

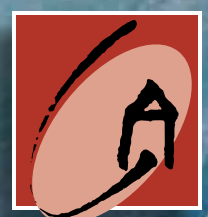


The Magazine of FEANTSA - The European Federation of National Organisations Working with the Homeless AISBL

Homeless in Europe

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**Homeless Health,
Health and Homelessness:
Overcoming the Complexities**



FEANTSA

IN THIS ISSUE

- 2 Editorial
- 4 EU Provisions and Recent Developments Relevant to Health and Homelessness
Stefania Del Zotto
- 7 Access for Homeless People to Healthcare in Northern Europe: The Danish/Scandinavian Perspective
Henrik Thiesen
- 11 Dysfunctional Healthcare for Homeless People in Barcelona
Joan Uribe Vilarrodona
- 14 The Health of Women in Dutch Women's Shelters
Irene Jonker and Judith Wolf
- 18 Reducing Health Inequalities in the EU
Edite Estrela
- 20 The Mental Health of Homeless People: Findings and Recommendations from a Survey in Mainland France
Anne Laporte, Erwan Le Méner, Marc-Antoine Détrez and Pierre Chauvin
- 24 Homeless Health Services, Tuberculosis and Economic Crisis: A Tale of Three Cities
Alistair Story, Marcel Slockers, Wouter Arrazola de Onate, Nigel Hewett and Rob van Hest
- 29 Should We Be Delivering Healthcare On The Street? The Role of Street Medicine in Providing Healthcare to Roofless People
Dr Angela Jones
- 31 Rethinking Training on Health and Homelessness: Challenging Utilitarian Approaches and Re-Owning Client-Centeredness
Mike Seal
- 35 A Snapshot of Health Issues Experienced By People Who Are Homeless in Ireland
Niamh Randall

LETTERS TO THE EDITOR

We would like to give you the chance to comment on any of the articles which have appeared in this issue. If you would like to share your ideas, thoughts and feedback, please send an email to the editor, suzannah.young@feantsa.org.

Homeless Health, Health and Homelessness: Overcoming the Complexities

It is often observed that homeless people appear disproportionately affected by health problems compared with the general population. This situation must be addressed, but we should avoid pathologising or psychologising homelessness. Neither should we typify homeless experiences. The relationship between health and homelessness is multifaceted. Addressing these issues therefore concerns many interrelated questions. These can include questions relating to cause and effect, services, training and data collection, amongst others.

How do mental and physical health issues, and financial and structural barriers lead to homelessness, and what effects does homelessness have on people's mental and physical health and their relationship with health services? How can we improve working with homeless people on health matters?

The following articles attempt to address these issues, and others, giving a picture of homeless people's health in Europe, as well as some of the reasons for their health problems and difficulties in accessing support, and offer some solutions to the complex problems raised by structural and practical difficulties.

Firstly, we must situate this snapshot of healthcare in the European context. The European Union (EU) has responsibilities on health, and services working on homeless health issues can benefit from an understanding of how this affects them. Stefania Del Zotto, former Policy Officer on Health and Social Protection at FEANTSA and former coordinator of the European Network of Homeless Health Workers (ENHW), outlines the EU's health-related priorities, which can be linked to improving homeless people's health.

While Europe has the possibility to improve healthcare for homeless people, structural problems can block their access to healthcare. Henrik Thiesen, Manager of the HealthTeam for the Copenhagen Homeless Community and a Member of ENHW, describes the obstacles to accessing effective healthcare for homeless people, addresses the differences between homeless people's health needs and the way they are perceived or dealt with

by mainstream healthcare, clears up some myths and suggests ways to improve coordination and thus treat homeless people's overall health instead of just focusing on emergency care.

Joan Uribe, Director of Saint John of God Social Services in Barcelona, Spain, discusses the effect of functional problems and poor coordination in health and social services on homeless people's health. He supports Thiessen's observation that homeless people's health situation matches neither the treatment they receive nor their own perception of their health, and notes that homeless people often only seek treatment when a crisis is imminent. Uribe identifies structural obstacles to homeless people accessing healthcare as including stereotypes and stigmatization and recommends linking health and social policies in order to include homeless people. It is observed that homeless people's health improves when their relationship with services is stable.

Another structural factor affecting housing situations and health conditions, mostly those of women, is the presence of violence. Intimate Partner Violence (IPV) can be a reason for the homelessness and poor mental and physical health of the people affected by it.¹ Irene Jonker and Judith Wolf, from the Netherlands Department of Primary and Community Care, report on the first study to describe the physical and mental health of women living in women's shelters in the Netherlands, which reveals that these women experience a disproportionately high rate of poor health, depression, use of medicines, and trauma compared with the general population. In recent years, the Netherlands have concentrated increasing efforts on preventing and combating IPV. This article describes some of the measures taken.

In the EU, vulnerable people can be less likely than others to have adequate access to health services. Edite Estrela MEP, rapporteur of a report recently adopted by the European Parliament on health inequalities, reminds us that while responsibility for health policy rests with Member States, EU policies can address the factors which create or aggravate health inequalities. She indicates that health inequalities are associated with socio-economic conditions and that health and wellbeing are key to

1 This situation corresponds with ETHOS Category 4, people in Women's Shelters and 10, people living under threat of violence: <http://www.feantsa.org/code/en/pg.asp?Page=484>

The articles in *Homeless in Europe* do not necessarily reflect the views of FEANTSA. Extracts from this publication can be quoted as long as the sources are acknowledged.



fighting exclusion. She therefore highlights the importance of meeting the needs of people in poverty, homeless people, migrant and minority groups and recommends adopting measures to mitigate the impact of the economic crisis on the healthcare sector, such as investing in infrastructure, optimizing funding and restructuring healthcare systems.

Unequal social situations and service-level problems also concern mental health and homelessness. Anne Laporte, Erwan Le Méner, Marc-Antoine Détrez and Pierre Chauvin report on a study into the mental health of homeless people in the Paris Ile-de-France region, who do not always receive adequate care from traditional homeless services. They make recommendations for better addressing mental health: prevention of social exclusion of people with mental health needs; detection of mental and physical health problems; support in accessing permanent healthcare; accommodation and housing; training and support for professionals and tackling violence, and give examples of French projects meeting these recommendations. The article suggests that the European Platform Against Poverty could foster innovation in EU approaches to mental health.

The way care for homeless people is organised and funded can also have dramatic effects on their physical health. Alistair Story, Marcel Stockers, Wouter Arrazola de Onate, Nigel Hewett and Rob Van Hest illustrate this using the example of tuberculosis control in Brussels, London and Rotterdam and predict the effects of funding cuts and reorganisation of public services on homeless people's health. They identify increasing evidence that welfare cuts expose people to homelessness and, consequently, to increased risk of tuberculosis, and that public service cuts result in less ambitious and more insular service responses which is likely to result in a shift back from ending homelessness to merely managing it.

Examining the structure of homeless health services and looking for solutions to allow homeless people greater access to them is important to make sure everyone is reached. Drawing on her experience of visiting patients in a street outreach scheme, Dr Angela Jones critiques traditional structures and asks whether we should be providing specialist homeless health services, or whether we should instead make

sure that the services that are open to others are also available to homeless people. She argues for a common sense approach to outreach healthcare for people sleeping rough in the UK, especially for the most entrenched – in the same way as social care outreach is an accepted form of intervention in homeless people's lives.

Treating homeless healthcare recipients as agents of their own healthcare is important for meeting their needs, says Mike Seal, who argues for training for healthcare practitioners that addresses the frameworks within which they operate: namely a utilitarian philosophy and reductive ideas about client-centeredness. He highlights the importance of staff members' attitudes, as the behaviour and expectations of homeless patients are often a reaction to their experiences of services, and some attitudes can constitute a barrier to healthcare for homeless people. For Seal, training can examine the views behind these attitudes, and adopting a rights perspective in training may provide an alternative philosophy within which to frame practitioners' ideas about care.

It is also necessary to have accurate and up-to-date statistical information about homeless populations so that healthcare for homeless people is properly targeted. Niamh Randall, National Research and Policy Manager at the Simon Communities of Ireland, describes the first ever National Health Snapshot study in Ireland, which addressed the deficit of specific information about homeless people's health. The study explores: physical and mental health; drug and alcohol use and access to medical services. The article argues that understanding the health needs of people who are homeless is critical to developing, designing and improving not only homeless services, but also health- and other related services – critical for addressing homelessness.

FEANTSA extends its sincere thanks to the authors who have contributed to this issue of the magazine.



EU Provisions and Recent Developments Relevant to Health and Homelessness*

By **Stefania Del Zotto**, *Policy Officer, FEANTSA*¹

INTRODUCTION

There is an obvious link between living conditions and individual state of health and wellbeing. Research shows that people who are homeless often suffer from a number of health problems, including issues related to physical health, mental health, substance abuse and dual diagnose. Rates of certain serious infectious diseases are significantly higher, while there are usually also high levels of substance misuse and far higher rates of mental ill-health among people experiencing homelessness than among the general population. Despite this, most of the time, access to healthcare, and therefore to their right to health, continues to remain a challenge for homeless people across Europe.²

Since FEANTSA's October 2006 European conference and report devoted to the right to health of people who are homeless,³ many developments relevant to health and homelessness at international, European and national level have occurred. The objective of the present article is to give an overview of existing provisions at European Union (EU) level, which are part of the current legal and policy framework in a number of relevant health-related areas, as well as some of the many initiatives of interest. Given the number of topics involved and the necessary limitations of an article, this exercise is far from being exhaustive. It will not include EU policy measures in other areas, which may have an impact on homelessness and health,⁴ nor mention other international instruments. Readers interested in knowing more on specific issues can rely on the links provided, as well as on recent work undertaken by FEANTSA in the area of health and social protection.⁵

GENERAL FRAMEWORK

Both the Treaty of Lisbon and the EU Charter of Fundamental Rights contain provisions relating to health.⁶ The former defines the scope of EU competence in the different policy areas⁷ and foresees that in relation to health, the EU's mandate is mainly meant to complement action taken at national level. In this context, the EU can carry out action to support, coordinate or

supplement the action of Member States relating to the protection and improvement of human health.⁸ Moreover, the Treaty states that while defining and implementing its policies and activities, the EU has a duty to take into account requirements linked to, among others, the fight against social exclusion and the protection of human health, the latter being further detailed in the section specifically devoted to public health.⁹

Article 35 of the Charter of Fundamental Rights of the European Union focuses on healthcare and reads: "Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities".¹⁰

As a result, it can be said that EU action aims at improving public health, preventing human illness and diseases and promoting cooperation on health issues. The EU Health Strategy, which builds on previous work and was put forward by the European Commission (EC) in 2007, provides an overarching strategic framework for cooperation and progress in the area.¹¹ It focuses mainly on strengthening cooperation and coordination, supporting exchange of evidence-based information and knowledge and assisting national authorities in decision-making.

As a part of this broader strategy, the Second Programme of Community Action in the Field of Health (2008-2013) came into force in January 2008 with the aim of complementing, supporting and adding value to Member States' policies in the area of human and public health, including through specific financing mechanisms.¹² The objectives pursued through the different types of action are to improve citizens' health security, promote health and reduce health inequalities, and to generate and disseminate health information and knowledge. The programme is implemented by means of annual work plans, which set out priority areas as well as criteria for funding.¹³

* References: <http://feantsa.horus.be/code/EN/pg.asp?Page=1369>



EU INITIATIVES AND ACTION ON SPECIFIC HEALTH-RELATED TOPICS

In this section, an overview will be given of recent EU initiatives and action in the areas of health inequalities, mental health, alcohol, drugs, food and gender-based violence.

