationships in public sector have played a major role in breaking the cycle of homelessness. Both stories are stories built with the aim of showing how the homeless woman's category breaks down into a wide variety of situations and lifestyles. The women's interview material is characterised by the importance of a timely, sufficiently long-term and trust-based worker–client relationships. In addition, the entire material is united by the significance of a home obtained on the principle of scattered-site and perceived as a home as part of the overall life situation.

Ethical reflections were given importance throughout the whole research process. Researchers submitted an application for access and research plan to both organisations of the research settings through the standard application process. After the application was approved, an information sheet was given to people we were recruiting for interviews. This sheet included basic information on the purpose of the research and emphasised voluntary participation and anonymity of participants (Kainulainen & Honkatukia, 2021, p. 117). Before the interviews, all participants signed a consent form. The interviews were carried out by two researchers, both of whom were careful to emphasise the fact that participation in the research was voluntary and that what the women shared in the interviews would be treated as confidential and would in no way affect the services they received. We decided not to include signifiers to any of the quotations for two reasons. Firstly, the quotations of the workers represent the view of the whole team and our aim was not to highlight any differences. Secondly, with both datasets, we left signifiers out to guarantee the anonymity of our participants.

4. Relationships with Homeless Women: Work at a Community-based Housing Unit

> Having a home can only improve quality of life if other core elements of psychiatric recovery are also present, such as hope for the future, meaningful

> activities, enjoying the company and support of others, and feeling included in society. However, permanent housing provides the conditions for normal, non-stigmatised housing. (Padgett, 2007, p. 1934)

This quotation from Padgett is the starting point for the analysis of our data: Support following the Housing First principle can mean working and creating relationships with women who feel homeless in their own home on a permanent tenancy.

Access to a flat does not always signify the end of the experience of homelessness, as one housing unit worker who participated in our study relates:

> I haven't heard any one of our residents call their flat a home….They sometimes correct me if I talk about a home, they say "this is not my home."

Life without a home of your own means much more than just a lack of housing. A home has a deeper personal meaning than a flat, as it includes material, social and emotional dimensions. In order for a flat to become a home, the resident must attach it to her feelings. Attachment can be difficult and without support too overwhelming as a result of past experiences of homelessness or traumatic events related to breakdowns of homes (Granfelt, 1998, pp. 103–116; Ranta & Juhila, 2019).

The place, in this case a housing unit, provides a backdrop and entangles to worker–client relationships. The interaction between the women who have experienced long-term homelessness and the housing unit workers is marked by psychosocial stress and the fact that for the women, housing services are a last resort option. An added strain may be caused by the feeling of homelessness, despite a permanent tenancy. For a person who is 'homeless at home' (Husso, 2003, pp. 220–229), a home no longer signifies a safe place of her own. Feeling homeless in one's own flat creates a tense to relationships in the unit: a housing service provider that follows the Housing First principle, yet a woman who feels homeless and whose opportunities for social participation are in many ways limited. Taking a step forward is difficult due to social exclusion, which many homeless women, especially those with serious mental health issues, have to face regardless of where and how they live (Padgett, 2007, p. 1934).

4.1. The Place of Relationships

The worker–client relationship forms the core of intervention, also in communities affected by various strains and conflicts (McMahon, 2018, pp. 147–164; Ranta, 2020, p. 15). According to the workers, the traumatised life courses of individuals who have experienced long-term homelessness do not change course at once. These life courses have evolved over several years, even decades, maybe across generations, and reversing them requires not only a flat and support from professionals but also the experience of a meaningful life (e.g., Vanhala, 2005, pp. 184–185).

Pathways in and out of homelessness can be very complex, and linear development towards a 'final state' of a permanent home or permanent homelessness are rare (De Decker & Segers, 2014, p. 611). The traumatic events suffered by women who have experienced long-term homelessness at different points of their life histories may have shattered the feeling of home so fundamentally that it has become difficult to grasp. They may never have had a home or may associate bad memories with various temporary lodgings, all of which for their part reinforce the feeling of homelessness. When relationship with the self is fractured and one's inner home is destroyed, it may be impossible to find a home anywhere. According to the workers, women's housing pathways included, in some cases, many evictions also from other supported housing units:

> The social services have assigned this place for them. The other option is staying outside. When you take that choice away, I don't know whether it's really, whether it feels like home.

For homeless women, limited choice for housing is firmly linked to structural factors, such as the housing market and the social service system. From the women's perspective, this may essentially mean an absence of choice. The only available choice is not necessarily designed with their situations in mind and corresponds poorly to the needs of women in need of housing (Mayock & Bretherton, 2016, pp. 278–280; Ranta et al., 2017, p. 173).

The workers of the housing unit expressed concern especially for the women whose lives were characterised by the question "Who would take me?":

> These are individuals with psychogeriatric issues who return here after an assessment period and the years go by….Where does that person go when they get older, I do worry about that a lot.

A supported housing unit cannot address all possible social and health issues. A flat that is supposed to be a home for the women cannot become a repository for psychosocial issues (Perälä & Jurvansuu, 2016, pp. 532–533).

4.2. Community Relationships

In the housing unit, relationships are strained by untreated substance abuse and mental health issues as well as the cumulative traumatic experiences that underlie and intertwine them. Communal living with strangers who are stigmatized with the same categories of problems may feel like objectionable, forced interaction. An unwell client may isolate herself inside a hard shell:

> Respondent: They don't want to deal with us. And if they are intoxicated, their behaviour is often very aggressive. Towards us counsellors, and also towards the other residents.
>
> Interviewer: If there's a resident who is paranoid, how does that manifest here?
>
> Respondent: Well, it will manifest as distrust towards us. And everything that happens, it's our fault. And the fact that we are able to control both their finances as well as their personal matters. We are here in order to make their life difficult….We become the embodiment of all their misfortunes. We are at fault for what happened to them.

Understanding the culture of homelessness and what socially excluded and stigmatised women have experienced and continue to experience helps workers protect themselves from taking aggressions and insults personally. The education of workers being in close relation with homeless women must be developed by providing a deeper and broader understanding of women's homelessness as a phenomenon, which will enhance their cultural competence. Workers must possess diverse skills in order to support, communicate and create trustful relationships with women who receive services. These skills also include recognising that the women may have complicated relationships with services. This is why they frequently rely on the help of frontline workers, who can respond to their crises with a more sensitive approach (Lemieux-Cumberlege & Taylor, 2019, p. 368):

> A rough day is one when your phone is ringing from the moment you come to work in the morning. Either it's the residents calling you or our partners, cleaners, laundry services. And since our doors are closed, we always have to be opening the doors. Then the alarm system goes off….The constant demands. And meanwhile your phone keeps ringing. And you can't even hear the person at the other end because of the noise. Then you try to find a quieter place.

The workers in the housing unit work in small teams of two in the daytime and alone at weekends. At times they come under high levels of time pressure to complete multiple tasks simultaneously. This may cause stress, especially combined with lack of time or an excessive workload. Eventually, the danger is that this will potentially contribute to both emotional exhaustion and affect one's sense of personal accomplishment. On the other hand, the sense of personal accomplishment related to one's work may act as a protective measure against burnout (Baker et al., 2007, p. 471). Looking beneath the surface and trying to understand a person's circumstances can help professionals cope with challenging worker–client relationships. Similarly, seeing one's work as meaningful can have a strong positive effect on work engagement (Mette et al., 2020, p. 10; Salem et al., 2018, pp. 670–672; Ward, 2018, pp. 55–74). Satisfaction and the experience of meaningful relationships were reinforced by small interactional episodes which were characterised by few, but honest words:

> Our residents are also able to say sorry. And it comes straight from the heart.
>
> It can be just a small thing, and when they thank you. It doesn't have to be anything major but they are grateful for many things.
>
> One resident called and said: "It's nice that you returned from your holidays."

According to the workers the housing unit community can be experienced differently by different women. For some, it may represent an objectionable last resort characterised by negative relationships and disillusionment. For others, it may represent a home associated with positive aspects such as safety, shared space and shared identities among women, and social relationships. The women within the community may already know each other from earlier stages in their housing pathways, and they may have a sense of community that is grounded in shared experiences (Hetling et al., 2020, p. 412; Junnilainen, 2019, pp. 76–119; Nousiainen, 2016, pp. 163–191). The workers discussed the significance of community interaction with elderly women who have lived in the community for a long time:

> For example, if someone hasn't seen a particular resident in a few days, they will often call us and ask if everything is okay with them because they haven't seen her. We will go and check and if everything is okay, we will tell her it's fine. They take care of each other.

Through their presence, the workers can show their appreciation for the sense of community among the women and acknowledge their right to be treated respectfully as individuals. Such activity can be referred to as presence intervention. The relationship based on presence signifies spending time together, either in conversation or in silence. The worker is present and available, even until the very end (Granfelt, 2013, pp. 231–237; Haahtela, 2015, pp. 54–57; Karttunen, 2019, pp. 135–146):

> We have a common space on the fifth floor where we have coffee together. Often at the weekends if I'm alone here, I'll just sit there for hours and talk with the women about anything and everything.
>
> We have also accompanied them on their final journey, so we have gone to funerals and since we are close, we can't help but cry when we send them off

> on their final journey. So, it's not, it's not easy for us either. It's impossible to do this job without becoming close to them.

4.3. Sensitive Topics: Unspoken Narratives

> And I guess it's also because some of them have spent their whole lives on the streets, so they have kind of become hardened, and they need to remain like that no matter what….They are hurting, but they don't know why they are hurting.

Even though the workers make themselves available and are present in various situations, the shared reality and the underlying emotional connection is difficult to achieve, especially if the women have had many difficult experiences that they are unable to confront:

> They talk very, very little….I think they are sensitive topics and they might be ashamed. Or it might make them feel so upset that they don't want that. So, they just numb themselves with drugs or alcohol, it's kind of an endless cycle. It's somewhere inside them, but it never gets out.

The workers state that the women are unable to discuss or share their trauma or cumulative history of trauma. They have had to survive on the street and in unsafe lodgings. They have learned to survive with the help of armour, which protects them from insults and rejection but simultaneously prevents them from accepting compassion and care (Thörn, 2004, pp. 153–185). The women may have adopted a cross-generational culture of reticence since childhood. They are building neither a victim narrative nor a narrative of agency; instead, they are building a sad, unspoken narrative. Substance abuse may provide a barrier for unbearably difficult emotions (Granfelt, 1998, pp. 142–145).

The women's experiences with the service system may also have contributed to the formation of a hard shell. Rejection may signify an even stronger attachment to violence, drugs and illness, which in turn may result in guilt and shame, staying silent and shielding oneself from the eyes of others. Such rejections may have cumulated along one's life history. Women's negative experiences and relationships with services may also result from a perceived lack of control or say in their everyday lives and feelings of surveillance and infantilisation, as attempts to 'order' their lives may have had significant negative ramifications (Mayock & Sheridan, 2020, p. 27; Vanhala, 2005, p. 270; Virokannas, 2017, pp. 274–283).

The restrictions set by the housing unit also contribute to the idea of a community of dysfunctional women. Research on women's homelessness has broadly discussed issues related to motherhood (Granfelt, 1998, pp. 117–132; van den Dries et al., 2016, pp. 179–208). Homelessness and the loss of home may be accompanied by unspoken and broken motherhood. If a woman's children have been taken into care, her motherhood is not always recognised and her possibilities to fulfil her motherhood are not explored. Living separately from one's own children and missing them can be too heavy a topic to share with the workers and other women:

> Based on what I have understood, I think she hasn't seen them and she misses them terribly. And it may come up when she is reminiscing on things that she used to do with her children. Then she often says she misses them. And you kind of have to be discreet….I never got the chance to ask her if she ever meets them… it's such a sensitive subject, so I can't really ask her.

Above one of the workers discuss how greatly she thinks one of the women misses her children. Bringing up such a heavy topic in worker–client relationship does not seem possible despite the fact that the woman had reminisced on moments she had spent with her children. Ethically challenging situations rarely indicate a clear approach; instead, the worker must make intuitive decisions (e.g., Juhila, 2018, pp. 253–257). It is possible that the woman in question wished that the worker would have taken a more forthcoming approach. It is equally possible that she appreciated the present, yet distant relationship. Since the workers are involved in the women's daily lives, it is important that they are able to respect the women's privacy. Respecting the women was embodied in one principle that was shared among the team, which was to make sure that whatever is promised to the women will also happen:

> Even something trivial, if it has been agreed upon, we will make sure it gets done.

5. Pathway towards a Home of your Own

Our second dataset consists of interviews with women who have received a flat of their own. The women had moved into their flats relatively recently, within the previous year. In the interviews, we discussed the stages on their pathway to home and the meaning of home. Each of the nine women had received psychosocial and/or financial support along their housing pathway. The women's housing pathways differed significantly. Some had lived in a cycle of crime, drugs and homelessness for years and after years in supported housing, had finally acquired a home of their own. Others had retired from a low-income career, which resulted in spiralling debts and foreclosures, and finally eviction.

The following two narratives describe the situations of women who have, with the help of psychosocial support in their worker–client relationships, been able to avoid becoming homeless or to break the cycle of marginalisation and start forging a new identity. The first narrative is based on interviews with two young women, and the second one on one interview.

5.1. The First Home of One's Own

"I'm mentally better now," she says.

Difficult teenage years took this woman who feels now mentally better away from home to a children's home. She discussed her difficult teenage years and yearning for peace and quiet amidst the bustle of the child protection facility. Her biggest source of safety had been a large dog, who remained with her through everything. Now her situation was different: She was about to graduate into a profession that she loved, she was dating and living in her first own home. She was also close to securing a job. A new home, a flat with a permanent tenancy on the top floor of a quiet building, just as she had hoped:

> There is a door code and you can't get in just like that and it's a bit higher so it's not the lowest level. It just feels safe in that sense even though there is only one exit. Because of some things in my childhood, it is really important for me.

Her narrative includes description of a close, supportive and helpful worker–client relationship. She had looked for her own flat together with a social worker from child protection aftercare services. Together, they had considered different options and filled in rental applications. The social worker had accompanied her to an interview with a non-profit organisation, which offered her a flat. The social worker had encouraged her to express her wishes regarding the flat.

As soon as she saw the flat she knew: "Yes, this is it." The flat was clean and beautifully renovated. The building housed mostly elderly people, and her childhood home was a short distance away. Although the neighbourhood has a reputation as a problem suburb, it did not bother or scare her.

The social worker helped her get started with independent living. Anne is "probably the best social worker I've had, sound and understanding; the kind of person it's easy to be with, easy to talk to. Anne gets back to me immediately after she sees my message." She took care of the paperwork and discussed all kinds of things related to a young person's life. There were things she didn't want to discuss with her parents. It was good to have another adult in her life.

She did not need support for living. She was able to cook and keep a clean home. She had previously taken care of her younger siblings, who enjoyed spending time at her place, in her new home. Now she had a place of her own where she could invite her friends. She liked it at home so much that "sometimes I don't really want to leave it. This is my own safe haven." She had started to trust her own capabilities and to see the possibilities that were open to her. Having "a place that cannot just be taken away and people around me who help me so that I'm not alone" gave her a sense of security.

Having a worker you connect with is highly significant to a young person living in a vulnerable situation. Child protection aftercare services promote independence, and secured housing is a prerequisite for independence. The client–worker relationship involves the same basic elements as client–worker relationships in the housing unit: trust, sharing meaningful things and support with practical matters. An interactional space where the client feels at ease is the foundation for mutual sharing and boosts confidence: People care about me and want to help me.

The narrative is characterised by two significant factors. The first one is the availability of support at a critical stage on one's housing pathway, when the young person is about to transition to her first own flat. When she was a teenager, she had to leave her childhood home and move to a child protection facility, which was a difficult experience. The young person has lived independently from an early age and, at the same time, is about to transition to working life. Her life course is guided by traumatic events, which is why it is very important that she receives professional support at the critical stage of transition. Another significant factor is renting a flat that feels safe from a non-profit organisation that is committed to helping residents with financial and other issues that may jeopardise housing. Listening to the young person's wishes and ensuring her freedom of choice, however limited, regarding the flat contributes significantly to creating a feeling of home.

For young women, homelessness can signify a rapidly advancing process of marginalisation (e.g., Viisanen, 2019) and mark the beginning of a sad narrative. At the time of the interviews, the narrative taking shape was positive and hopeful about the future.

5.2. From Rehabilitation to Studies

The woman in our second narrative told she had been under psychiatric care several times, both in inpatient and outpatient care, and defined herself as a person in mental health rehabilitation:

> For a long time I kind of held it together, but then I started getting into debt. I also had a gambling problem and my debts grew and grew and because of that my drug use and mental health got worse and worse.

The insufferable situation led to a suicide attempt, after which she found her strength:

> Immediately after I was discharged from the hospital, I contacted the substance abuse centre and got a quick appointment and after two weeks I went to a rehabilitation facility. I was first taken in for a month and then for another month. And that was definitely a turning point for me.

She was given a place in a rehabilitation housing community for women, but she felt like an outsider among the women who were much older than her. She lived with her sister sometimes, and occasionally she would stay with friends.

She got her drug use under control and started psychotherapy. Because she was homeless, a commitment to regular psychotherapy sessions proved too challenging, but she found help through a low-threshold organisation that also arranged for a flat. She went back to psychotherapy and started studies in a degree programme. Recently she had begun to identify herself decreasingly as a person undergoing rehabilitation from mental health and substance abuse issues and increasingly as a student:

> And it feels really good because for so many years it was like the drugs and the mental health issues completely defined me.

She was herself amazed at how she had been able to remain sober for months without a flat. She had cried when she did the laundry for the first time in her own home:

> I can't stress enough how meaningful housing is. I don't know where my path would have taken me if I didn't get a home of my own. It could have taken me in a very different direction because it was stressful staying in other people's homes.

This woman's situation is very different compared to the women whom the workers of the housing unit were most concerned about. She had timely access to psychiatric care, institutional rehabilitation and outpatient services. At the final stage of her care path, she found a form of psychotherapy that suited her. All in all, she had several trustful, supportive and helpful worker–client relationships. She was no longer bouncing between acquaintances, and her identity was shifting from that of a person in rehabilitation from mental health and substance abuse issues to that of a student.

6. Conclusion

The narratives of the housing unit workers related to a deep concern for the women whose mental and physical health was deteriorating. The workers had to assume responsibility for the safety of clients with psychotic symptoms and to work in an environment where some women were unable to take care of themselves and their flats. Workers felt frustrated by the inconsistence of care pathways in substance abuse care, psychiatric hospital care as well as gerontological services. Despite the emotional stress the workers felt their work as meaningful and discussed their affection for the women. Although the support given in the housing unit includes boundlessness and situationality (Juhila et al., 2020), this should not result in women being excluded from the special services. With an empathetic and flexible approach to clients' situations, more or less trust-based relationships were formed in the housing unit, which gave meaning to the work and thus supported the resilience of the workers.

The housing unit does not provide women a normal and non-stigmatising flat (Padgett, 2007) but neither it is a guarded last resort for people in the extreme margin of society (Hansen Löfstrand, 2015). For some women, the housing unit provides communal support, sharing a common history of experience about the way of life that is vulnerable in many ways. The workers of the housing unit have limited possibilities to influence the marginalisation that extends to various areas of women's life. However, this does not diminish the significance of worker–client relationships in the unit in the lives of women for whom many services still remain out of reach.

Our second research setting was a rental flat in scattered housing. Trustful, supportive and helpful worker–client relationships at different stages of the housing pathway and in different services enabled for their part access to a flat that became a home, including a sense of home. In both narratives, the woman had received what she needed from social and healthcare services. Getting sufficient support and help in a vulnerable situation in a trust-based worker–client relationship was a unifying theme of narratives of the women. Homelessness and problems with housing have been addressed as part of a holistic effort to improve quality of life together with the women either through adult social work, through child protection aftercare or through psychosocial services. Besides, the women had access to their own resources, such as studies and employment, and close personal relationships that supported coping. There was hardly any need for housing support as such. The public service system, which is an integral part of the Finnish Housing First model, had been able to provide sufficient support in the critical stages of the housing pathway for women whose situations, despite their vulnerability, were not chaotic pathways burdened by accumulated deprivation. Our research encourages the further development of trauma-oriented working methods and low threshold women-only housing options, from the perspective of women living in a spiral of marginalisation who trust no one.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Missing Hero: Co-Producing Change in Social Housing Programmes

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Abstract
The aim of this article is to develop theory and generate knowledge about the challenges and possibilities of co-producing change in a social housing programme. The purpose of the project was to implement the Housing First philosophy in the social housing programme in the city of Helsingborg, Sweden. The aim was also to create opportunities for service user involvement. Several innovative measures were implemented in order for these changes to occur from autumn 2016 to summer 2017. The social services commissioned a university course on which social workers and their clients studied together on equal terms to create project plans for the further development of their own workplace. A "Future" workshop was held by the researchers with representatives from all the different housing options (the shelter, transitional housing, category housing, Housing First apartments), both clients and social workers. Repeated dialogue meetings were conducted at the different housing options to discuss how service user involvement could be developed and to discover new ways of participation. This article is based on a strengths-based perspective using the theoretical discussions on social traps, as well as the concepts of enabling and entrapping niches. We show the importance of social workers identifying and supporting missing heroes—service users who want to participate and be involved in co-producing change. We also show that if an organisation is not prepared for the initiated changes, there is a risk of disappointment due to awakened expectations that are not fulfilled. Building trust is also an important component to emerge from the material, but we also found that change processes can be initiated that continue and have impact beyond the initial project's goals.

Keywords
co-production; enabling niches; gap mending; social housing; social traps; trust

Issue
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1. Introduction

Homelessness is a growing social problem in most European countries. The number of people experiencing homelessness is much higher in Sweden than the other Nordic countries (Benjaminsen et al., 2020; Knutagård et al., 2020). One reason for this is that the construction of new housing relative to the population growth has been lower in Sweden compared to its neighbouring countries. Consequently, the vast majority of the 290 Swedish municipalities have a shortage of rental apartments with rents that people can afford. Research highlights poverty as a significant cause of homelessness (Bramley & Fitzpatrick, 2018; Knutagård, 2019). Without a steady income, it is extremely difficult to enter the ordinary housing market or buy your own apartment or house. There is also a growing number of people experiencing homelessness from a migrant background (Hermans et al., 2020). In two of the major cities in Sweden, local municipal guidelines have been introduced that make a distinction between what is called 'structurally homeless' and 'socially homeless' (Hermans et al., 2020; Sahlin, 2020). Being categorised as structurally homeless excludes an individual or family from receiving help from the social services and only emergency housing will be provided on a day-to-day basis for individual applicants, and on a weekly basis for families. Even if the causes of homelessness are seen as structural, i.e., lack of housing and not having the financial means to afford housing on the ordinary housing market, the responsibility for solving the problem is placed on the individual (Sahlin, 2020).

In the past decade there has been a shift towards a more housing-led approach (the provision of ordinary long-term housing rather than emergency housing) in how to reduce homelessness (Pleace, 2018). In the Nordic context, Finland and Norway stand out in their national strategies on housing-led approaches. One key driver in this shift is the evidence of the effectiveness of the Housing First model in enabling people using Housing First sustain their housing (Padgett et al., 2016). As a model, Housing First has its origins in the "Pathways to Housing" organisation in New York at the beginning of the 1990s; the model was the brainchild of Sam Tsemberis (Tsemberis, 2015). The model was created because Tsemberis and colleagues had identified that many former patients with whom they had worked in the mental health sector ended up sleeping rough and that the services that were available became revolving-door interventions. The services that were offered did not solve homelessness, but rather sustained the problem. The spread of Housing First to Europe and the Nordic countries started in the last decade. The results are consistent with the results of research from the USA and Canada (Pleace et al., 2019). Housing First is contrasted with the continuum of the care model or the so-called housing staircase model (Sahlin, 2005). In Housing First, housing is seen as a prerequisite and as a means of recovery and community integration, while in the staircase model, housing is seen as the end goal. In the staircase model the client is expected to progress, step by step, towards independent living. People experiencing homelessness must show that they are 'housing ready,' and the rules of different temporary housing options in the staircase model are often associated with regulations and control; an individual often has to abstain from alcohol or drugs to get an apartment. The Housing First model is based on eight core principles: (1) housing as a basic human right; (2) respect, warmth and compassion for all clients; (3) a commitment to working with clients for as long as they need; (4) scattered-site housing and independent apartments; (5) separation of housing and services; (6) consumer choice and self-determination; (7) a recovery orientation; and (8) harm reduction (Tsemberis, 2015, p. 18). Research has highlighted that in order to combat homelessness, an integrated housing strategy is the way forward, based on a housing-led approach. To clarify, *housing-led* means that ordinary housing is used to solve homelessness. If someone runs the risk of losing their home, the first type of measure would be prevention. If someone ends up homeless, rapid re-housing in ordinary apartments should be the generic solution, while Housing First is a more specific model that is also combined with flexible support to stop people from becoming homeless (Pleace, 2018).

