Independence for the dependent

A mixed-method research into the deinstitutionalisation of clients in supportive shelters and protective housing

’s-Hertogenbosch

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Abstract

Residential homeless -clients- in supportive shelters or protective housing often dealing with a multitude of problems, makes designing the best support possible a challenge to say the least. And with further decentralisation of responsibilities from the governmental to municipal level, it is this challenge municipalities now face. With growing evidence that so called ‘staircase services’ are not capable or efficient in reducing homelessness and its associated problems, policy makers aiming to address homelessness must find alternative solutions. In this study, I have researched the effectiveness of deinstitutionalising clients from supportive shelters and protective housing towards independent housing with floating support. Prior research on this topic was almost exclusively done by evaluating interventions or from the perspective of the support professionals. This study however, using a coordinated mixed-method design, combined a survey and interviews to answer the following question from the client’s perspective:

"To what extent does the support network surrounding clients in supportive shelters and protective housing explain effective and successful processes of deinstitutionalisation towards independent housing.”

Combining the findings from the survey with the eighteen in depth interviews with clients in the region Meierij and Bommelerwaard resulted in new insights in what their needs and wishes are in regard to deinstitutionalisation. Stable and independent housing when combined with diverse, flexible and optional floating support, which focusses on harm reduction, can contribute to an increase in quality of life, improve self-efficacy and reduce financial, mental health and substance abuse issues. Policies must be in place to encourage care service providers to cooperate with each other and to acquire enough homes to house the former residential homeless. By giving back control to clients now dependent on institutional professional support, we increase the chances clients adhere to recovery oriented services, improve their quality of life and possibly save some money too.

Introduction

Problem Statement

"You are surrounded by patients whom are mentally ill (…). There are drug users, drugs are being used, alcohol, other stuff. They all intersect with each other."

– Excerpt from an interview conducted with a client in a night shelter in Haarlem (Boesveldt, forthcoming, p. 21).

With the decentralisation of responsibilities and budgets in relation to reducing homelessness from the governmental to the municipal level due to the introduction of the new Social Support Act (SSA), municipalities have been tasked to reduce rough sleeping and homelessness (Blokhuis, 2017). Homelessness however, as illustrated by the quote above, is a complex question demanding a complex answer. Policy makers aiming to address homelessness, face the challenge of tailoring the support for a population which is hard to define and differs country to country, city to city. Deinstitutionalisation from supportive shelters and protective housing towards independent housing with floating support are thought of as possible solutions to reduce the amount of people facing homelessness and its associated problems. But the needs and wishes of homeless people regarding deinstitutionalisation remains a topic not thoroughly researched.

The Central Bureau of Statistics (CBS) estimates that in 2016 there were approximately 30.500 homeless people in the Netherlands (CBS, 2016). In this study focussing on deinstitutionalisation, I am particularly interested in three forms of housing for homeless people, namely night shelters (*nachtopvang* in Dutch, for incidental overnight stay), supportive shelters (*Maatschappelijke Opvang* in Dutch, for longer stay accommodation combined with support) and protective housing (*Beschermd Wonen* in Dutch, for housing (often) combined with intensive support to improve self-efficacy and participation of clients with psychosomatic and/or psychosocial issues) (Vereniging van Nederlandse Gemeenten, 2016). The aforementioned housing forms generally serve as a 'staircase' service where a client will take steps to move between accommodations, with each step allowing the client more independence until they are able to live independently on their own (Pleace, 2012).

Research by Van Everdingen (2016) showed that approximately 75 percent of clients in night shelters experience severe mental health issues (*ernstig psychiatrische aandoening* in Dutch) and require coordinated and multidisciplinary care. Other literature corroborates these

findings and shows the prevalence of mental disorders and multimorbidity (mental illness in combination drug abuse) across substance use disorders is higher among people experiencing homelessness than the general population (Donley & Wright, 2018; Gadermann, Hubley, Russel & Palepu, 2014; Lee, Tyler & Wright, 2010). Additionally, research done by Fazel, Geddes and Kushel (2014) shows that homeless people experience higher rates of long-term physical health conditions than the general population. Consequently, people experiencing homelessness are over-represented in, and often dependent on, hospital and psychiatric care compared with the general public. (Fazel et al., 2014).

The general findings on the complex nature of homelessness summarized above, are indicative of the challenges the Dutch municipalities face when developing policies aimed at the deinstitutionalisation of clients dependent on supportive shelters or in protective housing. In response to lack of research done on deinstitutionalisation of homeless people within the Netherlands, this study was conducted to research and map the wishes and needs in regard to deinstitutionalisation from the perspective of clients in supportive shelters and protective housing. Thereby laying the foundation to retailor the municipalities' homelessness deinstitutionalisation policies to be based on actual needs and wishes of homeless people, improving the municipalities' capabilities to reduce homelessness and its associated problems.

Empirical Overview and Theoretical Review

Defining homelessness

Studies on homelessness focus mostly on people chronically without domicile (Brown et al., 2018; Collins, Malone & Scartozzi, 2013; Donley & Wright, 2018; Quinn, Dickson-Gomez, Nowicki, Johnson & Bendixen, 2018). Chronical homelessness being defined as individuals with a disabling condition (substance abuse and severe mental health issues included) who have been homeless for one year or longer or had four episodes of homelessness in the last three years (Brown et al., 2018). Homelessness can further be differentiated in three kinds: factual homeless (persons who do not have access to any form of secure housing, have to rely on night shelters or unfit housing and who had to sleep a minimum of one day a month in the outdoors), residential homeless (persons who are registered at night/supportive shelters or protective housing) and potential homeless (persons who live autonomously, but whom are on the brink of homelessness) (Wolf et al., 2002). When writing about homeless people from this point onwards, I am referring to chronical/factual and residential homeless people. Additionally, residential homeless people will be referred to as clients unless stated otherwise.

Problems associated with homelessness

Homeless people, compared to the general population, have been found to be at substantially increased risk for physical and mental illness, substance abuse, multimorbidity and mortality (Donley & Wright, 2018; Gadermann et al., 2014; Lee et al., 2010). Furthermore, homeless people, as compared to the domiciled population, have higher rates of nearly all infectious and chronic health conditions, including HIV/AIDS, hepatitis, and hypertension, as well as higher rates of alcohol or drug abuse and mental health disorders (Fazel et al., 2014; Lee et al., 2010). A US study examining costs of psychiatric care, substance abuse treatment and incarceration found that twenty percent of the sampled homeless people had accounted for sixty percent of all costs (Poulin, Maguire, Metraux & Culhane, 2010). Eighty-one percent of those in the high-cost group had a serious mental health disorder, contrasting the eighty-three percent of the homeless people in the low-cost group who had substance abuse issues and no mental health disorders. These findings are illustrative of the differences in severity of problems homeless people might experience. Interviews with case managers of housing programs indicate that homeless people who suffer from multimorbidity, suffering from a combination of substance abuse and mental health issues, are experienced as the most difficult population to serve and care for (Quinn et al., 2018).

Interviews with new factual and residential homeless people in four metropolitan cities in the Netherlands revealed that financial problems were the most common reason for them to become homeless (Van Straaten et al., 2012). Furthermore, the research done by Van Straaten et al. (2012) and research done by Van der Laan et al. (2018) showed that financial problems had the biggest negative impact on subjective quality of life for adolescent and homeless people and that care needs concerning finances were the second biggest issue the interviewed homeless people experienced, following housing related issues which was their most unmet need.

Needs and wishes of pre- and post-deinstitutionalised clients

Research into the needs and wishes of clients in supportive shelters and protective housing in regard to the process of deinstitutionalisation has proven to be a topic hardly looked into so far.

Forty-two interviews with Belgian social workers, housing and welfare organisations, policy officers and policy makers uncovered four central lines in support trajectories that improved chances of successful transition towards independent housing (Verstraete, Pannecoucke, Meeus & De Decker, 2018). Firstly, clients require hands-on support with the administrative application for social housing. Secondly, clients require help to prepare

themselves for an independed living by teaching them skills like financing, administration and housekeeping. Thirdly, a focus on meaningful daily activities like looking for (volunteering) work or for hobbies proved to counter loneliness, declined the risk of relapsing into previous patterns and habits and improved self-identification. And lastly, deinsitutionalisation was found to only be succesful when the social environment was willing to include former care receivers and to support them to some extent if necesarry. This can either be within the social informal network of the individual or in the neighbourhood they come to live in. Furthermore, the interviewed organisations were convinced that it is beneficial to bring organisations from different fields together as their clients reguraly have complex and multiple problems that require profesional support from different angles (Verstraete et al., 2018). However, the fact that the research ommtited the opinion of the clients themselves is in my opinion a missed opportunity to learn about their perspectives on, and experiences with transitioning towards independent housing.

Interviews with eighteen clients in England revealed their needs for alternative daytime opportunities, somewhere to else to go to or something else to do, opportunities to build on their own personal resources and interests and the importance of a single centre for homeless people providing these integrated services (Massie, Machin, McCormack & Kurth, 2018). The research further highlighted the need of clients to be heard and be able to express their opinion to facilitate a cohesive approach in designing a well-tailored support network surrounding the clients.

Deinstitutionalisation of homeless clients is not a novel idea and thus some programs have existed for quite some time already, developing strategies to adhere to the needs and wishes of clients as stated above. Independent housing program's successes seem strongly linked with the kind of support they are offering. Those that allow consumer choice over whether and in which services to engage (Rog et al., 2014) and programmes that facilitate mental health treatment adherence (Robbins, Callahan, & Monahan, 2009) seem strongly preferred by clients. Furthermore, clients were found to be more likely to engage in recovery-oriented services when given the choice, instead of being forced, to participate (O'Connell, Rosenheck, Kasprow, & Frisman, 2006). Much like from the client perspectives, service providers and case managers overwhelmingly responded that client engagement and support was the key to housing stability (Quinn et al., 2018).