The topic of health inequalities has gained increased political attention in recent years. This is reflected in the EC Communication published in October 2009,¹⁴ where the Commission considers health inequalities as a “challenge to the EU’s commitments to solidarity, social and economic cohesion, human rights and equality of opportunity”. The Communication identifies a number of key issues to be addressed in cooperation with Member States and other relevant stakeholders, including – and this is an important element – developing the contribution of other EU policies and mechanisms to tackling health inequalities. Among others, it proposes to make more use of existing tools within the Social Open Method of Coordination¹⁵ and to address health inequalities through an increased use of funding opportunities offered for instance by the Cohesion policy.¹⁶ Furthermore, more recently, a report on health inequalities highlighting the mutual links between poor health and poverty has been planned among the key initiatives to be taken in the framework of the European Platform Against Poverty and Social Exclusion, which is one of the tools of the Europe 2020 Strategy.¹⁷

In the area of mental health, following a consultation held in 2006, a European pact on mental health and wellbeing was launched in June 2008 by the European Commission, the Slovenian Presidency and the World Health Organisation Regional Office for Europe.¹⁸ While recognising the challenges ahead, the Pact calls for (voluntary) partnership in action in five priority areas, one of which relates to stigma and discrimination. Signatories commit to contribute to the implementation of the pact through exchange of information, identification of good practice examples and the elaboration of recommendations and action plans. Thematic conferences have been held to disseminate relevant results and to raise awareness on the different aspects involved, while an EU Compass for action on mental health and wellbeing has been created in view of making available useful information online. In addition, a number of recent surveys and studies carried out by Eurostat and the European Foundation for the Improvement of Living and

Working Conditions have been published recently, which contain interesting data and policy pointers on mental health at EU level.¹⁹

As for alcohol, the harmful and hazardous consumption of which has an indisputable impact on people’s health, social and economic consequences and tends to contribute to health inequalities, the European Commission issued a communication on the topic in October 2006, which aims at mapping action already in place at national level, identifying good practice as well as areas of socio-economic importance and Community relevance where further progress could be made. One of the five priorities for action is the protection of young people and children from harmful alcohol consumption.²⁰ The EU’s role, which again is based on the principle of subsidiarity, is to support Member States, finance relevant projects and foster cooperation among interested parties. A first progress report on the implementation of the strategy was published in September 2009.²¹

In September 2008, the Commission issued an EU action plan on drugs (2009-2012), which is accompanied by the evaluation of the first action plan covering the period 2005-2008, and is aimed at implementing the EU drugs strategy 2005-2012. Although drug legislation is primarily a matter of national competence, the EU’s role in the fields of justice and public health is recognized by the Treaty. The two main pillars of the plan are the reduction of drug demand and drug supply, while it contains three cross-cutting themes – coordination, international cooperation and information, and research and evaluation. As part of its awareness-raising and mobilization efforts, the Commission also launched its European Action on Drugs campaign in June 2009, while in the Council Conclusions of January 2011 there is an invitation to Member States to work closely with civil society organisations in the development, implementation and evaluation of drug policy at national level. The European Monitoring Centre for Drugs and Drug Addiction publishes, on a regular basis, annual and thematic reports of interest.²²

Relating to food, in the framework of the Common agricultural policy, for more than twenty years the European Commission has been managing a programme aimed at the distribution of food for the most vulnerable. Initially based on the supply of surplus stock, the programme has been gradually

The topic of health inequalities has gained increased political attention in recent years.



amended to allow for supplementing decreasing surplus stocks with purchases on the private market. The participation of Member States in the programme is voluntary and, in 2010, 19 of them took part in the scheme. Recent revisions put forward by the Commission have increased the EU budget available in the framework of the programme, of which the ceiling is now 500 million Euros a year, as well as introducing a number of improvements, including dietary considerations. However, the future of the programme remains uncertain and the basis for such a programme remains controversial, to such an extent that some Member States have brought a case relating it to the European Court of Justice.²³

Finally, as for gender-based violence, it is worth mentioning that in September 2010 the Commission adopted a Strategy for equality between women and men for the period 2010-2015, which recognizes the widespread problem of violence against women and foresees the adoption of a EU-wide strategy to combat violence against women, as well as the promotion of gender equality in asylum and health policies.²⁴

CONCLUSION

From the above, it appears quite clearly that in the last four years a large number of relevant and promising policy initiatives have been shaped and implemented at EU level with regards to health, which have an impact on fighting homelessness. Let us hope that they will trigger renewed attention and commitment to the health and wellbeing of every one of us, including those who, due to a number of circumstances, are the most vulnerable.

While for obvious reasons I decided to focus on policies, which are of direct relevance to health and homelessness – and where the EU has on the whole mainly a subsidiary role, I would like to conclude by saying that there is scope for much more to be said on policy areas relevant to homelessness which are not necessarily health-related and where EU action has a direct impact on people's lives, including the way individuals are granted access to their rights.



Access for Homeless People to Healthcare in Northern Europe: The Danish/Scandinavian Perspective

By **Henrik Thiesen**,¹ MD, Manager, HealthTeam for the Copenhagen Homeless Community, Member of the FEANTSA ENHW on behalf of The Confederation of Housing for the Homeless (SBH),² Denmark

During the last ten years, projects have been aiming at describing and implementing healthcare for people who are marginalized for different reasons. Different specific health problems in specific groups have been addressed and it has led to more diverse view on ailments that can be found among socially vulnerable people. There is a lack of correspondence between much of the research done on homeless health and the practical projects implemented to improve homeless people's health.

Access to healthcare for people living marginalized in Scandinavian societies has been studied and published in several reports over the years but the research which looks at homelessness and access to healthcare is often not very aware of how people who are homeless use the health system and how the structure of the general health system can promote or obstruct, not access to healthcare but access to *systematic* health- and prevention measures which would improve their all-round health and not just treat isolated health problems.

To get a clearer picture of why homeless people use the health system as they do, we have to take a closer look at different groups and also relate these groups to indirect evidence from other fields to get a picture of the general situation. The interesting thing is that by looking at vulnerable people's use of healthcare we also get an idea of where our health systems have faults that influence all patients regardless of social status. When we look at faults in our provision of healthcare to vulnerable people we also look directly at system-faults that costs enormous amounts of money and, when addressed properly, can release funds for other purposes.

The main problem in describing homeless people's access to healthcare is to get the definitions straight:

1. Who is homeless and what is homelessness?
2. How is general health among those we describe as homeless; what kind of diseases do we see and what is the burden of diseases compared with the rest of the population?
3. Given that every homeless person has access to free healthcare, what are the barriers and how is the health system used by people who are homeless?

When these basic conditions are described, it is possible to make at least some analysis of the dynamics of the use of healthcare and describe how the use of health systems is furthering or obstructing health in homeless or marginalized people.

WHO IS HOMELESS, AND WHAT IS "HOMELESSNESS" IN HEALTH REPORTS?

The definition of "homelessness" has not, in the Scandinavian reports I am aware of, been standardized to allow comparison. In the initial work on my own report from 2005,³ we targeted rough-sleepers and defined them as those being "without a roof for 14 days or more" while, in a similar study from Stockholm in 2001,⁴ a broader definition was used. In a series of reports⁵ on homeless people's health to the Council for Socially Marginalized People, surveying 1290 persons, an attempt was made to compare the group to the general population but the inclusion criteria were vague because the interviews were made by non-health professionals and the individuals themselves. The grouping of those interviewed is *alcohol-misusers, psychiatrically ill people, homeless people, drug-misusers, poor people and others*. This

[T]he general health system can promote or obstruct [...] access to systematic health- and prevention measures which would improve [...] all-round health and not just treat isolated health problems.

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² <http://www.sbh-boformer.dk>

³ Evalueringsrapport for Sundhedsprojektet, Kontaktstedet Mændenes Hjem og Kontaktstedet Forchammersvej. H.Thiesen & J. Schacke Copenhagen, 2004. An English extract can be found at <http://www.hjemlosesundhed.dk/downloads/Extract%20of%20the%20Health-project%20evaluation%20report.pdf>

⁴ En klinisk pilotstudie av 35 hemlösa i Stockholm – Stockholms Läns Landsting / Karolinska institutet, 2001, ISBN 91-631-1795-9 (A clinical pilot-study of 35 homeless in Stockholm) can be ordered at <http://www.folkhalsoguiden.se/Rapport.aspx?id=905&cid=288&ptitem=69&ptpage=0&saitem=7> (text in Swedish)

⁵ SUSY UDSAT - Sundhedsprofil for socialt udsatte i Danmark 2007 (Health profile of Socially vulnerable people in Denmark 2007) http://www.si-folkesundhed.dk/upload/susy_udsat_rapport_090408.pdf (text in Danish)



grouping can be problematic and may be meaningless if the context is not described. Many homeless people might have problems relating to several of these groups and the demarcation of each group is debatable.

The ETHOS-typology seems to be the most valid and appropriate tool to describe homelessness situations but it is only proper to use when used to describe homelessness at a single moment in time. In an attempt to use ETHOS to follow the status of patients in my team, we assessed their ETHOS “score” every 6 months, but the result was not useful. For instance one patient was sleeping rough at admission, lived in a shelter for 6 months and left the shelter again just before the 6 months were over. The result was that there didn’t seem to be any change but in reality this was the first in a series of housing situations which led to permanent housing 2 years later.

Scandinavian citizens will often have a broad range of social care available to them and the group described will be comprised of people who for different reasons are homeless for a fixed period of time, who move in and out of homelessness or can be found at different stages of homelessness over a longer period.

HOW IS GENERAL HEALTH AMONG THOSE WE DESCRIBE AS “HOMELESS”, WHAT KIND OF DISEASES DO WE SEE AND WHAT IS THE BURDEN OF DISEASES COMPARED WITH THE REST OF THE POPULATION?

When the basic definition of homelessness is in place, the description of health is the next barrier. Very seldom do health-professionals conduct direct medical examinations; psychiatric evaluations are more common. The most marginalized among homeless people, such as rough-sleepers, are usually not included and there is widespread confusion that gives bias to clinical comparisons between homeless-groups and between homeless people and the general population.

When healthcare is universal and public, as in Scandinavia, there is little private healthcare and it is definitely not used by vulnerable people.

Therefore, the social security number is a tool, available in Scandinavia, to assess all kinds of contact with the health system. With access to this number and

permission to use it, it is possible to get an impression of overall health by looking at the use of the health system and what is diagnosed when people contact the system.

The usefulness of these data is limited by knowledge of general health in individuals and by the fact that many homeless people use the health system when it is impossible to delay treatment anymore, or in a semi-random fashion for whatever comes up as the most important at a certain point in time. For instance, an alcohol user will be more prone to seek help for alcohol withdrawal at the end of the month when social security has run out than at the beginning when funds are available.

When data on contact with healthcare is used, it is important to recognize that it doesn’t say anything about individuals’ need for treatment nor does it say anything about the complexity of health problems.

In the above-mentioned report on homeless rough-sleepers, we did a thorough somatic examination of 75 homeless people, screening for hepatitis and HIV, describing life-time drug and alcohol use, and assessing accessible hospital records. Screening for anxiety and depression was done using the ICD 10 core symptoms.⁶ National registers of somatic and psychiatric hospital admissions and diagnoses, death registers and drug treatment registers were related to the group as a whole. Through this very time-consuming method we found an average of 6.5 somatic, 1.7 chronic psychiatric disorders and 5.5 substance-related disorders in homeless individuals. We also found that, regardless of other drug use, alcohol was the most damaging to general health. The Stockholm study showed similar results in 2001.

When this direct observation is taken into consideration, a lot of the data-based results can be used to create a more complete picture of the general health problems among homeless people and it can also give some advice on how these problems could be addressed. The general data from the healthcare system also give a picture of the burden of disease compared with the general population and with other socially vulnerable groups. These data generally show that homeless people have a higher degree of all types of diseases than everybody else, including the most disadvantaged in society.

6 <http://www.who.int/classifications/icd/en/>



GIVEN THAT EVERY HOMELESS PERSON HAS ACCESS TO FREE HEALTHCARE, WHAT ARE THE BARRIERS AND HOW IS THE HEALTH SYSTEM USED BY PEOPLE WHO ARE HOMELESS?

Thus, describing health problems is difficult, the influencing factors are multiple and the complexities of diseases are large in quantity and composition. With so many competing factors, it is impossible to say anything about what combination of diseases and problems the homeless individual will have but some interesting trends can be extracted when these different pieces of research are combined with knowledge of the dynamics of health systems.

One of the basic premises we had in our work from 2000-04 was that homeless people have very poor health because they use drugs and drink excessively and do not have access to healthcare because of exclusion from services. When we combined the knowledge on individuals with systems data we found a very frequent use of hospital-based services, mostly emergency healthcare, but the diseases treated at these times were very different from the ones found at the somatic screening. In other words – there was a discrepancy between the severe chronic diseases found in almost everyone and the acute traumas and acute alcohol-related problems which were treated in the emergency rooms.

What has become clear and what has been underpinned by later research is that the cohesion of services and communication between systems was absent and that was one of the main obstacles to achieving better health for the individual. The problem was not that emergency healthcare was the only available way to get treatment but that the system in a universal healthcare system is managed by “gatekeepers” who are supposed to give treatment as early as possible, at the lowest possible level and as cheaply as possible. This role is managed by the general practitioners and what we saw was that a very low percentage of our patients had a working relationship with their general practitioner.