An important principle in Housing First is self-determination. This idea corresponds well with another growing practice of service user involvement in social work practice, education and research (McLaughlin et al., 2021). In Helsingborg municipality a Housing First project started in 2010 (Knutagård & Kristiansen, 2019). The project became a permanent service in 2013 and the local politicians also decided to scale-up the Housing First programme. In the following years, the social services aimed to implement the core principles of Housing First in all the housing options in the social housing programme. The local social housing programme had its roots in a 'staircase' logic. One important aspect was to increase the service user influence at the different housing options (Knutagård & Kristiansen, 2018). In this article we will analyse how some places and initiatives created niches that were enabling for the participants, while other places led to a niche compression and, in the end, the social trap closed. We will discuss these concepts further in the following section. We use the project in Helsingborg as a case study. The project ended in 2017. The concepts of traps emerged from the empirical material, particularly how organisational barriers prevented some participants from engaging in the change processes or made it more difficult to sustain the initiatives that had been started. The concept of enabling and entrapping niches were not active parts of the project but have emerged in our ongoing work on the gap-mending concept. The gap-mending concept entails a constant reflection on what causes and mends gaps between social workers and service users in social work practice, education and research (Askheim et al., 2017). In one of our research projects, we conducted a follow-up study of students who participated in the mobilisation course. The mobilisation course is an elective course in the seventh semester of the social work programme at the School of Social Work, Lund University. It is also offered as a commissioned course. The results of this study will be presented in a forthcoming book. We have also continued to study the implementation of Housing First in Sweden. Both examples have shown that they can generate new opportunities for participants if people can meet on equal terms. The aim of this article is to generate knowledge about the challenges and possibilities of co-producing change in a social housing programme. Our ambition in this article is theory development and we use the empirical data to illustrate our theoretical argument. We have seen synergies between project ideas that were created during the course and later realised, co-producing research projects that have included former students (by *students* we mean course participants who were students on the social work programme, and clients/residents and participants who were social workers) of the course and their project ideas with developmental work at the social service department. The synergies that we have seen made us start to think more specifically about what type of spaces enable co-production. What kind of components are necessary to create spaces that are enabling?

2. Social Traps, Missing Heroes and Social Niches

In this section we present the theoretical framework we have developed based on our field experience. The framework combines social traps and missing heroes with the concept of social niches.

A social trap is when actors end up in an unfavourable situation that will be disadvantageous to all of them (Rothstein, 2005). The fundamental problem with social traps is that they are very difficult to remedy. A core component is the concept of trust. When people trust each other, and particularly trust in others to participate, it is possible to create a space for co-production and collaboration. In this respect, our actions are connected to what we expect other people to do. If actors do not trust other actors to engage in a certain action, it is likely that the individual will not act on their own. This will lead to a situation in which the outcome will be irrational for the collective, but the action might be rational for the individual. Rothstein (2005, p. 13) connects trust with the collective memory—it is difficult to "rationally decide to forget." This type of situation can have devastating consequences. A key concept in Rothstein's argument is anticipation. A collective memory of persecution, discrimination and violence is not easy to forget and is connected to the stories that are being told by different categories of 'the others.' Rothstein (2005, p. 21) points out that social traps can lead to "stable but inefficient equilibria." This is a situation in which the actors involved have no incentive to make any effort to change their behaviour or actions. There can be short-term benefits for some actors, but the state of inefficient equilibria will, in the long-term, be negative for everyone involved. The problem is that when people start to distrust each other, the risk of ending up in a social trap rather than a collaborative change process is present. This elucidates the relationship between trust and social traps. It takes time to establish trusting relationships, but it is easy to destroy a relationship by not being trustworthy. Both mistrust and social traps are situations that involve a lot of work, time and loyalty to rebuild, once the trust is lost and the trap has closed.

When groups are prejudiced towards each other, it is very difficult to overcome the mistrust that exists between them. However, there are certain conditions that can circumvent the prejudice in intergroup contacts:

> Prejudice (unless deeply rooted in the character structure of the individual) may be reduced by equal status contact between majority and minority groups in the pursuit of common goals. The effect is greatly enhanced if this contact is sanctioned by institutional supports (i.e., by law, custom or local atmosphere), and provided it is of a sort that leads to the perception of common interest and common humanity between members of the two groups. (Allport, 1979, p. 281)

These four conditions can reduce prejudice in intergroup contact: (1) equal status; (2) common goals; (3) cooperation between groups; and (4) institutional support (Pettigrew & Tropp, 2011, p. 61). Allport (1979, p. 9) states that "prejudgments become prejudices only if they are not reversible when exposed to new knowledge." Subsequent research has confirmed Allport's contact hypothesis and a meta-study conducted by Pettigrew and Tropp (2006) showed that of the four identified factors, the most important one was institutional support. Institutional support and long-term commitment, as we will show, are crucial for enabling co-produced projects to be sustainable.

In this article, we see the hero as a person who is keen to get involved in co-production. The missing hero could be the same person, because if the context is not right, the person will not participate (Platt, 1973). The reason for this depends on whether the person believes that other people will also get involved in the change process and also whether the environment can be seen as an enabling niche rather than a niche that is entrapping.

Taylor (1997, p. 219) defines a social niche as the "environmental habitat of a category of persons, including the resources they utilize and the other categories of persons they associate with." By using an ecological metaphor, Taylor places the focus on the relationship between human beings and the environment. For human beings, the immediate environment can be seen as the 'community' and the 'neighbourhood' (Ryke et al., 2004). In order to include a strengths perspective and how a place can be symbolic and subjectively constructed, Ryke et al. (2004) extended Taylor's original definition. They define the social niche as:

> The living environment of people, including the place in which people find themselves and the places typically utilised by them, the circumstances of that place, both social and natural/physical, the resources available to them and typically used by them, the other categories of people who are typically associated with those people, the contribution or initiative of people in it and the meaning that people construct in regard to their place and purpose. (Ryke et al., 2004, p. 1935)

What we are particularly interested in here is the distinction Taylor (1997) makes between enabling and entrapping niches. The distinction between the two illustrates ideal types, but even though niches exist in a purer form, they often contain both enabling and entrapping aspects. The enabling niche can be seen as a strong environment and therefore minimises the risk of getting into a social trap because the people who belong to the enabling niche are ready to surrender their individuality for the good of their community (Ryke et al., 2004). Often, entrapping niches are places that the most marginalised groups in society are more or less forced to inhabit.

The entrapping niche is characterised by a space that stigmatises those who are trapped. The social category defines the members of the niche. This categorisation is particularly done by people outside of the niche. People within the niche tend to only associate with each other, which limits their social relationships. There are very limited economic resources and limited opportunities to achieve a higher status or position in an entrapping niche. It is also more difficult to have long-term goals and it is hard to acquire skills that can help a person to escape (Rapp & Goscha, 2012; Taylor, 1997). Homelessness, for example, increases the likelihood of people ending up in an entrapping niche.

Being part of an enabling niche does not stigmatise and people in the groups are not only defined by their social category. Even though people in the niche mainly associate with other people in the niche, there are opportunities to interact with others. The economic resources are sufficient in enabling niches. The niche offers opportunities to work towards long-term goals and there are also opportunities to get higher positions and learn new skills that enable a person to progress to other niches (Rapp & Goscha, 2012; Taylor, 1997). Gap-mending strategies are an example of how the interaction between niches can be mended to increase the possibilities for people to escape previous entrapping situations and positions (Heule et al., 2017). In order to mend the gaps, participants need to reflect on the factors that caused the gaps. This process takes time, as trust might require participants to look beyond their prejudiced views of each other.

This article is based on a strengths-based perspective. Instead of focusing on deficiencies or shortcomings, people's inherent strengths are at the fore. In a strengths-based approach, well-being and the human potential is the fundamental focus. In a problem-orientated approach, "the client's situation must be made to fit predetermined categories and those categories are not the ones that the client would devise as an adequate description of his or her situation" (Rapp & Goscha, 2012, p. 7). The client's problems are seen as being caused by themselves, which also makes them responsible for their own situation. If we take homelessness as an example, this is often the case. Blaming the victim can result in an inverted model of cause and effect (Whang & Min, 1999) comprising four stages:

> All of this happens so smoothly that it seems downright rational. First, identify a social problem. Second, study those affected by the problem and discover in what ways they are different from the rest of us as a consequence of deprivation and injustice. Third, define the differences as the cause of the social problem itself. Finally, of course, assign a government bureaucrat to invent a humanitarian action program to correct the differences. (Ryan, 1976, pp. 8–9)

One challenge is that those action programmes or interventions that are intended to cater for marginalised groups tend to be niches that are entrapping rather than enabling.

3. Participatory Action Research

The design of our research project is based on participatory action research (Bradbury, 2015). There are four main reasons why we have considered this approach to be relevant. The first concerns ethics. There are ethical aspects about giving all interested parties the opportunity to participate, ensure that their voices are heard and their perspective is given the same space as the voices of researchers and practitioners (Askheim et al., 2019; Beresford, 2005). Another important area is about quality and improvements. Many people believe that research is improved if service users participate because the questions they ask are different from the questions asked by researchers and practitioners. Service users can also facilitate access and involvement of other service users in research projects (Askheim et al., 2019; Brydon-Miller et al., 2004; McLaughlin, 2009). A third area addresses the importance of personality development. Participating in action research can result in developing the participants' personality (Askheim et al., 2019; McLaughlin, 2009). The fourth area is human rights. This is similar to the ethical perspective in action research. The focus is on giving marginalised and discriminated groups the opportunity to give their perspectives on social problems (Askheim et al., 2019; Beresford, 2005; Brydon-Miller et al., 2004).

The empirical material of this study comprises field notes from 26 dialogue meetings at the different housing options in the social housing programme. Field notes from five steering group (project group) meetings are also included, as well as documentation from one "Future" workshop. One taped interview with a social worker and an expert by experience is also used. In this interview the focus was on the experience of participating in a participatory action research project. As researchers, we have participated in different ways. We have all taught on the commissioned course used by the social services as one of its initiatives to create a space for co-producing change. We held the "Future" workshop and participated in the dialogue meetings. During the entire project there has been a project group that included representatives from the social services, social workers from different housing alternatives, people with experience of homelessness or other social problems, representatives from the Research and Development unit in the city, as well as researchers.

Our ambition was to try to maintain a continuous dialogue with the other participants (social workers, experts by experience, residents at the different housing options) in the project in order to strengthen the collaboration and interactions with them. These are important prerequisites for participatory action research to work (Grant et al., 2008; Kristiansen, 2016). For example, this meant that at our project meetings we reflected on our roles as well as the other participants' roles in the project and how we could develop and improve the dialogue meetings. In relation to the meetings, we reflected on the four conditions described by Allport (1979) that are essential in intergroup contact (equal status, common goals, cooperation between the groups, and institutional support). We also invited and engaged the service users in the research process. They designed a questionnaire on their own and interviewed people with lived experience of homelessness. It is important, however, to recognise that there are also some risks involved in participatory action research. There are ethical problems regarding, for example, confidentiality. It can be difficult to guarantee confidentiality and it is therefore important to ensure that everyone is informed about what is expected of them and what they themselves can expect from the research project (Gelling & Munn-Giddings, 2011, p. 105). Askheim and Raak Høiseth (2019) state that service users should participate on the same terms as researchers and service users must therefore be informed and educated about confidentiality and other research ethics, etc. There could also be conflicts related to the goals and intentions of the project. It is important to ensure that participants are involved in the initiative, as well as the influence and design of the study (Gelling & Munn-Giddings, 2011, p. 105). If the participants are not properly invited to participate in the project, their involvement might become a form of tokenism (McLaughlin, 2009).

4. Co-Producing Change

The municipality, more specifically, the social services department, had successfully implemented a Housing First programme in the city. The results showed a high housing retention rate: 85% of tenants were still housed after the Housing First project ended in 2013 (Table 1). The tenants reported positive life changes such as better contacts with family and friends, better health, and a better financial situation. The tenants also stated that their trust towards social services had increased (Knutagård & Kristiansen, 2018; Kristiansen, 2013). The positive results from the Housing First programme led to the desire to try and change the whole social housing programme by introducing the core principles of the Housing First model. The key objective was to increase the involvement of service users in the different housing options in the local social housing programme used by the social services in its homelessness work: emergency housing; low threshold housing; transitional housing; training flats; and social housing apartments (Table 2). Even though the Housing First apartments were part of the same organisation, the other housing options in the social housing programme were based on a staircase logic.

Three key activities were used to enable the involvement of the residents in the different housing options and to investigate the possibility of the different measures that could be taken. The social services commissioned a course that is held at Lund University (Heule et al., 2017). During the course, social work students study together with people with lived experience of different problems such as homelessness, mental health problems or substance abuse, etc. During the course, one of the tasks is to co-create project plans that aim to tackle a current social problem. At this stage, the social services recruited 'students' who were both residents and staff at the different housing options. This enabled them to take the course together, and when designing the project plans, they could target their ideas towards the question of how to increase service user involvement in the social housing programme in the city. During the course, a "Future" workshop was held to kick-start the work on the projects (Jungk & Mullert, 1987). The "Future" workshop is a good way of getting everyone involved and participating, as well as ensuring that all voices are heard. Because of the action-orientated outcomes of the "Future" workshop, and the fact that the course could only be held once per semester, with a limited number of students, the social services asked the researchers to organise an additional "Future" workshop. This enabled more residents and staff to participate. The third activity to be initiated was dialogue meetings. These meetings were held at the different housing

Table 1. Housing First in Helsingborg 2010–2017 (number of tenants, evictions and housing retention rate).

	Tenants	Evictions	Retention rate
2010	2	—	100
2011	9	0 (0)	100
2012	16	1 (1)	93.75
2013	20	2 (3)	85.00
2014	34	0 (3)	91.18
2015	44	3 (6)	86.37
2016	49	0 (6)	87.76
2017	57	3 (9)	84.22

Table 2. The Social Housing Programme in Helsingborg 2017.

Social housing/rental guarantee apartments	Carnot—Training apartments
Type of accommodation: 2nd hand contract. The rental guarantees are 1st hand contracts with additional contracts. **Target group:** Addiction and mental health problems. **Number of places:** Around 165 apartments, of which around 30 are rental guarantees. **Description:** For people who are self-sufficient and follow the rules of the Rent Act. **Staff:** 7 + 1 coordinator. **The staff's mission:** Support, motivation, and supervision.	**Type of accommodation:** Training apartments. **Target group:** People with drug addiction with greater support needs. **Number of places:** 18 smaller apartments with shared kitchen (6 apartments/kitchen), 10 individual apartments and two 6-room apartments. A total of 34 places. **Description:** The residents must be motivated to move on to their own apartment or a social housing apartment. **Staff:** 8 + 1 coordinator. **The staff's mission:** Support, motivation and ADL (activities of daily living).
Fenix—Emergency housing	**G8—Training apartments**
Type of accommodation: Emergency housing and long-term housing for people who temporarily do not have the ability to manage their own housing. **Target group:** Addiction and mental health problems. **Number of places:** 31 permanent places + 6 places that can be used without a referral from the social services. **Description:** For people who are active addicts. **Staff:** 12 + 1 coordinator. **The staff's mission:** Support and motivation.	**Type of accommodation:** Training apartments. **Target group:** Addiction, people who are regarded as being capable of managing their own housing with support. **Number of places:** 47 in apartments. 3 apartments are used as 'temporary places' when people relapse. These apartments are shared with Pluto. **Description:** The residents must be motivated to move on to their own apartment or a social housing apartment. **Staff:** 4. **The staff's mission:** Support, motivation, and ADL.
Kronan—Congregate supported housing	**Pluto—Training apartments**
Type of accommodation: Congregate supported housing for people with more severe comorbidity (two or more conditions that a person experiences, e.g., substance abuse and mental health problems). **Target group:** Addiction and mental health problems. **Number of places:** 17 independent apartments + 1 apartment with 3 places. **Description:** People with a great need for support. **Staff:** 8. **The staff's mission:** Support, motivation, and ADL.	**Type of accommodation:** Training apartments. Requirements of abstinence. **Target group:** Addiction and/or mental disability. **Number of places:** 56. Three apartments are used as 'temporary places' when people relapse. These apartments are shared with G8. **Description:** People who remain abstinent and are motivated to move on to their own apartment or a social housing apartment. **Staff:** 4. **The staff's mission:** Motivation and ADL training.
Housing First	
Type of accommodation: Own apartment, 1st-hand contract with additional agreement for the first two years. **Target group:** People with substance abuse and mental health problems. **Number of places:** Unlimited based on access to apartments. Currently 32 apartments. The programme has been allocated a total of 57 apartments, of which around 20 have been transferred to the residents with their own contracts. **Description:** For long-term homeless people who are motivated to change. **Staff:** 3.75. **The staff's mission:** To give the individual active support and motivation in their pursuit of change, which could involve reduced substance abuse, employment, as well as supporting the individual in following the rules of the Rent Act.	

options on several occasions. The ambition was to listen to the views of participants, residents and tenants on practice local service user involvement and what kind of changes they wanted to see and in what way they could be part of this change. One of the participants stated: “It took a while for them [the service users] to understand that it was for real, that something was happening… it was not just talk and more talk.” The course design considered the principles of contact research insofar as the participants were all students (equal status). They developed projects together (cooperation towards common goals) and this was supported by leadership in the city of Helsingborg (which could be seen as institutional support).

Inherent to the Housing First model is enabling tenants to be involved and decide what they need in order to stay housed and to recover. The tenants in the Housing First programme also had a place where they could meet, to meet up with other residents, support workers, and just sit down and have a coffee and talk for a while. They had their own apartments to which they could return. The housing options in the social housing programme differ greatly regarding the individual’s own space and integrity. Many of the people who lived in other types of housing situations had to share kitchens and bathrooms, and their ‘own’ rooms might be visited by other residents or staff. The rules that regulate the place might therefore threaten the individual’s integrity. In most cases, regulations regarding the work environment and staff safety come first. Housing options in the social housing programme (e.g., emergency shelters, transitional housing, training flats) run the risk of “violating a person’s space, time, energy, mobility, bonding, and identity” (Rapp & Goscha, 2012, p. 12).

For people experiencing homelessness, this type of problem is always significant and the fact that such problems exist also contributes to their lack of trust in social workers and various authorities. We have learned that if we want to engage people and get them involved in participatory action research projects, we need to show them that we take their everyday problems seriously. This can build trust and make it worthwhile for them to participate in the project. The different initiatives that were used in the project had the ambition to create a space in which everyone could be involved on equal terms. Rothstein raises an important point:

> The thought is that we may be prepared to seriously listen to and accept opinions and arguments from those whose interests or ideas are different from our own, but only provided that we can trust that the other side is equally ready to do so. (Rothstein, 2005, p. 51)

During the project, enabling niches were created for the participants. We will show two examples. In the first example, the enabling niche could not be sustained. The project idea that was created was supposed to be implemented in one of the housing options, but the institutional support was not sufficient, so the social trap closed. In the other example, the combination of enabling niches created opportunities for the participants to get a job, study, or had other positive outcomes. Having a Housing First apartment was in itself an enabling niche.

5. The Trap Closes

During the project period, some of the niches that had enabled the co-production of change started to close. During the so-called mobilisation course, several residents became involved in project ideas that they believed were plausible and possible to implement, and which were supported by their fellow residents and staff. There was one person in particular, Murray, who can be seen as a missing hero. He and several others put in a lot of effort to increase the residents’ influence on the daily life at the housing unit where he lived—congregate transitional housing. This place comprised separate rooms in which the residents lived, but with a shared kitchen and other facilities. There were apartments close by that were also connected to this house. This was one of the difficulties in getting all the residents involved in the process, because those residents living in apartments had their own space and were not as dependent on the shared spaces. For many of the residents living there, having something meaningful to do was high on their priority list. They started table-tennis tournaments between the housing options in the social housing programme. Another challenge was that it took a lot of time from the point when an issue or suggestion was raised to receiving a green light from the management. The entire project had institutional support from the top end of the management, but the understanding of what the project was really about was not sufficient in the middle management. This resulted in gaps between those who participated on the ground level, and the different management levels between the residents and the director of social services. The support was from a management group that was quite far removed from the daily decision making of the housing option. This had serious consequences for Murray and the project idea he was trying to implement, since he was not given the necessary resources to take it further. It was not a question of a huge amount of money, just a small sum that would give the residents cash to travel by bus between the different housing alternatives, or to buy paint to re-paint the units. Even the staff who had participated in the joint course encountered difficulties. When enabling niches face a lack of resources, it leads to what is called a *niche compression*. It was a very ambitious project in many ways and it really tried to make provision for the participant being part of and co-creating the actions needed to strengthen the possibilities of service user involvement. The project funding was only for one year (the second half of 2016 to the first half of 2017, so-called seed money), with the main focus on investigating how service user involvement could be implemented. This created some confusion, since once the project had started, the residents and staff were more interested in creating real change, rather than figuring out what could be changed.

6. A Niche That Enables

Location is an important factor in the discussion about enabling niches. Some physical locations are less likely to be enabling than others. In our research there is another key component that is key: relationships. Relationships are key to creating and sustaining enabling niches. As we have previously seen, the challenges of sustaining the initiated change process were a lot harder at the more congregate housing options. One of the Housing First tenants, Bertha, describes her experience of taking the course:

> Emma [the support worker] forced me to attend the mobilisation course. She has always pepped me and supported me….Then you stood there, you two, you and Marcus, friendly professors and listened to me, you probably don't understand how much it meant to me….The actual work on the mobilisation course, I don't know if I can put it into words, but you got a completely different kind of self-esteem… suddenly you meant something… my group was important… yes, I actually felt like a real human being… and not just an old drug addict. It was at the mobilisation course that I got in touch with you….It was a completely different world for me.

Bertha's statement shows the importance of the mobilisation course as a niche that enabled and empowered Bertha to believe in the power of the group and that gave her new confidence about who she was. Being acknowledged and approved by fellow students and teachers had a gap-mending effect that also affected her self-confidence and trust after the course. Bertha was subsequently employed as a support worker in one of the housing options and had many representative assignments within the network of the commissioned course. The value system and the institutional norms between the course and the Housing First project were more in line than other housing options in their vision of enabling and listening to marginalised groups. However, as enabling niches, both the commissioned course and the Housing First project depended on the surrounding institutions, which also limited the effects for the participants.

Even though it was more difficult to transform the housing options in the social housing programme, a few significant transitions can be noted. There was a stronger focus on housing retention, i.e., that the residents would not be evicted if they relapsed. One critical aspect of the project was that the staff who worked with Housing First found it hard to be involved in implementing the Housing First principles in the other parts of the social housing programme. According to a social worker:

> There was never anything, there was talk, but many of us were ready to board this ship. I compared it to a large ship… that we were ready to board, but it became a ship with a lone sailor and I was not allowed to join and I had loads of ideas about how to work. Finally, we would get to do something useful and there were many more than me who were excited about it, but it became only a word, housing retention, and it was interpreted differently, depending on the housing option.

Even though the ambition was to implement the core principles of Housing First in the social housing programme, the experience and knowledge of the Housing First support workers were not used. One of the support workers told us that "our boss wanted to call Stockholm and learn about how they worked with Housing First, when everyone else [within the organisation and from other municipalities] called us and asked us [about how to work with Housing First]." This led to a *niche shift*, which meant that some of the Housing First staff decided to leave their jobs and start their own businesses. In this way, they created a new platform where they could make the most of their potential and experience.

7. Conclusion

When we look at the outcome of the different measures, they all created enabling niches. The problem was that it was much more difficult to sustain the enabling niche in the more congregate housing options in the social housing programme than in the Housing First programme. These findings support a more housing-led approach to ending homelessness since having your own apartment is an enabling niche in itself. Even though housing is essential, having a job or having something to do and feeling a sense community is also important. In this context, creating spaces (both physical and virtual) that are enabling can enhance the options. The results suggest that the potential of enabling niches lies in between cross-sectoral collaborations rather than within specific services. It is not impossible to transform more congregate housing options into enabling niches, but it is a lot harder due to competing institutional logics. The results show the importance of social workers identifying and supporting missing heroes—service users and staff who want to participate and be involved in co-producing change. The results also show that if an organisation is not prepared for the initiated changes, there is a risk of disappointment due to awakened expectations that are not fulfilled. Building trust is also an important component to emerge from the material, and trust will decrease if what is said and what is done are two different things. The results have also shown that change processes can be initiated that continue to have an impact beyond the initial project's goals.

The results of this study correspond with the conditions that Allport highlight as necessary in intergroup contact. They also correspond with the concept of enabling niches. Gordon Allport's findings show that under certain conditions, contacts between rival groups could reduce prejudice and discrimination. As previously mentioned, the conditions that were seen as important were: equal status, common goals, intergroup cooperation and the support of authorities, laws or customs. None of these conditions are easy to adopt, particularly not in institutions or organisations that are characterised by a clear hierarchy between service users and employees. Some of the housing options that participated in our research project could be compared to Goffman's total institutions. They upheld many procedures that were disciplinary towards service users and which threatened their integrity (Goffman, 1991). Even if employees and residents from these organisations were able to develop mutual trust as students on equal grounds within the framework of the mobilisation course, this framework had a very limited bearing on the housing organisation, which was characterised by a different institutional norm. Both employees and tenants from these organisations testified that they had been disillusioned by the difficulties they faced in their joint efforts to change their organisation in order to better respond to the needs of those people who lived there. Allport specified that unless the contacts were characterised by informal personal interaction and cross-group friendships, the contacts would risk becoming superficial and would cause people to resort to stereotypes. In environments that resemble total institutions, the gaps tend to be upheld and cross-group friendships will be disciplined and punished. However, our study also showed that enabling niches can enhance the effect of empowerment for marginalised groups that use one niche as a steppingstone to another niche. Some students were empowered by the mobilisation course and were subsequently employed by other organisations, such as the Housing First programme, which acknowledged their growth and potential.

This article has analysed a case that shows that both staff and service users can become motivated and build mutual trust in enabling niches, characterised by more equal status and which enable cooperation and the development of common goals. However, if these values are not supported by the larger institutional setting, they have limited sustainability and can lead to renewed prejudice and disappointment. It also shows that institutional change takes both time and long-term commitment on the part of management at all levels of the involved organisations.

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Conflict of Interests

The authors declare no conflict of interests.

