Fund for European Aid to the Most Deprived

Background information on holistic approaches to material deprivation

6th FEAD Network Meeting on 'The Whole-Person Approach'

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Social Europe

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1. Introduction

FEAD provides support to the most deprived and disadvantaged people in the EU. Its recipients include a wide range of target groups for which deprivation is a multifaceted experience across multiple aspects of life. The degree to which FEAD directly addresses the various interrelated causes and consequences of deprivation varies (also depending on the choice of OP I or OP II). However as a minimum partners are expected to provide accompanying measures as tools to support the social inclusion of the end recipients. Based on the FEAD annual reports from Member States, several such measures have been adopted, such as social counselling, health and mental health counselling, legal counselling and budget advice. A key challenge for FEAD is to develop approaches enabling these measures to be tailored to the needs of individual recipients, in cooperation with other stakeholders.

The 6th Network Meeting will focus on examples of good practices in applying the whole-person approach to FEAD delivery. In the following sections, key information on the global and EU policy context, relevant research and ongoing practices within FEAD are provided as food for thought for the meeting.

2. Global and European policy context

At **global level** there is increasing awareness that eradicating poverty requires catering for multiple needs and aspects of human life. In the **UN**'s Sustainable Development Goals, it is stated that, "Poverty is more than the lack of income and resources to ensure a sustainable livelihood. Its manifestations include hunger and malnutrition, limited access to education and other basic services, social discrimination and exclusion as well as the lack of participation in decision-making."[1] A rights-based approach to poverty moves from the indivisibility of civil, cultural, economic, political and social rights for all people.

By addressing poverty together with social exclusion, the **EU** is traditionally attentive to non-material aspects of a person's wellbeing. Even the definition of material deprivation reflects a consideration of various aspects of the person's life and dignity. The Social Protection Committee has developed a Quality Framework for Social Services, according to which services should be person-centred (i.e. address in a timely and flexible manner the changing needs of each individual with the aim of improving their quality of life as well as of ensuring equal opportunities) and comprehensive (i.e. be conceived and delivered in an integrated manner which reflects the multiple needs, capacities and preferences of the users and, when appropriate, their families and carers, and which aims to improve their wellbeing).[2] With the Social Investment Package, the EU advocates "adapting integrated services, cash benefits and assistance to the critical moments in the life of a person, and preventing hardship from materialising later". One-stop shops are advocated to ensure an integrated approach to service provision.[3] The European Pillar of Social Rights calls for social protection and inclusion for everyone, including a minimum income ensuring "a life in dignity at all stages of life", and effective access to enabling goods and services.[4]

[1] United Nations (2015) Sustainable Development Goals, Goal 1: End poverty in all its forms everywhere http://www.un.org/sustainabledevelopment/poverty/
[2] The Social Protection Committee, A Voluntary European Quality Framework for Social Services SPC/2010/10/8 final http://www.edf-feph.org/sites/default/files/spc_qf_document_spc_2010_10_8_final1.pdf
[3] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020 COM (2013) 83 Final. http://eur-lex.europa.eu/procedure/EN/202419
[4] Commission Recommendation of 26.4.2017 on the European Pillar of Social Rights C(2017) 2600 final https://ec.europa.eu/commission/publications/commission-recommendation-establishing-european-pillar-social-rights_en

In addition, a number of initiatives have been taken by **EU stakeholders** in recent years to explore the benefits of a whole-person approach to the provision of services to the most deprived. For instance:

- The European Social Platform has disseminated case studies in order to demonstrate that "Promoting investment in services is not only about the amount of resources needed – it is also about the approach taken in their design and delivery. Services should be people-centred and tailored to meet each individual's needs. They should promote users' human rights and aim to empower people and make them more independent."[5]
- FEANTSA has promoted the dissemination of holistic approaches to homelessness, combining housing with health and mental health interventions also aimed at addressing drug use. According to the organisation, "a holistic (whole-person) approach should address all the causes and consequences of drug and alcohol use in the context of the person's environment."[6]

3. Summary of relevant research

Defining the whole-person approach

In literature on poverty, paying attention to the whole person has been at the core of the basic needs approach[7] in the 1970s and the 'capabilities' approach later on.[8],[9] According to Amartja Sen's theory, poverty is to be seen as deprivation of capabilities. Functionings are states of 'being and doing' such as being well-nourished or having shelter. Capabilities are the set of valuable functionings the person has access to. People do not just need resources, they also need to be able to use them in order to conduct the kind of life they consider valuable. Several factors affect the capability of the poor to make use of commodities: individual physical conditions, local environment characteristics, public service availability, community relationships, conventions and customs, distribution patterns within the family and so on.[10] The capability approach therefore proposes an integrated view of the human person as a starting point for measuring and combating poverty.