The latest report⁷ to the Council for Socially Marginalized People shows that the vulnerable group selected in 2007 was using hospital-based healthcare much more often than average Danes, and this was clarified in an article in 2010⁸ where it was shown that poor people use general practitioners much less than

comparable groups who are not below the poverty limit. A quick assessment of 512 patients in my current street-team shows that 359 (70%) do not know their GP.

WHAT CAN BE LEARNED?

Two myths regarding healthcare in universal systems can be qualified. One is that health problems are due to lack of treatment. This is not true in the sense that treatment is given but coordination and completion of treatment is lacking. It also seems that treatment is always focused on immediate needs while chronic diseases are not taken care of because these need coordinated and long-term contact. The other is that only emergency healthcare is available for homeless people. This is true in the sense that the coordination is lacking.

The key coordinator in a universal system is the general practitioner and a large proportion of homeless people are not able to make appointments with their GP for various reasons. The secondary, hospital system is more and more specialized and automated which means that the individual units lose their capability to find other health issues and they lose their ability to coordinate outside their own framework.

This means that two functions have to be reorganised to secure equal access to *proper* healthcare. One is internal coordination in the hospital system and the other is modifying general practice and primary healthcare.

Some examples of successful practices exist:

In Copenhagen, a project called “project social-nurse” was launched a year ago. Here, dedicated nurses with knowledge of the specific health issues and problems in relation to treatment systems help drug users to complete treatment in hospitals and at the same time work in liaison with the regular staff to defuse conflicts and coordinate treatment with the surrounding social and drug-treatment system.⁹

In London, Dr. Nigel Hewett, who started providing healthcare for homeless people in a GP setting more than 10 years ago,¹⁰ has set up a coordinating GP-service inside the University College Hospital in London which aims at giving support to homeless people both during hospitalization and after discharge.¹¹

[T]he cohesion of services and communication between systems [is] absent and [this is] one of the main obstacles to achieving better health for the individual.

7 Socialt udsattes brug af sundhedsvæsenet (The use of health services by socially vulnerable people) http://www.sj-folkesundhed.dk/upload/socialt_udsattes_brug_af_sundhedsv%C3%A6snet_-_endelig_rapport.pdf (text in Danish)

8 Low income and number of contacts with general practice. J. N. Arendt, Ugeskr Læger 2010;172(21):15191-15197, Article in Danish but English summary can be accessed here: http://www.ugeskriftet.dk/portal/page/portal/LAEGERDK/UGESKRIFT_FOR_LAEGER/Artikelvisning?pUri=/UGESKRIFT_FOR_LAEGER/TIDLIGERE_NUMRE/2010/UJL_2010_21/UJL_2010_172_21_15191

9 Projekt socialsygeplejerske (Project Social-nurse), <http://kabs.dk/organisation/kabs-viden/projekt-socialsygepleje.aspx> (Text in Danish)

10 How to provide for the primary healthcare needs of homeless people: what do homeless people in Leicester think? N C Hewett. Br J Gen Pract. 1999 October; 49(447): 819.

11 <http://www.uclh.nhs.uk/news/pages/uclhhomelessprojectscoopstopaward.aspx>



Perhaps homeless-health systems will be able to show the way for mainstream health services in a few years.

Regarding healthcare in modified GP-setting outside the hospital system a street clinic with a GP, dentist and other health services has been available in Stockholm since 2001.¹²

Our team in Copenhagen, since 2005, has removed the clinic walls completely to address the fact which our research has shown, that it is the system around the GP and not the GP who is the barrier. The Copenhagen HealthTeam for Homeless People¹³ is a general practice entity which works entirely in a network-based organisation. Removal of the clinic has also removed the last barrier for those who are not able to seek specific places at specific points in time. As a GP-entity we can treat all problems when they arise, we can refer patients to the secondary system and most important of all we can coordinate the treatment of chronic health problems which has been shown to be the major obstacle to better health and not only treatment. The provision of medicine has been another obstacle to continuous treatment and the team provides medicine for everyone in need.

Undocumented migrants have not been described here. Access to healthcare for this group is often declined by individual states or patients are presented with a demand for payment for anything but acute treatment. Even if a prescription is obtained, there might not be money to buy the medicine and thereby health deteriorates quickly for homeless migrants. This has to be addressed and preferably on a supra-national level. The small flexible units like the Health-Team can provide a lot of basic care for little money but the funding can be drained if national or regional systems do not provide funding.

Many minor homeless-health projects have proven to be able to improve the general health of homeless people but many of the severe problems with coordination within large health systems seem to be increasing, demonstrating a need for a concerted effort if we are to avoid even more severe health problems among patients with multiple problems.

Perhaps homeless-health systems will be able to show the way for mainstream health services in a few years.

12 Gratis sjukvård för de allra mest utsatta http://www.lakartidningen.se/old/content_0332_33/pdf/2497_2499.pdf (Swedish text)

13 HealthTeam for Homeless (<http://www.hjemlosesundhed.dk/?English>)



Dysfunctional Healthcare for Homeless People in Barcelona

By **Joan Uribe Vilarrodona**,¹ *Ph. D. In Social Anthropology, Director of Saint John of God, Social Services, Barcelona, Spain*

This article stems from the results of a study on the state of health of and healthcare for homeless people in Barcelona.² The research study was conducted to fill the information gap on the healthcare needs of these people which were largely unknown to us.

The Catalonia Health Survey (known by the Spanish acronym 'ESCA') was used, duly adapted for the homeless population, to interview 611 people representative of the entire homeless population of Barcelona – a universe of some 1900 people on a given day, which suggests a total population of around 3000 people per year.

Moreover, it enabled us to update and expand our knowledge of the different profiles and social situation of homeless people, as well as to get to know and analyse three aspects relating to their health:

- The actual state of their health
- Their own perception thereof
- The healthcare provided.

It was noted that none of the three correspond with each other: the group's state of health is worse than they think or express, and the healthcare they receive is below the level that they need.

As for the socio-demographic profile, some of our most significant data point to a group where 87.7% are men and 12.3% women. Nearly half (50.7%) of these people are not Spanish. 22.7% were born in Barcelona.

In general terms, the average age is 44.5. These people live and spend most of their time in public spaces.

More specifically, 32.9% live in the public arena. 26.7% spend the night in preliminary reception centres; 26% in residential centres for homeless people; 8.3% in shanty towns, hovels or tents, and 5.6% in social inclusion flats or flats temporarily shared with other people.

In general, most have not been in this situation for more than 3 years: 27.6% less than six months and 46.9% between 6 months and 3 years. One quarter of them (25.9%) find themselves in a more chronic and more permanent homeless situation.

Some data on their living habits and social and economic environment indicate that more than half of the people questioned (55%) receive no aid whatsoever and nearly 33% of the people in this situation have to survive with an average monthly income of €274.54.

13% work, mainly in precarious jobs with an average monthly salary of €866.16.

However, in contrast with this very low employment rate, most have primary education (66.4%, of whom 45.6% finished school), 9.8% have a degree, and at 2.7%, the illiteracy index is similar to that of the general population.

As regards the results on health, 79.2% have chronic disorders – from one to more than three. It is worth noting that 41% of women and 24% of men have more than three chronic disorders, an average higher than the general population.

There is also a connection between morbidity owing to chronic disorders and the period in a homeless situation: the longer such period, the higher the morbidity rate. The most frequent illnesses or disorders, by order of importance, are:

- Musculoskeletal (67.6%)
- Cardiovascular (57.2%)
- Mental morbidity (49.1%)
- Drug addiction – alcoholism (28%) and other drugs (18.2%)

A direct connection has been established between being homeless and the quality and number of actual hours of sleep, mental morbidity – stress, anxiety, angst and fear in particular – as well as neurological and musculoskeletal chronic illnesses. Mental morbidity is the disorder that is treated most frequently, in particular with medicines to ease tension or insomnia.³

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² Les persones en situació de sense llar de Barcelona: perfils, estat de salut i atenció sanitària; Uribe, J., Alonso, S.; Fundació Jaume Bofill, Barcelona, 2009. <http://www.fbofill.cat/index.php?codmenu=11&publicacio=507&submenu=false&SC=12012007040643&titol=&autor=&ordenat=&&tags=> For a copy of the book (in Spanish) contact the author by e-mail juribe@ohsjd.es

³ We believe that given a mental morbidity rate of 49.1%, or nearly one out of two people, a specific plan must be implemented urgently to deal with the mental health of homeless people.



When focusing on morbidity with the use of medicines and services, a discrepancy between morbidity and treatment is generally detected:

- 77.8% of all people diagnosed with a cardiovascular chronic ailment do not take medication.
- 50.5% of all people with musculoskeletal chronic disorder do not receive pharmacological treatment prescribed by a doctor.
- 45% and 35.75% of people who require medication for HIV/AIDS and diabetes respectively state that they do not take such medication.

It has also been noted that homeless people tend to seek medical treatment in a critical or risk situation, i.e. in an emergency and not during a monitoring or prevention phase. It has consequently been found that health professionals are consulted essentially through emergency services or during critical health situations, instead of continued treatment of homeless people's illnesses.

Twice a year on average, and in concrete terms at least once, more than half of homeless people population (52.7%) consulted or went to an emergency service, 94.4% in public hospitals.

In the last twelve months prior to the interview, 20.8% had been hospitalised for at least one night.

Similarly, it is worth stressing that people who live in centres for homeless people are the ones who consult health professionals the most. Accordingly, there is a connection between having a link with social services for homeless people – residential centres, professional supervision, etc. – and receiving continuous health-care. In particular, the frequency and high percentage of homeless people who spend the night in residential centres and facilities and who have consulted nursing professionals and social workers, is 41.4% and 45% in shelters and 26.1% and 26.5% in residential centres. Conversely, only 31% of homeless people were visited by a health professional or social worker.

In light of these results, it is worth stressing the concept of "health inequalities" - the risks faced by or vulnerability of a certain segment of the population, in particular concerning health coverage or

use of health services – which shows that homeless people are in general confronted with acute situations of inequality, with most serious implications for their health and chances of survival.

PROPOSALS

The European Union's goal to end rough sleeping by 2015 is difficult to achieve, in the very least, and may prove impossible if the efforts and resources to that end are not increased.

A substantial increase of the resources available as well as in their coordination and efficiency is perceptible in Barcelona. Nevertheless, our current socio-economic growth model is incorporating the creation and maintenance of pockets of poverty at a higher rate than we are capable of addressing, which have tendency towards increasing in volume and intensity, and are becoming permanent.

All this is being exacerbated by the appearance of punitive legal frameworks criticised by many social and academic circles, which criminalise poverty and, in so doing, add a new problem, that of the tacit institutional legitimisation of the stigmatisation of socially excluded people.

Given these observations, and given the lack of policies for cooperation between health and social services concerning homeless people, a number of proposals have been drawn up:

1. The right to health may not be dissociated from the right to decent housing and employment/income. The study has shown the extent to which not having decent housing and income makes puts the right to health at risk, which has a detrimental effect on their health in itself. We must therefore propose that decisive policies be pursued to provide decent housing to all homeless people. Without such stability, it is difficult, if not impossible, to gain continuous access to social services in general, and to health services in particular, not forgetting mental health. We are referring to inter-sectoral policies that provide a cross-sectional approach to the housing, employment, health and social work needs.