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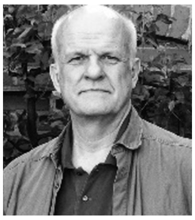

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Article

From Home to Community: Reflecting Emotions Related to Mobility

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Abstract

This study investigates how clients' emotions are invoked and reflected in client–worker interactions and the meanings they have regarding leaving home. We concentrate on floating support work, which aims to support people suffering from mental health and substance abuse-related issues to improve their living in the community. Our theoretical framework is based on the geography of emotions, and we draw on both the interactional and relational approaches thereto. The research material is gathered from Finland and England. We draw on mobile ethnographic and discursive approaches, and our data consists of transcriptions and field notes gathered during floating support visits (N ⍰19) that took place either at or outside of a client's home. Our findings demonstrate how the connections between places and emotions, the emotions connected to leaving one's home, the emotions reflected while being out in the community, and the reflections of emotions after being out in the community are constructed and reflected in client–worker interactions. The study highlights that these emotions are a necessary and demanding part of promoting clients' social inclusion in the context of floating support work.

Keywords

emotions; floating support; from home to community; mental health; mobility; substance abuse

Issue

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1. Introduction

Recent decades have seen a transition in long-term mental health and psychiatric services, which now generally take place at community-based rather than institution-based facilities (De Heer-Wunderink et al., 2012, p. 1102). In the literature, this development has been conceptualised as 'deinstitutionalisation' (Fakhoury & Priebe, 2007). Another term, 'home turn,' outlines how institutional services targeting people living at the margins of welfare have been replaced by offering support and services in their homes and communities (Hall et al., 2021). These developments have led to the increased prevalence of working practices that focus on floating or mobile support (e.g., Juhila, Holmberg, et al., 2020; Ranta & Juhila, 2020). As a whole, community-based services and 'home turn' are generally seen as responses to critiques targeted at large mental health and residential institutions, as well as office-based services (e.g., Hall et al., 2021).

The goals of deinstitutionalisation and home turn policies and practices are to advance the active citizenship of people living at the margins of society, strengthen their self-determination and autonomy, and emphasise their right to equal housing (Miettinen & Teittinen, 2014; Tideman & Tossebro, 2002). Another important goal is to enhance their social inclusion (De Heer-Wunderink et al., 2012, p. 1102) and social connectedness, which are said to be key strategies for improving the lives of people with mental health problems (Hare-Duke, 2017). Still, community-based services have been criticised for further marginalising people who are already isolated by bringing services into their homes (e.g., Kröger & Leinonen, 2012; Tucker, 2010, p. 446). This becomes especially evident in cases where individuals don't want to leave their homes or participate in social, societal, and communal activities. Furthermore, Richardson (2019, pp. 36−42) states that the home environment can trap and isolate people. She argues that the home can be an emotionally and physically dangerous place if evaluated in terms of phenomena such as violence, abuse, or gender inequality. Conflicts in the home can threaten one's emotional, social, and physical health, but fears of these threats can also emerge when thinking about leaving home. Home is a place that provides security and comfort, and thus it is difficult to leave. However, spending a lot of time at home and being able to organise and manage one's home space has also been shown to promote a sense of inclusion and feelings of control and social normalcy, as some places outside the home can cause fear, pressure, and anxiety (Tucker, 2010, pp. 444–447).

According to Wong et al. (2014, p. 685), studies concerning the community and social integration of people, "in recovery from mental illness," have not focused enough on the social and relational dimensions of integration, including the ways that people acquire and re-establish membership in their various communities. It has been argued that mental health practitioners need to explore the emotional/cognitive, moral, and social competencies of people recovering from mental illness in order to best help them achieve community inclusion: Emotional competence is needed to develop reciprocal community relationships (Wong et al., 2014, pp. 690, 693).

This article focuses on situations where leaving home is somehow difficult due to mental and/or physical restrictions, loneliness, or a lack of social skills or knowledge of how to act in certain situations. These reasons are often connected to emotions; feelings of insecurity, fear, or anxiety, for example, can cause voluntary isolation.

Our goal is to demonstrate how clients' emotions are connected to leaving home and community engagement, and how these emotions are reflected in the interaction between clients and workers. We focus on client–worker interactions that support people in operating outside their homes and participating in activities in their communities. We define this kind of floating support work as going out into the community. Floating support work takes place "in people's own homes to support their living in the community, prevent evictions, and, thus, reduce the risk of homelessness" (Juhila, Holmberg, et al., 2020, p. 1). These services are diverse and can include everything from practical help and guidance on everyday issues to more therapeutic conversations to walks in a nearby community (Juhila, Hansen Löfstrand, & Raitakari, 2020). In this article, we ask two specific questions:

1. How are clients' emotions invoked and reflected in client–worker interactions?
2. What kinds of meanings do these emotions have in relation to leaving home?

2. Everyday Mishmash of Emotions

Every action we take in daily life is connected to emotions. The people we interact with, the goods we use, and the environments and spaces we operate in evoke a wide range of emotions in us. Depending on the individual, the ability to manage such emotions varies and can sometimes lead to conditions that impair one's quality of life. The spatially-engaged approach to the study of emotions is well known, especially in the field of human geography (e.g., Davidson et al., 2007; Fahnøe, 2018; Ranta & Juhila, 2020). According to Bondi et al. (2007, p. 3), emotional experiences and attachments are always located and felt in places and produced in relationships between people and environments. If these feelings are negative, they can lead to avoidance of certain places. Fahnøe (2018) shows how homeless peoples' negative emotional experiences are triggered by certain places, such as homeless hostels or day centres, with certain personal and political dimensions that constitute socio-spatial exclusion from places and services, demonstrating how important it is to examine the clients' emotional reactions connected to leaving home and operating in the community.

Emotional contradictions in floating support work happen for workers as well their clients (e.g., Ferguson, 2010; Muzicant & Peled, 2018). O'Connor (2020, p. 646), who studied social workers' understandings of emotions in practice, argues that "emotions are inherent in the relational, organizational, and socio-political context of this practice, which involves practitioners working with other people's and their own emotions." She continues: "Emotions are frequently constructed as central to practice, yet at the same time are seen as potentially harmful phenomena which require containment and control" (O'Connor, 2020, p. 646).

Emotions are a major factor in social (care) work, as client-professional encounters often contain challenging topics that can generate powerful feelings in both parties (e.g., Koprowska & van Nijnatten, 2019). Processing sensitive feelings for both clients and workers goes hand in hand with everyday ethics in professional work (Banks, 2016). Banks (2016) uses the term 'emotion work' as one ethical dimension of professional life when working with vulnerable people. In her description, emotion work contains various aspects, such as "being caring, compassionate, and empathic; managing emotions; building trust; responding to emotions of others" (Banks, 2016, p. 37). In this article we approach the emotion work by means of how workers reflect the client's emotions and respond to them.

The concept of emotion work was originally developed by Hochschild (1979, p. 561), who used it in connection with work environments. Working with emotions means 'managing' them; this is not always successful. In our study, this can mean that a client who feels anxious when leaving their home, for example, is helped to identify and process those feelings as they are constructed in certain situations and environments. Hochschild (1979, p. 561) divides emotion work into two types, "*evocation*, in which the cognitive focus is on a desired feeling which is initially absent, and *suppression*, in which the cognitive focus is on an undesired feeling which is initially present." When applied to floating support work, this division becomes visible when a client suffering from anxiety either manages to operate outside of the home without the challenging emotion or recognises and labels anxiety as an unsuitable emotion in certain situations or environments. Our demonstration works with the framework proposed by Banks (2016, p. 41), in which she refers to emotion work as an effort people make to both feel certain emotions (e.g., comfort, calm, joy) and to handle emotions (anxiety, fear, or insecurity). In our study, emotion work is seen as a key part of professional social care and floating support work.

3. The Interactional and Relational Approach to Emotions

What does it mean to feel anxious, calm, or joy? Are emotions reflections of our inner experiences, memories, and bodily feelings, or are they just biological or neurological processes that can be measured or cured medically? We draw on an interactional and relational approach to identifying emotions (e.g., Gergen, 2009; Hochschild, 1979). Gergen (2009, p. 99) states that "confusion in identifying emotions again suggests that the emotions are not simply there in the head or body to be discovered. Rather, what we call emotion is created in co-action." Simply put, people construct their emotions in relation to certain historical, social, and cultural practices.

Emotions are constructed through psycho-social, bodily, and material relationships and boundaries that are continually present in our daily lives and affect our actions. We are "being moved" by other factors, by other people, art, or beautiful landscapes (Bondi et al., 2007, p. 7). This continuous movement does not only construct pleasant emotions; it also refers to feelings that can threaten our well-being. Emotions "are forms of action that acquire their intelligibility within relationships and… gain their value from their social use. It is not that we 'feel emotions' so much as we *do* them" (Gergen, 2009, p. 102).

In our study, emotions are 'done' through verbal, bodily, material, and situational interactions between people (e.g., Gergen, 2009, pp. 102–111). For example, when a floating support worker asked a client who has difficulty shopping on his own how it felt when they went to the store together, the client answered: "It was a bit easier." Ease is 'done,' or *constructed*, in relation to four contexts: in relation to conversation, namely the worker and client describing their feelings on the situation, in relation to floating support and emotion work, when the worker helps the client to manage uncertainty, in relation to the place and action that caused the unwanted emotion, and in relation to a culture in which an adult person is assumed to shop independently.

4. Methods

This study draws on the mobile ethnography (e.g., Ferguson, 2016; Novoa, 2015) and discursive approaches (e.g., Hall et al., 2014; Koprowska & van Nijnatten, 2019). Mobile ethnography emphasises both researcher mobility and mobility in relation to theoretical and analytical perspectives (Novoa, 2015, p. 98); it enables researchers to capture everyday moments in the material world and use their senses during data collection (Ferguson, 2016; Novoa, 2015). This method was utilised to observe how workers and clients interact during floating support visits. Researchers kept diaries of these encounters and audio recorded conversations when appropriate. The discursive approach was utilised to micro-analyse the written and spoken data by focusing on *what* was said and *how* it was said regarding emotions, mobility, and leaving the home (Koprowska & van Nijnatten, 2019, p. 346).

4.1. Data and Ethics

Our data consists of transcriptions and field notes gathered during floating support visits that took place either at or outside a client's home (e.g., walks, shopping, bus rides, and visits to the cafeteria). The data was gathered in Finland and England during two separate research projects (the Geohome, "Geographies of Home-based Service Interactions at the Margins of Welfare in Finland and Sweden 2017–2022," and "Responsibilisation of Service Users and Professionals in Mental Health Practices 2011–2016"), both focusing on service encounters at the margins of welfare. Both research projects were approved by the Regional Ethics Committees and all participants gave their informed consent before participating in the study.

The study participants were all adults living independently in their own apartments, either around city areas or close to larger housing units, who have problems related to mental health and/or substance abuse. They needed different levels of support to manage independent living and daily activities. The support visits made by the floating support workers consisted of several kinds of practices, from cleaning or making food to supportive discussions. The educational background of the workers varied from practical and psychiatric nurses to social care students and workers.

The data from Finland was gathered from three floating support services located in three different cities during 2017–2018 while the English data was gathered from two floating support services located in two different cities during 2011–2013. This study focuses on floating support visits that prioritise on clients' mobility and going out into the community. In the first phase of analysis, we coded two data sets from England and Finland

and looked specifically for home-visit interactions where clients' mobility and need of going out into the community was in focus. After the coding we found 10 support visits from the Finnish data set and nine from the English data set of relevance. These 19 support visits constitute the data analysed in this article. The Finnish data consists of seven support visits with audio recordings (a total of three hours and 39 minutes) and field notes (a total of 10 pages), and three support visits with only field notes (a total of six pages). The English data consists of nine support visits with audio recordings (a total of five hours and 13 minutes) and field notes (a total of 10 pages). Altogether, there were 13 separate clients (one support visit had five clients at the same time) and seven separate workers from Finland and eight separate clients from England. The number of individual workers in the English data was hard to estimate.

4.2. Analysis

The analysis was divided into three phases (see Table 1). First, we sorted through the entire data corpus and focused on those parts where workers and clients were either *on the move* or *talking about the movement* or *mobility*. At this point, we were considering the reasons why they were going out to the community, which led us to notice how these visits had different *functions* regarding movement and mobility. We then analysed the deeper meanings connected to these functions and how the thoughts of leaving one's home or actually being on the move evoked a wide range of emotions, which were then addressed in several ways in client–worker interactions. We then focused on those parts of the data where emotions were *talked* into *being* and how these emotions were related to mobility and leaving one's home to visit certain environments. Finally, we identified four separate ways that the emotions were invoked and reflected and defined them as *the connections between places and emotions*, *the emotions connected to leaving one's home*, *the emotions reflected while being out in the community*, and *the reflections of emotions after being out in the community*. The detailed process of analysis and key contents and interpretations are presented in Table 1.

The next section demonstrates the findings of our analysis through four data excerpts describing how clients' emotions are invoked and reflected in client–worker interactions and the meanings these emotions have in relation to leaving home.

5. Findings

5.1. Connections Between Places and Emotions

In the following excerpt, a middle-aged woman living alone in an apartment near a supported housing unit talks with a researcher and a support worker after walking in her neighbourhood during a floating support visit. Even though the client lives on her own, she still has access to the supported housing unit and its activities. Her regular support visits usually focus on outdoor activities. The walk is about to end, and the participants are discussing the client's previous and current housing; diverse emotions connected to the clients' earlier residence and current home are revealed:

> Researcher: Have you longed to come back here [to the supported housing unit], or is there a big difference now that you live close, but alone?
>
> Client: I can't say I longed to coming back. There was this kind of feeling when living here… a very safe feeling when living in this house [located in the housing unit]. But I get that safe feeling in my own home as well. I'm there behind the locks, alone, so I'm safe.
>
> Worker: If you lived farther away would you feel the same way?
>
> Client: Hard to say, yeah. I might….I think there's some kind of a bond between my life [and the housing unit], as it [housing unit] is so close [to my apartment].
>
> Worker: Yeah, and you are involved in activities there anyway.
>
> Client: Yes.
>
> Worker: This is probably the ideal solution for you.
>
> Researcher: Did it wanting to move away from here come from you, or did it come more from…?
>
> Client: Yes, the care workers recommended it for me as I'm in such good condition and I'll survive, yeah. At first, I did not want to leave this house by any means; I was so attached. But when I left, I was so happy I had gotten my own apartment.
>
> Worker: Yeah, and your own sauna. You went to the sauna very often. And it's lovely that you have a balcony.

The link between place and emotion is constructed when the researcher asks the client, referring to a housing unit, "have you longed to come back here?" The client begins to compare the two forms of housing in relation to safety and recalls that she felt safe while living in the housing unit. However, the client connects the same emotion to her current living situation by saying: "But I get that safe feeling in my own home as well." The emotion of safety is constructed in relation to home, a place culturally associated with security and privacy. In addition, the emotion strengthens as the client elaborates: "I'm there behind the locks, alone, so I'm safe." This seems to imply that the area outside the home is threatening, and that being alone means that no one can hurt her. This conversation

Table 1. Phases, contents, and interpretations of the analysis.

Analysis phase	Content	Interpretation
1: Concentrating on the parts where participants were either on the move or talking about the movement or mobility	The mobility involved: • regular shopping and other trips that were included in floating support services • helping clients who had (bodily) disabilities • supporting clients who didn't have many social relationships or suffered from fear of social encounters • teaching clients, e.g., going to the grocery store to buy food	Mobility had functions related to: • floating support as a service • clients' bodily restrictions • means to prevent loneliness or isolation • sites of learning and managing in daily life
2: Analysing deeper meanings connected to functions of mobility	Mobility in relation to client–worker interaction: • was used as a tool to discuss diverse topics • created abilities for clients to learn daily chores • made insecure situations where clients needed support visible • enabled thoughts and discussions of how something felt	Mobility had certain meanings in client–worker interaction: • created and promoted conversations • supported psycho-pedagogical actions • allowed for emotional support • enabled increased understanding of the emotions and senses of the clients
3: Focusing on the emotions and their relationship to mobility and leaving home	Emotions are talked into being in relation to: • cultural perceptions and norms related to home and independent living • bodily aspects of leaving the home • temporality: past, present, future • direct, emotion related questions and positive feedback	Emotions are invoked and reflected in client–worker interactions through: • connections between places and emotions • emotions connected to leaving one's home • emotions reflected while being out in the community • reflections of emotions after being out in the community

provides a strong example of why leaving one's home can be difficult.

The link between place and emotion has another meaning as well. After the worker's question regarding whether the client would have the same emotion of safety if she lived further away from the housing unit, the client refers to a bond between her life and the housing unit. The emotion of safety is constructed in relation to the short physical distance between the two places and the activities at the housing unit. The client describes this connection as a 'bond,' a term often used to depict close relationships between people. The researcher asks how the client ended up moving away from the housing unit, and it turns out that previous floating support workers encouraged her to do so, as she was in such good condition and could live on her own. Essentially, the workers used positive feedback as a tool to support the client in the managing of her emotions of insecurity and fears of moving out of the housing unit. The client describes how she had originally resisted the move: "At first, I did not want leave this house by any means; I was so attached. But when I left, I was so happy I had gotten my own apartment." The account reveals both a strong sense of place and an emotional contradiction; there is both a strong attachment to an old apartment and eventual happiness after leaving it. The worker resolves the contradiction and strengthens the client's emotions of happiness by referring to certain spaces (balcony) and activities (going to a sauna), which she uses to help construct an attachment to the client's current apartment and confirm her decision. Overall, this conversation shows the direct, emotion-related impact that the workers can have on clients' emotions and how they relate to place and time.

5.2. The Emotions Connected with Leaving One's Home

The next excerpt pertains to a man in his 40s who suffers from agoraphobia and serious difficulties leaving his home; he has not really left his house in about 10 years. He usually feels comfortable and enjoys being in his backyard but has not gone very far into his front yard. If he goes too far, his legs start to shake and he starts to feel uncomfortable. He has friends who help him with everyday tasks such as shopping and taking the garbage out. The floating support workers have been asked to help the client gradually leave his property. In this excerpt, the worker and the client are discussing the time the client has spent in his home and how he should proceed in terms of leaving it:

> Worker: Yeah, but I think what you need to think about is where do you want to be in 12 months' time?
>
> Client: Well, it's like what I've just been saying in the kitchen, and I know, don't get me wrong, I know I am one of these people where sometimes I'll say a lot of things and you know.
>
> Worker: Put things off a bit.
>
> Client: I put things off, but I do need to motivate myself and start doing these things. And I think one thing that will help me more with outside, it's not because of people looking at me…[unclear] but when I'm out there, I think if I've got like a bit of weight knocked off me it will improve my breathing.
>
> Worker: For your mobility as well.
>
> Client: Yeah, and I won't find that when I'm out I'm saying oh I need to go back in because blah, blah, blah. I feel as though I'd be able to stay out more.
>
> Worker: But there's got to come a point when you've got to say to yourself, right, this is when it's going to change.
>
> Client: Yeah, I know.
>
> Worker: I mean, if you're serious enough about it, and I think you are.
>
> Client: Yeah, well the thing is I am, and I don't want to stay like this.
>
> Worker: It's been how long now, 10 years?
>
> Client: Yeah, because I was thinking about this the other day.
>
> Worker: It's a long time [name].
>
> Client: Because I thought, well you're 41 now, you're going to be 42 in September, you can't keep wasting the years.
>
> Worker: See those 10 years, you'll never get those back.
>
> Client: Exactly, so it's something that I need to do, but I think first things first, what I'm going to do, what I'm going to get sorted, and I am going to get it sorted as well, I'm going to sort my house out, get it tidied, and I am going to get it tidied.
>
> Worker: Well, I mean it's all part of, like, a new beginning, if you like.
>
> Client: Yeah, get my house sorted out, but also I'm going to start going on the [indoor] bike, I'm going to start going on the bike again and work at going on the bike, because after a week of me going on the bike I do feel better. But I'm going to stick with it, and I am going to do it, and I'll let you know how I get on. I will tell you, I won't lie to you.
>
> Worker: No.
>
> Client: I'll tell you the truth, but I think if I just go on the bike a little bit and just feel that bit better in myself, I reckon I'll be more up for.
>
> Worker: Yeah, you've got to look at the positive side, just what benefits you'll gain from it.
>
> Client: So yeah, I am going to do it, and I mean that as well, I'm not saying it and then like oh I can't do it. My back does hurt me still, I do have problems with it, but it's not like it was when I had problems getting out of bed.
>
> Worker: Like you say, if you lost a bit of weight that [would] probably [help].
>
> Client: Well, that's why I want to go on the bike.
>
> Worker: Yeah.

This discussion begins with the worker's rather direct address: "What you need to think about is where do you want to be in 12 months' time." The term 'need' constructs an emotion of seriousness in relation to the client's situation and his time spent inside the house. The client attributes his actions to being the kind of person who "put things off a bit," as the worker concludes. The client affirms this and agrees: "I do need to motivate myself and start doing these things." The client's reference to motivation and the need to do something constructs a vague reluctance or stagnation in relation to leaving his home, but also reflects how he feels the necessity to do something about it. However, the client has an idea of how to increase his motivation. He explains that the reluctance to leaving his house is not connected to the people outside, but rather to the emotions constructed in relation to bodily aspects, such as weight and breathing. The worker confirms the client's pondering on the benefits of weight loss and adds that it would also help his mobility, referring to both bodily mobility and movement within the community. The client agrees: "Yeah, and I won't find that when I'm out I'm saying oh I need to go back in because blah, blah, blah. I feel as though I'd be able to stay out more." He constructs an emotion of inability in relation to being outside the home environment, which would be improved if he lost some weight.

The worker transfers the responsibility of change to the client by saying that "there's got to come a point when you've got to say to yourself, 'right, this is when it's going to change.' " This expression constructs emotions of decisiveness and self-reliance, as if leaving home is a choice that needs to be made. The worker continues: "I mean, if you're serious enough about it, and I think you are." The client confirms: "Yeah, well, the thing is I am, and I don't want to stay like this." The discussion continues by focusing on the past 10 years, which the client has spent in his home. This reflects the earlier construction regarding the emotion of leaving home as a choice based on whether the client is sufficiently serious about wanting the change in his life; this illustrates the complexity of the situation. The client does not want to stay like this, but who or what prevents him from making the choice to leave home? The worker goes on to state that the client can't keep wasting the years; these strong impressions reflect the strong emotions connected to misplaced life and the necessity to fix the situation.

The client agrees and offers new ideas for improving his motivation to leave home. The client's accounts of the emotions of credibility and commitment to leaving the house are constructed in relation to concrete actions, such as tidying the house, indoor biking, and promises of commitment. The client shows that he is seriously trying with this talk of planning, but these acts would also be a very demanding lifestyle change compared the duration of his situation. Still, the worker constructs an emotion of hope by saying: "Yeah, you've got to look at the positive side, just what benefits you'll gain from it." The client responds by confirming that he will do it, despite his back problems. Overall, this excerpt demonstrates the client's fear of open places and illustrates the equivocal emotions tied to temporal, bodily aspects as well as the cultural norms related to leaving one's home and the difficulty in disentangling them.

5.3. The Emotions Reflected While Being Out in the Community

In the next excerpt, a worker and a male client are talking while walking down the street. Significant background noise complicated the transcription of the conversation. The client has had difficulties leaving his house since his wife passed away three years ago. In a separate interview, the client told the researcher that he had no contact with other people and was in his 'comfort zone' after his wife died. Additionally, his previously diagnosed anxiety only got worse after his wife's death. Within the last year, he has been able to go out with the help of the floating support team. Thus, the aim of the service in this case was to get the client out of his home. The client told the researcher that he needed a distraction to avoid anxiety attacks:

> Client: Yeah, so I mean that's, how weird it is now because I was, I mean I told you there [unclear] it's because you're anxious because you haven't done it. I was a bit wary thinking, oh no, you're not going there today, but you don't exactly have to do it because otherwise you'd never conquer.
>
> Worker: Well, that's it yes, of course.
>
> Client: You get anxious but, well without, when you said like go to the bank, it was like oh yeah. But come Monday yeah, because I know exactly you need to do it, so yeah.
>
> Worker: It's been good so far, because I think we've, I mean, today, I didn't expect us to progress any further than we have been, but previous to this we've always gone further.
>
> Client: It's funny as well, because when I used to have that fear, my hands sweating and things like that, you know the first one we ever did, the cafe.
>
> Worker: Yes, on the corner.
>
> Client: Yeah…[unclear] I don't even think I could easily walk and it doesn't register anymore.
>
> Worker: There was a time when…
>
> Client: I couldn't imagine that as well like…[unclear word] that long road.
>
> Worker: Oh, it's amazing.
>
> Client: I've cycled it…
>
> Worker: Are you still using public transport?
>
> Client: Taxi….I had no problem whatsoever, I've never been on a bus…[unclear] so yes I do, I mean…
>
> Worker: Well, one thing at a time.

The client first considers that even the thought of going into the community can construct an emotion of wariness or anxiety, but that these emotions can be resisted by being aware of the fact that the only way to conquer them is to go. The worker provides positive feedback by saying: "It's been good so far because I think we've, I mean today, I didn't expect us to progress any further than we have been." This expression provides a concrete example of how mobility and being in the community can be used as a tool to track the client's progress. The emotion of joy related to client's progress is constructed in relation to the positive feedback and the milieu where the client and the worker are walking.