Housing First

There is a growing body of evidence, primarily from the US and Canada, that a programme like Housing First (HF) is an effective and cost-efficient manner to reduce homelessness, which can attain better successes than other approaches, particularly for people with mental and physical health issues (Groton, 2013; Palepu, Patterson, Moniruzzaman, Frankish & Somers, 2013). The fundamental idea of HF is that, from a harm reduction perspective, providing homeless people with a house (a stable foundation) would make it easier to stabilise and reduce mental health and substance abuse issues, financial problems and help make the housing as successful as possible (Groton, 2013; Pleace, 2012). HF services trust clients to pay the rent themselves and take care of the household whilst giving the clients considerable choice and control, allowing them to continue drinking or using drugs and opting in or out of psychiatric, drug and alcohol care services as they see fit, all the while remaining in housing provided by HF. Whereas traditional 'staircase services', requiring clients to go through a series of 'steps' (like abstinence from drugs and alcohol) before given access to housing, are under scrutiny following evidence that the 'staircase' approach fails to provide stable housing for homeless people (Pleace, 2012).

Not only is the HF programme efficient in reducing homelessness, in some countries it proved to be very cost efficient. The Canadian HF programme featured participants that had experienced a long period of sleeping rough over their lifetime, had one or more severe mental health issues and ninety percent had at least one chronic health condition. It found that after two years of participation, every $10 invested resulted in an average savings of $21,72 in health care, justice and welfare costs. Costs made to serve clients with the highest needs (those suffering from multimorbidity issues) when entering the program were reduced the most.

As reported by Massie and colleagues (2018), evidence from multiple countries suggests that HF can break the cycle and repeated nature of homelessness. The programme as adopted in the US highlights the programme's merit in its low barrier approach (Collins, Malone & Clifasefi, 2013) and in Australia it has led to increased housing stability and better access to healthcare (Holmes et al., 2017). An evaluation of a HF programme in the Netherlands showed that self-perceived quality of life went up considerably for 89 percent of the clients (Maas, Al Shamma, Altena, Jansen & Wolf, 2012). The programme improved housing and financial stability, opportunities for daytime activities, physical and mental health, and self-efficacy for the majority of clients, with a minority of clients still experiencing financial problems. In the words of Massie and colleagues (2018, p. 11):

"Clearly the HF model does not remove the complex causes of homelessness, but it does fundamentally shift the way in which homelessness is responded to by accommodation providers and support services."

Yet the availability of suitable housing can be scarce. Policies must be designed to incentivise an ongoing turnover of housing units, whereby current residents move up to other (further autonomous) independent housing programs and make room for new homeless people flowing in from night/supportive shelters or protective housing (Quinn et al., 2017). Likewise, in order for people to move up from protective housing and live independently, there need to be affordable housing options available (Quinn et al., 2017).

A gamut of research has been done into what it means to be homeless, the possible consequences of homelessness and how and under what conditions transitioning to independent housing possibly offers a solution to improve the wellbeing of homeless people and reduce homelessness altogether. Stable housing and finances, opportunities to improve self-efficacy and the way (floating) support surrounding homeless people is tailored are recurring themes when talking about success factors, needs and wishes in regard to deinstitutionalisation. Warranting further research into what conditions need to be met for efficient and successful deinstitutionalisation of homeless people.

Research question

This study, therefore, proposed the following research question:

"To what extent does the support network surrounding clients in supportive shelters and protective housing explain effective and successful processes of deinstitutionalisation towards independent housing."

Based on my literature review, the following hypotheses were tested with the subsequent sub-question:

1. Clients in supportive shelters and protective housing need stable housing and finances as a foundation to work on other problems they might experience (Groton, 2013; Massie et al., 2018; Palepu et al., 2013; Pleace, 2012).
   "What are the needs and wishes of clients in supportive shelters and protective housing in regard to independent housing?"
2. Clients in supportive shelters and protective housing must be trained and given the opportunity to learn to live autonomously and be facilitated in building on their own personal resources (Maas et al., 2012; Massie et al., 2018; Verstraete et al., 2018).
   "What are the needs and wishes of clients in supportive shelters and protective housing in regard to the process of deinstitutionalisation?"
3. Clients in supportive shelters and protective housing need tailored and optional (floating) support available to them, capable of addressing (severe) physical and mental illnesses, substance abuse issues or multimorbidity problems their clients might experience (O'Connell et al., 2006; Palepu et al., 2013; Quinn et al., 2018; Robbins et al., 2009; Rog et al., 2014).
   "How should the (floating) support network be designed according to the clients in supportive shelters and protective housing in the process of deinstitutionalisation?"

The hypotheses as stated above can be summarized respectively in three concepts possibly improving the chances of effective (well prepared) and successful (without relapsing into homelessness) deinstitutionalisation of homeless people towards independent housing: stability, self-efficacy and harm reduction.

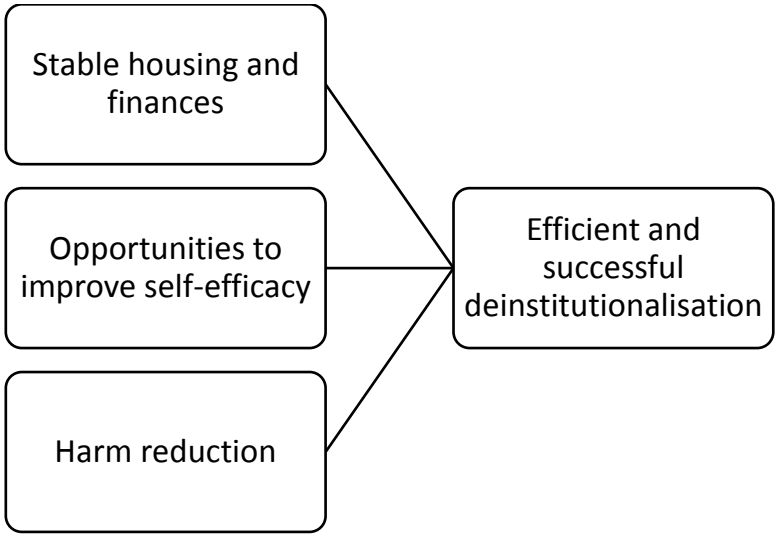

Figure 1: Model of conditions for efficient and successful deinstitutionalisation

Research Method

The centre municipality ’s-Hertogenbosch has asked me to map the needs, wishes and attitudes of the clients currently residing in supportive shelter and in protective housing in the region Meierij and Bommelerwaard in regard to deinstitutionalisation.

Design

I therefore made use of a qualitative research design, enabling me to make use of in-depth and more complex data allowing me to study not only what the needs, wishes and attitudes of the clients in regard to deinstitutionalisation are, but also how they are formed so that they may be explained (Neuman, 2013, p. 167-169). Furthermore, this research was based in the grounded theory methodology (Neuman, 2013, p. 70-71). The theory that I had developed allowed me to focus my hypotheses toward three main factors for efficient and successful deinstitutionalisation. Using secondary data in the form of semi-structured interviews with supportive shelter clients and clients living in protective housing, I was able to strengthen my theory inductively by creating strong data-theory linkages (Neuman, 2013, p. 177). The data from the interviews was gathered by student researchers and student assistants who paired up with an experienced expert in a research carried out by the University of Utrecht under supervision of Dr. Boesveldt.

This research, however, was in part also done through quantitative analysis. Using my contacts and the obligations the protective housing service providers have towards the municipality of ’s-Hertogenbosch, I was able to map key characteristics of all their clients (e.g.

gender, age, presence of mental illnesses and/or substance abuse issues and more) in the region Meierij and Bommelerwaard by way of survey. The survey contained binary and multiple choice questions with options to expand. The full survey can be found in Appendix 1. However, as the focus of this study is on the qualitative design, I will only present the descriptive statistics from the survey under the next header where the population used for this study will be discussed. These descriptive statistics will be referenced throughout the rest of this research report.

This mixed-method study design, combining qualitative and quantitative research, enhances the validity and credibility of my inferences and provides more insightful understanding of the results (Greene, Benjamin & Goodyear, 2001). I specifically used a coordinated mixed method design whereby both methods were mixed at the end of this study, using the interviews to help illustrate and enhance the findings from the survey.

Participants

The survey send out to protective housing service providers revealed there are 547 clients in protective housing in the region Meierij and Bommelerwaard. Of whom, 372 men, 174 women and 1 unknown with an average age of 42. When looking at the issues they are most often dealing with, I found that clients in protective housing struggle the least with judiciary problems (n=81), followed by cognitive impairment issues (n=122), substance abuse issues (n=195), financial issues (n=292) and mental health issues (n=240) and severe mental health issues (n=269). Mental health issues in particular are the most common problems, with a total of 509 clients struggling with them to a different extent. Comorbidity issues were also analysed and I found that 189 clients suffer from a combination of mental illnesses and substance abuse issues, 77 of whom having severe mental health issues.

Data from the region Meierij and Bommelerwaard in 2016 showed that from the approximately 300 clients in the region relying on night/supportive shelters, the majority were found to often have a multitude of problems ranging from financial debt, physical, mental and drug abuse issues, joblessness and/or lacking meaningful daytime activities (’s-Hertogenbosch, 2016).