2. The health system should be more accessible for homeless people and should facilitate their access to prevention and treatment programmes. We suggest that facilitating access to this segment of the population may point to action on this front in addition to that which would be implemented for the general public.
3. Channels and/or agreements are needed to correct the discrepancy between the morbidity of the group studied. The healthcare received should be revised or implemented, including during the disease monitoring phase.
4. We also suggest concrete conventions intended to solve and/or address:
 - a. The search for affinities between the health field – defined by certain policies, objectives, factors and interests – and the social field, defined by others, to bring about a language, objectives, and joint work with homeless people;
 - b. Exploring the possibility to integrate primary care as the natural and efficient way into monitoring the health of homeless people;
 - c. Homeless people leaving emergency services, after prompt care or hospitalisation: coordination and social monitoring should provide support and continuity in health work;
 - d. Work based on the personal trajectory of the person receiving care: the unique history of the person receiving care, independently of time, organisation or institution and the social or health sector that provides the service at all times;
 - e. The monitoring of a person by professionals in each case.
5. We understand that the health field requires an external ally which, owing to the state of the health and personal situation of these people, helps homeless people with their health needs. It is therefore necessary to guarantee greater coordination between the associations, institutions and organisations that work with these people by unifying the criteria and conventions for care, coordination and monitoring of the cases, referral of social care histories of people who have received one or another form of basic care, and unified databases, amongst other tools. We are not referring solely to associations and organisations from the social sphere, but also and particularly to social services in conjunction with health services to proceed to formal, generic coordination, making it possible to provide treatment and monitoring with the same chances of success as the general population.
6. Also, and to the same end, consideration should be given to extending social resources through greater involvement of health and mental health services for certain, less independent profiles, occasionally or permanently, in social resources such as day centres, and council or residential flats, among other possibilities.
7. Finally, cases of direct or structural violence that reach public opinion and which are only a small, albeit painful, sample of what homeless people go through, are evidently part of the persistence of stereotypes, maintained in part by institutionalised messages resulting from legal frameworks that criminalise poverty and exclusion. All this maintains and increases the added difficulties that homeless people have to cope with, including those relating to their right to health. For this reason, we believe that an extra effort is needed to educate society and thus help to change the negative stereotypes concerning homeless people.

The health system should be more accessible for homeless people and should facilitate their access to prevention and treatment programmes.



The Health of Women in Dutch Women's Shelters

By **Irene Jonker**,¹ *Researcher at the Department of Public Primary and Community Care* and **Judith Wolf**,² *Professor at the Department of Primary and Community Care, The Netherlands*

In certain cases, the abuse is so serious or the violence so threatening that women seek refuge in women's shelters, sometimes taking their children with them.

INTRODUCTION

The prevention and fight against domestic violence has been high on the political and social agenda for years. The term "domestic violence" refers to current or former physical and/or sexual violence between former or current intimate partners, adult members of a household, or grown children and a parent (Sugg et al., 1999). Domestic violence occurs in all social strata and in all cultures in Dutch society (Movisie, 2009). If we examine only violence by (former) partners, known as Intimate Partner Violence (IPV), then 12% of the population (1 in 8 people in the Netherlands) has been affected by it at some point (Dijk et al., 1997). The prevalence of mental and/or sexual violence by a current or former partner is about 25% in the United States (Tjaden and Thoennes, 2000) and varies between 4% and 30% in Europe (Hagemann-White, 2001).

Women who are victims of IPV have to cope with serious health problems. Not only do they often endure (serious) physical injuries such as wounds and broken bones (Stark et al., 1979), they also suffer from psychosomatic problems such as eating disorders (Heise et al., 1999; Plichta, 2004), post-traumatic stress disorder (PTSD) (Woods et al., 2008), depression (McCauley et al., 1995; Saunders et al., 1993) and chronic pain (Coker et al., 2000). Physical ailments such as abdominal pain (Mark et al., 2008), bladder infections (Bonomi et al., 2009), gynaecological problems (Letourneau et al., 1999) and more frequent sexually transmissible diseases (Plichta & Abraham, 1996) often occur in women who have been sexually abused. Furthermore, women who have been physically, sexually or psychologically abused have a significantly higher chance of using cigarettes, alcohol and/or medication to excess (Campbell, 2002; Plichta, 2004).

Research has demonstrated that problems are often chronic and that they often persist long after the abuse has ceased (Zlotnick et al., 2006).

In certain cases, the abuse is so serious or the violence so threatening that women seek refuge in women's shelters, sometimes taking their children with them. More than 16,000 women (and their children) sought the help of such shelters in 2007 in the Netherlands (Dutch Federation of Shelters, 2007).

This article provides insight in the health of women that use the services provided by women's shelters. The data come from a large-scale study (Wolf et al., 2006) conducted in 2005 at the request of the Dutch Ministry of Health, Welfare and Sports by researchers from Radboud University Nijmegen Medical Centre and the Netherlands Institute of Mental Health and Addiction.

RESEARCH REPORT ON THE "USE AND USEFULNESS OF WOMEN'S SHELTERS"

The research study included, in particular, interviews with 218 women in eighteen women's shelters throughout the Netherlands (nearly half the total number of such institutions in the country). These women were selected at random so as to obtain as representative a sample as possible. Before the interview, the women were screened to ascertain whether they met the criteria set, namely:

- Age: 18 or older
- Country of birth: born in the Netherlands or born abroad
- Reason for stay: abuse by (former) partner or others
- Phase of stay: crisis shelter (stay of 1 to 3 weeks) or follow-up shelter (3 weeks or longer).

Of the 218 women, 114 were in a crisis shelter and 107 in a follow-up shelter. Their average age was 32. More than half were of non-Dutch origin (Surinamese, Moroccan, Turkish). Nearly all the women had suffered psychological abuse, a large majority had faced physical violence, and a third of them reported sexual violence. The women had a low level of education and low employment participation.

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Before their stay in women's shelters

Prior to their current stay in shelters, most of the women (83%) lived in their own home. The remaining women lived with their families (9%), on the basis of a sublet, without lease (2%) or elsewhere (6%). More than one third of the women (37%) were at the time of the interview still registered in the municipality where they lived previously. The majority (62%) had however registered in another municipality in the meantime, apparently where the women's shelter is established – and 1% was not registered anywhere. Before going to women's shelters, most women lived with their (former) partner, who was also the person who threatened or abused them. 5% lived with their parents, 7% with their brothers, sisters or other family members, 4% with their in-laws, and 4% with other people. Only 4% of women lived alone prior to being admitted to women's shelters, with children in certain cases.

29% of women who had to flee threats and abuse went directly to women's shelters (where the interview took place). The other women ultimately reached the shelter through other routes. Nearly half stayed initially in another women's shelter (47%), 43% went to family/acquaintances, 13% stayed in a facility for homeless people, and 41% stayed (also) somewhere else. It is striking that 7% of the women born abroad in the crisis shelter slept rough before they came to a women's shelter (Wolf, et al., 2006).

These results support previous research by Wolf et al. (2003) that accessing women's shelters is a relatively laborious process. Many women refer each other to women's shelters (Wolf et al., 2003).

Own assessment of physical and mental functioning

The subjective health quality was measured in the study using Lehman's Quality of Life Scale (Lehman, 1983; Lehman et al., 1992; Lehman, 1995). Women could express their health experiences on a scale of 1 (terrible) to 7 (excellent). Women in the crisis shelter considered that they had poor mental health (3.8). In the follow-up shelter, they deemed their mental health significantly better, but nevertheless still average (4.3). In percentage terms, 45% of the women in women's shelters are not happy with their mental health. Among women in the Dutch population as a whole, the percentage of women with poor mental health is far lower (19.2% in 2003, measured with the MHI) (RIVM, 2006).

Women find their physical health average in both phases (average score of 4.4 on a scale of 7). In percentage terms, 57% of the women in women's shelters considered their health to be good to very good. Among women in the Dutch population as a whole, the percentage of those who considered their health to be good to very good was substantially higher (78%) (RIVM, 2005).

Table 1. Medicine use by women in women's shelters

	Crisis shelter		Follow-up shelter		Total	
	N _{range} =111-112		N=103		N _{range} =214-215	
Medicine use	Use (%)	Number of days (Average, SD)	Average (%)	Number of days (Average, SD)	Use (%)	Number of days (Average, SD)
Yes	57		63		60	
Medicines						
Sleep-inducing drugs	13	11 (9)	13	20 (9)	13	15 (10)
Antidepressants	13	23 (10)	8	27 (6)	10	24 (9)
Sedatives	19	19 (12)	12	23 (10)	15	20 (11)
Painkillers	41	9 (10)	50	10 (9)	46	9 (10)
Antipsychotics	2	26 (7)	3	26 (6)	2	26 (5)

Use of medicines and substances

About 60% of the women in women's shelters take medicines, which is high compared with the use of medicine by women in the Dutch population as a whole (an average of 36%) (RIVM, 2005). Most of the women interviewed take painkillers, followed by sedatives, taken by about one fifth of the women in the crisis shelter, and by 12% of the women in the follow-up shelter. Antipsychotics are scarcely ever used. The average number of days that women in women's shelters use medicines varies between 9 and 23 days in the crisis shelter and between 10 and 27 days in the follow-up shelter. Antidepressants and sedatives are, together with sleep-inducing drugs, used the most per month. The few women who take antipsychotics do almost daily.

A small number of women, both in the crisis and the follow-up shelter, say that they use drugs and alcohol (8%). These are primarily alcohol and cannabis, and rarely also heroin, methadone and/or cocaine. Alcohol had been consumed on average three days in the last thirty days. What is striking is that four women in the follow-up shelter indicated that they used cannabis and did so very frequently (17 days per month). Women born in the Netherlands in the follow-up shelter use significantly more drugs and/or alcohol than women born abroad.

More than half of the women in the crisis as well as the follow-up shelter smoke. That is twice as high as the percentage of female smokers in the Netherlands (STIVORO, 2004). The number of smokers is significantly higher among women born in the Netherlands than among those born abroad, particularly also in the follow-up shelter. The average number of cigarettes per day in the crisis and follow-up shelter is around fifteen, which is comparable with the daily average number of cigarettes smoked by the Dutch population (STIVORO, 2004).



Table 2. Depression complaints by women in women's shelters

	Crisis shelter	Follow-up shelter	Total
Depression according to CES-D (%)	N=95	N=83	N=178
No depression ⁱ	20	36	28
Light depression (16-20.5)	8	14	11
Moderate depression (21-30.5)	33	27	30
Severe depression (31 or higher)	39	23	31
CES-D Score			
Average ⁱⁱ	26.7	22.1	24.6
Standard deviation (SD)	(11.)	(11.)	(11.5)

i LogReg: No Depression vs Depression: Crisis $z=2.6$, $p=0.01$, Born abroad $z=2.0$, $p=0.04$
 ii LinReg: Crisis $t=3.1$, $p<0.01$; Born abroad $t=3.1$, $p<0.01$

Table 2. Depression complaints by women in women's shelters

	Crisis shelter	Follow-up shelter	Total
Trauma according to IES (%)	N=89	N=75	N=164
Traumatised (IES > 26) ⁱ	87	81	84
IES Score Average (SD)			
IES Total ⁱⁱ	44.1 (14.8)	41.4 (17.8)	42.9 (16.2)
Avoidance ⁱⁱⁱ	21.3 (8.4)	21.8 (10.5)	21.3 (9.5)
Reliving ^{iv}	22.8 (8.3)	19.6 (9.6)	21.5 (9.4)

i LogReg: Traumatised vs Not Traumatised Women born Abroad $z=2.8$, $p<0.01$
 ii LinReg: Born abroad $t=3.4$, $p<0.01$
 iii LinReg: Board abroad $t=2.9$, $p<0.01$
 iv LinReg: Crisis $t=2.4$, $p=0.02$; Born abroad $t=3.0$, $p<0.01$

Depression

Depression symptoms are less prevalent among women in the follow-up shelter than among women in the crisis shelter. This takes nothing away from the fact that a substantial number of women in both types of shelter suffer from a form of depression. More than two thirds of the women in the crisis shelter and half of the women in the follow-up shelter suffer from moderate to severe depression. Depression complaints are noted on the basis of the validated self-assessment list of the Centre for Epidemiological Studies Depression Scale (CES-D) (Hanewald, 1987; Radloff, 1977). One fifth of the women in the crisis shelter and more than one third in the follow-up shelter have no depression complaints. The differences found in depression between the women in both phases of shelter are significant. Furthermore, women born abroad are significantly more depressed than women born in the Netherlands (data not in the table).

Trauma

The degree of trauma among women in women's shelters is determined on the basis of the Dutch version (Brom & Kleber, 1985) of the Impact of Events Scale (IES) (Horowitz et al., 1979). A score of 26 or higher on the total IES indicates post-traumatic stress disorder (Brom & Kleber, 1985; Chemtob et al., 1997). Most of the women are traumatised. In the crisis shelter, 87% of women have, according to the IES, post-traumatic stress disorder, whilst 81% of the women in the follow-up shelter are severely traumatised. Women born abroad are significantly more traumatised than women born in the Netherlands; the difference is 94% to 82% in the crisis shelter, and slightly higher in the follow-up shelter, namely 97% to 71%.

In the follow-up shelter women relive past experiences more often than in the crisis shelter. Furthermore, women born abroad differ significantly from women born in the Netherlands on the reliving and avoidance subscales.



CONSIDERATION

This study made it possible for the first time ever to sketch a profile of women that use women's shelters. The women interviewed were faced with an accumulation of violence and social exclusion. These are very vulnerable, low-skilled women with serious health problems.