In the health and social care field, the whole-person approach has gained recent momentum. The innovation potential of this approach is especially evident in healthcare, where the need to go beyond disease-specific interventions and adopt a more comprehensive stance is crucial. However, this approach is also relevant to the social policy field, as it highlights the potential effects of social support on the health and wellbeing of vulnerable people. **Whole-person care** refers to "making the connections between physical health, mental health and social care needs".[11] It is understood as "The coordination of health, behavioural health, and social services in a patient-centred manner with the goals of improved health outcomes and more efficient and effective use of

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[5] Social Platform (2017) Investing in services for peoples wellbeing. A collection of case studies, http://www.socialplatform.org/wp-content/uploads/2017/03/investing_in_services_for_peoples_well_being_final_230317.pdf
[6] FEANTSA (2017) Good practice guidance for working with people who are homeless and use drugs http://www.feantsa.org/en/feantsa-position/2017/02/28/good-practice-guidance-for-working-with-people-who-are-homeless-and-use-drugs
[7] Maslow, A.H. (1942) A Theory of Human Motivation. *Psychological Review 50 (3)* pp. 370-396
[8] Sen, A. (1985) Commodities and Capabilities. North-Holland: Amsterdam.
[9] Nussbaum, M.C. (1997) Capabilities and Human Rights. *Fordham Law Review, Vol. 66 (2)*
[10] Sen, A. (1999) *Development as Freedom*. Oxford University Press: Oxford.
[11] Bickerstaffe, S. (2013) Towards whole-person care. Institute for Public Policy Research: http://www.ippr.org/files/images/media/files/publication/2013/11/whole-person-care_Dec2013_11518.pdf?noredirect=1

resources."[12] Furthermore, "Coordination between multiple providers and agencies serving a single individual is the key goal in a whole-person care model."[13] Whole-person care has been presented as a "new paradigm for the 21th century"[14] but similar concepts such as **integrated care** or a holistic approach have been used for a longer time.

Why should a whole-person approach be adopted?

The whole-person approach has been put into practice to address the **causes and consequences on health and wellbeing of specific forms of material deprivation, such as food insecurity or homelessness.**. While mental health issues are not present in all cases of poverty, some interesting associations can be found in the literature.

The **association between food insecurity and depression and other mental health issues** has been acknowledged[15], and a link between material deprivation and mental health issues has been found in a UK study[16]. Ill health and disability were found to be significantly associated with food bank use. A total of 44.2% of food bank users reported a longstanding illness or disability, compared with 28.4% of non-users. Mental health problems were also found to have a significant association with food bank use. Two-thirds (66.4%) of those who had used a food bank reported a mental health problem, compared with 31.6% of non-users.[17] It has been noted that food insecurity is particularly harmful to the mental wellbeing of children.[18]

An association of homelessness with mental health issues and drug use has also been established. Research has found that the proportion of homeless people who are problematic drug users is significantly higher than in the general population. Homelessness and drug use are often symptoms of other problems, for instance, mental health problems, or the result of an institutionalised background, such as in state care or prison.[19]

The **effectiveness of anti-poverty interventions in reducing mental health issues** has been subject of a recent systematic review. The effectiveness of psychosocial interventions at individual and family level, such as parenting support programmes, could be established. However, little evidence has been found on the impact of broader community-based interventions on mental health, e.g. community outreach workers or service-based interventions such as debt advice.[20] Financial stress commonly causes isolation, despair and depression. Evidence suggests that case management and support which incorporates financial counselling and financial literacy can assist in moderating the impact of financial stress and helping those at risk of homelessness.[21]