Eighteen interviews were conducted with clients in supportive shelters and protective housing in the municipality of ’s-Hertogenbosch, Meierijstad and Sint-Michielsgestel. Respondents were recruited for the interviews using a mix of quota sampling, snowball sampling and convenience sampling (Neuman, 2013, p. 273). In practice this was done by way of flyers spread (see Appendix 2) around homeless care institutions, by contacting care

institutions where the clients reside and visiting those institutions themselves to spread information about the research. The interviews were conducted in Dutch, which made Dutch language skills a prerequisite to participate, clients had to be eighteen years or older to participate and gender was irrelevant.

Procedure

When reached, possible participants received a recruitment letter detailing the goal of the research and interviews (see Appendix 3). The letter further informed the possible participant how the research will be conducted anonymously and that the interview was to be recorded, but that the recording would only be accessible for the researchers. How participation is fully voluntary and that the interview could be stopped at any time the participant wishes, without having to state the reason why. And that the participant would receive a gift certificate (*VVV bon*) of ten euro for participations, even if the interview is stopped prematurely. The recruitment letter also addressed the informed consent which can be found in Appendix 4. The informed consent had to be signed by the participant before the interview would commence.

The informed consent checks if the participant has read the recruitment letter and was able to ask questions about the research; if the participant had enough time to decide if they wanted to participate in the research; if the participant knows he/she participates on a voluntary basis and can stop the interview at any time for any reason; that the interview will be recorded and anonymised; and that the participant agrees that the data gathered from the interviews will be used for the goals of the research as stated in the recruitment letter. The informed consent also gave the participant the opportunity to sign up to receive the results of the research and enrol for a repeat of the research the next year.

The interviews were conducted by duo's consisting of a student or assistant researcher and (for this research trained in interviewing) experienced experts. Notes were taken during the interview and the interviews were transcribed using pseudonyms to ensure anonymity. All gathered data related to research was exchanged either through psychical media or through encrypted services. Data was only stored on internal or server hard drives that could be reached by password protected computers only accessible to me.

Instruments

As the research done by Dr. Boesveldt was a continuation of last years' research, the same semi-structured questions were used to interview participants this year (see Appendix 5). The questions were divided in seven topics: introduction; deinstitutionalisation; regionalisation;

structure; visions on the future; cooperation; and contact information. I did not use the full range of questions however; instead I focussed on questions about the experiences, opinions, needs and wishes of clients in regard to deinstitutionalisation, independent housing and what clients require (in support and skills) to live independently. Examples of these questions (freely translated from Dutch to English) include:

- "What are your and other's opinions on deinstitutionalisation?"
- "How happy are you with the (floating) support you are receiving?"

The interviews were transcribed, coded and analysed using Atlas.ti (version 8.3.2). The full code-tree used for this study can be found in Appendix 6. The program allowed me to uniformly analyse the interviews, highlighting trends and differences between interviews. Sensitizing concepts were formed using the discussed literature and the answers of respondents. Sensitizing concepts include stability, self-efficacy and harm reduction. The responses were coded axially to differentiate global subjects (e.g. deinstitutionalisation and independent housing) and underlying subjects (e.g. experiences, opinions, needs, wishes), which were further used for my analysis. Additional analysis was done to connect key codes related to addiction and housing, addiction and support, housing and pace, housing and skills and housing and self-efficacy.

High internal validity was granted by working inductively from data towards theory, checking the theory by analysing additional interviews and documenting my process of research in detail (Kolb, 2012). External validity was kept to standards by reaching a sufficient number through multiple sampling methods with a distribution of clients in supportive shelters and protective housing participants (Neuman, 2013, p. 273).

Results

The eighteen participants who were interviewed for this study can be divided in three categories, as was done in the main research by Dr. Boesveldt: in favour of deinstitutionalisation, deinstitutionalisation under certain conditions and not in favour of deinstitutionalisation. The pseudonyms for the participants used in this study, the category they fall in regarding deinstitutionalisation and their current housing are shown in Table 1.

Table 1*: Participants in, or previously, in supportive shelter and protective housing divided in preferences toward deinstitutionalisation and current housing*

Pseudonym	Category	Current Housing
Niels	Deinstitutionalisation	Independent
Joep & Jordy	Deinstitutionalisation	Supportive shelter
Alex	Under certain conditions	Independent
Guus, Miranda & Mark	Under certain conditions	Supportive shelter
Ruben, Tom, Kim, Arend, Harold, Johan, Chris, Twan & Diederik	Under certain conditions	Protective housing
Ria & Henk	No deinstitutionalisation	Protective housing

The complex process of deinstitutionalisation is reflected in the method in which the following central research question will be answered:

"To what extent does the support network surrounding clients in supportive shelters and protective housing explain effective and successful processes of deinstitutionalisation towards independent housing."

Based on prior research, I hypothesised that this question had three themes to it, shortly summarised in housing, preparedness to transition and support. These three themes are subdivided in their respective hypotheses and sub-questions which, when answered, form the basis to answer the central research question of this report. Every theme consists of their respective hypothesis and sub-question, answered using the eighteen aforementioned interviews with clients in supportive shelters and protective housing.

The results are presented per theme by the one or two quotes that best convey the message related to the result. In the next chapter, the discussion, all results will be neatly tied together and linked back to the survey and prior research on these topics.

Opinions on independent housing

The first theme relates to housing, with the following hypothesis:

"Clients in supportive shelters and protective housing need stable housing and finances as a foundation to work on other problems they might experience"

Which will be researched using the following sub-question:

"What are the needs and wishes of clients in supportive shelters and protective housing in regard to independent housing?"

In my analysis of the interviews, I found that the need for independent housing was often referred to in reference to the current dwelling of the participants, namely in the sense of displeasure related to their living environment. The following quotes from Alex and Diederik are from them looking back on their time in a supportive shelter.

> *"I'm an independent person. If I would stay there for weeks, I think I would go crazy. (...) If you stay there for three weeks, you'll soon be confronted with your own frustrations. You're there with lots of people, lots of cultures. You can't escape, just like prison."* (Alex - independent)

> *I was there for a week and a half, but I hardly spend any time there, only to sleep, basically. I got there at nine, ten and I was gone in the morning at six. I couldn't do my own thing at all there. That was extremely difficult for me."* (Diederik - protective housing)

But it is more so the variety of persons surrounding the respondents, that are cause for displeasure. Mental illnesses are were found to be common amongst residential homeless (Gadermann et al., 2014), which, according to some participants, can be difficult to deal with.

> *"People who are psychiatrically not well, they don't belong here, I honestly mean that. (...) It's really sad, it really makes me sad, yeah. They need psychiatric care, but they won't find that here"* (Miranda - supportive shelter)

> *"Other people can't deal with them. They stink... they don't wash themselves, you know?"* (Mark - supportive shelter)

Substance abuse issues are likewise commonly found among residential homeless (Donley & Wright, 2018). Other people who deal with substance abuse issues may contribute to sustained addiction habits among their peers. Multiple participants of this study mentioned the difficulties of leaving the vicious circle of addiction whilst surrounded by other users.

> *"Yeah, that's why I'm drinking every day. There's thirty people there. There are dealers inside."* (Tom - protective housing)

"You're not addicted for no reason, right? Look, those others pull others back in, who are trying to get out. They come back in and then they pull others back in again. The weaker ones have it the toughest here." (Mark - supportive shelter)

A home of your own also allows you to retreat and have a bit of privacy, which is missed by some of the respondents.

"You sleep here with twelve others boys in the room. You never have any rest. Now and then, when I'm on the toilet, I'll stay there for five minutes longer, than I'm alone for a while. That's what I find most difficult here, that you're never alone."(Mark - supportive shelter)

However, an informal network might be equally important. Being able to invite friends and family over for instance, is also sought after by some.

"I've been very lonely. The day that my daughter approached me is the day my life started to change. (…) Then my youngest son came and months after that, things worked out with my oldest son. And then I was welcome to come to my ex. You can just see the upward trend." (Niels - independent)

A home base, so to speak, is more than a place where you are able to invite friends and family over. A stable home can also be a jumping off point to regain some self-efficacy for some participants.

"This is my last piece of freedom I still have, before this ships sinks, figuratively. This is my only anchor, that I have a place for my own to get away from my problems for a bit. (…) It is my way of escaping for a bit, so I can have a rest for a couple of hours, so to speak. Your living environment, your own home actually, it needs to be safe. (…) I always say, if you want to help someone, you need to be stable, so if you're not stable yourself, you can't help others." (Alex - independent)

"I fight really hard for it. And in three weeks, if everything works out, I'll hear if I get an apartment. So I fight real hard. They don't always see that. But I mean. I want to do things on my own. Come on." (Miranda - supportive shelter)

Indicated needs during the transition towards independent housing

That last quote serves as a welcome stepping stone to take a closer look at the second hypothesis:

"Clients in supportive shelters and protective housing must be trained and given the opportunity to learn to live autonomously and be facilitated in building on their own personal resources."

And its subsequent sub-question:

"What are the needs and wishes of clients in supportive shelters and protective housing in regard to the process of deinstitutionalisation?"

Much like as was found in the research done by Massie and colleagues (2018), the majority of interviewed respondents seem to agree that living independently would be a welcome addition to their lives, but how and the pace in which this transition should take place, differs from person to person. Some of the participants pleaded for a more hands-on approach to push clients towards the transition into independent housing, whilst others argued that every client must be treated according to their wishes and own pace to improve chances of successful deinstitutionalisation.