Women found their own physical health to be reasonably good; their mental health less so. More than two-thirds of the women in the crisis shelter reported moderate to severe depression complaints, and more than 80% of the women interviewed had post-traumatic stress complaints. The use of medication is high (60%), certainly by comparison with that of women in the Dutch population (36% on average). A small portion of women said that they used drugs or alcohol (8%). This percentage is evidently an underestimation; women find it difficult to admit to such use. Indeed, addiction behaviour can be a reason for not being admitted to women's shelters.

In conclusion, women in women's shelters have clearly poorer health than women in the Dutch population. Serious mental complaints such as PTSD and depression, and excessive consumption of cigarettes, alcohol and medication are conspicuous. Women born abroad are in this study more affected than those born in the Netherlands.

POLICY

Recognition of physical and mental problems among mistreated women is relevant when they report to shelters. The development of a reliable and phased assessment is important at the time that a woman comes in. Risk assessment, screening of physical and mental problems, but also estimation and forecasts come into play here. Our research centre has been commissioned by the Dutch Federation of Shelters to prepare a proposal to take stock of the problem so as to be able to address these needs.

Furthermore, in 2005 the Dutch Federation of Shelters developed the "Women's Shelter Emergency Places" directive as a reaction to the problems and lack of clarity at the front door of women's shelters. The emergency places are intended for women (and children, if any) who as a result of (a threat of) acute violence become homeless or cannot remain in their own home. At the time when they seek help, no accommodation can be provided elsewhere in women's shelters (Dutch Federation of Shelters, 2005).

Efforts have been stepped up to combat domestic violence in the Netherlands. In 2004, the government drew up an incentive regulation for advice and support centres on domestic violence, which in 2008 led to a network of near nationwide coverage of such centres (Movisie, 2009; Vink & Geurts, 2008). These centres provide a heedful ear, advice on possible action, and references to professional help. Such help is geared first and foremost to stopping violence. The type of professional help offered depends on the situation (are children involved?) and on the victim's wishes (whether or not to continue the relationship). Help is offered by, e.g. the Public Welfare Board (AMW), Mental Health Institutions (CGZ) and Victim Assistance Bureaux (Movisie, 2009).

Another measure is the introduction of the Temporary Restraining Order Act, which entered into force on the 1st January 2009. This Act is intended to combat domestic violence by taking action early, including when the victim does not want to report the matter to the police. A restraining order (initially for 10 days) is issued against the perpetrator (usually the male partner) at the first signs of household violence. Both the perpetrator and the victim can find peace in this way. Social assistance is brought into play during this "cooling-off" period. Women are provided with support at home, a forced departure from the home is avoided, and the inflow in women's shelters is limited to cases where there is no alternative.³

The development of a reliable and phased assessment is important at the time that a woman comes in [to a shelter].

³ References: <http://feantsa.horus.be/code/EN/pg.asp?Page=1353>



Reducing Health Inequalities in the EU

By **Edite Estrela**,¹ *Member of the European Parliament for Portugal, Member of the Group of the Progressive Alliance of Socialists and Democrats in the European Parliament*

Health and life expectancy are [...] linked to social inequalities and poverty.

The European Parliament has recently adopted my report on “reducing health inequalities in the European Union (EU)”.² Nevertheless, concerns over the extent and the consequences of health inequalities – both between and within Member States – have been expressed over the years by the EU Institutions and many stakeholders.

In 2007, the EU Health Strategy set out the basis to carry out further work to reduce inequities in health. The European Council of June 2008 also underlined the importance of closing the gap in health and in life expectancy between and within Member States. These principles were reiterated in the 2008 Commission Communication on a Renewed Social Agenda, which restated the fundamental social objectives of Europe through equal opportunities, access and solidarity, and announced the Commission Communication on “Solidarity in Health: Reducing Health Inequalities in the EU”, presented in October 2009 with the purpose of outlining a European strategy to reduce health inequalities.

The Charter of Fundamental Rights of the European Union proclaims that “everyone has the right of access to preventive health care and the right to benefit from medical treatment” and that “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”. While the primary responsibility for health policy rests with Member States, EU policies can contribute by taking into account the objective of addressing the factors which create or contribute to health inequalities across the EU population.

Health inequalities vary from county to country, from region to region and are associated with socio-economic conditions, and might be aggravated by issues of gender, cultural background and religion. This means that they are linked to a wide range of factors which affect health, namely: living conditions; health-related behaviours; education, occupation and

income; access to health care, disease prevention and health promotion services as well as public policies, influencing the quantity, quality and distribution of these factors.

Health and life expectancy are thus linked to social inequalities and poverty. Despite some progress, major inequalities still exist. Rates of morbidity are higher among those in lower educational, occupational and income groups and substantial inequalities are also found in the prevalence of most specific diseases, mental illness, and most specific forms of disability.

On the other hand, the combination of poverty with other vulnerabilities such as childhood or old age, disability or minority background further increases health risks.

Health inequalities may start early in life and persist not only into old age but subsequent generations. Hence the importance of this matter and the urgency of a solution.

The present context of global crisis tends to make things worse. The crisis has, obviously, a severe impact on the healthcare sector in several EU Member States on both the supply and the demand sides. On the supply side, the economic and financial crisis may lead to a reduction in the level of funding for health and long-term care services as a result of budget cuts and lower tax revenues, while the demand for health and long-term care services may increase as a result of a combination of factors that contribute to the deterioration of the health status among the general population.

Measures to mitigate the impact of the economic crisis on the health care sector, such as investing in health infrastructure, optimizing funding to the health care sector and restructuring and reorganising the health care system are necessary.

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In this regard, it is extremely important to give particular attention to the needs of people in poverty, homeless people, migrant and minority groups, people with disabilities, elderly people and children living in poverty, in order to improve access to disease prevention, health promotion and primary and specialised healthcare services, and to reduce inequalities between different social and age groups. It is fundamental to ensure healthy life conditions for all children, including actions to support pregnant women and parents.

Some respected voices say that the crisis is the result of persistent social inequalities. Also for that reason, it is essential that the reduction of inequalities is considered a top priority at all levels of policy making, taking into account the social determinants of health. That is why it is so important to make better use of European funds, such as the cohesion policy and the structural funds in order to support projects to address factors contributing to health inequalities.

The European Council and the Commission should also give greater recognition within the Europe 2020 strategy to the fact that health and wellbeing are key to fighting exclusion. For that purpose, we need to develop a common set of indicators connected to the socio-economic, cultural and environmental conditions and to set a methodology to audit the health situation in Member States aimed at identifying and prioritising areas of improvement and best practices.

Universality, access to high-quality care, equity and solidarity are common values and principles underpinning the health systems in the EU Member States.

Healthcare services should be provided in a manner consistent with fundamental rights, in order to maintain and improve universal access to healthcare systems and to affordable healthcare. Member States should promote access to high quality legal advice and information in coordination with civil society organisations to eliminate barriers and help citizens, including the most vulnerable, such as homeless people and undocumented migrants, to learn more about their individual rights.

EU-level policy-making should include the "health in all policies" principle and carry out effective impact assessments that take health equity outcomes into account.

It is crucial to develop an integrated, cross-sectoral, strategic approach to reduce health inequalities in the EU effectively, taking into account the social determinants of health and lifestyle-related risk factors, such as alcohol, tobacco and nutrition, by means of actions in policy areas such as consumer policy, employment, housing, social policy, the environment, agriculture and food, education, living and working conditions and research.

I hope that the adoption, by the European Parliament, of my report on "reducing health inequalities in the EU", may be an important step to address health inequalities in the EU, in particular when Europe faces the enormous challenges of economic recovery, without further compromising the health of the European citizens, and in particular of those who are most vulnerable.



The Mental Health of Homeless People: Findings and Recommendations from a Survey in Mainland France

By Anne Laporte¹, Erwan Le Méner², Marc-Antoine Détrez³, Pierre Chauvin⁴, France

Homeless people are often vilified as combining mental illness with social exclusion through labels like “drunk, stoned, crazy and sick” (Snow et al., 1986) - a common portrayal of homeless individuals that clearly pays scant regard to the wide range of life courses, situations and patterns of homelessness. And yet nothing is more certain than the difficulties and distress that welfare workers experience when confronted with psychiatric disorders. They have been a major focus of discussion by social exclusion professionals since as far back as the mid-1990s both in France (Girard et al. 2009; Lazarus & Strohl, 1995)

and Europe (FEANTSA, 2006; Council of the European Union, 1999⁵). Can we therefore talk about the mental health of homeless people while recognising the illness and difficulties that result for professionals, but without conflating or “psychiatrising” the situations of homelessness? The Samenta survey (from the French “SANTéMENTale et Addictions” - mental health and addiction among homeless people in the Ile-de-France Region), carried out by the *Observatoire du Samu Social de Paris* and INSERM⁶ attempts to do just that (Laporte & Chauvin, 2010).

THE SAMENTA SURVEY

The survey was conducted at a time of high government concern for the (mental) health of homeless people (Orain & Chambaud, 2008, Girard et al., 2009). Its initial aim was to describe the prevalence of severe psychiatric (psychotic, mood or anxiety) disorders among the homeless population of the Ile-de-France Region more than ten years after the survey by V. Kovess and C. Mangin Lazarus (1997).

The survey was conducted by questionnaire in 2009 among a random sample of 840 French-speaking adults in the Ile-de-France Region contacted through hot meal distribution points, day centres, shelters and welfare hotels, and representing a total population of 21,176 people.

The questionnaires were administered by interviewers working in pairs, comprising a professional survey taker and a clinical psychologist, who also carried out an open clinical interview after the questionnaire was completed. The findings as to mental disorders, investigated using standard tools (especially the MINI - Mini International Neuropsychiatric Interview) and psychologists’ clinical reports were compared with the opinion of psychiatrists specialized in social exclusion who trained the paired interviewers. This arrangement was designed to avoid the over- or under-estimating that often mars prevalence surveys on mental health based only on standardized instruments administered by non-clinicians (Falissard, 2006).

The Samenta survey was funded by the *Haut Commissaire aux Solidarités Actives Contre la pauvreté et à la Jeunesse* (Office of the Commissioner for Active Solidarity Against Poverty), the Department of Health and Sport, the *Institut de Veille Sanitaire* (Healthwatch Institute), the *Institut National de Prévention et d’Education pour la Santé* (National Institute for Preventive Health and Health Education) (INPES), the Paris Prefecture, the *Observatoire National de la Pauvreté et de l’Exclusion Sociale* (National Observatory on Poverty and Social Exclusion), the Ile-de-France regional council and Paris City Council.⁷

APPROXIMATELY ONE THIRD OF RESPONDENTS HAVE A SEVERE DISORDER OR ADDICTION

It is clear that severe (psychotic, mood, or anxiety) disorders are overrepresented among homeless people relative to the general population: 31% have at least one of these disorders. The survey found a prevalence ten times higher than the general population for psychotic disorders (13.2% versus 1-2% - Bellamy et al., 2004), and double the rate for depressive disorders (severe to mild: 20.3% versus 11% - *ibid.*). Similar findings were made in the vulnerable

groups in the SIRS Greater Paris area cohort⁸ (Roustit et al., 2008), bearing out the pronounced social and event history gradients associated with this illness. Similarly, one in five was alcohol dependent and 16% were regular cannabis users - three to five times higher respectively than in the general population (Legleye & Beck, 2007). These findings are consistent with those of international baseline surveys (Fazel et al., 2008) and clearly confirm the assumption that homeless people have a higher prevalence of more severe psychiatric disorders or addictions than the general population (see Table 1).

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5 Council Resolution of 18 November 1999 on the promotion of mental health

6 French State Centre for Scientific and Technological Research

7 Further details on the Observatory website: <http://observatoire.samusocial-75.fr/>

8 The *Santé, Inégalités et Ruptures Sociales* (health inequalities and social alienation) (SIRS) cohort is a socio-epidemiological, longitudinal survey of a representative sample in Paris and its neighbouring *départements*. The data cited here are for 2005.