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[12] JSI. (2014) National Approaches to Whole-Person Care in the Safety Net: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=3
[13] JSI. (2014) National Approaches to Whole-Person Care in the Safety Net: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=3
[14] Hutchinson, T.A. (2011) Whole Person Care, A New Paradigm for the 21st Century. Springer: New York: http://www.springer.com/gp/book/9781441994394
[15] Compton, M.T. (2015), The Social Determinants of Mental Health, APA: https://www.appi.org/Social_Determinants_of_Mental_Health
[16] BBC News. (2015) Deprivation and mental health link 'strong and consistent': http://www.bbc.com/news/uk-scotland-32715463
[17] GoWell. (2016) Food bank use among residents of Glasgow's deprived neighbourhoods: http://www.gowellonline.com/assets/0000/3896/BP28_food_banks_web.pdf
[18] Child Food Insecurity and Mental Health
[19] FEANTSA. (2017) Good practice guidance for working with people who are homeless and use drugs: http://www.feantsa.org/en/feantsa-position/2017/02/28/good-practice-guidance-for-working-with-people-who-are-homeless-and-use-drugs
[20] Wahlbeck, K., Cresswell-Smith, J., Haaramo, P. et al. (2017) Interventions to mitigate the effects of poverty and inequality on mental health, *Social Psychiatry and Psychiatric Epidemiology*. Springer: doi:10.1007/s00127-017-1370-4
[21] Steen, A. and MacKenzie, D. (2013) Financial Stress, Financial Literacy, Counselling and the Risk of Homelessness, *Australasian Accounting Business and Finance Journal*, Vol. 7 (3) Special Issue on Financial Planning and Financial Instruments. doi:10.14453/aabfj.v7i3.3

The opposite effect, i.e. **the effects of mental health interventions on poverty and deprivation** has also been assessed, although mostly for low and middle-income countries. A review of studies on this topic found evidence that mental health interventions yield economic benefits, at both the individual and household level. *"*Of the 19 associations tested, 10 showed mental health treatment or rehabilitation interventions to have significant beneficial effects on economic status, and 9 showed a nonsignificant beneficial effect (or no tests of significance were reported). No studies indicated that mental health interventions have a negative economic effect."[22]

How can a whole-person approach be taken in practice?

In health care and social work, the possibility to put in place a whole-person approach has often been linked to "**case management**". Case management is defined as "a collaborative process which assesses, implements, coordinates, monitors and evaluates the options and services needed to meet an individual's health needs, using communication and available resources to promote a quality, cost-effective outcome".[23] Case management and care coordination, coupled with health care services, have been found to be effective in improving health outcomes in vulnerable populations such as low income mothers, children and older people. Studies suggest that these vulnerable populations experience health gains when their care is coordinated across primary, specialty, behavioural, and social services.[24] Several **methodologies and models of case management** have been elaborated in the context of community mental health and applied to deprived populations such as the homeless: Critical Time Interventions (CTI), Intensive Case Management (ICM) and Assertive Community Treatment (ACT)[25] are some examples. The Critical Time Intervention is a specialised intervention, provided at a "critical time" of transition (typically from institutional to community care), which connects people with formal and informal community support, is time-limited and concentrates on a limited number of focus areas.[26] ICM consists of management of the mental health problem and the rehabilitation and social support needs of the person concerned, over an indefinite period of time, by a team of people who have a fairly small group of clients (fewer than 20).[27] ACT is an approach whereby a multidisciplinary team provides proactive care to clients in the community, emphasising home visits and other outreach activities.[28]

Case management indeed works better when it is accompanied by **outreach activities**. The sequence can be: home visits by multidisciplinary teams of case-handlers; needs assessment with the help of a template (this could even become a smartphone app for outreach workers); and guiding clients to find their way through local support services (this sequence is applied for instance in the MISSION project).

[22] Lund, C. (2012) Poverty and mental health: a review of practice and policies: http://mandelainitiative.org.za/images/docs/2012/papers/159_Lund_Poverty%20and%20mental%20health%20-%20a%20review%20of%20practice%20and%20policies.pdf
[23] Holosko, M.J. (2017), Social Work Case Management: Case Studies From the Frontlines, Sage
[24] http://bluecrossmafoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf
[25] EU NL. (2016) Denmark – Implementing Housing First, in Integrated approaches to combating poverty and social exclusion: Best practices from EU Member States:http://www.effectiefarmoedebeleid.nl/files/3614/6668/9668/WEB_93954_EUNL_Brochure_A4.pdf
[26] CUCS Institute. Critical Time Intervention (CTI) Presentation: http://www.endhomelessness.org/page/-/files/Critical%20Time%20Intervention%20Presentation.pdf
[27] Cochrane. Intensive case management for people with severe mental illness: http://www.cochrane.org/CD007906/SCHIZ_intensive-case-management-people-severe-mental-illness
[28] Dixon, L. (2000). Assertive community treatment: Twenty-five years of gold. *Psychiatric Services*, vol. 51, pp. 759-765.

Cooperation between agencies and provision of integrated services is the necessary complement to case management from the institutional point of view. An OECD review has highlighted that service integration can be beneficial to both users and providers: it has the potential of addressing multiple underlying issues of vulnerable populations simultaneously; it improves access to services by most vulnerable groups such as the homeless; but it also reduces cost burdens as it prevents duplicated visits and interventions.[29]

[29] OECD (2015), Integrating social services for vulnerable groups and bridging sectors for better service delivery.