The worker inspires the client to remember the physical reactions he had when the floating support visits began: "I used to have that fear, my hands sweating and things like that, you know the first one we ever did, the cafe." These emotions of fear are constructed in relation to a certain cafe on the corner, as the worker confirms. Recalling their earlier visits in the community concretises the client's proceeding, as he states, "Yeah…[unclear] I don't even think I could easily walk, and it doesn't register anymore." Fear transformed into ease, which is amazing, as the worker describes. However, despite the good progress, there seem to be new challenges to overcome. The discussion transfers from walking to riding the bus when the worker asks about public transport. The client says that he did not have problems using taxis but that he had "never been on a bus." Based on their conversation, it could be assumed that future bus rides could cause the same kind of emotions as that first walk to the cafe. The client seems cautious, but willing to try a bus ride when he says: "I do, I mean." The worker supports the clients' thoughts and constructs the emotion of calmness in relation to gradual progress by saying: "Well, one thing at a time." Overall, this excerpt illustrates how being out in the community invokes variety of inconsistent emotions and bodily reactions that change over time and based on the clients' condition.

5.4. Reflections of Emotions after Being Out in the Community

In the next excerpt, the client in his early 30s, worker, and a researcher went to a grocery store together. Shopping is difficult for the client because he has a hard time making choices and deciding what to buy; he also suffers from depression and anxiety. One aim of the floating support visits is to help him cope independently with daily chores. In the excerpt, the worker and client are reflecting on the shopping trip after returning from the store:

> Worker: How do you feel after we were with you at the grocery store? Was it different than when you go there alone?
>
> Client: Yes, there was a small difference.
>
> Worker: How did it differ?
>
> Client: I don't know, I talked to people more. Usually I don't say anything.
>
> Worker: But did it feel that… was it harder to be in the store or did it make it easier? Did it have any influence on that?
>
> Client: It was somehow easier or… although you didn't suggest anything or the like…
>
> Worker: What do you think, what made it easier?
>
> Client: Hmmmm…
>
> Worker: Was it easier to make decisions, although we didn't suggest anything? Or was it just easier to be in the store? What do you think?
>
> Client: Well, maybe that, if it was hard to decide or I didn't know how to decide, there was someone to ask instead of pondering it by myself for an eternity.
>
> Worker: Yeah, yeah. So that you weren't required to ask but knew that you could if you needed to. Okay. If you go shopping, just to get something, whatever, like food, do you have that same feeling, that it would be nice if there was someone you could ask?
>
> Client: I don't know about the grocery store, maybe, but I don't go to other kinds of stores so often. It sort of depends.
>
> Worker: But, for example, we went to H&M once, and you had been there by yourself but hadn't found anything, and then once we went together you bought that shirt. Did it feel easier? Well, I guided you to ask a salesperson, and then you asked, and the shirt was found. Was it easier when I was with you?
>
> Client: Yes, at least in the clothing store.
>
> Worker: So is it that, that you feel insecure, this is just an idea, tell me if I'm off track. But do you feel insecure because you don't know what you are making decisions about?
>
> Client: Yes, fairly. It's hard to make decisions. Especially with clothes….I've sometimes bought things that didn't fit.
>
> Worker: Do you have that same insecurity in the grocery store? Do you think that you are going to make a mistake when buying something?
>
> Client: In the grocery store, it's more that I don't fancy anything specific and the selection is large. So that's [laughs] great.

> Worker: You have talked about earlier, that going to the store is difficult for you. Especially going to the grocery store. You have said that you have to go to the grocery store quite often because you can't plan what to buy for the next several days. So, [you buy] what you fancy at that moment. But what do you think, would you like us to go to the store together more? Say if it's something you wouldn't like; it is just an idea.
>
> Client: I don't know, why not? But it is not necessary.

The worker inspires the client to talk about his emotions related to shopping when she asks: "How do you feel after we were with you at the grocery store? Was it different than when you go there alone?" The client admits that there was a small difference, but he seems to have trouble specifying. However, he notices that he spoke to people more. The worker continues to discuss his emotions, asking: "But did it feel that… was it harder to be in the store or did it make it easier? Did it have any influence on that?" Difficulty and ease are constructed in relation to the store and the presence of the worker and the researcher. Specifying emotions connected to shopping still seems difficult for the client, but he believes that being in the store was easier. The worker continues with more specific questions concerning the emotion of ease, which can be interpreted as both trying to help the client recognise certain emotions and trying to help them determine the factors that could help him engage in the community in the future. Finally, the client connects the ease to the emotion of comfort to making decisions while shopping and describes how being in the store would be easier if "there was someone to ask instead of pondering it by [himself] for an eternity." The term 'eternity' highlights both the client's difficulty in making decisions and the intention of the floating support visits.

The worker reacts to the client's account and further specifies by asking whether there were any differences between shopping in different stores. The client hesitates and the worker brings up an earlier trip to the clothing store, recalling how the client did not manage to buy a shirt alone but succeeded when they went to the store together. The worker continues to ask about the clients' insecurity in decision making and constructs it in a very sensitive way by asking the client to clarify whether the worker was off track. By this, the worker can avoid implying that they know how the client feels and offer the client the possibility of disagreeing or explaining. However, the client agrees: "Yes, fairly. It's hard to make decisions. Especially with clothes….I've sometimes bought things that didn't fit." The fear of making mistakes mixes with emotions of insecurity and to the difficulty with making decisions. The worker also offers a solution by asking whether the client would like the idea of them going to the store together more often. The emotions of respect and free will are constructed in relation to the client's subjectivity and autonomy. This excerpt illustrates the potential difficulty in having these conversations and the importance of recognising the different emotions related to places and activities. It also reflects cultural perceptions and expectations of an independent adult who can make their own decisions.

6. Discussion and Conclusion

This study demonstrates how various place-related emotions are constructed and reflected in client–worker interactions. We have shown how emotions are made visible in communicated actions (Koprowska & van Nijnatten, 2019) and in relation to the socio-cultural contexts in which people operate daily (Gergen, 2009). In this study, the socio-cultural context is the normative presumption that adults should be able to live independently and leave their homes without difficulty. Our study demonstrates that living according these requirements can be contractionary and that emotions have a significant meaning for vulnerable people and the promotion of their social inclusion.

During the client–worker interactions, feelings of security to fear or despair to hope were situationally and continually constructed. This confirms how emotion work (Banks, 2016; Hochschild, 1979) is an inseparable part of floating support work. The biggest surprise was that explicit emotional expressions (e.g., "today I feel…" or "it felt really…") connected to certain places and environments were rather rare in the discussions. The clients seemed to have difficulties with spontaneously talking about their emotions. However, the workers helped the clients specify and recognise their place-related feelings and manage the emotions that prevented them from leaving their homes. They walked on the streets and in nearby neighbourhoods with the clients, made plans about how to proceed step-by-step, and went to stores with them. These practices made it possible for them to influence the emotions that prevent clients from leaving their homes and make their progress more visible. It was also notable that, in some cases, it was not the place or environment that brought up the difficult feelings, but rather the socio-cultural practices maintained there (e.g., riding the bus or buying clothes). Authors have shown how floating support work at the margins of community care is connected to situationality, boundlessness, and empathy (Juhila, Hansen Löfstrand, & Raitakari, 2020). In the core are activities that cover diverse aspects and needs of everyday life. Our study adds the idea that emotion work is a necessary activity and a key part of promoting clients' social inclusion.

Our findings reflect Fahnøe's (2018) position that strong place-related emotions, like fears, uncertainty or physical affections, can be so comprehensive that staying home and avoiding them can offer a form of self-protection. Nevertheless, our data demonstrates how clients actively work with their contradictory place-related emotions and how willing they are to be able to act in the communities. We argue that learning to leave the safety of the home and go out into the community requires time and commitment from both clients and floating support workers. We conclude that future policy should consider that going out to the community can require very demanding lifestyle changes from people living at the margins of welfare, and to recognise the importance of floating support services in the future as well.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

“Body Work” in Home-Based Substance Abuse Care

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Abstract

This study examines “body work” in the context of home-based substance abuse care in Finland, which is provided to adults with intoxicant problems and needing short- and long-term support in their everyday lives. This article is concerned specifically with body work, which can be defined as care work focusing directly on the bodies of others. Through a twofold analysis of 13 audio-recorded home visits and ethnographic field notes, it examines what body work is in home-based substance abuse care, how close body work is and how workers and clients negotiate about it. The study shows that home as a site of care has an impact on substance abuse care. The worker’s home visit settles into a tension relation between private and public even if the care is a part of weekly routine. Body work is holistic care work necessitating slight, medium, and extreme bodily intimacy in taking care of and supporting client’s well-being. During the home visit, worker and client negotiate the body work and its content. Worker and client communicate verbally and non-verbally by gaze and body movements. Often the workers have to balance between disciplinary, participatory, and caring approaches to support the client living in the best possible way.

Keywords

body work; care work; dirty work; home visit; home-based care; substance abuse care

Issue

This article is part of the issue “Home- and Community-Based Work at the Margins of Welfare: Balancing between Disciplinary, Participatory and Caring Approaches” edited by Kirsi Juhila (Tampere University, Finland), Cecilia Hansen Löfstrand (University of Gothenburg, Sweden) and Johanna Ranta (Tampere University, Finland).

1. Introduction

There is an increasing emphasis on community care in social and health care. As a result, social and health care workers have established themselves in clients’ homes and everyday lives. In this study, I will examine “body work” in the context of home-based substance abuse care in Finland. The care is connected to housing; it is intended for adults with intoxicant problems and needing short- and long-term support in their everyday living. Some of these clients have impaired functioning abilities as a result of substance abuse, as well as various mobility, memory, and mental health problems. These problems cause challenging and vulnerable situations in clients’ daily life regarding personal hygiene, laundry, and food shopping, as well as taking care of their own affairs. To cope with these difficulties, clients often need care, support, and help from workers.

Julia Twigg (2000a, 2002) brings together care and body work. She defines “body work” as a worker’s “care work” that focuses directly on the bodies of others (the clients), trying to interact with them (Twigg, 2000b, pp. 395–397; see also Twigg et al., 2011; Wolkowitz, 2006). Silva Tedre (2001, 2004) likewise takes the view that caring includes body work in the relationship established between the caregiver and the person in need of help (see also, e.g., Cohen et al., 2013; Twigg, 2000b). Following Buse and Twigg (2018), who acknowledge the usefulness of body work in understanding care work, I use the same concept to focus on home-based substance abuse care (see also England & Dyck, 2011; McDowell, 2009; Widding Isaksen, 2002). According to Cohen et al. (2013), body work in the context of care work requires worker and client to negotiate the social meaning attached to the body, that of touch and physical intimacy (see also Korvajärvi, 2016; Selmi, 2013).

Through negotiation, client and worker reach a common ground between body work and the content of the care work taking place.

Body work has recently become a research interest in social care studies and has been studied in a number of different ways (Gimlin, 2007; McDowell, 2009; Shilling, 2005; Twigg, 2000b; Wolkowitz, 2006). Body work has been analysed in the work of various occupational groups, such as flight attendants (Hochschild, 1983), hairdressers (Sanders et al., 2013; Ward et al., 2016), cosmetologists (Korvajärvi, 2016). Several researchers have also been interested in the role of body work in nursing (Twigg, 2000a; Twigg et al., 2011), using worker interviews and/or observations as research data. There are few studies of body work in substance abuse care, particularly in care contexts using naturally occurring interaction data (see Cohen et al., 2013). That is one reason why I am especially interested in how workers and clients talk about body work in their professional interaction.

The research questions I pose are: What is body work in home-based substance abuse care? How close is body work? How do workers and clients negotiate it? The data consists of 13 audio-recorded home visits and ethnographic field notes. The analysis of the data first follows Lise Widding Isaksen's (1994, 2002) theory of body contact in the actions of care as my analytical frame. After that, formed categories were analysed based on discursive interaction analysis (e.g., Hall et al., 2014).

This article shows the importance of examining body work and how it is done in private homes. The home as a site of care has an impact on substance abuse care in many ways. The privacy boundaries of a client's home are trespassed when public help such as home-based substance abuse care enters their home. To overcome this, workers must balance between disciplinary, participatory, and caring approaches that make their client feel acknowledged and supported in the best possible way.

2. Body Work in Home-Based Substance Abuse Care

The home as a site of care has a strong impact on substance abuse care. The common notion of home is not that it should constitute a place of work. Often it is portrayed as a private living space where social meanings and embodying aspirations are formed (McDowell, 2009). Various services in health and social care, such as substance abuse care, have increasingly moved to clients' home environments. "The home" has thus become an arena for substance abuse care—a place where private as well as social meanings and institutional norms meet.

In home-based substance abuse care, home visits are tailored to the clients' needs and wishes and are carried out in accordance with institutional rules and guidelines. Thus, it can be said that the workers end up entering a tense public–private relationship. When a worker crosses the threshold of their client's home, aspects of the private and public spheres are blurred and mixed. Therefore, receiving help and opening their door to a public worker is not always easy for the client. On the other hand, going to a clients' home is seen by the worker as entering a foreign private world (Ferguson, 2018). Although day-to-day home visiting may become routine, it's still full of challenges and emotions.

Body work in a client's home requires a specific kind of interaction between worker and client. Mol et al. (2010) point out that care is not always verbal. When workers take care of clients, client and worker are directed towards each other and interact bodily, for example, with touch or body movements. This interaction may be synchronous and sequential. For example, when client and worker take a walk together their action is synchronous, and when a worker vacuums the client's home and the client wipes away dust, their action is sequential. Care in the context of home-based substance abuse care is holistic, it requires meeting the physical, mental, and social needs of the client. From the worker's point of view, it is sometimes unclear if the work is about keeping the home space clean and tidy or about meeting the emotional needs of the client.

The relationship between care workers and clients is always one-sided: The client is the object of care and the worker provides care for them. The more holistic the client's need is, the closer the body work and the more intimate the care (Bowlby et al., 2010; Tedre, 2004; Widding Isaksen, 2002). Therefore, body work in care can be seen as "ambivalent work" because it involves touching, closeness, pleasure, and emotional intimacy (England & Dyck, 2011; McDowell, 2009; Twigg, 2000b). Widding Isaksen's (1994) research on body work focuses on the distance between worker and client, that is, on how bodily close client and worker are in home care (see also Cohen, 2011). Care tasks involving only slight body contact are, for example, cooking and cleaning. Washing another person's hands and face or feeding them is considered medium body contact. Tasks that demand extreme body contact include changing continence pads, emptying one's commode chair, and changing bedlinen. Touching, lifting, dressing and undressing someone also demand extreme closeness with another body compared to shopping on behalf of another person (England & Dyck, 2011). The so-called "dirty work," such as washing a client's body, is also an example of extreme body work requiring body contact (Widding Isaksen, 1994). Body work may be primarily physical, but it is also emotional support work (Twigg, 2000b).

Care work often has the status of "dirty work." A care worker often has to deal with a clients' bodily secretions, for example when washing the clients' body (Widding Isaksen, 2002). In Douglas' (2002) classificatory system, "dirt" is often related to smells and textures. Care work can be perceived as dirty work because it implies seeing and touching bodily products that are identified as dirty (Widding Isaksen, 1994), but cleaning dirt from the client's body and their environment is a key part of care work (e.g., Hansen Löfstrand et al., 2016; Widding Isaksen, 2002). However, care workers do not describe their work as dirty work; instead, they present their work through emotional aspects (Twigg, 2000a). Looking only at verbal communication misses the large non-verbal component of what is specific to care practices. This is why Mol et al. (2010) consider the importance of studying both verbal and non-verbal interactions between worker and client.

3. Data and Method

The data used in this study was gathered in the context of home-based substance abuse care work in Finland. Participants are care workers and people needing short-term or long-term support in their lives, housing, and everyday living. Clients live in their own homes in supported housing communities where the use of intoxicants (drugs/alcohol) is sometimes allowed, but not in every apartment. The workers make home visits, and take care of and support the clients in their everyday lives, including cleaning and handling their own money. Home visits differ in their institutional functions and aims. Workers have their own key to every client's home, and they have the right and obligation to go into these houses with their own keys if required by the arrangement agreed to by the client. Care is provided by nurses, practical nurses, and care workers with higher educational qualifications.

The research data consists of 13 home visits gathered in the autumn of 2017 and spring of 2018 using mobile ethnography, which Novoa (2015, p. 99) describes as the "translation of traditional participant observation onto contexts of mobility by following people around and engaging with their worldviews"—in other words, the researcher follows the workers and clients, audio-records their conversations, and takes field notes (see also Ferguson, 2016; Lydahl et al., 2020). The field notes include information concerning home visit interaction, practices, and the material environments of visited houses.

Mobile ethnography enables a researcher to access, observe, and sense client–worker interactions (Lydahl et al., 2020), and build an understanding of home-based substance abuse care. Data gathering in a client's home requires sensitivity on the part of any researcher and respect for the client's privacy. From the clients' point of view, letting a researcher into their home is not self-evident and requires judgment (see Pink, 2004). When doing research on marginalized groups in society, ethical issues must be carefully considered. For this experiment, the Ethics Committee of the Tampere Region was consulted and found no ethical obstacles with the proposed study. At the beginning of each home visit, I asked all clients' permission to enter their private space, giving them an opportunity to close their doors and deny me access to their homes. I also discussed the aim of the study with all participants before making observations and audio-recordings. All participants were informed about the voluntariness of the study and that they could suspend their participation at any time. Participants were informed that their personal identifiers, including names, would be changed or removed to ensure anonymity. All participants signed written consent forms, which included this information.

My approach in data analysis was twofold. First, the analysis of audio-recordings and field notes was theory-based and relied on Widding Isaksen's (1994, 2002) theory of body contact in situations of care work. This theory focuses on how "bodily close" client and worker are during the home visit. To examine the degree of closeness between clients and workers, I used coding (see Krippendorff, 2013) and the help of the ATLAS.ti program that systematically codes all physical contact (see Charmaz, 2014). I coded the data into three categories, culminating in a total of 72 instances: (1) slight bodily contacts (58), (2) medium bodily contacts (5), and (3) extreme bodily contacts (9). In the second phase of the analysis, I considered slight, medium, and extreme body contact categories more closely by looking into how workers and clients negotiated situations of body work in their interactions. Here I applied discursive interaction analysis (see Hall et al., 2014), which means that I concentrated on how workers and clients cooperated through verbal and non-verbal communication—like physical and intimate touch, body movement—on how to handle body work.

In the next section, I introduce three illustrative examples of my analysis from the gathered data. I chose one example from every category (slight, medium, and extreme body contact). Each example is typical and illustrates in different ways how care work is done in home-based substance abuse care and how body work is a strong component in it.

4. Analysis

4.1. Care Work: Guiding and Advising

The worker is going to visit a client who has a long experience with home-based substance abuse care. The client has injured his hand, and this was brought to the worker's attention. The worker is concerned about the client's well-being and his professional duty is to check on it, so the worker decides to make a home visit. The worker walks to the client's door and rings the doorbell. The client opens the door, greets the worker, and invites him in. The worker and client walk through the hallway directly into the living room. As they walk, the worker explains the reason for his visit. The worker sits in an armchair opposite the client, making direct eye contact. The worker checks the condition of the client's hand and tries to convince the client that he needs medical care:

1. Worker: The reason why I came was to see how your hand is doing.
2. Client: So and so.

3. Worker: Well now, lift it up, like that [the worker shows the client with his own hand how the hand should rise].
4. Client: It won’t go up.
5. Worker: How’s that then?
6. Client: So it won’t go up. Look, there’s no strength in it [the client tries to raise his hand but fails].
7. Worker: So you can’t lift it. Not at all.
8. Client: No, so this will go up, but not this. Yes, it will.
9. Worker: Now we should go to see the doctor.
10. Client: What for?
11. Worker: So [your hand] there. There’s something broken in it.
12. Client: The bruises have gone already.
13. Worker: Yes, but there’s something, some other problem now because your hand will not go up.
14. Client: No, it won’t.
15. Worker: Now, it’s not normal for it not to.
16. Client: Now it’s not really normal [laughs].
17. Worker: So. When shall we go?
18. Client: Not me.
19. Worker: Should we make an appointment [at the health centre]?
20. Client: Yes, make an appointment there. Then we can go and show them, but I don’t know if they’ll be much help with it.

The worker begins the interaction by giving an account of why he is making the home visit. He is concerned about the client’s welfare. The client answers the worker’s question about the condition of his hand: “So and so” (turn 2). The worker looks at the client, thereby showing that the question has been directed to the client and it is significant. The worker uses body work when he expresses his emotions. He asks the client to raise his hand and verbalizes how he should do so. The worker illustrates this to the client with his own body (turn 3). The client gives an account of how his hand is moving and reinforces it by trying to lift the hand up (turns 4, 6, 8). The worker suggests to the client that he should go to see a doctor (turn 9), to which the client replies that the bruises on the hand have healed. The client resists the worker’s proposal to go to the doctor (turns 10, 12, 14, 18). The worker tries to change the client’s mind. He tries to get the client to participate in his care decision (turn 13). In the end, the client gives the worker permission to make an appointment with the doctor (turn 20), though he doubts he needs to visit a doctor.

The client invites a worker into his home. The encounter between worker and client takes place in a space that is usually open to guests. During this home visit, the worker is verbally and physically present, but not in bodily contact with the client. The worker makes assessments by observing the client’s actions, guides and negotiates with the client about his need for help. The worker’s focus is on the client, and he balances between caring and participatory approaches (for example, turn 3). Through the questions he poses, the worker indicates his concern (and feelings) for the client’s health. The worker does not make the decision to visit the doctor alone. He involves the client in the decision-making. Together with the worker, the client makes an assessment of his own care and makes the decision to seek treatment. The worker’s use of verbal and bodily interactions can be described as sequential, i.e., client and worker take turns when saying and doing things. In the example when the worker and client use the informal mode of address, the emotional intimacy between worker and client becomes visible (e.g., Brown & Gilman, 1960; Clyne et al., 2009).

4.2. Care Work: Assessment and Control

Two workers are going to visit a client. The reason for the home visit is the suspicion that the client has been drinking alcohol. The workers have a breathalyzer with them. The client does not know that the workers are coming for a home visit. When the workers arrive at the door, they ring the doorbell and open the door with their own key at the same time. The client invites the workers inside; they greet each other. One of the workers (worker 2) walks with the breathalyzer in her hand to the kitchen and sits at the kitchen table next to the client. She maintains eye contact with all participants. The other worker (worker 1) stays in the hallway. The workers tell the client why they have come to visit him and how they would like him to blow into the breathalyzer. During the discussion, worker 2 puts on gloves and fixes the mouthpiece to the breathalyzer. The home visit begins with the worker asking the client how his day has been:

1. Worker 2: How has your day been?
2. Client: How’s that?
3. Worker 1: Well, how has it been going?
4. Client: I don’t know.
5. Worker 1: You don’t know yet.
6. Client: How has the day been?
7. Worker 2: Well, how’s it been going?
8. Client: All to Hell.
9. Worker 2: I see.
10. Worker 1: Why?
11. Client: Everything I’ve experienced has been just about unsatisfactory and pointless.
12. Worker 2: I see.
13. Client: Even suspicious. Especially that pipe of yours, [the] breathalyzer [laughter]
14. Worker 2: [Laughs]
15. Worker 1: So this thing got more suspicious.
16. Worker 2: This is one of those breathalyzers.
17. Worker 1: If you’d still just blow into it.
18. Worker 2: A blow for happiness [the device pings]. Thank you.
    [Client blows into breathalyzer]
19. Client: Why?
20. Worker 2: Why?

21. Client: Yes.
22. Worker 2: Just blow. Thank you.
23. Worker 1: There, now. That went well.
24. Worker 2: You made us very happy again.
25. Client: What about me?
26. Worker 2: You can be just as happy, too, like me.
27. Client: I'm not [happy at all] [laughs].
28. Worker 2: But you blew zero.
29. Worker 1: That is good.
30. Client: Oh, yes, I know that.

At the beginning of the home visit, the workers explain why they have come to visit the client. The worker presents a direct question to the client (turn 1) and the client answers that question in a way that shows suspicion regarding the exact purpose of the worker's question (turn 2). Worker 1 repeats the question (turn 3), to which the client replies: "I don't know" (turn 4). Worker 1 states: "You don't know yet" (turn 5). The conversation between the workers and the client is emotionally loaded, which brings tension to the home visit. Worker 1 asks the client why it has been "all to Hell" (turns 8, 10). The client answers that his experience has been irrelevant, and he thinks that the workers find this suspicious (turns 10, 11). He justifies his answer with the breathalyzer (turn 13) brought by the workers.

Worker 2 presents the breathalyzer and hands it to the client (turn 16). Worker 2 is prepared to get the client to blow on the device. She has plastic gloves on and puts the mouthpiece on the breathalyzer. When the device is ready for operation, worker 1 asks the client to blow into it, guiding the client's activity with verbal instruction (see Enfield, 2006). The client looks at the breathalyzer and asks the worker why he needs to blow (turn 21). Worker 2 does not give an account of her pursuits and evades the client's question. After that she briefly asks the client to blow: "Just blow" (turn 22). She is reinforcing that the client should blow into the breathalyzer rather than question the workers' action. After the event, the workers give their client positive feedback (turns 22, 23, 24, 29).

The client home visit is sudden and unexpected. The workers have become aware of suspicions about the client's intoxication. The client is not allowed to use drugs/alcohol in the apartment, so the workers take a disciplinary approach: It is the workers' institutional responsibility to control the client's use of substance abuse. During a home visit, the workers assess the client's functioning ability by observing his actions and by means of a technical tool—the breathalyzer. In care work, a worker's control task also becomes visible in how they handle themselves in a client's home. Worker 1 positions herself "bodily close" to the door and worker 2 "bodily close" to the client. The conversation between workers and the client also shows that the client is aware of practices in the housing community when the client is suspected of using intoxicants.