> *"Some people need that push. You really need to grab them by the hairs, that's different for everyone. I notice it here as well. Some people already go to work, even if they don't need to, they get up at six. Others you need to pull out of the sofa."* (Guus - supportive shelter)

> *"Yeah but if I can't do it… than it won't happen. You know, if I'm not doing well, or if I feel I'm not ready for it, my own home. It's not going to happen. (…) And you know, I want it. I can hardly stay here all my live and other people need this place too. But if I'm not ready, I'm not going to take that risk. I've burned myself before, I won't do that again."* (Tom - protective housing)

> *"Every person is different. Everyone needs different things, more attention, more support, those sort of things. So to generalize everyone, I don't agree with that at all. Everyone has their own problems and opinions.* (Guus - supportive shelter)

Especially the participants in protective housing are wary of transitioning to fast. Prolonged stay in institutions was mentioned by some of the participants as being detrimental to their abilities to live on their own. In agreeance with the findings from Verstraete and colleagues (2018), multiple participants in this study exclaimed their need to re-learn housekeeping skills.

> *"The only thing you need to do is take off your sheets, the rest is done for you. Cleaning, cooking, everything. You don't have to do anything. (…) Like when I need to make a call to my judicial financial manager, they call for you. This makes it more difficult for me to move out on my own."* (Arend - protective housing)

> *"So, you think that people who stay in here too long, that they become institutionalised?"*
> *"Yeah, I think so. They're in a negative spiral… they don't want to get out anymore."* (Harold - protective housing)

Other conditions mentioned by the participants include being heard in their wishes and be taken seriously by their support, safety nets like monitoring to prevent relapses, check-ins to keep an eye on the participants and clear arrangements how to floating support should be designed. From a professional perspective, case managers and service providers interviewed by Quinn and colleagues (2018) agreed that client engagement and support is of high importance to ensure housing stability.

> *"Do you think you are ready to live independently?"*
> *"I think so. I've build in some safety nets, you know. That case manager that keeps an eye on me. If I have that kind of supervision, I think I'll be fine."*
> *"And you took that initiative yourself?"*
> *"Yeah, I did that myself, I suggested it."* (Guus - supportive shelter)

> *"The support needs to keep coming. I think then, then there's a chance it will succeed. If it's like okay, and you're on your own now, no that won't work for me at all."* (Twan - protective housing)

Another condition broached in the interviews was the need for work, or meaningful daytime activities, which, according to Verstraete and colleagues (2018), were found to improve chances of successful transitioning towards independent housing.

"Yeah that's fun, man. You're alive again, a part of life. I've been addicted for so long, stuck in such a fake world. I was stuck in a loop. Wake up, get money, buy dope, smoke dope, get money… that's all it was."
"And they've told you that when you're living here independently, you can keep doing your daytime activity?"
"(…) Yeah, I'll keep going to the farm." (Tom - protective housing)

"I'm applying for everything I can find. If tomorrow someone were to offer me a job to clean gutters for forty hours a week, I'll be a gutter cleaner tomorrow. I don't really care anymore what kind of work I do." (Alex - independent)

But sometimes, some things are better left to the professionals. Multiple participants talked about having no desire to handle their own finances or administration, preferring professionals to take care of it for them. For some participants this decision is made for some peace of mind, whilst other participants think it is a necessity. While Verstraete and colleagues (2018) argue that clients being able to handle finances and administration themselves is key for them to live independently, multiple participants of this study would gladly have it taken care of for them.

"I've decided for myself that even if I'm debt-free, I'll still want the help with my finances. It just works well for me; I don't have to do anything myself for my finances and I don't have to worry. And I know now, that when I start to worry, when I have to many things going on in my head (…) I'll start making mistakes. (Diederik - protective housing)

"That's something I'll never learn. I'm sixty one, right. I don't have eternal life. I hope I have twenty good years left, but in the meantime I'll get older. You'll become less smart, that's just how it is. And especially with my usage… I think I smoked a quarter of my brains away." (Tom - protective housing)

Designing the (floating) support

Financial aid and stability is only one part of the puzzle, however. As shown before, the respondents often come in contact with people, or are people themselves, who need psychiatric help, or who are dealing with substance abuse issues. This leads into the third and final hypothesis:

"Clients in supportive shelters and protective housing need tailored and optional (floating) support available to them, capable of addressing (severe) physical and mental illnesses, substance abuse issues or multimorbidity problems their clients might experience.

And the last sub-question:

"How should the (floating) support network be designed according to the clients in supportive shelters and protective housing in the process of deinstitutionalisation?"

Here is where I will have to refer to results mentioned at the beginning, where I displayed the respondent's quotes about dealing with their mental illnesses and addiction themselves, or with those of others. In some cases, there is only so much floating support can do for a person suffering from severe mental health or substance abuse issues (Fazel et al., 2014; Lee et al., 2010). Participants in this study seem to agree not everyone will be able to transition to independent housing right away; some participants talked about needing drastic professional intervention first. For others who need it, a combination of floating support and clinical support may suffice.

> *"I've spend six months in a clinic in (...), on terms of the judicial authorities, because I committed a lot of crimes, robberies, those sort of things, all for drugs. The judge was done with me and gave me a choice. Either I get mandatory therapy for two years, maybe longer if it doesn't work well, under ISD, or go to the clinic I just mentioned. Twenty-eight years, I was done as well. So I chose the clinic and it went great. Six months… first time, completely clean."* (Guus - supportive shelter)

> *"If they really push it, crazy things will happen on the street. I hear voices and see people myself and I didn't understand where they were coming from. (...) I said to someone, I'm spiralling out of control. (...) If there're no places like (...), then I don't know where I would've ended up."* (Twan - protective housing)

Based on prior research by Robbins and colleagues (2009) and Rog and colleagues (2014), the other part of the hypothesis states the (floating) support should be optional to improve client engagement in recovery services (O'Connell et al., 2006). Something the majority of the participants in this study seem to agree with.

> *"Nine out of ten people don't want to be helped, they're stubborn. I can imagine that you've lived your life independently for thirty of forty years and you're fifty now and*

you get into that circuit where there are lots of rules and things you need to take responsibility for. That can be really frustrating." (Alex - independent)

"Yeah, try it yourself first. If that doesn't work, then they can help. That's what I appreciate. Not being helped first and then do it yourself, no. Do it yourself, you can always get help afterwards." (Tom - protective housing)

"That would be good. You know, sure, it'd be good if someone would come to visit me once a week. If only to see how things are, sure. But I want to be independent. I'm quick to… I want to do my own thing. On my own squared centimetre as I call it." (Miranda - supportive shelter)

And lastly, as was found by Massie and colleagues (2018) and Quinn and colleagues (2018), participants in this study reaffirmed the importance of a good match between client and the person supporting them.

"What went amazingly well is, the moment I got into the Wmo, I got (…), she's a biter and so is (…)."
"So a match with your support is very important."
"That's want I want to add, yeah." (Niels - independent)

"How are you experiencing the help from your case manager?"
"Really good. Such a stand-up guy. (…) He has a great sense of humour, that's important. And he talks like me. He knows when to be serious, when he can make a joke. When he can say something or shouldn't say something. We complete each other in that sense." (Guus - supportive shelter)

The three concepts: stable housing and finances; opportunities to improve self-efficacy; and harm reduction, which formed the basis of my three hypotheses related to efficient and successful deinstitutionalisation, were all confirmed by the participants in this study. The next chapter expands on these findings; tying all results together and linking them back to prior research and my findings from the survey.

Discussion

In this chapter, I will again make use of the three hypotheses/-sub-questions structure to discuss the main findings of this report. Further on, the strengths and limitations of this report will be discussed before finishing this report off with the implications of this research, my recommendations and a concluding statement highlighting the main insights.

Needs and wishes in regard to housing

"Clients in supportive shelters and protective housing need stable housing and finances as a foundation to work on other problems they might experience"

Oftentimes, the need for independent housing was referred to in reference of the current living conditions of the clients. Stating that due to the sheer amount of people surrounding them, often with troubles of their own or hailing from different cultures, basic needs like privacy and independency were lost. Although stable housing was never explicitly named by participants as a prerequisite for success in treatment, it can be argued based on the results, that clients struggling with substance abuse issues have a low chance of recovering whilst being surrounded (further illustrated in the results of survey, which show more than a third of clients in protective housing struggle with substance abuse issues) by others also dealing with their addictions. In that sense, as can be inferred from the interviews, instable housing has proven to be detrimental to clients dealing with substance abuse issues, possibly creating a vicious circle of users pulling each other back in. This sustainment of addiction habits is in stark contrast to the effects of harm reduction which makes HF so successful in combating substance issues (Groton, 2013; Pleace, 2012).

Moreover, a home of their own means freedom and independence for the participants of this study. The ability to have people over, a place to retreat to and implication that your own house allows you to do things your own way, were all named as positives aspects of living independently. The latter reason is especially interesting, as independency has been positively linked to a higher quality of life, physical and mental health improvements and an increase in self-efficacy (Maas et al., 2012).

As shown in the results of the survey and the interviews with clients, financial stability, or organised administration, is a struggle for over half the population. All of the participants who spoke on the subject preferred to distance themselves from their financial responsibilities,

stating they are unable to do it themselves, or preferred to have their finances taken care of by someone else for some peace of mind. Signing over these responsibilities could prevent the big negative impact financial problems have on a person's quality of life (Van Straaten et al., 2012) and can be linked back to the harm reduction perspective of HF as described before, which increases the likelihood of successful independent housing (Groton, 2013; Pleace, 2012). The transition towards independent housing might take some more work, however.

Needs and wishes in regard to deinstitutionalisation

"Clients in supportive shelters and protective housing must be trained and given the opportunity to learn to live autonomously and be facilitated in building on their own personal resources."

Evidence was found that clients need training in how to maintain their house, this is partly in line with results from a research done by Verstraete and colleagues (2018). Counter to that study, however, this study found clients were not at all inclined in learning how to do their administration or finances, often speaking fondly of giving away that responsibility. Financial and administrative stability might be one of the foundations to successful independent housing, but I have not found any evidence that the clients must be themselves responsible for a positive effect on the process of deinstitutionalisation.