Table 1. Prevalence (%) within twelve months of psychiatric and behavioural disorders, and addictions in different studies in the general population, homeless people and prison population

	STUDIES						
	ESEMeD (2000)	ANADEP 2005	Health Barometer (2005)	Kovess (1996)	Samenta (2009).	Fazel (2008)	Falissard (2004)
Population type	General	General	General	Homeless	Homeless	Homeless	Prison
Sample size, n	2 894	6 498	16 883	715	840	5 684	800
Place:	France	France	France	Paris	Ile-de-France	World	France
Tools used	CIDI	CIDI-S	CIDI-S	CIDI-S ⁱ	MINI	Meta-reg. analysis	MINI
Psychotic disorders				16.0 *	13.2	12.7	17.0
Major depressive disorders	6.7	5.0	3.2	23.7	20.3	11.4	24.0
Generalized anxiety disorder	9.8	5.1			4.0		17.7
Medium and mild depressive disorders			4.2 0.4		6.0 7.9		
Personality disorders					21.1	23.1	
Alcohol dependence	0.3	10.3	8.5	14.9	21.0	37.9	11.7
Drug use				10.3	17.5	24.4	14.6
Regular cannabis use			2.7		16		

* Lifetime (5.8% over 6 months)

ⁱ CIDI-S: Composite International Diagnostic Interview - Short

FINDINGS TO BE HANDLED WITH CARE

But these results should not be taken as equating mental illness with social exclusion. The prevalences recorded are nowhere near the figures of up to 90% of sufferers sometimes reported. Some findings belie the stereotype: for example, the homeless population has proportionally more lifetime non-drinkers than the general population (17.4% versus 8.4% - Beck et al., 2006). They also have to be seen relative to the immense diversity in the homeless population. Marked differences are to be seen according to social and demographic characteristics, the services used by homeless individuals (see Table 2), but also according to the event histories of the homeless people and their health status before or after becoming homeless.

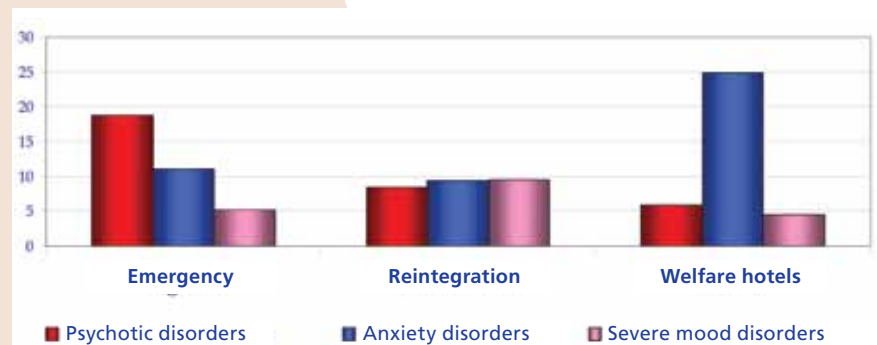
The shelter provision residents and users interviewed are mostly male, older, and rarely living with a family. Among those who slept most often in public spaces in the 12 months preceding the survey, 44% had a severe psychiatric disorder, more than half of which were psychotic disorders. Among welfare hotel residents (mostly foreign-born women, living alone with their children), the proportion of severe disorders amounted to 25.6%, primarily anxiety disorders (adjustment disorders, other stress-related disorders).

Overall, the prevalence of severe disorders varies considerably with where the individuals were interviewed, and even more so with where they reported having slept most often in the year up to the survey (see Figure 1).

Table 2. Selected characteristics of respondents by place at which surveyed

Type of provision	n	Females %	Average age (years)	Born in France (%)	Living with at least one child (%)
Emergency	10600	15.2	42	41.6	13.4
Reintegration	7750	47.8	34	48.8	44.0
Welfare hotel	2850	73.4	34	10.5	89.5

Figure 1 - Prevalence of severe disorders by where respondents slept most often in the 12 months up to the survey





HOMELESS PEOPLE WITH SEVERE DISORDERS ARE PARTICULARLY EXCLUDED AND VULNERABLE

The most severe disorders are more prevalent among people in low-threshold than other forms of provision which are more enabling to a return to mainstream society. Take the example of individuals with a psychotic disorder: 19% of those attending a day centre, hot meal distribution point, emergency shelter or resettlement centre suffer from such a disorder. This is double that of the survey population as a whole, and twenty times more than in the general population. But these forms of provision offer little or no social or medical support. That a quarter of the interviewees reported having slept most often in a public space in the year up to the survey also demonstrates the difficulties the most vulnerable have in accessing provision that will help ease them back into society, and that professionals have in keeping them there. Again, these facts must be approached with caution: homeless people with a psychotic disorder more often reported receiving medical follow-up than those with other severe disorders. However, only 37.7% did report such a follow-up. While it is difficult to specify the care needs of homeless people through this survey, the findings are problematic for two categories of person: those diagnosed as having a severe disorder but who have never sought care (22.9% of the population with severe disorders); and those self-excluded from care living in places that are apt to distance them from care and social support (public spaces, emergency provision, welfare hotels).

For individuals with a severe disorder, missing out on care and support goes together with a higher frequency of violence suffered than for the rest of the homeless population, who are much more often the victims of violence than the general population. In the twelve months up to the survey, the most common forms of assault were demeaning or humiliating words or looks suffered by 43.1% of persons with a severe disorder and 27.3% of people with no obvious disorder. Verbal threats had been offered to 33.3% of persons with at least one disorder compared to 10.5% of those with no disorder; among the former, 25% had been the victim of theft (against 12.5% of people with no diagnosed disorder), 15.7% of

physical abuse (versus 7.3%) and 8.1% physical injuries in fights (versus 3.9%). Sexual assaults in the past twelve months were reported by 2.3% of persons with at least one disorder and 0.3% of those with no disorder.

Findings like these should prompt thought about how to develop targeted provision that helps protect and promote the recovery of people with severe mental disorders (Davidson et al, 2008).

RECOMMENDATIONS

The recommendations to come out of the Samenta survey focus on six areas: preventing the social exclusion of people with severe disorders; identifying psychiatric disorders and mental distress; support towards long-term care; support for routes into temporary accommodation and housing; training and support for front-line workers; and tackling violence suffered. Without going into the detail of these recommendations⁹, it is worth saying that there are currently initiatives working in that direction. The "Un logement d'abord" (Housing First)¹⁰ programme being trialled in Marseilles, Lille and Toulouse provides housing and then specific care to people with severe disorders with no preconditions (including abstinence or following a treatment programme). This measure is intended to show that those habitually and permanently excluded from it can stay in housing and care. Another example is the proposal to link together mobile psychiatric and vulnerability outreach teams (EMPP) in the Ile-de-France Region under the auspices of the Regional Health Agency. EMPPs would then act as a referral agency for mental health, coordinate street workers, deliver more efficient networking between specialised exclusion practitioners and other front-line staff (medical ambulance service, fire-fighters) and psychiatric services. If such schemes prove to be effective, they should be rolled out quickly on a larger scale to (finally) address this situation which, while it may ultimately concern only a small number of people and has long dragged on to general indifference, is no less a health emergency. The European Platform Against Poverty could be a central forum at EU level for analysing, evaluating and disseminating innovations in the approach to mental health.

9 Accessible at: <http://observatoire.samusocial-75.fr/PDF/Samenta/SAMENTA.pdf>

10 http://www.developpement-durable.gouv.fr/IMG/5_fichedesynthesechezsoid%27abord26janv2010.pdf



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The European Platform Against Poverty could be a central forum at EU level for analysing, evaluating and disseminating innovations in the approach to mental health.



Homeless Health Services, Tuberculosis and Economic Crisis: A Tale of Three Cities

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*“Public health is purchasable; within certain natural limitations a city can determine its own death rate.”
Hermann M. Biggs, New York City Board of Health, Annual Report, 1905¹*

Providing effective medical care for homeless people challenges traditional health services which depend on timely presentation, adherence to prescribed treatment and [...] the patient’s ability to rest, recuperate and recover in [...] a ‘home’.

Written over a century ago, the words of Herman Biggs, Commissioner of Health for New York State, still resonate profoundly. Social inequality concentrates the burden of disability and disease on the most deprived communities within our society and cuts short their lives. Homelessness is the most striking manifestation of deprivation and inequality in our modern cities today and, among the many health problems faced by homeless people, tuberculosis (TB) remains the social barometer through which we can still measure how purchasable public health is.

In this article we use TB to illustrate differences in the organisation and funding of care for homeless people in three European cities against a backdrop of economic austerity, major funding cuts and reorganisation of public services.

INTRODUCTION

People experiencing homelessness are in a chronic state of social and medical crisis and die prematurely from treatable medical conditions. Their daily struggle to meet the most basic needs, shelter, sustenance and safety, relegates their health needs to a lower priority. Providing effective medical care for homeless people challenges traditional health services which depend on timely presentation, adherence to prescribed treatment and advice and critically, the patient’s ability to rest, recuperate and recover in an environment outside of the healthcare system – namely a ‘home’. Consequently, for homeless people, common illnesses progress, injuries fester and patients’ physical and mental health, addiction and social problems deteriorate and compound one another. Effective models of care must address this interaction and provide simultaneous social and medical support.²

TB and Homelessness

TB is a disease of poverty internationally, the determinants of which are predominantly social. TB thrives where poverty, manifest in poor housing, overcrowding, malnutrition, stress and social exclusion, combines with weak health systems and political indifference to inequalities. In the European Union (EU), rates of TB are now highest among the most socially excluded risk groups and especially homeless persons, drug and alcohol users and people who are or have been in prison.³ These risk factors commonly overlap, e.g. in most European countries, 30% or more of homeless people are estimated to have associated drug addiction problems.⁴

TB control is founded on early case detection and supporting patients to complete a course of treatment lasting a minimum of six months. The concentration of disease in risk groups is a major challenge to TB control as socially excluded patients are harder to find and harder to treat. Tackling TB in the most vulnerable populations must be a key element in any comprehensive strategy to reduce and eventually eliminate TB across the EU.⁵

TB programmes are complex public health interventions that must address the individual needs of the sufferer and protect the wider society from contagion. Effective TB programmes require political commitment to tackle the underlying social determinants of disease and ensure sustained and sufficient investment, and a high level of collaboration between specialist medical services, health and social care providers and the communities affected. TB rates are a sensitive measure of the overall effectiveness of national and local public health systems and evidence of uncontrolled TB transmission reflects a failure of these systems.

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Major outbreaks of TB involving hard-to-reach populations have been documented in London, Rotterdam and Brussels.^{6,7,8} These cities differ markedly in size and organisation of services, but all harbour significant socially excluded populations at risk of TB. Around one in six of all notified TB patients in London and Rotterdam were homeless, problem drug users or (ex)prisoners.^{9,10} While the response in Rotterdam appears to have effectively controlled TB among these populations; in London TB outbreaks are ongoing

THE ROTTERDAM PERSPECTIVE

Organisation of Healthcare for Homeless Persons

The number of problematic, illicit drug users in Rotterdam and homeless persons was estimated in 2003 and 2005 at 2,856 and 2,500 respectively.^{11,12} In Rotterdam, care of homeless persons aims to address basic social needs alongside treatment for addiction, mental and physical health problems.

The organisation and funding of medical homeless care services was comprehensively described in a previous article in March 2008, including the main medical problems and number of patients and consultations.¹³ In Rotterdam, it was realised around 2002 that comprehensive action had to be taken against the deprivation of the socially excluded “hard-to-reach” and “hard-to-find” groups. An increase of illicit drug use, and especially a shift to different drugs, e.g. cocaine, escalated into more violence, crime, psychiatric distress and an increase in clinically and socially complex disease, often attributable to low body mass index. The answer came from a joint venture between local politicians, social day-care and night-care centres and medical care organisations which united to proclaim that homeless persons should not remain homeless but should be guided from the large-scale shelters and day centres into small-scale social housing and support projects. This included the large street prostitution zone in Rotterdam. The various social care organisations started to set up small-scale housing and care schemes and arrange the continuation of care in these projects, with a realistic perspective of independent accommodation under supervision of social workers. Social housing corporations enabled this by providing rented houses, dispersed over the city. Over the years, from the nursing beds in the night shelters, hundreds of persons followed this route after treatment and improvement of their medical problems.

Medical care services for homeless persons were reorganised, including, in 2003, the introduction of an electronic patient file used by multidisciplinary Street Doctor teams, who provided a comprehensive package of care, tailored to the needs of the individual. Infectious diseases were not only treated with medication but also by “prescribing” extra meals for cachectic cocaine abusers, with a body mass index lower than 20. The decrease of heroin users in Rotterdam resulted in less contact between drug users and care-providers, e.g. through the methadone maintenance programmes, but free provision of meals established this contact for the cachectic cocaine abusers. The organisations for social psychiatry and addiction established so-called “Assertive Community Treatment” teams, providing individualised and intensive care for the many homeless persons and illicit drug users with psychiatric illnesses.