The workers interact with their client verbally, bodily, and mechanically. Worker 1 observes and monitors the interaction between worker 2 and the client. Worker 2 gets the client to blow into the breathalyzer and is therefore in close bodily contact with the client. Direct contact between worker 2 and the client is prevented by gloves, which create a physical as well as an emotional barrier between worker and client (Twigg, 2003). Worker 2 is also in contact with the client's saliva when getting the client to blow into the breathalyzer, which may classify the task as "dirty work" (Hansen Löfstrand et al., 2016; Widding Isaksen, 2002). The bodily and verbal interaction between workers and the client during this home visit can be described as predominantly sequential.

4.3. Care Work: Physical Care and Dirty Work

The worker is going on a weekly home visit to a long-term client who uses a wheelchair. During the home visit, the worker helps the client take a shower, cleans the client's home, and changes the client's bedlinen. The worker prepares herself for the home visit by putting on rubber boots. The worker rings the client's doorbell and opens the door with her keys at the same time. She calls for the client and informs him of her arrival at the door. The client welcomes the worker. With the rubber boots on, the worker walks into the client's bedroom, where the client is waiting for her in bed. First, the worker prepares a wheelchair for the client by putting a towel on it and lifting the footrests up. Then she puts out clean clothes ready for her client. She prepares herself for the bodily encounter with the client by retrieving disposable gloves for her hands from the bathroom cupboard. After these preparations, the worker prepares the client for washing. She helps the client take off his clothes and puts them in the laundry basket. This example begins in the moment when the client is moving from his bed to the wheelchair with the help of the worker:

1. Worker: Then you can go there…
2. Client: I can't.
3. Worker: Well then, let's go.
4. Client: I'm not in a bad mood.
5. Worker: Well, it's all the same what mood you're in. Let's go in there [to the shower]. There now [worker helps client take off his shirt].
6. Client: You can take those off.
7. Worker: [Helps client take off his socks]
8. Client: And…
9. Worker: Like that. A bit closer still, I think?
10. Client: No, no. Get off that [expletive].
11. Worker: I'm watching just in case, and I'll catch you if you fall [client gets up from the wheelchair].
12. Client: I don't [want to].
13. Worker: There now.
14. Client: There's no need.
15. Worker: Then I'll turn the shower on for you and put on this apron and…
16. Client: Apron.
17. Worker: An apron so I don't get soaking wet. I'll put

[the shower] on for you, let's see if it's [the water]. Try it first.
18. Client: Aah!
19. Worker: I'll put it on, the apron first and then gloves like that.
20. Client: [sings] We homeless were born to leave!
21. Worker: There now, sorry to interrupt your singing, now we'll put some shampoo on. Is there anything in those?
22. Client: Yes.
23. Worker: You can wash yourself, I'll put a bit more. And then which sponge are we going to use, that green one or the blue one?
24. Client: The better one.
25. Worker: Whichever you think it is, last time we used the green one and you said that it's better than the blue one. Can I keep going here or what?
26. Client: Whatever.
27. Worker: Okay, so I'll take this one because it's a bit firmer for the one who's doing the washing.
28. Client: Whatever.
29. Worker: Tell me if I'm washing too hard so…
30. Worker: I'll leave the sponge so you can keep on washing yourself. Rinse when it's done.
31. Client: I'll rinse [sings].

On this home visit, the worker balances between disciplinary, participatory, and caring approaches. In the example, client and worker are negotiating how to take off the client's clothes and how to wash the client's body. The worker informs the client with words and body movements that she has completed the preparations. While the worker talks, she walks next to the client. The worker informs the client that he could move to the wheelchair (turn 1). The client sits on the edge of the bed, from where the worker helps him into the wheelchair. The client answers the worker that he is not sulking (turn 4). In her response (turn 5), the worker uses the pronoun "we" to make it clear that they will be engaged in the activity (washing) together. At the same time, the worker makes it obvious that washing a client's body is a routine task for her. During the conversation, the worker helps the client and wheels the client into the bathroom.

In the bathroom, the client presents a wish that the worker ignores. Instead, she asks the client if it is better for him if the worker comes closer when he gets out of the wheelchair and gets onto the shower chair (turn 9). The client verbally resists the worker's help and support (turns 10, 12, 14). The worker does not accept the client's refusal of help. The worker verbally and bodily makes visible her own activities: She tells the client that she will turn the shower on and then goes to put on a plastic apron and new plastic gloves (turn 15, 17, 19). Aprons and gloves are physical protections from wet, dirt (secretions) and skin contact. They also provide an emotional and intimate distance and barrier between client and worker (Twigg, 2000a, 2003).

While waiting for the worker to dress, the client sings in the shower (turn 20), thus the client signifies that he likes to be in the shower. The worker interrupts the client's private moment—she apologizes for doing so. The worker shows the client that washing the client's body could start with washing his hair (turn 21). The worker asks the client what colour sponge he would like to be washed with (turn 23). The client lets the worker decide that. The worker justifies her decision from the washer's point of view (turn 27). At the same time, the worker positions herself as a body washer, whose task is to take care of the client's hygiene and clean the client's skin of dirt (McDowell, 2009; Twigg, 2003). After this, the worker asks the client what kind of pressure she should wash the client's body with (turn 29). Once the worker has washed the client's back and buttocks, she leaves the client to wash his body independently. The worker asks the client to call her back into the bathroom after he has washed himself (turn 30).

This routine home visit takes place in the intimate spaces of a client's home—the bedroom and the bathroom, which are rarely accessed by strangers. The example illustrates the emotional, verbal, physical, and mechanical (when the worker is using a mechanical/technical device like sponge or wheelchair) interaction between client and worker. In her activities, the worker takes into account the client's needs and wishes. The worker's work appears to be body work, where dirt and cleanliness are strongly present. Emotional and physical intimacy in the encounter emerge in the sequential presence of physical and verbal interaction. The worker makes it verbally clear to the client what they are doing and when. The worker also pays attention to the client and involves the client in taking care of himself, such as washing intimate areas of his own body. In the interaction, the worker also strictly instructs the client and ignores the client's partially offensive comments.

5. Conclusion

This study illustrates what body work entails in home-based substance abuse care. The research questions concerned what body work is in home-based substance abuse care, how close body work is, and how workers and clients negotiate it. The physical structures of the home create a frame for care and interaction between client and worker. Many of the clients have problems that impaired functioning ability, mobility, and memory. To cope with their everyday lives, the client often needs help and support at home, requiring slight, medium, and extreme body contact between worker and client. Slight care work can be described as guidance, advice, and support. Medium or extreme body intimacy mainly concerns the client's physical well-being, such as washing the client's body or changing the client's sheets. As Douglas (2002) points out, care work can be seen as "low status work" especially when it involves dirt and body waste products. Body work in substance abuse care can also be suggested to be “dirty work” when workers are in contact with clients’ various bodily fluids, for example when they are doing treatment procedures for the client or changing bedding on the client’s bed (e.g., Douglas, 2002; Widding Isaksen, 1994). Many workers in the field of health and social care, like in substance abuse care and in elderly care, deal directly with the body and its wastes. That’s why their work is regarded as a low status work (see Twigg et al., 2011). In both care contexts, care is targeted at vulnerable clients and their needs for care are often holistic. Thus, the results of this study are, in part, general.

During the home visit, workers and clients interact verbally and non-verbally. Workers often communicate with talk, gazes, and body movements, and negotiate with clients about the content and aims of the home visit. Using various means of interaction, workers can create a calm or lively atmosphere and seek consensus with the clients on care work and its aims (see also Cohen et al., 2013; Enfield, 2006;). The workers’ talk and clients’ actions are guided by disciplinary, participatory, and care approaches. Through these approaches, workers seek to support clients living in their own homes (e.g., Wolkowitz, 2006). The client’s body becomes the subject of talk when it is the subject of care. The workers verbalize and illustrate with body movements their acts of care for the clients. Through talking, the workers guide the clients’ movements of the body, and through their own movements of the body, the workers illustrate to the clients how and what the clients should do. By talking, the workers give account of their own work and thus make their actions visible.

The workers also use verbal conversation to engage clients in their own care work. Often the workers invite the clients to participate in their own care care by using the pronoun “we”—together, worker and client take care of the client’s well-being. In addition, when the workers show their concern for a client’s situation and well-being, the workers use the pronoun “we” to indicate that “we as workers” are concerned about the client’s situation. In this way, the workers also reinforce the message that they are concerned for their clients. Touch is a key element in worker–client interaction. Without touch, the workers would not be able to perform care procedures or show sympathy to the clients (e.g., Mol et al., 2010). In the home visits analysed in this article, the enabler of bodily interaction and contact was often a material object such as tools used in care by the workers, e.g., the breathalyzer or the sponge, or the clients’ need for aids such as a wheelchair. On the other hand, the barrier to contact was protective equipment like aprons and plastic gloves that blocked skin-to-skin contact and created distance between clients and workers.

Home visits affect the meanings given to clients’ homes and the institutional norms of home-based care. When going to the client’s home, workers generally respect their client’s privacy. For example, they ring the doorbell and wait the client’s permission to enter. Yet certain institutional practices, such as control duty (e.g., when the two workers visited a client who they suspected to be intoxicated), made visible how a worker’s actions may invade the privacy of a client’s home: The home becomes the receptacle of institutional services. The analysis can be used to see how institutional rules and practices of substance abuse care give access to a client’s home and become part of a client’s everyday life and practice. This brings tension to the interaction between worker and client and emphasize the worker’s role as an institutional actor. Thus, the encounter between worker and client cannot be said to be symmetrical, but asymmetrical: Workers as professionals tend to have more power due to their institutional function and specialization. This can be seen especially in control tasks, where the worker has a dominant position over the client (e.g., Doel & Shardlow, 2005; Sias, 2009). The worker has the power to manage and evaluate the client’s activity and ability to function, guide, and advise them, and also to manage and change the focus of home visits. Instead, the client has the power to decide what kind of home visit it will be. When working with vulnerable clients, as workers in substance abuse care do, issues of power are always present and workers are forced to balance them when performing caring tasks.

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Conflict of Interests

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Article

Engaging with Hard-To-Reach Clients: Towards the Last Resort Response by Welfare Workers

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Abstract

Client non-cooperation is a widely recognised problem in welfare services. Being 'hard-to-reach' is considered a risk especially for the most vulnerable clients, for example in terms of increased homelessness. Such clients pose challenges to social inclusion, and services make some allowances to achieve engagement. However, even a minimum level of cooperation is required from hard-to-reach clients. In the context of home visiting, we study welfare workers' efforts to engage with clients who continuously avoid contact. We examine three services in Finland, England, and Sweden that provide floating support to clients in their own accommodation. Utilising Robert Emerson's idea of 'the last resort,' we analyse how workers justify their decisions to continue or terminate the support with the hard-to-reach. The data consist of team meeting recordings and home visit observations. We aim to demonstrate that justifications deployed to make the decision to end the home visiting service or tighten control, draw on 'last resort responses.' We identify three types of justifications: retrospective summaries on past failures to reach the client, intensifying remedial actions to engage clients, and characterisations of clients as uncooperative. While such justifications can be seen to draw on shared ethics, they have different ethical implications.

Keywords

floating support; hard-to-reach clients; home visiting; last resort; social work; welfare workers

Issue

This article is part of the issue "Home- and Community-Based Work at the Margins of Welfare: Balancing between Disciplinary, Participatory and Caring Approaches" edited by Kirsi Juhila (Tampere University, Finland), Cecilia Hansen Löfstrand (University of Gothenburg, Sweden) and Johanna Ranta (Tampere University, Finland).

1. Introduction

Hard-to-reach clients, also termed as 'service refusers' (Beresford, 2005) or 'care avoiders' (Cortis, 2012), are common in welfare services (Froonjian & Garnett, 2013). According to Cortis (2012, p. 352), hard-to-reach clients refer to "those people eligible for assistance but who, for a range of reasons, do not usually take up the help available" or are "difficult for service providers to engage." Within social care, the notion of hard-to-reach client is well recognised. In the 1950s, Lindenberg (1958) and Tinker (1959) described the challenging relations between the services and hard-to-reach clients in a way that today remains relevant: A fundamental paradox lies at the heart of commitment and needs. In other words, if these clients would commit to care without problems, would they need help in the first place? The hard-to-reach clients might need help exactly *because* they are hard-to-reach and thus face risks associated with isolation. Reaching elusive clients is a challenging task especially in the current community care where clients spend less time in long-term institutional care (Emmel et al., 2007). From the perspective of social inclusion, home visiting hard-to-reach clients can be compared to 'outreach work' with clients that cannot effectively be reached by existing services (Andersson, 2013; Grymonprez et al., 2017). To identify this group, policy makers have constructed a category of hard-to-reach clients "to organise and encode members of particular populations on the basis of their marginalisation from welfare services" (Cortis, 2012, p. 352). They become transformed "into entities that the organisation can recognise and process" (Hjörne et al., 2010, p. 305).

The impetus for this article stems from examining data collected from services offering floating support for vulnerable clients in three national contexts: Finland, Sweden, and England. We noticed that despite the different context, workers in each service spend considerable time just contacting and motivating their clients in the first place. This article presents a variety of workers' efforts to deal with non-cooperating clients and unrealised home visits. Not being able to meet clients challenges floating support workers' key mission to support clients via visiting the home and engaging in face-to-face interaction in their personal environment (Juhila et al., 2021). This article studies what happens when this mission continuously fails: How do workers justify their decisions to continue or terminate home visits with the hard-to-reach? Such justifications are analysed as 'last resort responses' (Emerson, 1981), or stages towards the last resort response when the support does not proceed as planned.

2. Last Resorts: Literature and a Tool for Analysis

Empirical studies drawing on last resorts can be examined in terms of three approaches: some examine 'last resort services,' others 'last resort procedures,' or 'last resort responses.' All have a bearing on this article but the last one forms the basis of our analysis.

Last resort services refer to those services which are at the end of the line in terms of managing particularly troublesome clients. Emerson (1981, p. 1) refers to psychiatric hospitals or juvenile incarceration as remedies which are available to be used but which "are considered likely to compromise or defeat the very ends they were intended to achieve." Harnett and Jönson (2020, p. 1) describe 'wet eldercare,' "where goals of abstinence are abandoned in favour of goals of increased wellbeing for older people with long term substance disorder." The justification is that such clients have tried and failed all other forms of treatment, so they are provided with accommodation, care, and a 'decent life,' whilst their substance abuse is tolerated within certain limits. A similar characterisation is made of methadone maintenance programmes by Järvinen and Miller (2010, p. 805). The programmes are usually provided for people with a long history of drug addiction when all other interventions have failed. Concern is addressed towards these services resulting in participants seeing themselves as "fundamentally different from other people and unreachable by more therapeutically oriented measures" (Järvinen & Miller, p. 820).

Last resort procedures identify steps that professionals take to assess and monitor the decline in clients' compliance with the rules of the service, for example, if they are attending designated meetings and carrying out agreed tasks. As clients begin to miss such targets, the professional may make allowances at first and 'give them the benefit of the doubt.' Heimer and Staffen (1995, p. 649) studied how hospital staff managed the lack of support by parents for their sick infants. Effort was made to maintain positive assessments of the parents, what they call 'reintegrative social control': For example, mothers who did not visit their infants were telephoned. If inappropriate behaviour was not repeated, staff members concluded that the parents were learning. But if parents were recalcitrant, non-compliance was monitored and "only after numerous attempts to reshape parents' behaviour is the state's child welfare agency contacted" (Heimer & Staffen, 1995, p. 650). The move from the characterisation of parents as supporting their infant to those who are not able to care for them requires a major realignment, and only takes place in extreme circumstances. Reintegrative social control importantly lays out steps taken to engage with the client prior to the move to last resorts, similar to the remedial actions described by Emerson (1981). Formal procedures may be deployed to facilitate monitoring of the move to last resort responses (Miller & Holstein, 1995). Having moved through various procedures, the formulation of last resort is finally mobilised.

Instead of considering last resorts as appertaining to characteristics of services or procedures, in our analysis we return to Emerson's statement of them as 'social control responses' (Emerson, 1981, p. 1). In this way, many social institutions are likely to deploy last resort responses, when they attempt to manage difficult clients. Last resort responses are preceded by various justifications by the workers. According to Emerson (1981), the last resort response is always preceded by first resort responses. The support process (e.g., a series of home visits) has a beginning and a middle phase that can be described as what Emerson calls the 'normal remedies' as the first responses. In cases managed over time "responses are properly invoked in a specified order, with those regarded as milder preceding the more severe" (Emerson, 1981, p. 6). In these cases, first-resort decisions are typically presented as what should or ought to be done.

In the last resort phase, the inappropriateness of normal remedies is established by constructing a history of how prior remedies had been appropriately deployed but were demonstrably unsuccessful. No other course of action is viable but the last-resort sanction (Emerson, 1981, p. 6). To invoke a last-resort sanction successfully, it must be shown that normal remedial actions either are specifically inappropriate or have been tried but have failed to contain the trouble. In contrast to 'normal remedies,' last-resort decisions are typically framed in an idiom of necessity. With the last-resort decision, "there is no alternative" (Emerson, 1981, p. 5).

Importantly, last resorts responses provide a justificatory decision logic that Emerson (1981, p. 19) describes in the following way:

> When control agents contend that they use certain extreme sanctions "only as a last resort," they are offering not so much a factual description of their own procedures as an *account*… demonstrating (or at least asserting) the rational, necessary character of those decisions.

This view is useful in our analysis utilising interactional data with workers' talk and action. We approach last resort responses as a feature of organisational interactions in which formulations of clients' non-cooperation are constructed and negotiated. Last resort responses make particular use of contrasts between preferred and unpreferred versions of clients (first and last resort responses) and tend towards extreme notions of character and behaviour.

3. Floating Support Settings

In line with the premises of community care, the services we examine aim to facilitate vulnerable clients' meaningful lives within their local communities by supporting them in their own accommodation. Each service employs welfare workers with different vocational backgrounds, such as practical nurses, substance abuse workers and home care workers. We study the following three floating support settings situated in three countries.

The Finnish service is a non-governmental organisation operating under an outsourcing contract with the municipality. Clients' tenancy is tied to floating support, so there is an organisational expectation for the clients to cooperate by participating in regular home visits, as well as workers achieving a certain amount of home visits per month. In this sense clients have obligations to be present at home visits. The apartments are owned by the municipality. Tenancy contracts are signed between the client and the commissioners that administrate the tenancies. The target group is clients with co-occurring mental health and substance abuse problems. The workers can to some extent influence the clientele by communicating their opinions on the suitability of a client to their service for the municipal decision-makers, i.e., the commissioners.

The English service is also a non-governmental organisation operating under an outsourcing contract with the municipality. However, tenancy is separate from support as the clients mostly live in their own or rental apartments with no ties to the support service. In this sense the possible ending of floating support does not have such significant consequences for clients as they can remain in their apartment. The service has a generic orientation and is intended for people with a wide range of mental health problems. Some clients with significant challenges have a care coordinator from the community mental health team who is responsible for managing the client's overall services.

Unlike the two other previous services, the Swedish service is run by the municipality. The service is based on the Housing First model (Hansen Löfstrand & Juhila, 2021; Tsemberis, 2010) which means that the client's right to the apartment is the top priority, with less obligations regarding clients' cooperation. Tenancy contracts are signed between the client and the municipality's real estate office, who are acting as an intermediary between the tenant and the landlord. Clients within the housing first unit have an opportunity to take over the contract after 18 months. During this time, the real estate office checks that rents are paid, if any disturbances have been reported and makes a final inspection. If tenants do not pay rent, then the 18 months trial period is prolonged. However, more than one missed rent or multiple disturbances can mean that the tenant is evicted. The service targets previously homeless people, most of them having substance abuse and mental health problems.

We included these different contexts because we noticed that despite the different countries, workers in each service spend considerable time just talking about how to engage with their clients in the first place, whether in team meetings or at home visits. Workers often need to motivate the clients and manage cancellations and unrealised visits. The commonness of non-cooperating clients is demonstrated in the data: There were originally 24 observed home visits in Sweden of which eight were cancelled. In the English and Finnish meetings, discussions concerning approximately 20 clients where observed, of which seven English and five Finnish clients were discussed in terms of their non-cooperation. Workers in all services made similar efforts to reach their clients: Travelling to clients' homes without gaining access, rearranging their schedule, trying to reach the client by different means, and negotiating how to proceed amongst themselves and with other professionals. While all three services recognise the challenges to engage all clients, they aim for at least minimal cooperation, such as the client being present at most visits or otherwise easily contactable. Consequently, they must decide if they have tried all available options or when it is not worth proceeding further, in terms of their own time and the consequences for clients of terminating contact.

4. Data and Analysis

The data included in this article is chosen from data corpuses collected in the following research projects funded by the Academy of Finland: "Responsibilisation of Service Users and Professionals in Mental Health Practices" (2011–2016) and "Geographies of Home-Based Service Interactions at the Margins of Welfare in Finland and Sweden" (2017–2021). The data consist of:

1. Ten team meetings where floating support workers discuss clients in the current caseload on a

weekly basis. Five consecutive meetings in the Finnish service were audio-recorded in 2012, and five consecutive meetings in the English service in 2013. Both data sets were collected over approximately two months. Each meeting lasted on average one hour.

2. Four home visits conducted by floating support workers in the Swedish service in 2018. A researcher took notes as she observed the visits on the spot and preparations made before and after the visits. The fieldnotes from four different home visits were collected over the course of four months.

While in team meetings workers discuss unrealised home visits in an institutional meeting gathering without the client present, in field notes the researcher describes the actual, ongoing situation of trying to conduct the visit on the spot, at the client's home (shadowing ethnography; see Lydahl et al., 2020). Consecutive home visits were observed, as well as consecutive team meetings which were recorded, to capture the development of clients' situations and the workers' justifications applied at various stages of the process. In other words, support described in both data sets was analysed as a process.

We started the analysis with team meeting recordings that were transcribed verbatim. All talk on non-cooperating clients was identified, resulting in 23 instances dealing with absences of clients (11 in Finnish and 12 in English data). From these instances we identified one client from both services with particularly persistent 'hard-to-reach' features: They had missed most home visits and demonstrated longstanding absences. As we presented these two client cases from Finland and England in our international research team meeting, we learned that Swedish data, collected for the same research, also included one client that was systematically absent during home visits. This was included as the third case which, by focussing on actual home visits, provides an additional perspective to team meetings where home visits are discussed.

All three hard-to-reach cases that we chose to study in more detail were then scrutinised from the point of view of workers' justifications. We use the term justification to refer to workers' different responses or reactions while accounting for their decisions working with non-cooperating clients. In other words, justifications are workers' ways to argue for progress towards the last resort response, whether that response is the termination of service or introducing more control measures. Besides this common way to use the term, we also draw on Scott and Lyman (1968, p. 51), who point out that when people are justifying their or somebody else's behaviour, they are neutralizing the conduct and its consequences. In other words, justification involves verbal work through which workers can mitigate clients' non-cooperation and support their own procedures. In our view, last resort response is then a particular type of justification. Rys et al. (2013) present a similar understanding of the relation between justifications and last resorts. In their study on physicians' and nurses' moral justifications for using continuous sedation for patients, they find last resort responses to be the most used justification for this extreme medical act (Rys et al., 2013, p. 537).

The three cases were analysed by concentrating on key moments where workers justify the moves towards the last resort response. We found that each client case (while having their own contextual and personal features) was justified by workers in three ways:

1. Failures: pinpointing the failed efforts to reach the client (marked with grey highlight in data extracts). These justifications identify the increasing seriousness of the case with workers talking about the incidents of failing to reach the client and demonstrating a decline in clients' compliance with the rules of the service.
2. Remedial actions: introducing new interventions and allowances to reach the client (marked with orange highlight in data extracts). These justifications range timewise from mild to later stronger actions, offering the client a chance to become a 'remedial client.' The worker proposes new ways of contacting the client and making visits more successful. Remedial actions refer to workers' efforts to overcome the previous failures.
3. Changing characterisation of the client (marked with blue highlight in data extracts). These justifications include the shift from more positive formulations, such as constructing explanations regarding why the client is not present, towards more negative formulations that make particular use of extreme versions of clients' character or their elusive behaviour.

5. Findings: Justifying the Move to the Last Resort Response

The findings are reported in three sections, each illustrating a specific process for moving to a last resort-decision: straightforward ending of support (Example 1), gradual ending of support (Example 2), and increased control with continuing support (Example 3). The analytic focus is on how the move to last resorts is justified by workers, both in team meetings (Examples 1 and 2) and home visits (Example 3). The examples feature three clients—Pauline, Oliver, and Bengt (pseudonyms)—who persistently avoid contact with floating support.

5.1. Example 1: Straightforward Ending of Support as a Last Resort Response

Pauline from England receives floating support due to her long-term mental health problems. The service operates under a contract with the municipality. In the following team meetings, the workers examine temporally their various failed efforts to reach Pauline, highlighting her non-cooperation:

> 17 May
>
> Worker 2: Yet again she's not in for a visit, she's not answering her phone, she's not responding to our messages. You tried to get in touch with her.
>
> Worker 3: I phoned [worker from another organisation] yesterday, but I requested that they phone me back and they're sending a message but I haven't looked this morning.
>
> Worker 2: We have seen her out and about in town.
>
> Worker 3: With friends.
>
> Worker 2: With friends, so we know that she's still in the area. We know that she's alive, we know that she's okay, but she's just not engaging with the service at all.