Much more in agreeance with prior research, this study found considerable need for meaningful daytime activities or work. Clients were found to be highly motivated to work or be active. As prior research found, work or daytime activities can give meaning to someone's life, can counter loneliness, help prevent relapses in previous patterns and habits, improves self-identification and allows clients to learn to build on their own personal resources (Massie et al., 2018; Verstraete et al., 2018). The results from this study further gives weight to the notion that clients bode well when offered help in finding meaningful daytime activities or work, alongside their transition to independent housing.

Another striking finding would be that almost all respondents agreed that the process of deinstitutionalisation must be given form on an individual basis. Some could use a push, some must be given more time than others, but all want to be heard. These sentiments are in line with prior research done by Massie and colleagues (2018), who highlighted the needs of clients to be heard and be able to express their opinion to facilitate a cohesive approach in designing a well-tailored support network surrounding the clients. The results make clear that

the majority of the clients cite continued support as a condition before they are willing to take the plunge in independent waters.

Needs and wishes regarding (floating) support

"Clients in supportive shelters and protective housing need tailored and optional (floating) support available to them, capable of addressing (severe) physical and mental illnesses, substance abuse issues or multimorbidity problems their clients might experience."

As was shown in the results of the survey and the interviews, a substantial number of clients in protective housing are dealing with severe mental illnesses and substance abuse issues, sometimes a combination of both. These findings confirm prior researches stating that homeless people have been found to be at substantially increased risk for mental illness, substance abuse and multimorbidity issues (Donley & Wright, 2018; Gadermann et al., 2014; Lee et al., 2010). To nuance these findings, mental health issues are a prerequisite to be eligible for protective housing. The fact that for more than half of the clients in protective housing these mental health issues can be classified as severe and that a third of all protective housing clients in the region suffer from comorbidity issues is, however, quite striking. Exact numbers for these issues for clients in supportive shelters could not be found (warranting a survey under supportive shelter service providers), but data from the region Meierij and Bommelerwaard (2016) showed that the majority of the clients were found to often have a multitude of problems, including mental health and drug abuse issues. The results from the interviews in this study further illustrated these findings, where clients expressed their hardships in escaping the vicious cycle of addiction. Clients suffering from multimorbidity issues are often referred to as the toughest clients to care for, needing a broad constellation of support do deal with the multitude of problems they commonly seem to have (Donley & Wright, 2018; Verstraete et al., 2018). These findings warrant further research into the exact number of clients who deal with substance abuse issues in supportive shelters and the severity of substance issues among all clients in protective housing and supportive shelters.

The needs in terms of intensity of the support vary between the clients, however. The need for professional contact ranged from not at all, as some believe that when you live independently, you should no longer need support, to two moments in a day. Those clients in between these extremes were a bit more nuanced, preferring a short period of support after transitioning towards independent housing and possibly scaling it down from there. Flexibility

to adjust intensity of support deemed necessary and the ability to call on support when needed seemed to be the key here for most clients. Furthermore, seemingly all clients agreed that the relationship with the professional supporting them was an important success factor for their recovery and wellbeing. These results line up almost exactly with prior research that found clients strongly preferred consumer choice programs (Robbins et al., 2009; Rog et al., 2014), which in turn was found to increase the likelihood of clients engaging in recovery-oriented services (O'Connell et al., 2006). Similar to what Quinn and colleagues (2018) found, client engagement and support seems paramount to housing stability.

Strengths and limitations

The sheer number of persons in supportive shelters and protective housing, their geographical spread and the variations in support the clients are receiving due to differences in care providers and municipalities in the region, warrant more interviews than that were conducted now. The original plan was for forty-five interviews to be conducted within the region Meierij and Bommelerwaard. Only eighteen interviews in three out of eight municipalities were carried out however, slightly lowering the external validity of this study. Although qualitative research norms dictate that a sample of fifteen to twenty interviews should provide rich enough data to be able to generalize the results, for the sake of full coverage of the region, more interviews would benefit the external validity (Neuman, 2013, p. 282-283).

The lower than planned number of interviews also influences the internal validity in regard to data saturation. It cannot be fully assured the point of data saturation has been reached due to the fact the interviews did not fully cover the region. This also increases the likelihood of a selection bias in participating clients. The respondents who volunteered for these interviews knew what the interview was about and could be more motivated than other clients to speak about deinstitutionalisation as they feel they have a chance to transition themselves. This might have led towards skewed results where I found that the majority of the respondents were in favour of deinstitutionalisation. However, the possibility of a selection bias is counteracted by the results of the survey, which found the respondents to match very well with characteristics found in the population and results from the main research by Dr. Boesveldt (forthcoming), which found similar outcomes regarding deinstitutionalisation in other regions.

To be better able to generalize the results of this study and increase the odds of data saturation and decrease the likelihood of selection bias, more interviews can be held with clients stemming from the remaining municipalities. Furthermore, future researchers could use

the population sizes of these municipalities in order to determine a weighted distribution of the number of interviews to be held in each municipality.

The strengths of this study lie in its ecological validity. All clients were interviewed in their current living environment or an environment of their choosing, be it in supportive shelter or protective housing, by a trained interviewer and experienced expert. The interviews were made to feel as natural as possible by conducting them in the current dwelling of the clients and by having someone accompany the interviewer who was previously in that exact same situation themselves. Thereby lowering the exerted control over the study, allowing the clients to speak as naturally as possible, which in turn allows me to be better able to generalize the findings of this study. Furthermore, all participants were anonymised and informed that participation would net no personal benefits regarding policy outcomes. No claims can therefore be made that the responses of the clients felt artificial or disingenuous as all clients often gave heartfelt responses, sometimes in stark opposition of current policies or how support was given, without shying away from using crude words from time to time.

The way the interviews were conducted, together with the full coverage of the survey among clients in protective housing, greatly alleviate threats to the external validity of this study, even some of the threats to its internal validity as well. Even though a lesser than ideal of interviews were conducted, the genuine nature of the responses add great weight to the results, which found the majority of clients positive towards the process of deinstitutionalisation, with or without meeting certain conditions.

Conclusion

To finally answer the main research question of this study:

"To what extent does the support network surrounding clients in supportive shelters and protective housing explain effective and successful processes of deinstitutionalisation towards independent housing."

Tailored support to fit the individual needs of the clients is undeniably important. As found under the first hypothesis, stable independent housing and finances are a boon to clients struggling with substance abuse issues and has been positively linked with a higher quality of life, physical and mental health improvements and an increase in self-efficacy.

As can be concluded from the results of the second hypothesis, clients were often found saying they need continued support when transitioning to independent housing and that this

support must be tailored to their individual needs. Supported in going back to work or finding meaningful daytime activities was found to be a prime example of one of those needs as a majority of clients agreed that living independently means more than being able to take care of your own home, but also means doing something worthwhile. Being supported to find work or meaningful daytime activities could help clients counteract loneliness, help prevent relapses in previous patterns and habits, improves self-identification and allows clients to learn to build on their own personal resources.

And lastly, based on the results of the third hypothesis, the support needs to be able to deal with complex psychiatric and substance abuse issues. Not all clients were found to be in the highest risk group, but the substantial number of clients that dealt with these issues cannot be understated. The intensity of support varies greatly between clients, however, further strengthening the claim that the support network must be well tailored to the individual needs of the clients. Making the floating support optional and flexible for some clients and a good match with the professional supporting them was found to be very much sought after by the participants. By designing the support as pro-consumer choice, having clients have say over whether and in which services to engage, might very well be the key to motivate clients to adhere to recovery-oriented services.

Policies on cooperation between service providers, housing corporations and the municipalities must be in place to offer this vulnerable population in supportive shelters, protective housing the broad range of interventions they need. The more diverse the constellation of support, the better the chances are of recovery from the multitude of problems these clients might have. Psychiatric institutes, substance abuse clinics, social work and the municipalities all have a role to play in the recovery of these clients. For instance in the way support is up- and downscaled between the general social-district teams from the municipality and the FACT teams who can offer more specialised care if needed. Furthermore, policies must be in place to avoid the support being stonewalled by archaic administrative rules and laws. Covenants for instance, can be drawn up and signed to allow different organisations to exchange information about their clients, allowing them to coordinate care from a shared pool of information. Providing stable independent housing in the strained Dutch housing market might prove to be a challenge, however. Interventions and programs like Housing First require a substantial investment upfront to procure the houses needed to deinstitutionalise clients in supportive shelters and protective housing. But studies have shown investments in Housing First are easily earned back in terms of money saved in the long run by offering an alternative for expensive institutionalised care, by (eventually) eliminating the need for homeless shelters,

all the while improving chances of clients recovering from substance abuse issues, improving their mental health, increasing their self-efficacy and raising their overall quality of life.

As one of my colleagues often likes to jokingly say: “They’re just like people.” But this small quip is very indicative of how we sometimes regard homeless people, be it on the streets or in institutions. Everyone has a story, and everyone wants to be in charge of their own life. Maybe it is time we give back some control to clients. Make them more responsible for their recovery and allowing them to live independently, as they see fit, with the support they themselves deem necessary.