4. Examples of existing practices applying the whole-person approach

Within FEAD, many Member States implementing OPI have introduced elements of the whole-person approach in the provision of material assistance. While this is sometimes limited to information and referral, in a significant number of cases more structured approaches have been taken to cater for the needs of end recipients. Also, ways have been found to adopt a whole-person approach in a particular context, such as that provided by FEAD delivery.[30]

In some cases, families – rather than individuals – have been the object of the holistic, tailor-made approach. The **LEAP project (Malta)** for instance offers personalised support to families and uses its elaborate network to direct families to the relevant social service providers (e.g. housing authorities, social security services, labour market intermediaries, education pathways, childcare facilities, after school programmes, etc.). LEAP Project staff spend approximately an hour with the families by carrying out home visits which are then used to put together a family profile. A **SWOT analysis of the family** is conducted to help see which channels are to be followed to effectively help families out of poverty. A **social mentor** is assigned with every family so as to build a relationship with its members. The joint work carried out by the social mentor (supported by a multidisciplinary team) and the family members eventually lead to the identification of present and emerging needs. Following this process, an **agreed care plan** is created to address the needs of the family through a holistic approach.

Another example of integrated support to individuals, with an eye on the overall family situation, is provided by the work of Caritas Slovenia. Caritas volunteers **engage with FEAD end recipients when they pick up their food packages and offer a listening ear**. This is one of the more difficult parts of the process, as end recipients are generally hesitant to open up and share their stories. The conversations gradually increase in length as the volunteers are able to gain the trust of the end recipient. Ultimately, volunteers attempt to make an **individual assessment of the end recipient's needs**, so as to determine which services are most appropriate. The volunteers subsequently direct the FEAD end recipients to appropriate professionals within the Caritas network.

Understanding vulnerable people's comprehensive needs requires professional skills. However sometimes volunteers build a relationship with vulnerable people more easily, because they are not perceived as part of an institutional system. With this in mind, the **Italian Red Cross** has developed **training modules for volunteers** who want to become voluntary social workers. At the end of the course, the volunteers are able to lead a **dialogue** with beneficiaries in a more efficient and appropriate way when distributing food to their homes and assess whether there are other vulnerabilities to address and whether the beneficiary is ready for further social inclusion interventions. The general course for voluntary social workers lasts 26 hours and covers subjects such as: the welfare state and social work, beneficiaries and local needs assessment, working in a network, planning social action, listening actively and building a supportive relationship.

[30] Examples taken from: *Reducing deprivation, supporting inclusion: FEAD case studies*. Publications Office of the European Union: Luxembourg, 2016

5. Conclusions

Fighting poverty entails addressing the multiple needs of deprived people. This requires a holistic approach which takes into account material, psychological and social wellbeing simultaneously. The necessary implication is the provision of services in a coordinated and integrated manner.

This is a challenge for social services in general. For FEAD there are additional constraints provided by the scope and delivery mode of the Fund. The scope of FEAD OP I, in particular, places a large accent on the provision of material assistance. FEAD delivery is also largely based on voluntary work. Still, FEAD interventions should be part of a network of social support. It is therefore important that managing authorities, implementing partners and stakeholders work together to find the right mix of instruments to implement a whole-person approach where appropriate.

A number of **questions** merit discussion in this context:

- Each person is different from the other: how can gender, age, family circumstances and other specific aspects be taken into account when delivering FEAD assistance?
- Who decides what the person's needs are and how are they defined/with which instruments and tools? And how can it be ensured that the end recipient has an active role in defining his/her own needs and responses?
- How can the "other needs", besides material deprivation, be concretely addressed, and what are the opportunities and limitations of FEAD action in this respect? Should FEAD focus on providing information only and refer to other services, or go beyond that (e.g. provide counselling and advice)? How can the skills of volunteers be enhanced in order to better address the whole person, without aiming to transform them into professional social workers?
- And especially and above all, how can FEAD interventions be integrated into the broader network of social services (when and where they exist) and other relevant support networks?

The **6th FEAD Network Meeting** provides a valuable opportunity to start addressing some of these issues. By tapping into the knowledge and experience of the FEAD community on the subject, it will help make FEAD even more relevant to the needs and expectations of deprived people in Europe.

Contact us

Visit our website: **http://ec.europa.eu/feadnetwork**

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We look forward to hearing from you!

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