Workers report futile visits where Pauline has not been at home when visited at appointed times. This has happened repeatedly: "Yet again she's not in for a visit." In addition to presenting the failed visit, the workers summarise the remedial actions they have carried out to reach her: messages and phone calls both to Pauline and her care worker. Workers bring up past occasions where they have seen Pauline in a town with friends. Note the upgrading of the justification from "she's still in the area" to "we know that she's alive." She doesn't seem to be at any particular risk nor difficulty even though she has not used floating support: "We know that she's okay." The workers are reassured they cannot be blamed for abandoning a vulnerable client and can frame her as "just not engaging with the service at all." This characterisation of a clearly disengaged client serves already as the initial move towards the last resort response of terminating the support, even though such a decision has not been made. However, in the next meeting the same failures are brought up again and the same remedial action of calling the other worker repeated:

> 24 May
>
> Worker 1: Pauline, nobody's seen her for weeks.
>
> Worker 2: Right.
>
> Worker 1: She doesn't answer the door, I tried to ring [worker from another organisation] again yesterday but she wasn't in.

In the next meeting, Worker 1 starts by recapping the futile efforts to reach Pauline "for the last god knows how many weeks." A tone of frustration emerges as the efforts of these pursuits are emphasised:

> 31 May
>
> Worker 1: Pauline, I've tried to contact her for the last god knows how many weeks. I've spoken to [worker from another organisation] who referred her. She hasn't spoke to her either although we have seen her out and about with friends in the town, so we know she's fine, she's just totally disengaged with staff. I phoned her yesterday at two o'clock and left another voicemail message stating that if she didn't contact us before I visit town that her support would be ending, so she didn't ring back so we've now ended support with her.
>
> Worker 2: Do you think it would be worthwhile letting her care coordinator know?
>
> Worker 1: She doesn't have one.
>
> Worker 2: Oh, she doesn't have one.
>
> [Worker 1 starts to talk about another client.]

Three justifications to terminate support are deployed: first, the workers have finally managed to contact Pauline's worker from another organisation, who has also not seen Pauline. Second, the workers repeat the same characterization of someone who apparently is doing well and at no particular risk despite not receiving their support, as workers have seen her "out and about with friends" and they say they "know she's fine." Third, remedial action is carried out which no longer aims at maintaining her support. Instead, she is informed by voicemail of the conditions under which the support will be terminated.

From the workers' point of view, they have now done all the necessary actions and Pauline is framed as having decided herself that she does not need support, since she did not take up the offer to ring back the workers to continue the support. Pauline is now characterised as "totally disengaged with staff," an extreme formulation designating the unavailability of any other means to reach her. The straightforward ending of support is further justified by workers' remedial action to orient to future work that is in line with their ethical responsibility to check the possible collaborators who should know about the termination, in this case, the care coordinator. The fact that "she doesn't have one," can be heard as further justification for termination, since the lack of a care coordinator implies that she does not have serious mental health problems. Also, terminating the support will hold no consequences to Pauline's tenancy.

In summary, the last resort response is justified by retrospective reports that show both Pauline's non-commitment and appropriate professional actions carried out to reach her. The last resort response is justified by recapping these retrospective reports several times. Pauline is characterized as independent, clearly making her own choice not to receive support.

5.2. Example 2: Gradual Ending of Support as a Last Resort Response

Oliver has severe substance abuse and mental health problems. Unlike Pauline's service above, in the Finnish service the client loses tenancy if floating support is ended. In this sense, ending support has more serious consequences for Oliver. In this example, the last resort response of ending support is constructed more gradually and over a longer timeframe:

> 5 October
>
> Worker: He has been calling [workers] every now and then complaining about his misery and distress. and we have tried to tell him that we do not deal with these things over by the phone and have guided him so that he would be at home at a certain time and we will visit him and then we discuss these issues face-to-face. And, we have agreed a couple of times that he will be there and then we have gone there and the man is not around. And then we have entered the apartment with our own keys and left him a letter, stating that he should contact us so we can talk these things through and discuss what would be the best way for us to support him. Yesterday was the last time we did a home visit with [worker] and we had agreed with him that he would be there and he was not there. But then he called me, turned out he has not been in the apartment at all and had not seen our note we left there. But he called me, at two yesterday afternoon and was drunk so that he must have been at his mates.' but he could clearly talk about things and said he simply cannot stay alone in that apartment and he feels he needs a place with more support.

Oliver is framed as not being totally out-of-reach as he keeps phoning the workers. However, this is not considered the appropriate way to engage with workers from the service's point of view. The primary aim of the service is to carry out home visits and the number of completed home visits will be important when negotiating a new contract with the municipality. As Oliver is not at home as agreed, he is characterised as a client who does not participate the way the service requires. While understanding his distress and characterizing Oliver as somebody who understandably finds it difficult to be at home by himself, the workers still insist on "discussing these issues face-to-face." Next, the remedial action of more serious intervention is reported where workers have used their own key to enter the apartment (unlike in two other services, using the key is allowed). While entering Oliver's empty home, workers leave a letter urging Oliver to contact them. After this yet another futile home visit is described. At this stage Oliver is still characterised as not totally uncooperative: "but he called me." Another excuse is raised in mitigation: Oliver has told workers that "he simply cannot stay alone in that apartment" and "needs a place with more support."

After another three weeks with no successful visit, workers upgrade the seriousness of Oliver's disengagement by planning stronger remedial action, i.e., reporting their difficulties to commissioners. From the team meeting:

> 26 October
>
> Worker: I will raise up Oliver's situation in the commissioners' meeting. It is on Monday so we will hear what they think, but I will tell them what we have discussed here and how things have been progressing and how he is very vaguely committed with this thing. There has been one successful visit and that's that. And there has been promises that he will start coming here [meeting point of the NGO] but there is no sight of him whatsoever.

Oliver's case is shifted to a more formal stage as the commissioners are informed about the problems with home visits to Oliver (except one successful visit). When consulted regarding the future, the commissioners can instruct the service how to react. In the upcoming commissioners' meeting, the worker plans to describe Oliver as "vaguely committed," as someone who makes false promises to cooperate.

In the next team meeting, the commissioners' meeting is not brought up in the team discussion. However, the worker's tone is more frustrated and the plan to end Oliver's support is presented for the first time:

> 9 November
>
> Worker 1: And honestly our understanding is now finishing. As he is in no way collaborating and there has been few times we have reached him by the phone. Well he still drinks. And he has promised to come here to solve this situation but nevertheless has not yet appeared. On Friday we did a spontaneous home visit with [worker] and we let ourselves in with the key as he was not at home and again we left a serious letter on the desk stating that now, now your rental agreement is valid by the end of November. At this point it finishes then, and I hope that he would at least contact us regarding how he will continue.

The formulation of Oliver's disengagement is maintained, even though he is reachable by phone. There have been different strategies of remedial action: phone calls and encouragement in the hope that Oliver will be present for a visit. The same remedial action, entering with own key and leaving a letter has now upgraded the seriousness by proposing an imminent ending of the rental agreement. Oliver is now characterised as someone who cannot handle such responsibilities nor can he "at least" let workers know "how he will continue," suggesting an inconsiderate response. Importantly, the last resort response is presented: "At this point it finishes then."

In the next meeting, the characterisation of Oliver changes from partly cooperative to totally uncooperative, further confirming the adoption of the last resort response for ending the support, partly drawing on the commissioners' opinion:

> 30 November
>
> Worker 1: It feels so crazy like you were running after some teenager, trying to chase him all around the world. like you never see him anywhere and cannot talk to him. I dunno this is so weird this running away thing going on with Oliver.
>
> Worker 2: I'm just thinking that should we call his social worker?
>
> Worker 1: Yeah she needs to be notified, where we are with Oliver. But the thing is that he has our apartment and the city is paying for it all the time. [the commissioner] said in our last meeting that this makes no sense, the city won't cover costs for this kind of a guy who doesn't benefit from support in any way and use it. And that is a fact. But the thing is, I wonder can we really, as he is within our support now, well we should anyhow try to consistently guide him towards more supported options. And not act like we will just kick him out in the street.

The emotional tone in which the process with Oliver is described as "crazy" seems to question the legitimacy of the work. Oliver is characterised as a "teenager," with workers trying to "chase him all around the world." The workers' justification is that they have already done everything they can and have acted according to their professional ethics. In the beginning Oliver at least phoned workers, and his absence was partly interpreted as him telling the workers that he cannot cope in the apartment alone. There is a shift to a more extreme formulation of the recurrent impasse: "You never see him anywhere." Responding to the commissioners' opinion, the support is finally terminated, characterizing Oliver as "a guy who doesn't benefit from support in any way."

In summary, after the decision to terminate, the workers recognise their responsibility to guide Oliver towards a different placement with "more supported options." Support is ended progressively and ethically by planning Oliver's future in collaboration with other actors and seeking a more appropriate service for him.

5.3. Example 3: Increased Control with Continuing Support as a Last Resort Response

The final case is located in Sweden and presents Bengt, who is a client of the municipality's Housing First programme due to his previous homelessness. He receives floating support from the team. This example is different from the previous ones as the last response does not include plans to terminate Bengt's support at any phase. Instead, workers continue support by increasing control and mitigating his absence, while still drawing on similar justifications to previous last resort responses utilising failed attempts and remedial actions. The first observed home visit starts with workers entering Bengt's apartment:

> 24 May
>
> We go to Bengt's house and enter the front door and call on Bengt's door but get no response. Marita tries several times. Jonas takes out a card in hardcover in A5 where the Housing Organization and the Administration for allocation of social welfare's logo is printed. He writes the following on the card "Hi! We have tried to reach you and it was a long time since we heard of you. Call us! With kind regards. Jonas tries to put the card in the mailbox, but it is glued shut. Marita says that it is common with their clients. However, Bengt has a mailbox in the stairwell, so we put the card there instead. When we go out, Jonas asks, "is it us he avoids?" Marita replies that it may be "he's in a period [of drug/alcohol use] and I think he's stuck in the old and thinks he's going to get lectured.

After Bengt fails to answer his door, the remedial action of leaving him a note is carried out. The card kindly says that workers have tried to reach him and urges Bengt to phone them. The mailbox is glued shut which strengthens Bengt's characterisation as someone "hard-to-reach": He is not physically present and cannot easily be approached by post either. Explanation and normalisation for this behaviour is provided by the worker: "It is common with their clients." The workers seek reasons for Bengt's avoidance by characterising him as someone who has possibly started using drugs again. Importantly they do not say that they will lecture Bengt, but rather that Bengt thinks that he is going to "get lectured." Being "stuck in the old," in this context refers to the idea that Bengt thinks he will be reprimanded for using drugs again, which he will not, the workers later explained. As part of the Housing First programme, the workers subscribe to a harm reduction approach, in which using drugs is not a cause for eviction nor sanction.

The workers make another unannounced home visit, observed by the researcher, but again no answer. However, they noted an open balcony door with a light in the bathroom, implying that somebody might have been at home, but the workers were not let in. Before the next visit observed by the researcher, the worker informs her colleagues about Bengt's situation:

> 5 June
>
> Marita says that they did not get hold of him for a long time and when they last entered the apartment they did not even meet Bengt. Instead, someone who claimed to be Bengt's friend opened and said that Bengt was asleep. Marita says she thinks that they should leave a note to Bengt saying they are worried and will contact the police if Bengt does not get in touch with them. The other workers agree that sounds like a good idea. "What do we write on this piece of paper," Marita wonders. Eva, her colleague, asks "Has anyone taken over his apartment?" Elin and Boel, other colleagues, say almost at the same time that they have also had that thought. Elin says that Marita can try to write something about supporting Bengt with the rent. Apparently, Bengt has failed to pay 3 rents and there is now a risk that he will be evicted if he does not pay. Eva says that they should write "we are worried about you. If we do not hear from you then we'll enter the apartment with the police. "If someone has taken over the apartment, it might be easier to get them out if one says that the police will come, says Elin.

The previous failed efforts to visit Bengt are reported: As before, the workers have not "get hold of him for a long time." However, a new kind of problem is reported where, during the last home visit, someone else had opened the door. As the workers suspect that this person might have "taken over his apartment," a significant increase of control supersedes the previous remedial action of merely leaving a note. The current note includes more serious threats and concerns. First, the workers propose stronger control, as they inform Bengt (or somebody living in the apartment) that they plan to involve the police, to secure Bengt's apartment from others who might have taken it over. Second, the note highlights the problem of rent arrears, suggesting Bengt could be supported with the rent. While not explicit in the note, a possible eviction is implied. Bengt is now characterised as an upgraded risk if he loses his tenancy contract. Although eviction does not mean terminating support (unlike with Pauline and Oliver), it would create extra problems to address. The workers would have to participate in negotiating a new tenancy for Bengt, as well as finding ways of supporting him to keep the new contract. Furthermore, Bengt is characterised as vulnerable to others taking advantage of his apartment.

A few months later, when workers again are observed by the researcher, they succeed in visiting Bengt. This extract lacks the different justifications to move towards the last resort response, because the last resort response has already taken place in the form of increased control when workers suggested to involve the police to get access to Bengt's home:

> 18 September
>
> We still go to the outer door, Marita is calling, and he opens. We walk halfway up to his apartment door. He stands in the door and Marita presents me—"This is [researcher], can she come in? She will study how I work." It's fine, Bengt says, and we go in [descriptions of the home]. Bengt has produced three coffee cups. Me and Marita sit down on each side of the kitchen table. Bengt sits on the short side after he poured coffee for us and presented a packet of vanilla cookies. Marita and I tell him about my study, and Marita stresses that it is voluntary to participate and if he should regret it, he can also say afterwards that he does not want to participate. Bengt has no problems with participating he says and I give him the written information and asks if it might be okay for me to record the conversation between Marita and him. It is.

Finally, Bengt opens the door and a home visit is conducted that can be interpreted as successful. Bengt acts like a welcoming host, by offering the worker and researcher coffee and biscuits, and by informing them of his willingness to take part in the research. Support provided to Bengt during the home visit is successful, as seen by the way the visit continues after this extract: the research describes Bengt and Marita as starting to sort out the rent and having a shared plan to manage payments.

In summary, throughout the process, the workers did not withdraw the support at any point, although it was seen as an (unpreferred) option. Instead, the last resort response was an increase in control and insistence to secure the apartment for Bengt. Control was used to re-establish the service, not to end it. In this respect, Bengt's example contrasts with those above, as support continues, and the last resort response uses stronger measures: highlighting possible eviction and plans to invite the police to inspect the apartment. There is a fine line between stronger remedial actions and what constitutes as last resort response. Furthermore, the characterisation of Bengt remains more positive than in two previous cases.

6. Conclusion

We have studied floating support workers' efforts to reach clients who are persistently absent when the worker makes a home visit. Analysing the workers' efforts to re-engage with these clients, we identified three types of justification the workers use for last resort responses to terminate support or, alternatively, increase control and insistence: First, retrospective summaries on past failures to reach the client; second, intensifying remedial actions to engage with them (unannounced visits, phone calls, leaving notes, entering the apartment and consulting other professionals); and third, characterisations of clients as uncooperative. Once remedial actions have repeatedly failed, the decision-making containing the last resort response is invoked.

As we studied team meetings and home visits conducted by a group of workers, the justifications draw to some extent on shared notions of the ethics, values and working practices of the services (Saario et al., 2018). However, the ethical implications vary considerably between each example, especially concerning the termination of support. Pauline's case (the first example) demonstrates how the service was ended with little scrutiny. Pauline apparently showed little motivation and seemingly was not at increased risk without the visits. Furthermore, the service did not hold wider responsibilities for Pauline's ongoing care, nor did they need to justify termination to other agencies. Ending the service was more complicated in Oliver's case (the second example), as he was seen by workers as needing extra support, with which he concurred. The service was committed to engage with Oliver and, after the termination, still participated in planning his future. In both cases the workers, in consultation with their colleagues, actively constructed the last resort responses. In contrast, in Bengt's case (the third example) support was not ended but increasingly controlling measures were carried out due to outside circumstances (possible intruders at his home and rent arrears). Stronger measures were proposed while not withdrawing the case but carrying on until Bengt was reached again.

Furthermore, the different last resort responses can be viewed from the point of view of workers' relation to the autonomy of clients (Lydahl & Hansen Löfstrand, 2020). It could be that the service is terminated in Pauline's and Oliver's cases, as there is respect for clients' making their own choice of not opening the door and having workers visiting them, whereas the workers continued to pursue Bengt even after several absences on his part. Perhaps, also the looser ongoing responsibilities in the contract between clients and the workers in the first two services seem to suggest that they engage in less remedial work. Such dilemmas can be mapped in terms of a continuum between promoting client autonomy and choice versus control and insistence. The services examined here are near the client autonomy end of the continuum. In contrast Brodwin (2013, p. 64) examines assertive community treatment teams in the US, where the worker cannot end involvement with the client and where compliance (especially with medication) is the central concern. He discusses criticisms of such services as coercive, "overt paternalism" (Brodwin, 2013, p. 181), contrasted with "developing long term relationships oriented around clients' own goals" (p. 184). Both extremes of abandoning the uncooperative client and imposing treatment are last resort responses.

We suggest that processes towards last resort responses are important to study because they are essential features of organisational interactions in which formulations of clients are constructed. Besides home visiting programmes, engaging hard-to-reach clients is an issue in many social care services. Furthermore, being hard-to-reach is considered a risk especially for the most vulnerable clients, such as the clients studied in this article. While our data do not show the consequences of non-cooperation from clients' own perspective, severe consequences are reported by earlier research including evictions, increased homelessness, self-harm and suicide (e.g., Doherty et al., 2003; Maeseele et al., 2013; Stenius-Ayoade, 2019).

This article illustrates a variety of workers' efforts to deal with clients' non-cooperation by applying Emerson's idea of 'the last resort' in everyday interaction of social care work. While we demonstrated different ways individual workers respond to clients with whom it is difficult to maintain contact, more research is needed to clarify the process of decision-making concerning the ending of support. Especially different service models and their contractual practices may have a significant role in decision-making concerning non-cooperating clients. This calls for paying attention to the different processes that precede workers' last resort responses, as well as recognising the organisational procedures and services that build on the logic of last resort.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

"It's about Living Like Everyone Else": Dichotomies of Housing Support in Swedish Mental Health Care

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Abstract

The deinstitutionalization of psychiatric care has not only altered the living conditions for people with severe mental illness but has also greatly affected social services staff. In the Mental Health Act launched by the Swedish government in 1995, a new kind of service called 'housing support' and a new occupational group, 'housing support workers,' was introduced. However, housing support does not currently operate under any specific guidelines regarding the content of the service. This study explores housing support at local level in various municipalities of one Swedish county. The data is based on discussion with three focus groups: care managers, managers for home and community-based support, and housing supporter workers. The perspective of institutional logics as a specific set of frames that creates a standard for what should or could be done, or alternately what cannot be questioned, is applied to analyze the constructed meaning of housing support. The meaning of housing support is constructed through three dichotomies: process and product, independence and dependence, and flexibility and structure. These dichotomies can be understood as dilemmas inherent in the work and organizing of housing support. With no clear guidelines, the levels of organizational and professional discretion create a space for local flexibility but may also contribute to tremendous differences in defining and implementing housing support. We discuss the potential consequences for housing support users implied by the identified discrepancies.

Keywords

focus groups; housing support; institutional logics; welfare work

Issue

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1. Introduction

This article focuses on housing support (HS) and its meaning in the context of deinstitutionalized mental health care in Sweden. Here, we investigate questions about HS and severe mental illness (SMI) by focusing on contested issues of professional identity, the constructions of meaning of HS, and the various logics that inform

HS's organization and provision at local levels. The aim is to shed light on the intrinsic complexity of providing home-based social support to persons with mental illness living independently in the community. This goal will be accomplished by using the lenses of institutional logics, which is a theoretical framework that identifies and accounts for the many and various social influences on institutions.

2. Housing Support

HS was introduced in Sweden in the 1990s, and it is an important social welfare response to the goals of normalization and social integration for a number of vulnerable groups. Broadly speaking, HS is meant to support users in their daily lives (which includes both home life and life outside the home), and ideally it should be achieved via an establishment of relations with those users (Andersson & Gustafsson, 2019; National Board of Health and Welfare, 2010). Yet, with no guidelines nor policies regulating its provision or organization, HS remains surrounded by organizational and professional uncertainty as well as a lack of clarity about contacts and relations between housing support workers (HSWs) and users. In addressing these uncertainties, this article brings to the fore the understandings of, and meanings assigned to, HS by the HSWs themselves, their immediate team leaders, and managers of community-based mental health support.

HS has emerged as essential for enabling the everyday life and providing non-clinical support to people with SMI who are living independently (Brolin et al., 2018; Shepherd & Meehan, 2013; Shepherd et al., 2014). This population of people is faced with the task of managing their social lives, interacting with others, and establishing their home lives in the context of a community. However, SMI very often impedes social abilities, and without appropriate support, independent living may turn into life in loneliness and social isolation.

The uniqueness of HS in the context of independent living is related to the fact that HS turns the home into a site of professional intervention (Gonzalez & Andvig, 2015)—it actively uses the private space of a user for a professional purpose (Juhila et al., 2016). The context of professional work performed in private spaces is largely built on the quality of relations existing between HSWs and users, and creates special circumstances for negotiating own positions, roles, and performing various tasks. HSWs face numerous emotional and bureaucratic challenges (Ericsson & Bengtsson Tops, 2014; Ericsson et al., 2016) involving, among other things, a need to balance duties and relations to clients (Shepherd et al., 2014) while simultaneously negotiating their own position in relation to other mental health care professionals (Shepherd, 2019).

Along with most western countries, in the latter half of the twentieth century, Sweden reorganized psychiatric care according to the principles of deinstitutionalization, which meant closing the old mental hospitals and replacing them with smaller units and open care. In Sweden, the process started in the mid-1970s with a nationwide implementation of Community Mental Health centres with outpatient units as a complement to psychiatric hospitalisation. Ideally, every psychiatric clinic would be responsible for all in- and outpatient treatment within a defined catchment area (sectorisation). The aim was to improve the living conditions of persons with SMI and facilitate the transformation from a patient to a person, and for that person to become an active citizen in society (National Board of Health and Welfare, 1970, 1980).

However, the pace was slow, and evaluations showed that persons with SMI did not necessarily benefit from open care's lack of support for social needs relating to daily life matters (Stefansson & Hansson, 2001). In 1988–1989, a survey was conducted by Statistics Sweden with the aim of investigating the living conditions of the Swedish population. In this survey it was found that people with SMI had living conditions far worse than average for the Swedish population as a whole, and significantly lower than for example groups with physical disabilities (Prop, 1993). As a response to the result of the survey, the Swedish Government commissioned a parliamentary committee to make proposals for a reformation of psychiatry and psychiatric care in Sweden, which resulted in the 1995 Psychiatric Care Reform. The reform clarified the responsibilities of social services and psychiatry. Social services would be responsible for providing support to persons with SMI in questions of housing, employment and everyday life, thereby establishing the conditions needed for integration into society. The task of the county psychiatry council would be to develop psychiatric treatments and prevent psychiatric illnesses.

3. Institutional Logics

To explore the emerging meanings attached to HS, we take of the perspective of institutional logics. The concept of institutional logics (first introduced by Friedland & Alford, 1991) expanded the field of institutional theory by drawing attention to societal influences on institutions, the ways institutions change, and the role individual actors play in that process of change (Johansen & Waldorff, 2017). Institutional logics are commonly used to help understand contemporary institutions and observing these logics at work can be used to "represent frames of reference that condition actor's choices for sensemaking, the vocabulary they use to motivate action, and their sense of identity" (Thornton et al., 2012, p. 2). With its focus on material practices and symbols, this new perspective has brought heightened awareness of the making of institutions in practice and their exposure to both external forces and internal processes of interpretation. Rather than seeing institutions as closed and finished entities, the perspective of institutional logics brings forward the everchanging character of institutions that are transformed in the course of everyday practices.

Essential to the understanding of institutional logics and their functions is the notion that multiple logics guide institutions and organizational behaviors. These multiple institutional logics may entail very different, and sometimes conflicting, directions for institutions and institutional actors (for instance, differences between family and market logics; see Martin et al., 2017). Institutional complexity, which increases along with the number of institutional logics and their degrees of incompatibility, can be seen as the result of multiple institutional logics (Greenwood et al., 2011). Multiple and divergent institutional logics may lead to tensions, but at the same time, they may also provide a scope for creative solutions (Martin et al., 2017). For these reasons, the perspective of institutional logics is especially relevant for analyzing the contradictions and dichotomies surrounding the complex institutional setting of HS and the various logics that need to be effectively managed at the frontline of practice (Lipsky, 2010).

Institutional logics is also committed to exploring the local embeddedness and enactments of these logics by various institutional actors (e.g., Currie & Spyridonidis, 2016; McPherson & Sauder, 2013; Pallas et al., 2016). Thus, while conditioning choices and behavior, institutional logics are also “somewhat elastic, being sensitive to local actors’ capacities and motives to actively and continuously interpret and enact their different parts” (Pallas et al., 2016, p. 1680). Institutional logics can be applied in various way on the ground, depending on the situational constraints, the actors involved, and the positions of those actors in the specific situation. In a way, the more problematic the institutional logics and its various elements, the greater the level of engagement and adaptation of institutional logic to a particular situation or circumstance (Pallas et al., 2016).

A good example of how different institutional logics can stem from actors and local context, and how similar logics can translate to different outcomes, was presented by McPherson and Sauder (2013). Their micro-study of drug court proceedings showed that, especially in the context of contest or conflict, different logics originating from the same institution can be employed by different actors to achieve different goals. Conversely, they also demonstrated that any particular institutional logic may be used differentially depending on who applies it, which means that the same logic may be used to serve different purposes. That variation in application of institutional logic at the ground level reflects situational constrains as well as actors and their positioning within given situation. In a way, the more problematic the institutional logics and its various elements, the greater the level of engagement and adaptation of institutional logic to local circumstances (Pallas et al., 2016). Crucially, as Pallas et al. (2016) emphasize, it is the active process of local translation that brings institutional logics to live and thereby, testifies to various enactments and consequences of the same logics.