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Appendices

Appendix 1: Survey distributed to protective housing service providers

1. Geslacht
    a. Man
    b. Vrouw
    c. Overig
2. Beschermd Wonen vorm
    a. All Inclusive
    b. Thuis
    c. Begeleid
3. Zorgverleden
    a. BW All Inclusive
    b. BW Thuis
    c. BW Begeleid
    d. MO
    e. Overig -> typ antwoord in veld
4. LVB problematiek
    a. Aanwezig
    b. Niet aanwezig
5. Verslavingsproblematiek
    a. Aanwezig
    b. Niet aanwezig
6. Psychiatrische problematiek
    a. Aanwezig
    b. Niet aanwezig
    c. EPA aanwezig
7. Financiële problematiek
    a. Aanwezig
    b. Niet aanwezig
8. Justitiële problematiek
    a. Aanwezig
    b. Niet aanwezig
9. Kwaliteit sociaal netwerk
    1. Sociaal Isolement
    2. Beperkt
    3. Matig
    4. Voldoende
    5. Goed
10. Voert dagbesteding intern uit
    a. Ja
    b. Nee: voorliggend veld
    c. Nee: voert geen dagbesteding uit
    d. Niet van toepassing
11. Reëel afschaal perspectief
    a. Ja, naar BW Thuis
    b. Ja, naar BW Begeleid
    c. Nee
12. Reëel uitstroom perspectief
    a. Ja, binnen 3 maanden
    b. Ja, binnen 6 maanden
    c. Ja, binnen 1 jaar
    d. Ja, binnen 2 jaar
    e. Ja, binnen 3 jaar
    f. Ja, binnen 5 jaar
    g. Nee

Appendix 2: Recruitment flyer

Deel je verhaal en ontvang een tegoedbon van €10,- !

Universiteit Utrecht

Maak jij gebruik van de Maatschappelijke Opvang of Beschermd wonen? Of heb jij hier eerder gebruik van gemaakt en ontvang je ambulante zorg? Dan nodigen wij jou graag uit voor een gesprek!

De Universiteit Utrecht doet onderzoek naar ervaringen rondom wonen, aangeboden hulpverlening en het weer zelfstandig wonen na verblijf in een voorziening. Voor dit onderzoek zijn wij op zoek naar mensen die hun ervaringen willen delen over de uitvoering van gemeentelijk beleid. Uiteindelijk hopen wij zo beter zicht te krijgen op wat er goed gaat of nog beter kan. Om het cliëntenperspectief zo goed mogelijk te achterhalen zijn ervaringsdeskundigen samen met onderzoekers getraind om interviews af te nemen (maximaal 1 uur). Je verhaal wordt anoniem verwerkt.

Dus, wil jij je ervaringen wel delen, een bijdrage leveren aan dit onderzoek en de tegoedbon in ontvangst nemen? Neem dan contact met ons op door te mailen naar n.f.boesveldt@uu.nl

Of bel: 0638075054 Bij voorbaat dank!

Appendix 3: Recruitment letter

Namens: Nienke Boesveldt, hoofdonderzoeker, onderzoeker en ervaringsdeskundige co-onderzoeker

Beste deelnemer,

U bent gevraagd mee te werken aan vijfjarig onderzoek onder Nederlandse gemeenten door de Universiteit Utrecht. Het onderzoek gaat over ervaringen omtrent wonen in maatschappelijke opvang of beschermd wonen, aangeboden hulpverlening en de ervaringen van cliënten rondom het zelfstandig wonen na verblijf in een voorziening.
Voor dit onderzoek willen wij graag weten hoe we de ervaringen van cliënten kunnen verklaren door wat er in de gemeente waar zij wonen wel of niet wordt gedaan. Om deze ervaringen te kunnen achterhalen is uw deelname belangrijk. Bij ieder vraag zijn wij geïnteresseerd in uw persoonlijke situatie en uw ervaring met de uitvoering van het lokale beleid. Voor het onderzoek naar het beleid houden wij ook interviews met mensen die bij de gemeente werken, of in de hulpverlening.
Door het interview wordt informatie opgedaan over dit vraagstuk. Uw deelname aan dit onderzoek draagt dus bij aan het vergroten van de kennis, over hoe de ondersteuning verbeterd kan worden en hoe gemeenten dit kunnen vormgeven.
We houden het interview in een ruimte waar het prettig is voor elke betrokkene bij het interview, zoals de lokale herstelacademie.
Uw deelname is anoniem: niemand zal de onderzoeksresultaten naar jou kunnen herleiden als persoon. Al uw gegevens en informatie zijn vertrouwelijk. De interviews zullen worden opgenomen, de opname is alleen toegankelijk voor de onderzoeker, zodat deze de informatie kan verwerken.
Deelname is geheel vrijwillig en u ontvangt een cadeaubon van 10 euro. Als u besluit te willen stoppen dan kan dit altijd (dus ook tijdens het interview). Als u wilt stoppen, hoeft u hier geen reden voor op te geven, en u ontvangt wel uw cadeaubon.
Als u de resultaten van dit onderzoek wilt ontvangen kunt u dat aangeven op de toestemmingsverklaring, die aan u wordt gegeven en besproken voordat wij het interview starten. U heeft de keuze de resultaten via uw hulpverlener/ ondersteuner te ontvangen of via een persoonlijke e-mail. Ook kunt u toestemming geven volgend jaar weer te worden benaderd voor dit onderzoek. En ook voor het gebruiken van de onherkenbaar gemaakte gegevens van het onderzoek voor ander onderzoek, zodat we niet onnodig mensen hoeven te interviewen.
Als u vragen heeft kunt u contact met mij opnemen, of met uw hulpverlener/ ondersteuner.

Bedankt voor uw deelname!

Nienke Boesveldt

Contactgegevens
n.f.boesveldt@uu.nl
06 38 07 50 54

Appendix 4: Informed consent

Universiteit Utrecht

Toestemmingsverklaring deelnemers aan vijfjarig onderzoek naar zelfstandig wonen in de wijk

Bedankt dat u mee wilt doen aan het interview. Om mee te kunnen doen is er *eerst officiële toestemming nodig*. Hieronder staan stellingen, als u akkoord bent, kruis dan het vakje 'ik ga akkoord en wil meedoen met dit onderzoek' aan. Als u akkoord bent, beginnen we met het interview.

- Ik heb de informatiebrief gelezen en kon aanvullende vragen stellen en deze zijn beantwoord

- Ik had genoeg tijd om te beslissen of ik mee wilde doen aan dit onderzoek

- Ik weet dat meedoen op vrijwillige basis is en ik op elk moment kan stoppen met het interview

- Ik weet dat het interview wordt opgenomen, maar dat gegevens anoniem blijven

- Ik geef toestemming deze gegevens te gebruiken voor de doelen die in de informatiebrief staan

☐ Ik ga akkoord en wil meedoen met dit onderzoek

Datum:

Naam en handtekening respondent:

Naam en handtekening onderzoeker (s)

Eindresultaat ontvangen:
Kopie eindresultaat ontvangen:

☐ Ik wil het eindresultaat van dit onderzoek ontvangen per email: ……

☐ Ik wil het eindresultaat ontvangen via mijn contactpersoon

☐ Ik wil het onderzoek niet ontvangen

Deelname volgend jaar
Dit onderzoek duurt in totaal 5 jaar. Volgend jaar zouden wij u mogelijk graag nog eens interviewen. Vind u het goed wanneer wij volgend jaar weer contact met u opnemen? U bent dan niet verplicht mee te doen, als u dat niet wilt.

☐ Ik wil misschien nog wel een keer meedoen aan dit onderzoek

☐ Ik wil slechts één keer meedoen aan dit onderzoek

Universiteit Utrecht

Beschikbaarheid gegevens voor ander onderzoek

☐ Ik geef wel toestemming voor het anoniem gebruik van het interview voor ander onderzoek

☐ Ik geef geen toestemming voor het anoniem gebruik van het interview voor ander onderzoek

Interviewers moeten deze informatie opslaan onder het interview nummer en er een aantekening van maken dat de toestemming is gegeven.

Appendix 5: Interview questions

Nienke Boesveldt – Vragenlijst cliënten

NB: Zorg ervoor dat je voor het afnemen van een interview, het lokale beleidskader van de gemeente waar je gaat interviewen hebt doorgenomen. Dit maakt het noemen van voorbeelden van gemeentelijk beleid bij de topics 'ambulantisering' en 'regionalisering' makkelijker, mocht de cliënt vastlopen.

Onderwerpen die tijdens de interviews aan bod zullen komen

- Ervaringen/meningen over/met het zelfstandig wonen
- Aangeboden hulpverlening
- Ervaringen cliënten rondom ambulantisering
- Netwerk

Bij iedere vraag zijn wij geïnteresseerd in zowel jouw persoonlijke situatie als in wat jij weet of denkt te weten over de drie bovengenoemde/eerdergenoemde onderwerpen.

Introductie

1. Hou oud ben je?
2. Waar kom je vandaan?
3. Kan je iets vertellen over waar je nu woont/slaapt? Ontvang je hierbij begeleiding?
4. Zou je kort iets over jezelf kunnen vertellen? Wat is je achtergrond en hoe ben je hier terecht gekomen?
5. Wat voor (vrijwilligers) werk doe je of heb je gedaan?

Ambulantisering

In Nederland willen gemeenten steeds vaker dat mensen die beschermd wonen of in een voorziening voor maatschappelijke opvang, zelfstandig gaan wonen met begeleiding aan huis, en niet langer in deze voorzieningen. Deze ontwikkeling heet ambulantisering.