Since 2006, the Dutch Government, together with the four major cities (Amsterdam, Rotterdam, The Hague and Utrecht) have strategically funded an ambitious programme to guide all homeless persons into temporary care and social rehabilitation and, from there, to clustered or individual supported housing projects, with social education training and employment guidance.¹⁴ In February 2010, the Counsellor for Health and Social Care in Rotterdam announced that almost all of the homeless persons in Rotterdam were in care, with about half of them in a more or less stable situation, abstinent or with their addiction controlled and having a job or participating in other day-time activities. In Rotterdam, these extra investments in “care” resulted in reduced costs of “cure”, and greatly reduced costs for law reinforcement, courts and prison. According to the Rotterdam Municipal Public Health Service, one Euro spent on “care” prevents between 2 and 3 Euros being spent on judicial costs. Structural funding of all key ingredients of the Rotterdam approach is needed, also in a time of possible budget cuts.

TB Control in Rotterdam

Prevention and control of TB among hard-to-reach groups requires tailor-made, low-threshold, flexible and innovative interventions. For TB control among homeless persons and illicit drug users, digital mobile X-ray screening was introduced in Rotterdam.^{7,9} The project was initially financed by earmarked grants from Rotterdam Council covering screening costs and staffing costs for additional treatment support. After four years, the screening programme was



Significant investment has improved the quality of hostel accommodation, day centres and street outreach services and established a pan-London database.

paid out of the regular yearly grant from Rotterdam Council. In the Netherlands, public health infectious disease control is decentralised and predominantly the responsibility of the municipalities, as described in the Public Health Act.¹⁵ The government provides the majority of the funds needed and a minority of the costs is recovered from Council tax. The mobile screening programme successfully reduced transmission and the number of homeless persons and drug users with TB after a recent infection.⁹ The number of homeless persons or illicit drug users with active TB in Rotterdam has decreased from approximately 25 per year around 2005 to around 6 per year recently.^{16,15} The overall trend of TB incidence in Rotterdam decreased by one-third, from around 225 patients in 2003-2004 to on average 155 patients between 2005-2009.¹⁵ The mobile X-ray screening activities could even be scaled down, as many homeless persons are now in supervised housing schemes and can visit the TB Clinic for screening, but the Municipal Public Health Service TB Clinic keeps structurally funded by law, irrespective of budget cuts.¹⁴

THE LONDON PERSPECTIVE

Organisation of Healthcare for Homeless Persons

The true scale of homelessness in London is unknown. Rough sleeping and single homelessness alone affects around 20,000 people in the capital.^{17,18} London has very high levels of problem drug use, with almost 63,000 opiate and/or crack cocaine users aged between 15 and 64.¹⁹

Health service provision in London and across the UK is undergoing the most radical reformation since the inception of the National Health Service (NHS) in the 1950s. The fundamental financing and management structure of health services is changing. Existing, locally responsible Primary Care Trusts (PCTs) are being dissolved and the role of commissioning (and providing) health services devolved to local health consortia led by General Practitioners (GPs). Change brings both risk and opportunity but much remains unclear about how the new coalition governments' policies will affect services for homeless people.

There has never been a single strategic approach to planning and providing health services for homeless people in London. The result is pockets of excellence but overall healthcare provision is fragmented with significant local variation, in coverage, quality and accessibility and difficulties in communicating and co-ordinating activities across PCT boundaries.

Incompatibility between information systems used by different health and social care providers has undermined efforts to standardise assessment and case management, share good practice and work effectively outside of building-based services. Critically, lack of shared information technologies and a consistent approach to measuring health outcomes has resulted in a dearth of quality evidence necessary to sustain and develop better services. Serious gaps in health service provision still exist, for instance, intermediate healthcare services for homeless people in London are virtually nonexistent.

Outside the health sector, significant progress has been made in the last 10 years. The former government established the Rough Sleepers Unit and then the Homelessness Directorate to tackle homelessness in its most extreme form, effectively reducing street homelessness in London and nationally. This work is now taken forward by the London Delivery Board who have committed to achieving that 'by the end of 2012 no one will live on the streets of London, and no individual arriving on the streets will sleep out for a second night.' Significant investment has improved the quality of hostel accommodation, day centres and street outreach services and established a pan-London database (CHAIN) for people who work with rough sleepers and the street population. Analyses of the CHAIN data identified 205 'chronic' rough sleepers which prompted a unique initiative in 2009 targeting this group, which has so far helped around three-quarters off the street.¹⁷ This intensive and highly personalised strategy of joint working, similar to the approaches described in Rotterdam, has recently been extended to other rough sleepers in the capital. Formal evaluation of its cost effectiveness across the system, including health, social care, criminal justice and employment is necessary if sustained funding is to be assured.

One in four (26%) of the 4,672 people who slept rough in London in 2009/10 were from Central and Eastern European countries that joined the EU in 2004 and 2007 and they partly contribute to a recent rise in the number of rough sleepers in London.¹⁷ There is little evidence of a decline in the numbers of single homeless people, many of whom still remain outside the statutory definition of homelessness and therefore not entitled to access many support services.²⁰ In London there are currently around 13,500 bed spaces for single homeless people in 247 accommodation projects across the capital.¹⁷ Many thousands more 'hidden homeless' people are living in unfit or inadequate accommodation.



Most homeless people face significant barriers to accessing mainstream NHS services. Three 'competing' perspectives to this challenge have been relentlessly debated without resolution. One perspective calls for the provision of specialist services which, while expensive, may yield better health outcomes and produce cost savings over time. Others advocate for increased support to improve homeless people's access to mainstream services while some specialists argue that the only way to actually address the healthcare needs of homeless people properly is to end their homelessness.^{21, 22}

An important innovation to improve integration of health and social care for homeless people is being promoted by a new charity called the London Pathway (www.londonpathway.org.uk). The model was first piloted in University College Hospital and includes GP-led ward rounds, with a specialist nurse co-ordinating homeless patients' care through regular multi-agency meetings to bring together health, housing, social care and the voluntary sector. The 'Pathway' approach has clearly highlighted the need for intermediate care provision for homeless people with complex needs – an intensive period of coordinated health, housing and social care on the same community site. The Rotterdam and New York "Housing First" homeless care models have demonstrated that intermediate care can reduce unscheduled hospital admissions and duration of stay but requires a community programme to enable prompt moves to social housing with floating support.

Recognising the urgent need for coordination and collaboration across London and England in the face of funding cuts and increasing poverty, the London Pathway is supporting a newly formed Faculty for Homeless Health (www.collegeofmedicine.org.uk/faculties/faculty-care-homeless-people) which brings together people with an experience of homelessness with a wide variety of health and social care professionals to promote improved healthcare for homeless people. A new Standards document has just been published and is available on the London Pathway website.

TB Control in London

The scale of the TB problem in London is daunting. Cases increased by 50% (from 2,309 to 3,450) between 1999 and 2009, and London now has the highest TB rate among western European capitals.²³ TB rates are highest among homeless people, problem drug users and (ex)prisoners.⁹ London's increase in TB is partly explained by an ongoing and extremely extensive outbreak of drug resistant

tuberculosis among marginalised groups, providing compelling evidence of uncontrolled transmission in the capital.^{24,25} An immediate and serious long-term political and financial commitment is needed from the UK Government through the NHS if TB is to be controlled in London.²⁶

In an effort to better inform control strategies, a comprehensive independent review of TB services in London was recently commissioned.²⁷ The findings revealed some stark similarities with health services for homeless people previously described. Thirty different TB services have evolved across the capital without any centrally co-ordinated plan and these services are fragmented with little accountability. Pockets of excellence and innovation sit alongside services where understaffed clinical teams struggle with an increasing caseload. The review highlighted the innovative work of 'Find&Treat', a pan-London screening and case management service for homeless and other hard-to-reach cases and recommended that this model be integrated into TB services across the capital. Funding for 'Find&Treat' from the Department of Health stopped in March 2011, and the project is now temporarily supported by NHS London.²⁸ Despite good evidence of the service's clinical and cost effectiveness its future remains highly uncertain.

THE BRUSSELS PERSPECTIVE

TB Control in Brussels

30% of all TB cases in Belgium are registered in Brussels Capital while it only holds 10% of the population (city TB incidence: 30 per 100,000). Extensive and ongoing TB transmission has recently been unexpectedly revealed by a large DNA-strain typing study. Almost half (48.1%) of TB patients were underprivileged (homeless and/or having less than one meal per day).⁸ As is commonplace in European capitals, TB is often misrepresented as a problem associated with migration. Strain typing has demonstrated cross-national transmission is limited and mainly occurs from Belgian-born to foreign-settled patients, or within the foreign-born community. TB transmission was most frequently associated with underprivileged, Belgian and Western European-born people.

Two organisations are collaborating in Brussels to control TB, providing free medical consultations, contact investigations and active screening of homeless people, drug users, prisoners and the underprivileged using Mobile X-ray Units and supporting treatment in the community. As the disease is now concentrated in risk groups who are "hard-to-reach" and "hard-to-hold" TB control is extremely labour

TB is often misrepresented as a problem associated with migration.



intensive, requiring extra nurses and social workers.²⁹ Essential measures to tackle TB need to be expanded through a network of health centres located to serve the most under-privileged communities, increased capacity for active case finding and treatment support and improved use of new diagnostic tools.

Brussels has a complex political structure with no less than six ministries responsible for TB. Time, energy and money are being wasted through poor coordination and the administrative burden falls on field workers and community organisations. Although no direct budget cuts are underway, funding for TB services has historically been inadequate and the chronic refusal to increase resources to reflect the scale of the problem puts the Brussels situation into danger alert. Budget limitations caused the closure of one of the two health centres in 2010. Chronic under-funding is clearly reflected in the high incidence of disease which is the same as twenty years ago. The TB situation in Brussels perfectly illustrates that public health is purchasable.

CONCLUSION

Across Europe and beyond, there is increasing evidence that weaker welfare states are associated with higher levels of homelessness³⁰ – new welfare cuts will expose an ever-wider cross-section of the population to homelessness and, consequently, to increased risk of TB.

Austerity measures are biting hard in London. Important accommodation and outreach services for single homeless people have lost ring-fenced budgets.

Radical changes to housing policy will inevitably reduce access to social housing for low-income single people. The cost of renting social housing is likely to increase to market levels at a time of reduced investment in building new affordable homes and increasing unemployment. The sustained and progressive commitment to fund homeless care services and essential public health measures for TB control in Rotterdam continues, but the future threat of budget cuts is not clear. In Brussels TB control among vulnerable groups is historically structurally underfunded and this under-investment in essential public health measures is becoming increasingly apparent as the epidemic evolves.

Perhaps most importantly, cuts to public services result in less ambitious and more insular service responses and inevitably, social injustices.²⁰ With regard to homelessness, this is likely to result in a shift back from trying to 'end' homelessness to merely 'managing' homelessness. As for TB control, few health interventions better illustrate the adage 'spend now to save later'. Current financial pressures in London and Brussels raise the very real prospect of the corollary, 'save now to spend later'. Short-term savings will come at a high price to all and be catastrophic for some.

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vi References: <http://feantsa.horus.be/code/EN/pg.asp?Page=1366>



Should We Be Delivering Healthcare On The Street? The Role of Street Medicine in Providing Healthcare to Roofless People

By **Dr Angela Jones**,¹ *General Practitioner, Inclusive Health, UK*

It is taken more or less for granted that social care agencies should provide some outreach services to homeless people on the street. The exact nature of the services may be a matter of contention and concern, especially if the services could be interpreted as enabling, “encouraging” or maintaining a “homeless lifestyle”. However, few would argue that, among entrenched rough sleepers, there are many who would be unlikely to access services unless approached directly on the street and, in that way, encouraged to engage with services.

The same cannot be said for the provision of healthcare to people who are roofless. Across Europe, a number of models are employed to cater for entrenched rough sleepers and other people who are roofless. These range from individual efforts by single clinicians, via small groups of volunteers, to dedicated state- or NGO-funded organisations operating multidisciplinary teams either directly on the street or from purpose built vehicles, the model employed depending on the health and social care systems in the individual countries concerned.