The perspective of institutional logics brings forward not only the dynamic side of institutions, but it also pays tribute to the individual and collective agency of institutional actors. In the context of welfare professionals, agency is often conceptualized in terms of professional discretion, which encompasses how professionals make judgements and decisions, and interpret policies, as they perform their work on the ground. Discretion typically involves structural and epistemic dimensions (Molander, 2016): While the epistemic dimension concerns the actor’s reasoning regarding preferred courses of action (which may vary from case to case), the structural dimension concerns the overall legal, institutional, and organizational frames that delimit the boundaries of professional conduct. The structural dimension of discretion reflects the influence of institutional logic on decisions and judgements made by professionals who, through their agency, actively respond to the various institutional logics (Garrow & Grusky, 2013).

Each institutional logic provides a set of assumptions about what should or could be done, or about what cannot be questioned, and each logic therefore simultaneously enables and constrains agency. One such logical framework relevant to HS includes the ideas of deinstitutionalization and normalization that were formalized with the Psychiatric Care Reform. The reform clearly promoted the notion that people with SMI would be able to enjoy ‘a normal life’ in communities just like everyone else. These ideas and new or altered organizations reflected the gradually changing perceptions of disability and the social status of persons with disabilities. Instead of ‘patients,’ people with SMI and other disabilities became increasingly regarded as (active) citizens (Lindqvist et al., 2012; Lindqvist & Sépulchre, 2016). How and whether this frame of deinstitutionalization is visible and enacted in the practice of HS has yet to be explored.

The positions and roles of HSWs can be also considered thorough the perspective of other social welfare professionals (like case and care managers) and the various institutional logics that affect them. For example, as welfare workers, HSWs might be affected by the overarching logic of bureaucracy that can potentially constrain their occupational role (professional logic; see Freidson, 2001) and the ways they would prefer to engage with people with SMI. At the same time, welfare professionals (managers) are urged to categorize individuals and standardize practices (Hasenfeld, 2010; Lipsky, 2010). On the other hand, the logic of individualization that is highly valued in western welfare states (and prevalent in the field) may push HSWs (and other welfare actors) to adapt to the will of the users and their unique situations. HSWs have the primary role of enabling contacts between clients and the outside world, which makes them the foremost bearers of social connectedness and relations for these clients (National Board of Health and Welfare, 2010). Research confirms that the quality of the relationship between clients and HSWs is the key to successfully providing HS (e.g., Andersson & Gustafsson, 2019; Gough & Bennsäter, 2001; Ljungberg et al., 2017).

In this article, we draw on the experiences of three occupational groups that, in their various positions, are responsible for planning, managing, and executing HS. In their voices, we can hear the various logics in play through their understandings of what HS is and the ways that the same institutional logics may potentially be interpreted and practiced differently by the representatives of those various groups. Our analytical focus is guided by the quest of identifying their institutional logics and understanding the ways in which those are enacted in practice. The complex and often contested context of providing HS for those with SMI is a rich source of material for investigating these issues.

4. Methods

The study is a part of a collaboration between the authors and a group consisting of former users of HS and professionals either working with HS (HSW, care managers) or with experience of people with SMI (a retired psychiatry nurse). The goal of the project is to explore the provision and organization of HS using the framework of institutional logics.

The empirical material consists of three homogenous online focus groups, suitable for capturing rich qualitative data where participants share opinions, experiences, and construct meanings about, in this case, HS (Kitzinger, 1994). Three categories of welfare workers participated: HSW, care managers, and managers for home and community-based support. In addition, one individual online interview was conducted with an HSW (the participant could not attend the meeting). These three categories of welfare workers were strategically chosen to represent the different domains that affect realization of HS at the frontline. Focus group interviews were conducted online because participants are situated in different municipalities (see Woodyatt et al., 2016) and to minimize the risks in light of the ongoing Covid-19 pandemic. The focus group interviews (audio and visual via Zoom) were recorded.

The HSW focus group comprised five participants from two different municipalities, and their levels of experience ranged from five to 20 years (the individually interviewed HSW had six years of experience). The care managers focus group comprised eight participants from seven different municipalities, and they had specialized on people with SMI from one to eight years. The managers for home and community-based support focus group comprised four participants with one to four years of experience from four different municipalities. All municipalities were in the same county in Sweden. All recorded interviews comprised of a total of 398 minutes of data.

In order to grasp the planning, management and execution of HS, interviews focused on six general themes: the meaning of HS in your context(s), how work is carried out, knowledge needed to perform the work, relevant education, examples from work considered hard or challenging, and collaboration with different stakeholders. For the focus group with managers for home and community-based support, we added two themes: competence required when recruiting and distribution of work tasks. Themes were chosen based on previous research on HS as well as discussions with the group of collaborators. Prior to the focus group interview, and as a kind of preparation and a way of triggering discussion, material based on excerpts from newspapers were sent to the participants. These newspaper excerpts contained interviews with managers and HSW and covered topics such as competence, how much HS users might need the services, and the meaning of HS. Each focus group and the individual interview started with a presentation of participants followed by a question about their thoughts and feelings about the material. The participants were also urged to talk freely, respond to each other, and exchange experiences. Typically, one or two of the participants in each focus group responded to the stimulus question by briefly commenting (such as "I found that interesting") on some part of the content in the stimulus material before moving on to talk about their own practice. That is, the participants themselves had the ability to control which paths the conversations took based on what they considered to be relevant and important. Two of the researchers conducted the interviews. Naturally, the individual interview was more of a discussion between the researchers and the respondent, whereas the researchers had a more peripheral role in the focus groups.

The recordings were transcribed verbatim and analyzed according to the following strategy. First, each researcher individually conducted an empirically-based coding and analysis of the transcripts to get familiar with the data. Terms used in this stage of analysis were thus close to the raw data. Second, after identifying overarching themes, the research team met to compare and discuss the themes each of us had found. Third, based on those discussions, a thematic matrix was constructed and supplemented with illustrative quotes from the different welfare workers. This thematic matrix was thereafter presented and discussed with the group of collaborators. This discussion highlighted the various difficulties HSW and other actors face when doing HS work in practice, for example, the need to adapt to the needs of the individual while simultaneously fulfilling duties in line with organizational imperatives. Such difficulties were understood as dichotomies of concepts and approaches creating dilemmas (cf. Lipsky, 2010) experienced and managed in the specific context of HS. Next, we expanded the analysis further by exploring and interpreting the different meanings attached to HS from the framework of institutional logics, focusing on the contradicting conditions and challenges embedded in the setting of HS and made visible by the data. From the new reading and thematization of the material, three different dichotomies of core concepts emerged in the process of analysis which makes up the findings and analysis section below.

5. Findings and Analysis

The analysis of focus groups revealed an apparent struggle common to all research participants in defining HS. Thus, for example, when trying to describe their own role, HSW often resorted to various metaphors, such as 'being a trigger,' or 'making the clients bloom.' While such metaphors highlight the visionary perspectives guiding individual workers, they cannot offer clear images of how to define the role and, by extension, the content of HS. In a similar vein, one of the care managers emphasized that in HS "it's about living like everyone else." Clearly, these statements can be conceived of as indicating that the normalization principle dominates the reasoning about HS. However, further analysis reveals that as a form of institutional logic, normalization can be applied and understood differently and may involve various elements.

Three separate dichotomies of core concepts were identified in analysis: process and product, independence and dependence, and flexibility and structure. These dichotomies can be understood as dilemmas inherent in the work and organizing of HS. The dichotomies also signify various types of agency and their active roles in redefining different institutional logics, pulling HS in diverse directions. These dichotomies bring forward political and organizational aspects, like the contextual settings for HS. On the one hand, HS is supposed to lead to the grand objective of individualization, however this objective is neither grounded nor situationally located in an organization. There is still a desire to fit needs into predetermined structures, however loosely constructed.

5.1. Process and Product

With the dichotomy of process and product, we illustrate the balancing act between understanding HS as a product-focused practice and as a process-oriented practice. The distinction between process and product indicates differential values and modes of working that may either embrace the notion of long-term engagement and its various aspects or focus on concrete activities and their accomplishment. We exemplify this dichotomy with two discussions that focus group members had about the practices of talking and vacuuming. First, the HSW focus group had this to say about having conversations with users:

> I am thinking about this thing with conversations, where we had a discussion about when and how to have conversations, because there are people that we go to that can be so caught up in a conversation and there is only conversation, and nothing gets done. And then, we had a discussion some years back, that the conversation is often a reward for a person. So, you put it at the end of… and limit it to a certain time, because otherwise you can spend an hour and there is just talk. (HSW focus group)
>
> That's the case for us as well. I mean, we don't have conversations where we sit down and talk like that, unless it results in….We always go through the schedule, what does the week look like? And you start there. Motivational talk, I mean. (HSW focus group)

HS is meant to provide support in daily life and, as many research participants emphasized, the ultimate purpose is to facilitate personal growth and positive change in people's daily lives and their social worlds. Simultaneously, HS is a type of welfare practice that is constrained by the same standardization and efficiency principles as other social welfare services. Engaging in this context in HS can therefore pose challenges regarding values and priorities at work. There is a gradual shift in focus from human processes of interaction that could typically be essential for 'making the clients bloom' to concrete products that can be planned, executed, and measured. Thus, the idea of talking to clients is discussed in terms of waste and meaningless activity. The only time when talking is appreciated is when it leads to something else, for example, it motivates clients to do something. 'Just talking' is not seen as something tangible enough to be recognized as an important part of social support. On the other hand, when introducing the idea of conversation as a part of a reward system, there is a recognition that it is a meaningful activity for the clients. Yet, in this context, the notion of doing one's job seems to override the principle of attending to client's needs and supporting social life.

While talking is not perceived as productive, some typical household activities are:

> HSW 1: I just thought I should add that it is very important that the assignment from the case manager is very clear, very concrete, it helps extremely when we go in and do this in practice. Is it fuzzy, it's broad formulation, it's… what can partly make it difficult in practice. But also, that the client gets another apprehension about what housing support is, what we are here for. And it has become much more brief, clear and in bullet point format. Just these five recent years that I have worked.
>
> I: Can you give an example of what a good assignment might sound like?
>
> HSW1: Yes, an example can be a shift from before where it said "support in the maintenance of the home."
>
> I: That's the fuzzy version?

> HSW 1: Yes, that's the fuzzy version. A little clearer version could be "to motivate to vacuuming the living room."
>
> HSW 2: That's a difference. (HSW focus group)

The example with vacuuming was recurrently used in various focus groups to indicate the concrete aspects of HS. In the context of no rules or guidelines to inform the practice of HS, those in charge of organizing and providing HS attempt to break the overarching goal of support into smaller activities that give specific frames for acting. In that process of translating the notion of support and with that normalization, HS is construed as including numerous activities that direct the behavior, and also allow visible outcomes of the work done. Considering the home-based context of HS, such concrete activities revolve largely around household chores. A clean apartment, washing dishes, and doing laundry thus become indicators of the effectiveness of professional intervention. Indirectly, however, such indicators reduce the potential influence of HS on the process of social integration. Too much focus on household chores that are used both as activities framing HS and providing measurable outcomes risks turning the household site into the intervention site. People with mental illness receiving HS may become more proficient in their household duties, but their social lives, which very often are affected by their underlying illness, may not be affected by this intervention at all.

The process–product dichotomy is also reflected in the research participants' talk about time:

> The length [of HS] varies a lot, it is not possible to decide ahead how much time is needed, there are the clients' needs and conditions that determine that. (Care managers focus group)
>
> The lack of clearness can also imply long interventions that are difficult to end. (Care managers focus group)
>
> If the clients have HS during a long time and do not move on, then home care becomes more relevant. (Managers for home and community-based support focus group)

HS is provided on individual basis and conditioned upon an assessment of needs. As a part of the assessment, it is recognized that the period during which HS can be provided may vary depending on the clients' wishes and needs. However, this person-centered logic that informs practice may clash with the logics of productivity and efficiency. The logic of productivity and efficiency may turn time (or more precisely, the length of the intervention) into a criterion of success. According to such reasoning, short periods of HS are indicative of success while longer periods may suggest a client's inability to progress, indicating a failure of HS. The product-oriented frame not only presents concrete activities that are deemed appropriate, but it also provides specific time intervals that are considered reasonable. It is noteworthy that such reasoning came up in interviews with both groups of managers, but did not come up during the focus group interview with HSW.

5.2. Independence and Dependence

The second dichotomy is in the balancing act of helping clients develop an independence in their daily lives, while setting up ground rules and structure surrounding everyday life. The importance of achieving independence is emphasized in all conversations; the independence of living 'like everyone else.' Who this 'everyone else' actually is is neither detailed nor explained, but rather emphasized by various people, and it seems to be understood as something obvious and strictly positive, something to aim and strive for.

However, the practice of HS is built on structures and content that can instead emphasize dependence on others. The independence of clients was mentioned often in the interviews, though not specified at all, leaving much room for interpretation. Client independence was always set in an organizational (and hence societal) context, leaving little or no room for questioning the claim of always aiming for independence.

The dichotomy of independence and dependence illustrates how independence is talked about in positive terms as the main goal of HS. However, the dichotomy also illustrates the deeply imbedded discourse of the limitations to this so-called independence. Independence comes with expectations and limitations connected to the practical work of HS, even in terms of regulations. Discourses about and explanations of independence are accompanied with a 'but,' explaining the limitations to independence in various cases:

> The client should participate, of course. Maybe you can't handle everything from the beginning, but then it is our thing to find ways for them to be as independent as possible in what they want….Because participation is pretty important, and that… that we can work on this together with the client [for them] to be more and more independent simply. That's how I think about it. (HSW focus group)

The quote comes from a HSW in a focus group, explaining the circumstances and daily work needed to achieve this independence for others. This comment was followed by another HSW adding support to the previous claim:

> I exactly agree with what you said. For me it's also about coming in when it comes to boundaries. In many of these decisions there is a very unclear limit. Where is the limit for how much we do, what we do, what we agree to do. There is always request for more in many cases. (HSW focus group)

This second quote addresses the matter of boundaries and additional requests for help. The exact moment that boundaries are set can be the moment when an HSW clearly steps in and takes charge of a situation. Because there is no limit to potential further requests to be made, the HSW must be firm in their positioning and boundary setting, however challenging doing this might be. The need for HS is based on a prior assessment which is supposed to have set the boundaries beforehand, but HSW are the ones meeting clients and hence are the ones faced with more requests from clients. As pointed out by a care manager in the dichotomy of process and product, the needs assessment is challenging, because "it is not possible to decide ahead how much time is needed, there are the clients' needs and conditions that determine that" (care managers focus group. HSW are the ones that must navigate between requests and needs within the loose organizational context of HS.

Moreover, the issue of stressing things to *do* is emphasized. Similarly, to the dichotomy of process and product, there is an emphasis on practical matters to attend to, such as housekeeping. The role of an HSW is not merely to show up and offer whatever support is needed, but instead, things must be done and completed. Practical issues are stressed because these give a sense of accomplishment, which in turn is thought to lead to independence.

The following quote is from the same focus group and conversation as the prior quotes, and here, the withdrawal of HS is pondered:

> And I think that….On the other hand maybe you can think that if you need your housing support several times a week then….I am saying, that surely you need some kind of maintenance dose of your housing supporter to not fall back into something. So I think it's a good thought to not just disappear. (HSW focus group)

So it is understood that mutually created dependence between HSW and client must come to an end at some point, however, the ending is not so easily completed. Everything else connected to the service and use of HS has fuzzy boundaries and limits that are difficult to determine, and the ending of HS is no exception. And, as in many cases of welfare work, clients receiving HS are not the ones fully in charge of their own situation.

5.3. Flexibility and Structure

Lastly, the dichotomy of flexibility and structure highlights the ambitions to have clients 'live like everybody else' and thus the need for professionals to be flexible and responsive in relation to a client's will, characteristics, and specific situation. However, at the same time, there are structures of practice that might complicate such ambitions. Consequently, negotiations need to happen on a daily basis between both clients and organizational representatives and between different occupational groups. In the following we present two examples of this dichotomy that focus on the content of HS and control of HS intensity.

The following example demonstrates reasoning in the care manager focus group about a client who initially was considered 'hard to work with' in terms of the goal of independence. Therefore, organizational flexibility was called for, and "maybe we promised a little too much verbally, even though it is not stated in the formal decision." Now, "the user's parents are very assertive" and say that more HS-activities to be implemented:

> There are things like, even though the user has training once a week, is out and about with the dog every day, they [the parents] still think that my staff should take the person and go for long walks together with the user and the users pet just because the person should have someone to talk to. And this is a person who moves, is active, is at work during the day and has co-workers, has activities every week and so on. And so still you must go out….It is not even reasonable….Do you understand? Most people, they have a job, they have leisure activities, they go out and walk the dog. That's it. That's where it ends. But then they demand much more….Yes, then I have to put my foot down. Tell the staff [HSW], this is how we think. Tell the care manager….Because we are played out otherwise by the user and the parents. (Care managers focus group)

Flexibility in relation to the user (and in this and other cases, the user's family) can only be accepted to a certain extent, otherwise 'we are played out,' indicating a conflict between the different parties concerning to content of, and by extension the amount of time dedicated to, the HS intervention. The rationale behind the position taken by the manager seems to be that the claims made to extend the HS stand in opposition to the logic of normalization indicated by the phrase 'most people.' If stretched too far, HS might be something that obstructs normalization and needs to stop. Even though flexibility and the logic of participation is, according to all participants, considered paramount for success, organizational boundaries need to be drawn. Since the structural dictates concerning content and intensity of HS are very loosely constructed, the manager invokes the logic of normalization as a tool for decision making.

The dichotomy of flexibility and structure also relates to relationships among organizational representatives. The structure of the purchase-provider model means that care managers assess needs and give assignments to others who then execute HS. From this follows a need to control that HS is used efficiently at the frontline and according to the assignment. The following excerpts exemplify this need for control:

> It is of course a challenge that it is not the housing supporters who should decide, but it is we who make the decision after investigating what the client's needs are. But if you have a good collaboration, you can give and take a lot there anyway. (Care managers focus group)

> Yes, it's a balance to go in and control everything, 'cause we don't see the clients as much as the housing support workers do. And they might see other things than what I do when I meet the client for an hour, an hour and a half, to make a decision. So, I think that what you are saying is very important, to have a good communication between housing supporters. In part so that it doesn't get out of hand, that they come up with many other assignments, 'cause it might not be in the assignment of housing support, but it might be some other function that should actually do these things. So it's a matter of both giving support, I think, to housing support workers, 'cause they might also find support things that I didn't catch in my needs assessment. But also to sneakily control a little so that it doesn't fly off… to have a good communication and be able to say that "this is your assignment.'' This is something else. (Care managers focus group)

The excerpt above illustrates that the care managers must maintain a balance between being flexible (since their knowledge about user's characteristics and situation are somewhat limited) and their task associated with their organizational position. The fact that good collaboration and communication with other workers means that one can 'give and take a lot' when it comes to reaching decisions about the content and intensity of HS is important from the point of view of care managers, since they don't see the clients as much as HSWs do. Flexibility is thus called for. However, good communications are also necessary for HS not to 'get out of hand' because HSWs can 'come up with many other assignments.'

6. Discussion

In this article we have analyzed the contradicting conditions embedded in the setting of HS, handled in everyday life by people in the frontline of practice (Hasenfeld, 2010; Lipsky, 2010). The above excerpts are examples of the ways in which HSWs deal with the specific challenges within their practice, which we describe here as diverse dichotomies. The dichotomies make available a deeper insight into the everyday life of HS and the sensemaking (Thornton et al., 2012) imbedded in HS. This study has focused in particular on HS for people with SMI, who have gone from being 'patients,' to increasingly being regarded as (active) citizens (Lindqvist et al., 2012; Lindqvist & Sépulchre, 2016). Living independently, people with SMI are faced with the task of managing their social life, interacting with others, and establishing their home life in the community context.

Using institutional logics as the framework for understanding the premises of the work in HS and the special conditions from which HSWs work allowed for an analysis illustrating a diversity of dichotomies (or contradictions in practice). These perceived dichotomies reflect and imply practical dilemmas, which are not only visible when it comes to how the work is defined, but also in the way that clients are perceived within that specific context of practice. For example, in the dichotomy flexibility and structure, 'good communication' (from the care managers) means being able to see that the structures of HS drawn up in the needs-assessment are adhered to (by the HSWs), although sometimes managers 'sneakily control a little' to ensure adherence. Interestingly, in all situations mentioned in interviews, it is too *much* HS rather than too little HS that managers feel they need to control, indicating that a logic of efficiency is being employed by all parties.

The dichotomies also signify various types of agency and their active roles in redefining different institutional logics, which have the effect of pulling HS in diverse directions. These dichotomies bring political and organizational aspects, such as the contextual settings for HS, into the fore of the discussion. On the one hand, HS is supposed to lead to the grand objective of individualization, however this objective is not grounded nor situationally placed within an organization. There is still a desire to fit needs into predetermined structures, however loosely constructed.

The case described here, of HS for people with SMI, shows that there can be a discrepancy between the spectra of grand visions and what is described as what happens in practice. The dichotomies identified here are between value-laden concepts, heavily burdened through organizational histories of right and wrongs. These values are not easily overlooked, and they create the setting in which today's HS practice is situated. The conflicting logics and expectations regarding HS and the work performed by HSW may push the practice in different directions, especially given the policy vacuum surrounding HS in Sweden.

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Conflict of Interests

The authors declare no conflict of interests.

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Article

Durable Homelessness: From Negotiations to Emulation

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Abstract

In recent decades, Sweden has seen extensive change in its housing policy, with emphasis shifting from "good housing for all" to marketisation and the supposed benefits of private ownership (Bengtsson, 2013; Grander, 2018). Consequently, Swedish society is now facing increasing homelessness rates, including whole new groups of social service clients due to housing shortages and people's difficulties accessing the housing market. This article examines the complexities emerging from diverging institutional frames and points specifically to a dividing line between those who can access housing independently and those who need support from the social services. The article describes how such a categorical division/dividing line is institutionalised in the organisation of the social services' work with homelessness and points to causes and effects of this situation. The case study is based on interviews and documents. The interviewees are staff from the municipal social services and the municipal public housing company. Our theoretical point of departure is Tilly's (1999) "categorical inequality," using exploitation, opportunity hoarding, emulation, and adaptation to explain how homelessness is (created and) maintained in our case study. The results show the dependency of social services on external actors and demonstrate the problematic consequences both for those referred to social services and for the practical work within them, including a requirement to stringently control clients. The results further show how it is possible for the social services to maintain collaboration with (public) housing companies at the same time as the most vulnerable clients are permanently denied housing.

Keywords

homelessness; social housing; social services

Issue

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1. Introduction

An excerpt from our data reads:

> In the mid-90s, when I worked at the social services unit, one of my clients lived with her family in a mould-infested house. She asked me "what shall I do?" and my first thought was: "What has happened?"… When I started [as a social worker] in the 80s, I would have called the landlord and scolded him. This was sort of the culture in the 80s. And then I thought, if this had been the 70s, they would have closed the bloody office and taken to the streets demonstrating, complaining about these oppressive landlords….And in the 90s one asks oneself: "What shall I do?" And now, it has gone even further… today they do not even get apartments….An enormous shift… to the advantage of the landlords. (Leo, social worker)

The design of the welfare structures is of pivotal importance for combating homelessness and ensuring people's right to housing. The number of homeless people and the nature of their situations is a telling story about the actual workings of a country's welfare regime. Whose needs do the social work practices reflect, and whose are being neglected?

Several researchers have described how social work historically has grown from "empty spots" stringently surrounded and defined by external pressures and societal interests that (today) may be considered peripheral to social work (cf. Beronius, 1994; Fox-Piven & Cloward, 1972; Polanyi, 1944; Villadsen, 2004). Social work has always, albeit in different designs, been a practice partly or wholly defined by societal pressure. In fact, Villadsen (2004) highlights social work practice as an analytical entry gate into understanding the "social contract," i.e., the rights and obligations of groups and individuals, in society. In this sense, social work practice is a clear signal of the forces that dictate society. It is within social work practice that the dividing lines between citizen and human, between productive and non-productive, and between rights and obligations, etc., are drawn (Villadsen, 2004). Social work with homelessness can be considered most central from this point of view because the lines drawn determine whether an individual will have a place to live in or not.

Here, we will analyse social work with those experiencing homelessness as described to us by social workers and others working in social welfare today, by highlighting practice in the light of broader societal structures and demands. We will focus on how social work practice constitutes durable homelessness in accordance with institutional demands (cf. Tilly, 1999).

2. Background

The municipalities in Sweden formally self-govern social welfare. During the 1980s, Sweden's universal social welfare was dictated by market logics (Sunesson et al., 1998), which had an important impact on social work with individual clients. Problems that had been regarded as structural were suddenly met with individual interventions and increased marketisation of housing policy (Sahlin, 2017; Swärd, 2020). Political pressure to deregulate the housing stock and sell parts of public housing to for-profit property owners transformed the housing stock from being a municipal political tool used to ensure everyone's right to housing into a housing market. However, ensuring housing for its inhabitants was still a municipal responsibility. Acute interventions, such as shelters, were re-introduced as part of the social workers' palette of possibilities for "helping" the homeless client (Knutagård, 2007). Researchers claimed that social housing policy had failed and pointed to increasing inequalities, e.g., differences in health and income, as contributing factors. Increasing polarisation, housing shortages, and segregation characterise this era (Clark, 2013).