1. Ben je bekend met deze ontwikkeling? Zo ja, hoe ben je hiermee bekend geraakt?
2. Wat merk je van deze ontwikkeling in je eigen gemeente? Zou je een voorbeeld kunnen noemen waaraan jij hebt gemerkt dat jouw gemeente deze ontwikkeling (ambulantisering) ook heeft ingezet?
3. Wat vind je van deze ontwikkeling? Zowel met betrekking tot jouw eigen ervaring als met betrekking tot andere personen die je kent. M.a.w. Wat vind jij ervan en wat heb je gehoord dat anderen ervan vinden?
4. Lukt het volgens jou al/nog niet om mensen die eerder in een voorziening of opvang verbleven nu zelfstandig te laten wonen. Waarom lukt het volgens jou wel/niet?
5. Denk je dat (begeleid) zelfstandig wonen voor alle cliënten een goede ontwikkeling is?
6. *Wanneer de cliënt reeds zelfstandig woont*: Hoe heb je de uitstroom uit de instelling ervaren? Heb je hierbij hulp/ondersteuning gekregen? Heb je er de tijd voor gekregen die je nodig had?
7. Hoe tevreden ben je met de hoeveelheid (ambulante) hulp die je krijgt? Waarom wel/niet
8. Hoe tevreden ben je met de organisatie/begeleiding waarvan je de hulp ontvangt? Waarom wel/niet

Regionalisering

Nog niet zo heel lang geleden (voor 2015) hielden vooral grote gemeenten (*geef voorbeeld van de centrum gemeente van die regio*) zich bezig met woonvoorzieningen. De laatste tijd wordt dit steeds vaker een taak van kleinere gemeenten. Iedere gemeente wordt op deze manier verantwoordelijk gemaakt voor het voorzien in de zorg voor haar eigen inwoners. Deze ontwikkeling heet regionalisering.

1. Ben je bekend met deze ontwikkeling? Zo ja, hoe ben je hiermee bekend geraakt?
2. Welke gemeente vind je dat er verantwoordelijk zou moeten zijn voor jouw zorg? Waarom?
3. Merk je iets van deze ontwikkeling in jouw gemeente. Kan je een voorbeeld geven waaraan je dit gemerkt hebt?
4. Wat denk je dat de gevolgen van deze ontwikkeling voor cliënten zullen zijn?
5. Wat vind je van deze ontwikkeling? Zowel met betrekking tot jouw eigen ervaring als met betrekking tot andere personen die je kent. M.a.w. Wat vind jij ervan en wat heb je gehoord dat anderen ervan vinden?
6. Zijn kleinere gemeenten volgens jou ook in staat om de zorg en ondersteuning voor hun inwoners op zich te nemen? Waarom lukt dat volgens jou wel/niet?

Structuur

De voorzieningen die je krijgt aangeboden kunnen afkomstig zijn van verschillende gemeentelijke afdelingen (zoals voor een uitkering of hulp bij dagbesteding of participatie), maar ook bijvoorbeeld van een zorgverlener of maatschappelijk werk. Ook willen we graag weten van informele ondersteuning die je mogelijk krijgt van buren, kennis/vrienden, familie.

Waar het hier om gaat is welke voorzieningen bijvoorbeeld dichterbij staan of welke je weinig ziet. Die kun je dan verder weg of dichterbij zetten op de tekening. Je mag ook aangegeven waar je tevreden over bent en wat volgens jou beter kan om jou te kunnen helpen bij zelfstandig wonen. We willen dus graag zowel weten waar je veel als waar je minder mee te maken hebt en waar je voldoende en waar je te weinig ondersteuning hebt ervaren.

1. Samen met jou wil ik graag een tekening maken van deze verschillende voorzieningen (instanties, hulp, begeleiding), vanuit jouw perspectief.

TEKENING MAKEN → ONDERSTAANDE VRAGEN BESPREEK JE AAN DE HAND VAN DE TEKENING.

CHECK ALLE DOMEINEN → BESPREKEN WAT JE MIST, WELKE RELATIES VERBETERD KUNNEN WORDEN, KNELPUNTEN.

1. Huisvestingsbeleid → In hoeverre heb jij contact met de woningcorporatie/jouw verhuurder? Of heeft jouw ondersteuner dit? Wat vind je hiervan?
2. Hoe is het contact met de buren/andere bewoners van het gebouw? Hoe voel je je in de buurt/woonomgeving?
3. Maatschappelijk werk/wijkzorg → In hoeverre heb je contact met andere aanbieders dan BW/MO? Hoe is dit tot stand gekomen? Hoe ervaar je dit?
4. Werk en inkomen → Hoe voorzie je in je inkomen? Hoe gaat dit? Wat kan er beter? Heb je contact met de bijstands- of UWV-consulent?
5. Is er sprake van een tegenprestatie voor je uitkering?
6. Heb je schulden? Is hier hulp bij?

7. Participatie/Dagbesteding/Re-integratie → Is hier iets op aangeboden? Hoe ervaar je de dagbesteding/het werken? Wat levert het je op (meer inkomen, structuur, contact met mensen, etc.) Zou je hierin nog iets veranderd willen zien?
8. Verslavingszorg → Heb je een verslaving? Wie helpt jou hierbij?
9. GGZ → Is er sprake van psychische problematiek? Wie helpt jou hierbij?
10. Blauw → Heb je contact (gehad) met de wijkagent of andere politiemensen? Hoe vaak?
11. Informele netwerk → Krijg je steun van je buren in je herstel? En van familie of vrienden?
12. Wie heeft er zicht/coördinatie op dit netwerk? Is er iemand die dit in de gaten houdt? Doe je dat zelf/iemand in je omgeving/professional (een casemanager?)?

Toekomstvisie

1. Wat heb jij nodig om zelfstandig te wonen?
2. (Waar wil je zijn over 1 jaar?)

Samen werken

Onderstaande vragen alleen stellen indien van toepassing. Bijvoorbeeld wanneer cliënt lid is van de cliëntenraad.

1. Hoe werk je samen met andere cliënten van MO/BW (peerondersteuning)?
2. Hoe werk je samen met beleidsmakers?
3. Hoe werk je samen met politici?
4. Hoe werk je samen met het publiek (social media)?

Contactgegevens

Onderstaande vragen alleen stellen wanneer cl'ient wil deelnemen aan volgende meting(en)

1. Wat is je (mobiel) telefoonnummer?
2. Op welk e-mailadres ben je te bereiken?
3. Heb je een Facebook-profiel?
4. Wanneer we jou op 1-3 niet kunnen bereiken, kunnen we je via een contactpersoon (e.g., vrienden, familie) benaderen? Heb je hier een (mobiel) telefoonnummer van?

Appendix 6: Full code-tree (zoom in)