As of today, there is a shortage of affordable housing for a large segment of Swedish society. Some groups in Sweden are (more or less) permanently excluded from the housing market for reasons that are not strictly financial, while other groups are at risk of exclusion due to high property prices and rents that are unaffordable for many (Listerborn, 2018; Swärd, 2020). There are 0.38% newly built apartments per capita in Sweden, which implies that population growth has far surpassed the production of new housing (Knutagård, 2018). In Sweden, compared to the other Nordic countries, a unique system has evolved for the provision of housing for people experiencing homelessness (Benjaminsen et al., 2020). Known as the secondary housing market, this system can be seen as social housing by stealth (it being invisible or hidden). It consists of apartments spread out within the ordinary housing market. The social services let the apartments from housing companies (predominantly public, but also private) and then sublet the apartments to their clients. This type of contract is called a social contract. The lease often runs for one month at a time with a notice period of one week. Sweden's most recent (2017) national homelessness count showed that there were 34,000 people experiencing homelessness—half of them within the secondary housing market. The national homelessness definition is divided into four situations: (1) acute homelessness, (2) institutional care and category housing, (3) long-term housing solutions (e.g., the secondary housing market), and (4) short-term insecure housing solutions (National Board of Health and Welfare, 2017).

The consequence of this system is that, even though the household lives in an ordinary apartment, they can quickly end up going back into a more acute homeless situation. Less than 10% of the tenants can take over their (first-hand) contract within a year (Knutagård, 2019; Knutagård et al., 2020). Research has shown that this system generates other types of housing alternatives underneath the secondary housing market (Knutagård, 2009; Löfstrand, 2005; Sahlin, 1996). Together, these different types of housing alternatives constitute the so-called staircase model where the client is expected to climb, step-by-step, in order to become "housing ready" and to progress to the end goal of an independent apartment with a first-hand contract (Sahlin, 2005). However, there are alternatives. The introduction of Housing First (HF) as an alternative way of working to end homelessness should, in the Swedish context, be seen as a niche solution when compared to the wider secondary housing market and the staircase model. Only 21 out of 290 municipalities in Sweden have implemented HF services, and in most municipalities, the HF services are small in relation to the other housing alternatives that the municipalities use (e.g., shelters, transitional housing, training flats, etc.; see Pleace et al., 2019).

3. Methods

3.1. The Case of Lysboda

Lysboda is a medium-size municipality with around 60,000 inhabitants hosting industrial companies and service companies alike. As with all Swedish municipalities, Lysboda witnessed the introduction of public housing companies and state-regulated rents in the 1940s and the deregulation of the housing stock in the 1990s (Sahlin, 1996).

Around 10 social workers work at the adult unit of the Social Services in Lysboda, mainly involving work with aid assessments of support, treatment, and housing for individuals with substance abuse. Like many places in Sweden, the issue of housing is constantly relevant, and it is difficult to find housing for those in need. A few years ago, a group was appointed that solely works with housing issues. The housing group reports to the unit manager. The housing group consists of four more employees: a housing coordinator who has a more prominent role in the negotiations with the housing companies and the overall responsibility for housing, a housing secretary who has a shared position between the municipal social services, the municipal housing company, and two administrative staff who have responsibility for a few contracts signed through the social services.

Today we find great variations between the local housing markets in Swedish municipalities. In some, all public housing has been sold, and in others, the public housing companies have a very large share of the rental market (Grander, 2018). In Lysboda about 1/3 of the tenancies are owned and managed by the city’s housing company, still the largest property owner in the city.

3.2. Material and Assessment of Analysis

The material for this article was collected as part of a case study on the de-implementation of efforts to combat homelessness and deal with mental illness based on recommendations in national guidelines. The municipal selection was based on the willingness and ability of municipalities to take part in the study, given that they had implemented or were about to implement HF or Individual Placement and Support (IPS). The municipality in this case was about to implement HF and, as we were involved, we tried to find a baseline of the current state of affairs regarding their social work with homelessness. This study is based on data from one municipality that is particularly and clearly attached to the previously established methods, characterised by qualification rituals on the part of the client, including stringent control of them. Social services in Sweden offer support to adults who, for various reasons, do not receive a housing contract themselves but how generous the social services are may vary by municipality, as does their formal organisation. Our case illustrates one way of organising social work with homelessness and shows the dependence on, and influence of, landlords in the formal and informal organisation of the social services. The reasons for being excluded from the housing market (by the landlords) can include financial difficulties, debts, mental illness, or lifestyles that make these individuals particularly unattractive to the housing market. The social services carry out investigations through social workers and can provide aid with initiatives that facilitate housing. The most prominent individual support in this town is 140 sublease (social) contracts for apartments, a shelter, and housing support through one team of social workers. Recently, this town decided to close the shelter and to implement HF, an initiative that promotes individual housing as the means (rather than the endpoint) of solving homelessness, provides flexible support, and promotes various aspects of well-being (Pleace et al., 2019). However, difficulties in finding vacant flats have hampered implementation.

Initially in the project, all known and available documents (guidelines, reports, decisions), as well as articles from newspapers that could be linked to efforts to combat homelessness, were collected and systematised. For this article, the first and second authors conducted 13 interviews with 21 respondents in 2020. We also took part in municipal-specific documents as pamphlets of the different contracts mentioned and municipal (written) routines regarding them, directives of the public housing company, and more general strategies set by the social welfare board. Although we do not refer to this material here, they are included in our analysis of the case. The interviewees were managers at different levels as well as politicians and employees of a housing company. We also interviewed professionals who meet clients at different levels in the studied organisations. The interviewees expressed themselves based on their professional or political roles in their work dealing with homelessness.

Seven respondents were interviewed individually (three of whom were interviewed on two occasions). Six group interviews were conducted with 2–4 participants. Some of the interviews took place in person, while others were conducted via videoconferencing due to Covid-19 restrictions. The interviews were recorded and transcribed and the material then analysed and categorised. In our interviews, we carefully followed administrative processes at the social work office and asked (historical) questions about how certain roles, groups etc. came into existence, e.g., what had certain roles been a response to and in what context. Pairing our categories—e.g., “a landlord’s perspective within the social services”—and looking at the historical formal developments that were described to us, as well as the informal consequences of them, we decided to use Tilly’s (1999) theorising on mechanisms that create and sustain durable inequality as our analytical tools. This case increases our understanding of the causal mechanisms that create unequal positions. From our material, we followed administrative processes at the social work office and sequentially organised instances of critical importance to understand the causes and effects of institutional demands in social work with homelessness in this municipality. Our analysis reflects all the interviews, mostly to a large extent. Cited under Section 5, Findings are trained social workers responsible for the service user’s aid decision (Eva, Karin, and Lisa). These social workers are not part of the specialized housing group but are responsible for most aid decisions regarding adults, including housing. Within the social services, the housing group is led by a trained social worker, the unit manager Leo, but the housing group staff (including the group manager) have other backgrounds. Cited from the housing group were the group manager, Adi, who was previously a caseworker, and Annika, who holds a shared position between the specialized housing group and the public housing company. Annika has a professional background as a leisure leader but has worked with housing issues for many years.

Official functions are stated in the text, all names are fictitious, but each quotation represents a statement from a single person. The municipality name is fictitious. The study has received ethical approval in accordance with Swedish legislation.

4. Theory

This article draws on Tilly's (1999) work on durable inequality and uses the mechanisms put forward by Tilly to understand how homelessness is (created and) maintained in a Swedish municipality. His work on durable inequality identifies how unequal categorical pairs (e.g., citizen/non-citizen, legitimate/illegitimate) become organisationally incorporated and institutionalised, which results in organisational conditions that maintain inequality. Tilly points to four mechanisms that are active in such an organisational incorporation and institutionalisation: exploitation, opportunity hoarding, emulation, and adaptation. Tilly (1999) claims that "people who control access to value-producing resources solve pressing organisational problems by means of categorical distinctions" (p. 8). Such people serve as gatekeepers and thus delimit social systems by exclusion. Of course, there are points of transit, but the borders are (at the very least) highly controlled. These categorical pairs are often incorporated and institutionalised in organisations dealing with social welfare and are more easily incorporated if these categorical inequalities already exist, and have spread throughout society (Tilly, 1999). The exclusionary power becomes even stronger when pre-existing external categories are connected and reinforced to internally constructed categories. For instance, when gender or nationality relates to internal categories that make a distinction between "worthy" and "unworthy" clients (cf. Knutagård, 2009; Sahlin, 2020).

Exploitation and opportunity hoarding are considered two mechanisms in which paired but unequal categories are incorporated at focal organisational borders. Exploitation appears when people with access to important resources organise to increase their profit at the expense of others who may be part of profit-creation but do not partake of the profit. Opportunity hoarding appears when people gain access to a valuable resource that is possible to monopolise and that substantiates the modus operandi of the organisation (Tilly, 1999).

The two mechanisms, emulation, and adaptation, make the organisationally incorporated categorical distinctions more efficient and generalise the influence of these distinctions. Emulation occurs when established organisational patterns are copied or when social patterns are copied from one context to another. Adaptation concerns, e.g., the development of daily routines based on institutionalised categorical pairs, upholding categorically unequal structures (Tilly, 1999).

Whilst exploitation may only be used by powerful people, opportunity hoarding, and emulation may be used by less powerful people if their actions are accepted by those in power. People who create durable inequality often aim at securing profit by either exploitation, emulation, or both (Tilly, 1999).

In our interviews, the respondents give reasons for why they work or do something in a certain way (Tilly, 2006). This is what Scott and Lyman (1968) call "accounts." When people give reasons, they generally use different types depending on the situation. Tilly (2008) distinguishes between for different types of reason: conventions, codes, technical accounts, and stories. People also use different reasons depending on the relationship to the receiver. Reason-giving confirms, negotiates, establishes, and transforms relations between the person who gives a reason and the receiver (Tilly, 2008).

5. Findings

5.1. Exploitation

The aftermath of Lysboda shows how the landlords in Lysboda have exploited the emerging housing market by denying more people and new groups of people the right to housing, thereby referring these people to the social services. Having the social services ask for apartments for tenants instead of having to deal directly with them has meant that the housing companies have managed to pass this risk onto the social services. A secondary housing market has been established in Lysboda where the social services are the holders of the master lease (the first-hand contract, and thus are the holders of responsibility) a situation in which the housing companies avoid normal accountability by transferring these risks to the social services. Although around 40% of the clients living in the second-hand apartments are considered self-sufficient by the municipality and in no need of support other than housing, the transfer of risk from the landlords to the social services creates conditions that make these people social service clients. In addition, for other more traditional social service clients to access housing, special contracts are formulated involving stringent control of the tenants. This is the exploitation by the housing company: The closure of access to housing for new groups of people to gain stability by transferring risk and decreasing costs that were previously considered normal risks for (any) housing company. In addition, this also concerns increased control over (some) clients who are subject to special contracts that are far more insecure and involve Social Services monitoring the client (cf. Wirehag, 2021).

5.2. Opportunity Hoarding and Emulation

A few years ago, a group within the social services was appointed that works solely with housing issues. The housing group reports to the unit manager and is led by a group leader who previously worked as the principal social worker. In addition to these management functions, the housing group consists of four more employees: a housing coordinator (who has a prominent role in the negotiations with the housing companies and the overall responsibility for housing), a housing social worker (who has a shared position between the social services department in the municipality and the municipal housing company), and two administrative staff (with responsibility for a few contracts signed through the social services). The housing group emerged almost organically, but once in place it is clear how the hoarding of apartments by the housing group and the closing of borders (information/negotiation) between (other) social workers and housing companies placed the housing group in a particularly influential position within the social service organisation. Although most in the housing group are not trained social workers, the group dictates what social work with homelessness in this municipality is. The trained social workers get orders for decisions from the housing group and must formally write the decisions.

Social work with homelessness, in this as in many Swedish municipalities, has emulated a social order building on an external unequal categorical pair that appeared relatively recently, as people with no or minor social problems became excluded from the regular housing market. Having no apartments of their own, the social services are highly dependent on the goodwill of the housing companies (cf. Wirehag, 2021). The social services in our case negotiated with the housing companies on their terms, having to rent apartments from landlords to sublet to this newly excluded group, thus incorporating this external categorical inequality into the routines of the social services. In addition, negotiating on the terms of housing companies in this municipality meant that an internal unequal categorical pair was activated in which individual service users were referred to as being worthy or unworthy during the Social Services' communication with landlords.

5.3. The Making of a Client

The social services identify and interact with individuals in need through applications, registrations, or the on-call route (application on-site), such assignments are then distributed to caseworkers by a group leader. When a social worker is given an assignment that involves a person who needs a home, the social worker decides roughly to "investigate the possibility of a social contract." In concrete terms, the social worker adds the individual's personal identity number to the housing group, which contacts various landlords with a request for an apartment. Here, the landlords can be offered various guarantees, such as that the social services will inspect the apartment weekly and/or that the apartment is rented with a sublease contract. In cases where the social services inspect apartments weekly, the right of occupation has been signed over to the social services after the person has signed a master lease (first-hand contract) with the municipal housing company. Such an agreement implies that the resident must accept that the social services have keys to the resident's apartment. The resident must also accept weekly inspections of the apartment executed by caseworkers (who report that many of the residents are not home when they inspect the apartments). In consideration of families with children, the caseworkers try to agree inspection times with the residents. In this way, the individual moves from being a person in need of housing to becoming a service user and client who must accept that the authorities interfere with their self-determination.

In Lysboda, this path to a master lease is lined by steps that subject the client to a strong screening with the need to pass multiple qualifications. Such steps include accepting and undergoing treatment, accepting that they sign away their right of possession, which means being able to accept and handle visits from social services who can enter the apartment with a key. Such steps extend far beyond what other tenants must accept. The service user must show that they are "housing ready" to, later on, maybe, receive a contract of their own. Here, we find sharp similarities to the staircase model described by, e.g., Sahlin (1996), Löfstrand (2005), and Knutagård (2009), and the recommendation, in the Swedish national guidelines, is that they should be eliminated (National Board of Health and Welfare, 2018).

If a landlord accepts a negotiated offer, the social worker decides on the signing of the contract. This is how one social worker describes the process:

> An order for a decision comes in [from the housing group]….Some questions have been asked about this person….Then they investigate [if] everything is ready [and] ask what decision I will make… and a bit in the form of what kind of thing it is, should it be a sublease or not, there can be a discussion of whether it should be a sublease or inspections and then they [the housing group] come and decide something. (Lisa)

The formulation of the agreement is thus not based on the service user's needs (other than a need for a home) or any other assessment made by social workers, but rather is dictated by the housing group, which justifies its influence on the decision by referring to the requirements of the housing companies. The housing group, as the housing companies' extended arm, has decisive influence over whether the agreement signed shall be a master lease or sublease, and whether the right of possession shall be negotiated, and whether the social services shall accept the responsibility for inspecting the apartment weekly. This process may also involve how the social workers formulate the care plans, as the social worker Eva explains: "Sometimes, the care plans come back because sometimes they [the housing group/housing companies] didn't think they were good."

5.4. Helping is Negotiating

The housing coordinator, Adi, with a central position in the housing group at the social services department, along with his colleague Annika, explains the hardship of negotiating apartments:

> Adi: We have a few names that, like, "no."
>
> Interviewer: They are a bit judged in advance?
>
> Annika: There may be someone working in a housing company who has a relative who knew someone and knows what he did in 1982….No, he will not have an apartment.

Adi previously worked as a case manager at the social services department and explains that his role has changed: As a caseworker, he mainly "chased homes." When he was new in his position a few years ago, he and a few colleagues had a serious talk with the housing companies:

> We realised that if we were to get any apartments, we had to think about how we conduct our work….[We have to] be honest [and] not deceive [the landlords], because it is so easy to say that I have got one here who is well-behaved when it is actually the opposite….We have a few [who cannot get a contract], they live with different friends, perhaps committed some petty crime, have been imprisoned for a while or gone for treatment for a while, like in and out all the time. (Adi)

Adi also explains his own role in focusing on the client when dealing with landlords. Labelling a client, or creating internal categories like "well-behaved," or "the opposite," is at best moralising over someone's past actions, while at worst, it is reproducing a personal stigma—sometimes perhaps both. Using such distinctions is a typical example of emulation, using the categorically unequal pair of the housing companies, incorporating these distinctions into the work of the social services with homelessness. While one would imagine that the negotiations between actors from the social work department and landlords would focus on the form and extension of support that the social work department can offer, the negotiation seems rather to focus on the personal characteristics of the client. Are they well-behaved or not? It is probably not in the interest of some clients that their names be mentioned, because the mere act of naming can apparently exclude them from the housing market permanently.

The landlords and the housing group act upon harmonising and emulating logics, and the housing group has become a means by which the housing companies may reject certain individuals and delegate risk (that would otherwise be a standard part of being a housing company) to the social services.

As we shall see, the reasons the social workers give about social work with homelessness and their decisions are not only supportive and preventive in relation to landlords, but also controlling towards clients who meet the demands of landlords. While some clients are provided with a contract on conditions that seem to mainly serve the housing companies, others are completely excluded, and the social services, having exhausted their resources on clients provisionally accepted by the housing companies, have no tools for integrating the most marginalised into the housing market. Adi's statements also show that it is the sharing of very specific information, such as names and internal categories that makes such exclusion possible.

The housing group describes itself a little jokingly as the "landlord group" that "matches apartments as much as possible." They explain that they receive assignments from the social workers:

> Adi: We have a queue of people who need help, and if we get in on a one-room apartment, it is not, like, the first in line, here's yours, but rather we look at who is this apartment most suitable for.
>
> Interviewer: What do you look at then?
>
> Annika: We look at the area, what we know about the client and how they would best succeed or fail, that's sort of how we think….If we have a substance abuser for example who is heading out, we don't want to put him in a house where we already know that a known substance abuser lives or in an apartment next door…..Likewise, we have contact with landlords who then say no substance abuse in their buildings. We do not want anyone with a history of substance abuse so.

Annika holds a position divided between the social services' housing group and the municipal housing company. At the municipal housing company, she is part of a team that handles social housing issues. Here she works together with an investigator and a housing coordinator. Her duties are primarily to monitor disturbances in the municipal housing company's apartment holdings. She describes the work as eviction prevention because she is the one who reports the disturbances to case officers at the housing company. Annika herself decides on the taking of various actions: Should a warning letter be sent? Has a problem gone so far that it is time for an eviction? Annika reports to investigators at the housing company who then carry out her decisions. Her position is a bridge between the housing company and the social services department. Her office is at the social services department, but she has access to the municipal housing company's registers (including the history of the residents) and can, for example, quickly see if anyone is behind on their rent. Annika explains the benefits of having access to the public housing company's register of their tenants and previous tenants: "I can easily look up NN, has he paid his rent? And I also have the payment history of NN."

The fact that she has dual roles is problematic because she is the one responsible for preventing evictions at the same time as being the one who decides upon consequences, in terms of warning letters and/or evictions. Annika's position exemplifies the paradox of the social worker: They are expected to be helping and supportive, but at the same time, controlling—and in this case, even penalising (cf. Järvinen & Mik-Meyer, 2003). The question arises whether Annika is a gatekeeper, deciding who is to be provided for and who is not, who is to stay in their home and who is to be evicted. From this situation, as is a general tendency in our data, professional social workers are not the ones defining what social work (with homelessness) "is," nor are they the ones protecting vulnerable clients at risk of becoming homeless.

This case indicates that the organisation of social work has evolved over time having been influenced by a broad range of demands through which social workers have had to navigate. Although our material shows that some of the professional social workers still try to make sense of their daily activities and the results thereof, others are more critical. Sahlin (2004) emphasises that the Swedish state has not intervened enough to end homelessness and presses the fact that persistent homelessness is the result of poor governance. Situating our case in its proper (political) context sheds light on the position of professional social workers, and how their social work practices with the homeless are dependent on the surrounding society.

5.5. Monitoring the Client

When we talked about the various contract types, some social workers reacted to the abuses connected to the situations where the tenant must give up their legal right of possession to get an apartment:

> It is a damned abuse actually. To be able to go into somebody's home with a key. Imagine, you can put yourself into it.... But of course, it is also a chance and an opportunity....But it is a check that you do and only a check. (Karin)

At the same time, there is a more pragmatic attitude that accepts the prevailing (power) structures that demand the service user's submission to housing companies and the Social Services' rules:

> It is nonetheless a check. It is still a check and so like… and actually an opportunity to check in on them, that their situation is OK, that we can see it. Because it is often people who have… had substance abuse and then we get a chance to see that, oh, now things are beginning to go wrong. (Eva)

Among social workers, some are strongly critical of the municipality's various housing options whilst there are others who instead describe them positively, thereby legitimising them as elements of social work. They give accounts of their actions that can be justified or excused with the help of organisationally anchored reasons (Knutagård, 2009; Scott & Lyman, 1968; Tilly, 1999, 2006). One way of justifying the use of such housing options is to refer to prevailing power structures: "It is actually the control that gives them [the service users] the contract; without the control, they would have never been able to live there, not a chance" (Eva).

The social services department does not own any housing of its own. The influx of apartments for the social services' clients is dependent on the goodwill of the housing companies. In this way, we can see how Tilly's (1999) causal mechanisms—exploitation, opportunity hoarding, emulation, and adaptation—come into play. The housing companies control the resources, the social services try to get access to housing, but the relationship between the actors activates emulation. The social services emulate the procedures of the housing companies and adapt to their ways of working to secure their niche so that housing can be obtained. The housing companies are the ones who benefit most from the relationship. This relationship is nothing new or unique to Lysbod. Sahlin (1996) drew attention to the same problem 25 years ago. But it does elucidate how the secondary housing market has become institutionalised. The social workers say that the housing companies exploit their position of power:

> The landlords use it to the max….Yeah, they see a chance. So, it is wow. Now you are about to be evicted, but if you get a sublease through the social services department then you can keep living there. So, they do see a chance in this. (Karin)

And despite the prevailing power structures, the social workers are critical of the housing companies' attitudes:

> It is more of a… social problem….You can have SEK 15,000 [EUR 1,479] in debt and no new ones since then, you are not eligible to live with us….What the hell is that….[It] may, after all, be a 20-year-old

> debt….[There are] unreasonable requirements today to be able to have a human right like a home. (Karin)

6. Conclusion

This article's point of departure was the recent changes in housing policies with the marketisation of housing causing increased homelessness. New groups of people are becoming service users due to their difficulties accessing a flat on their own. This article aimed to explore how the organisation of the municipal social work has turned into a means of creating and maintaining homelessness, as regards people in long-term housing solutions (e.g., the secondary housing market), situation 3 in the national homelessness definition, but also people in acute homelessness (situation 1), institutional care and category housing (situation 2), and those in short-term insecure housing solutions (situation 4) who may be excluded from housing on the basis of being unworthy. If offered an apartment, service users in any of these situations, but more often in situations 1, 2, and 4 may be subjugated to control and monitoring by social services (cf. Wirehag, 2021). The article was based on a case study in a Swedish city. Empirical data consisted of interviews with staff and documents from the social services and the public housing company. The analytical tool used here was Tilly's "categorical inequality," using exploitation, opportunity hoarding, emulation, and adaptation. The results showed the dependency of the social services on external actors, and the problematic consequences both for tenants and for the work at the social services, where the requirement that they control their clients has become normalised.

In this final discussion we want to highlight three main conclusions: (1) A power relationship between the social services and landlords has affected the organisation of the social services; (2) the exclusion of new groups from the housing market is reinforced by the social services signing contracts with landlords to sublet to this group; and (3) the effect of this is that the relationship between the landlords and the social services is maintained even though groups who traditionally turned to the social services for housing support may have it permanently denied, and that which is offered often comes with far more insecurity and monitoring than is experienced by ordinary tenants.

The relationship between the housing companies and the social services is a relationship of power (on the part of the housing companies) and dependence (on the part of the Social Services). Our case demonstrates how housing companies in this municipality exploit this power to transfer the risk that is normally associated with housing companies onto the social services.

New groups of people were excluded from the housing market and turned to the social services for help. The response to the increased pressure was to form a specialised housing group and to only allow this group to deal with the housing companies when acquiring apartments. This group felt they needed a new take on things and had to win back the trust from housing companies to negotiate for apartments. To do so, this group accepted that there were worthy and unworthy (potential) apartment-holders among their service users and had put an old internal (to social work) categorical inequality (worthy/unworthy) into work. In addition, an external categorical inequality, excluding new groups from housing on the regular housing market, was simultaneously incorporated into the organisational front lines of social work with the homeless.

By subletting to this new group which quite recently has been excluded from the general housing market, the social services emulate an external social order building on a categorical inequality in terms of access to housing. The winners are the landlords who are freed from any risk normally associated with letting apartments, as they have been transferred onto the social services. Subletting also carries costs that are borne by the service clients as they live under less safe housing conditions. Incorporating this external categorical inequality into the social services workings in this way is not only to the cost of people in this group but also the regular social service users as a traditional and internal (to social work) unequal categorical pairs (worthy/unworthy) are used to acquire apartments.

The working of external unequal categories, initially generated throughout the housing market and the exploitation of the landlords, emulated throughout the workings of the social services is maintaining inequality. However, alongside this, the incorporation and reinforcement of unequal categorical pairs along the organisational lines of the social services is also feeding inequality in terms of having access/no access to housing, generating *durable homelessness*, alluding to Tilly's *Durable Inequality.*

Our analysis illustrates how client positions are shaped and how those in need of social services' help are placed in a situation from which it is difficult to escape. Clients are categorised by the institutional demands of social work, but these institutional demands are structured by the broader context in which social work with homelessness in Sweden is situated. While social work with homelessness is a product of formal political processes and decision-making, its design is also greatly affected by informal processes and negotiations with local housing companies. In this case, the desire of housing companies to minimise their own risk by using the municipal social services has become entangled with the Social Services and has altered the institutional demands placed on the client.

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Conflict of Interests

The authors declare no conflict of interest.

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