Code	Code Group 1	Code Group 2	Code Group 3	Code Group 4	Code Group 5	Code Group 6	Code Group 7
0.0 intro							
0.1 Werk. Professional background/ job description		1. Structures					
0.2 context MO, BW (target groups) in region NAB			1.2.3 Beleidsdoelen. Goals				
0.3 huidige beschikbaarheid & woningtekort NAB		1. Policy model					
1.1 Beleidsveronderstellingen. Policy model		1. Policy model			2. In a decentred situation the efficiency would be lower than in a centred situation		
1.1.3.1 Causale veronderstellingen. Empirical connections		1. Policy model			2. In a decentred situation the efficiency would be lower than in a centred situation		
1.1.3.2 Normatieve veronderstellingen. Normative connections		1. Policy model			2. In a decentred situation the efficiency would be lower than in a centred situation		
1.1.4 aannames betreffende (on)zelfstandig wonen NAB		1. Policy model					
1.1.5 Housing First: bekendheid met		1. Policy model					
1.2.2 Rol. Role in strategy	1. Management						
1.2.3 Beleidsdoelen herstelttraject op maat, cliëntgericht NAB							
1.2.3 Beleidsdoelen. Goals		1. Policy model	1.2.3 Beleidsdoelen. Goals			3. Heterogenic networks' efficacy higher in preventing homelessness	
1.2.3 beleidsdoelen: (realiseren) zelfstandig wonen NAB			1.2.3 Beleidsdoelen. Goals				
1.2.3 Beleidsdoelen: ambulantisering.. en extramuralisering NAB			1.2.3 Beleidsdoelen. Goals				
1.2.3 beleidsdoelen: beschikbaar stellen betaalbare passende woonvormen NAB			1.2.3 Beleidsdoelen. Goals				Beschikbaar stellen betaalbare passende woonvormen
1.2.3 beleidsdoelen: Draagvlak/kracht wijk NAB			1.2.3 Beleidsdoelen. Goals				Making it work
1.2.3 beleidsdoelen: in kaart brengen vraag en aanbod woningmarkt NAB			1.2.3 Beleidsdoelen. Goals				
1.2.3 Beleidsdoelen: integratie in de buurt; making it work NAB			1.2.3 Beleidsdoelen. Goals				Making it work
1.2.3 beleidsdoelen: preventie, vroegsignalering, voorkomen huisuitzettingen NAB			1.2.3 Beleidsdoelen. Goals				Preventie huisuitzettingen
1.2.3 Beleidsdoelen: Regionalisering			1.2.3 Beleidsdoelen. Goals				
1.2.3 beleidsdoelen: sociale cohesie NAB							
1.2.3 beleidsdoelen: VMO NAB							
1.2.3 Beleidsdoelen: WVGGZ			1.2.3 Beleidsdoelen. Goals				Making it work
1.2.3 internal policy goal			1.2.3 Beleidsdoelen. Goals				
1.2.3.1 beleidsdoelen: cijfermatige beschikbaarheid woningen/ uitstroom NAB							
1.2.4 Instruments		1. Policy model		1.2.4 instruments		3. Heterogenic networks' efficacy higher in preventing homelessness	
1.2.4.1 instruments: Nazorg detentie				1.2.4 instruments			
1.2.4.2 instruments: beschikbaarheid passende, betaalbare woonvormen NAB				1.2.4 instruments			Beschikbaar stellen betaalbare passende woonvormen
1.2.4.2.1 transformatie voorraad				1.2.4 instruments			Beschikbaar stellen betaalbare passende woonvormen
1.2.4.2.2 nieuwbouw				1.2.4 instruments			Beschikbaar stellen betaalbare passende woonvormen
1.2.4.2.3 doorstroom, herverdeling bestaande voorraad NAB				1.2.4 instruments			Beschikbaar stellen betaalbare passende woonvormen
1.2.4.2.4 Skeeve Huse (& domus plus) NAB				1.2.4 instruments			
1.2.4.2.5 Housing First NAB				1.2.4 instruments			
1.2.4.2.6 gespikkeld wonen NAB				1.2.4 instruments			
1.2.4.2.7 Alternatieve woonvormen NAB							
1.2.4.3 instruments: integratie in de buurt; making it work NAB				1.2.4 instruments			
1.2.4.3.1 communicatie met de buurt NAB							
1.2.4.3.2 keyring methode				1.2.4 instruments			
1.2.4.3.3 sociaal wijkteam				1.2.4 instruments			
1.2.4.4 instruments: inzet ervaringsdeskundige, clientenraden, methodieken				1.2.4 instruments			
1.2.4.5 instruments: realiseren zelfstandig wonen NAB (?)				1.2.4 instruments			
1.2.4.5.1 urgentieregeling NAB				1.2.4 instruments			
1.2.4.5.2 prestatie afspraken NAB							
1.2.4.5.3 driehoekscontract/ kanscontract NAB				1.2.4 instruments			
1.2.4.5.4 (prestatie)afspraken en (urgentie) regelingen woningen NAB				1.2.4 instruments			
1.2.4.5.5 taskforce/ team langer zelfstandig wonen				1.2.4 instruments			
1.2.4.5.6 beschut wonen				1.2.4 instruments			
1.2.4.5.7 omklap contracten				1.2.4 instruments			
1.2.4.5.8 instruments: zelfstandig wonen NAB							
1.2.4.5.8.1 Voorwaarden zelfstandig wonen NAB							
1.2.4.5.8.1.1 opstapregeling							
1.2.4.6 instruments: preventie, voorkomen huisuitzettingen NAB				1.2.4 instruments			
1.2.4.6.1 Vroeg erop af, vroegsignalering				1.2.4 instruments			
1.2.4.6.2 Noodteams							
1.2.4.7 instruments: in kaart brengen vraag en aanbod woningmarkt NAB							
1.2.5 Doel Bereikt. Goal attainment by instruments		1. Outcome				3. Heterogenic networks' efficacy higher in preventing homelessness	
1.2.5.1 Doel niet bereikt. No goal attainment by instrument		1. Outcome				3. Heterogenic networks' efficacy higher in preventing homelessness	
1.2.5.2 Mogelijk doelbereik. Possible goal attainment by instrument		1. Outcome				3. Heterogenic networks' efficacy higher in preventing homelessness	
1.2.5.3. Mogelijke belemeringen doelbereik							
1.2.5.4 huisvestingsverordening NAB							
1.2.6 Relatie Beleid. Doelen perspectieven belangen							
1.2.6 Relatie Beleid. Strategy related to wider policy area		1. Structures					
1.2.7 Rekenschap. Accountability = theory management	1. Management						
1.2.8 Beleid adresseert belangrijkste problemen. General goal attainment of strategy		1. Outcome					
1.3 ervaringen instrumenten NAB							
1.4.2.7 contingentenregeling							
2.1 Tekening Structuur. Draw multi levels		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.1.1 VZ. Funds and policy addiction		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation	3. Heterogenic networks' efficacy higher in preventing homelessness	
2.1.2 GGZ. Dwang, Suicide		1. Structures					
2.1.2 GGZ. Funds and policy mental health		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation	3. Heterogenic networks' efficacy higher in preventing homelessness	
2.1.3 € en verantw AMW		1. Structures					
2.1.3 € en verwantw Participatie		1. Structures					
2.1.3 Huivesting, corporaties. Funds and policy housing		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation	3. Heterogenic networks' efficacy higher in preventing homelessness	
2.1.3 Politie Blauwe dwang. funds and policy coercion							
2.1.3 SI							
2.1.3 Wlkl Funds and policy income support							
2.2 expertise		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.2.1 expertise political level		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.2.2 expertise administrative level		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.2.3 expertise practical level		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.2.4 expertise theoretical level NAB							
2.3 funds strat. financial risks and irregularities		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.4 postion municipality within levels		1. Structures			2. In a decentred situation the efficiency would be lower than in a centred situation		
2.4.1 impact on daily work respondent	1. Management						
2.4.1.1 structures							
2.4.2 composition of the network	1. Management					3. Heterogenic networks' efficacy higher in preventing homelessness	
2.4.2.1 heterogenic network							
2.4.2.1 homogenic network							
2.4.2.1 instruments local network							
2.4.2.1 management of the network	1. Management						
2.4.2.2 stakeholder involvement NAB							
2.4.3 allocation of responsibilities NAB							
2.5 regelgeving huisvesting NAB							
3.1 work together homeless people	1. Management						
3.10 work together taskforce (bijzondere doelgroepen)							
3.2 work together practitioners	1. Management						
3.3 work together policy makers	1. Management						
3.3.1 work together municipalities, housing corporations (and care-institutes) NAB							
3.3.2 work together on intermunicipal level NAB							
3.4 work together politicians	1. Management						
3.5 work together public	1. Management						
3.7 ervaringen samenwerking NAB							
3.8 leren van onderzoek en/of andere gemeenten NAB							
3.9 Work together: Sociale Wijk Teams							
4.0 output							
4.0 toelichting op data							
4.1 Continuiteit GGZ zorgaanbod							
4.1 GGZ zorgaanbod. mental health service coverage		1. Output					
4.10 integratie in de buurt; making it work							
4.10 output extramuralisatie NAB							
4.11 in kaart brengen vraag en aanbod NAB							
4.11 inzicht vraag en aanbod woningmarkt NAB							
4.12 conflicts in collaboration							
4.12 HF							
4.13 output regionalisering NAB							
4.2 Ambulante (GGZ) zorg							
4.2 Herstelondersteunende,- gerichte zorg							
4.2 inzet ervaringsdeskundigheid in zorg							
4.2 inzet mantelzorg, informele zorg							
4.2 overall service coverage		1. Output					
4.2 Tom in de buurt (Sdl)							
4.2 Wijkzorg							
4.3 Tijdelijke huisvesting. Improved housing		1. Output					
4.4 Stabiele huisvesting. Permanent housing		1. Outcome					
4.4.5 Skeeve Huse NAB							
4.5 Trainingen/curssen mbt verhogen zelfredzaamheid							
4.7 (voorkomen) huisuitzettingen NAB							
4.8 beschikbaarheid betaalbare, passende woonvormen NAB							
4.8.9 daadwerkelijke, cijfermatige beschikbaarheid woningen voor uitstroom							
4.9 monitoring							
4.9 verdeling woningvoorraad NAB							
5.1 Participation		1. Outcome					
5.1.1 Income		1. Outcome					
5.1.2 Wonen							
5.10 Effectiviteit instrumenten zelfstandig wonen NAB							
5.12 behoefte aan creatieve oplossingen NAB							
5.13 nog nodig om doelen te realiseren NAB							
5.2 Gezondheid		1. Output					
5.2.1 Cijfers buitenslapen		1. Output					
5.2.3 In aanraking met politie/ justitie		1. Output					
5.2.4 Gehuisvest		1. Output					
5.3 Ervaringen clienten met ambulante hulp							
5.3 ervaringen clienten met ambulante hulp (1)							
5.3 ervaringen clienten met ambulantisering							
5.3 ervaringen clienten met hulp gemeente							
5.3 ervaringen clienten met hulp in voorziening							
5.3 ervaringen clienten met transitie							
5.3.1 Ervaringen clienten met ambulantisering							
5.3.2 Ervaringen clienten met hulp van gemeente							
5.3.3 Ervaringen clienten met hulp in een voorziening							
5.3.4 Ervaringen clienten met decentralisatie							
5.3.5 Ervaringen client mbt informele netwerk							
5.3.6 Ervaringen clienten met hulpverlening							
5.4 Data over publieke opinie		1. Output					
5.5 Belemmeringen doel							
5.6 aantallen clienten. homeless registered with PMHC		1. Output					
5.8 empowerment		1. Output					
5.9 Ervaringen client mbt woningbouw							
5.9 Ervaringen clienten omtrent informatievoorziening							
5.9 Ervaringen/meningen clienten mbt ambulantisering							
6.0 stakeholder satisfaction							
6.0 stakeholder satisfaction [Clone : 1]							
6.1 outcome ambulantisering, extramuralisering, NAB							
6.1 stakeholder satisfaction collaboration NAB							
6.2 stakeholder satisfaction goal accomplishment NAB							
6.3 succesfactoren, wat gaat al goed? NAB							
6.4 wat moet er nog gebeuren? NAB							
aanbestingen							
Als je kijkt naar welk aanbod er is, wat							
betrekken vrije markt NAB							
Dan hoop je dat met preventie te verster							
Gebrek passende woonruimte							
Interviewer 1: Ja. Ben je ook bij bepaal							
Interviewer 2: Was het geen voorwaarde o							
Ja, ik woon nu officieel bij mijn vriend							
Maar dat werkt tegen? Ihm werkt dat met							
NoName - 2434b374-30f5-4413-9a54-fdaf887d9208							
NoName - 86dfb2c5-8de5-4585-bf6b-0a04e1fe7f84							
Rekenschap							
Respondent 1: Ja. En ik heb te horen gek							
Respondent 2: Ja en dat zien de woningbo							
taskforce bijzondere doelgroepen NAB							
Toen ik binnenkwam heb ik heel veel nare							
toen ik nog op het Ministerie zat, heb i							
Zorg op maat							
zorgmijders NAB							