In the UK, which has a state-funded health system with universal access, the provision of healthcare to rough sleepers is more problematic. For a number of reasons, people experiencing homelessness often delay accessing healthcare, until their condition has reached urgent proportions. This may be because they have other competing priorities, such as obtaining money, food, clothing, drugs or alcohol or shelter. It may be because they have had previous rejecting experiences from health services or because they are embarrassed or fearful of stigmatisation or of the possible diagnosis. Most of us have a tendency to put off seeing the doctor or the dentist, hoping that the problem will just go away – it seems that people who are homeless, and especially the roofless, simply put it off longer than the rest of us.

With health systems that are purported to be universally accessible, the assumption is that people who do not attend are themselves at fault, rather than to enquire as to whether it is, in fact, the service that is less than accessible. This dilemma is at the root of the

whole “specialist versus universal” debate, which has dogged homeless healthcare for decades. Should we be providing specialist homeless health services for people who are experiencing homelessness, or should we instead make sure that the services that are open to others are also welcoming to homeless people?

In the UK, the specialist service model seems to have prevailed in the last decade, with most cities having developed some form of buildings-based primary healthcare provision, targeted at the needs of homeless people. This is supported by research into patient preference carried out by Hewett and is to be welcomed. The dedicated people who have fought for and delivered these services deserve a medal, or indeed many medals, for their dedication and determination. They will need yet more determination to preserve their services as the next round of NHS² reorganisation takes hold. However, there remains something of a “gap in the market” when it comes to the provision of healthcare to entrenched rough sleepers.

Who are entrenched rough sleepers? These are individuals who have slept on the streets or otherwise outside, perhaps in some kind of temporary structure, for a number of years, often decades. They have adapted to this lifestyle over time and are often unwilling, for a variety of reasons, to engage with any form of authority or organisation that may wish to persuade them to “come inside”. Many, probably the majority, suffer from chronic mental illness, sometimes complicated by drug or alcohol dependence. Almost all receive little or no healthcare and most never set foot in a doctor’s surgery. They may occasionally attend an emergency department. Many have undiagnosed and untreated long-term conditions. It is this group that still slip through the net in the UK, despite “universal access” and the widespread availability of buildings-based homeless general practitioner (GP) clinics.

Why is UK homeless healthcare so unwilling to come out onto the streets? Here are a number of arguments which have been offered to me against providing outreach healthcare:

[T]he assumption is that people who do not attend [health services] are themselves at fault, rather than to enquire as to whether it is, in fact, the service that is less than accessible.

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² National Health Service, the UK state-funded healthcare system



- *The financial argument:* healthcare staff, especially doctors, are an expensive commodity and it is not cost-effective to have them tramping around the streets. They are more effectively employed in buildings, with outreach workers bringing the clients to them.
- *The appropriateness argument:* it is not appropriate for everything to be offered to rough sleepers “on a plate”. If they begin to get healthcare on the street, it will just encourage them to remain as rough sleepers and not to make the effort to resettle.
- *The safety argument:* outreach is an unsafe environment which healthcare workers should not be exposed to.
- *The specialist argument:* this is an argument against deploying outreach GPs – what is really needed is specialist homeless psychiatrists and psychologists, given that many entrenched rough sleepers are suffering from mental illness.
- *The funding argument:* our service is funded to provide buildings-based services; we do not have enough staff/are not authorised to provide services on the street.

Whilst all these arguments may contain a grain of truth, they do not stack up as justification for the refusal of many GPs, even those working in specialised homeless health teams, to engage with entrenched rough sleepers in their area. Clearly, outreach services would need to be provided in a cost-effective fashion, and targeted at those most at risk and thus most likely to benefit. Referral and guidance from local social care outreach teams would help to target the healthcare, and joint street outreach with these teams would be an opportunity for both maximising safety and also for vital inter-professional learning and exchange. GPs manage the vast majority of mental illness in the UK and make referrals to specialist colleagues where necessary. They are also legally entitled to participate, with specialist colleagues, in the process of assessment for compulsory detention under the Mental Health Act, so are ideally placed to offer a useful combination of physical and mental healthcare to entrenched rough sleepers with multiple complex morbidities. Perhaps above all, the GP, and his or her team, is still held in esteem and respect by most people, as a person with high professional standards who can be trusted, who understands the concept of confidentiality and has an element of influence that may be helpful to the homeless individual.

In 2010, I undertook a pilot of street outreach as a lone GP, working with a group of the most entrenched

rough sleepers in London. The pilot period was short, only four months, and it seemed that each participating outreach team referred me their toughest cases to attempt engagement with! The lessons that I learnt from this work were:

1. Do not attempt this work alone: it is emotionally demanding and physically tiring. The medical and ethical challenges are extreme. Working within a team with good quality support and supervision are necessary to maintain one’s equilibrium and effectiveness.
2. Do not cover too large a geographical area: travel is also tiring and draining and this adds to the stresses of the work and reduces effectiveness.
3. Work in an area that you are familiar with: this allows you to use your local knowledge and contacts and to build up a network of expertise and support from local agencies.
4. Be patient: as every outreach team knows, it can take a very long time to build up enough rapport, or for the “right time” to come, when your patient may be ready to tell you that key fact or to take that key step towards recovery.
5. Be determined: it may be obvious to us that homelessness, and in particular rough sleeping, is usually harmful, in and of itself, especially when it is happening because of mental illness. Strangely, this is not always obvious to other authorities and you may need to be very persuasive in order to appraise them of the need, perhaps, to deprive a person of their liberty for a period or give them compulsory treatment for a mental disorder, in order to give them a chance of possibly leading a “normal” lifestyle in the future.
6. Take something to sit on: I had a small folding fishing stool, which I took with me. This enabled me to sit for as long as necessary without getting cramp or dirty clothing and listen to my patients in comfort, giving them my full attention.

In summary, therefore, I would like to plead for a common-sense approach to the issue of outreach healthcare for people who are sleeping rough in the UK, especially for the most entrenched. Many, if not most, are now reasonably close to a dedicated homelessness healthcare service, which can cater for their needs, and the majority will attend as and when needed. However, for a minority, who do not attend, and yet are clearly in need of healthcare, whether for physical ailments or suspected psychiatric illness, surely it makes sense for the local GP service to make a “house call”, on the street. Not only might this avoid an expensive emergency-department visit, but it might also be the beginning of a fruitful therapeutic relationship, which could play an important part in the recovery and housing of that homeless individual.



Rethinking Training on Health and Homelessness: Challenging Utilitarian Approaches and Re-Owning Client-Centeredness

By **Mike Seal**,¹ *Head of Youth and Community Work at Newman University College, Birmingham, UK*

In principle, healthcare in the UK should be available and accessible to all, as we have a National Health Service (NHS). In practice, however, access to healthcare for homeless people remains difficult (Bevan: 2007, Jones:2009). Homeless Link (2010) say that many homeless people are refused services, and Croft-White & Parry-Crooke (2004) say that primary care doctors (GPs) still resist registration for care for homeless people, particularly when those people have multiple needs. The later report (2004) also found that where problematic drug and/or alcohol use was one of the presenting problems, the barrier was almost insurmountable; with only a handful of GPs in each of the case study areas they examined being prepared to register this group of clients.

In the context of training (Jones: 2009) workers recounted occasions where GPs refused to see homeless patients who were late for their appointments or where their clients were removed from GP lists simply for non-presentation. More generally, when talking to support practitioners, many raised concerns that homeless people with multiple health needs were not receiving the full range of services due to the problems of accessing a timely medical assessment (Croft-White & Parry-Crooke:2004).

More positively they found that the provision of appropriate care had been achieved by some agencies particularly where dedicated health services had been able to visit and deliver a service within homelessness agencies (where service users often felt more comfortable). However, there continued to be gaps in appropriate care including the need for comprehensive check-ups and health screening which could be carried out in any location. Given this, we need to ask why provision is still patchy. Jones (2009) lists wider issues in the dynamic of health care as being:

- Low expectations / low prioritisation of health by the individual
- Personal characteristics of individuals including distrust, fear, anger,
- Behavioural issues leading to poor acceptance by / engagement with services
- Perception of complexity / difficulty in caring for the individual among health staff
- Stigmatising or discriminatory attitudes or behaviour among health workers and staff
- Lack of skills and training among staff in the key areas of communication, mental health and substance misuse
- Lack of coordination of health and social care services, leaving staff unsupported in addressing the individual's issues holistically
- Difficulty in making local needs assessment due to the hidden and mobile nature of this group and its lack of representation in census and other data
- Lack of access to usual modes of communication such as the post, email, telephone, written and broadcast media necessitates special (expensive) efforts

However, what remains unanalysed is why such issues prevail, despite a plethora of information, training and guidelines issued by the UK government Department of Health (DH 2007), the Royal College of General Practitioners (RCGP:2002) and numerous others. Any training programme will need to get to these fundamental reasons. The perceptual and attitudinal factors on behalf of staff are of particular importance, as the behaviour and expectations of clients are often as a reaction to their experiences of services (Groundswell:2009a) and this is where training can come in, as we may have a chance to look at the views behind these attitudes. In this article I will argue that at the root of some of these issues are two factors: firstly that people are subject to a utilitarian approach to medicine that needs to be challenged by a rights perspective and secondly that we need to re-own, or redefine what we mean by client-centred.

The provision of appropriate care had been achieved [...] where dedicated health services had been able to visit and deliver a service within homelessness agencies.

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THE DOMINANCE OF UTILITARIAN APPROACHES

I do not have scope to go into definitions of utilitarianism. However, Mill (1863) broadly saw it as a view that the best course of action is the one that creates the greatest good for the greatest number of people. Given that homeless people are in a minority, and have many health issues and needs in accessing services which are resource intensive, at least initially, such an approach would argue not to prioritise services for them. Several authors have noted the philosophical dominance of utilitarianism in the modern NHS (Humphreys: 2007, McMaster:2004). Jones (2009) postulates that primary care services are set up to deal with the majority and are rarely flexible enough to meet the needs of homeless people. Jones (2009) recounts that a psychologist put this down to a more fundamental flaw in the strategic thinking of the NHS:

'I think it's health [services] and the NHS which excludes our population...the investigation of effective treatment is happening within health [services] and they exclude the homeless population, so that's why...the threshold is too high. And they exclude for very real reasons, the health service itself works on an exclusion basis. If you exclude certain people then we can treat a load of other people. (Jones: 2009 pp 12)

Training needs to engage with the principles of the NHS at this fundamental philosophical level (Jones: 2009). It should enable the attitudes of staff to be addressed more generally.

Traditionally, utilitarian approaches are contrasted with Kantian deontological perspectives, (Humphreys: 2007), more commonly using the notion of rights. Adopting a rights perspective in training might provide an alternative philosophy by which we can frame practitioners' philosophies of care. The EPSCO Council Conclusions on an EU Voluntary European Quality Framework for Social Services would support such a view, and offers us leverage in challenging utilitarian approaches.² It says that social services should be 'key instruments for the safeguard of fundamental human rights and human dignity,' going on to say that 'Service providers should respect the fundamental

rights and freedoms as outlined in national, European and international human rights instruments, as well as the dignity of the users'.

RE-OWNING CLIENT-CENTREDNESS AND DEVELOPING AUTONOMY

Jones's (2000) research quotes a nurse challenging the utilitarian principle of the NHS, saying that 'if you get health right for homeless people, you get it right for the rest of the population'. Humphreys (2007) takes the view that utilitarian approaches do not focus on the agency and autonomy of the individual, or see them as vital. Hence that approach makes the NHS less personal, and less client-centred (arguing for instance for more call centres, because it reaches more people, and less doctor-client time). I have written previously about how the concept of being client-centred is very contested, and at the same time a thing most people would subscribe to (Seal:2008). In its most reductive, and neo-liberal, form, it is about people having choice, but for homeless people it is often Hobson's choice: they take what is on offer or go away. I would argue that we need, in training, to deconstruct the term more fully, particularly for homeless people.

I think there are three dimensions to client-centeredness that need to be acknowledged and explored in training. Firstly, there is what we mean by "centred". One of the recommendations in 'Keys to Engagement' (Sainsbury: 1998) was that teams must develop a style of working which matches the needs of the clients. On face value this is something that most would agree with, but I think it has an important implication: that it is we who need to change the way our service is delivered to meet their needs, rather than we need to remove the 'barriers', or 'enable' them to access our service. In the focus group, "client-centred" was defined as 'looking at the client's views of their needs and wants and starting from there, rather than what services can provide and imposing eligibility criteria'. Bevan notes from his research that most homeless people with multiple needs in Britain see services as unresponsive to them at the point of need. And when they do not conform to the structure of the services for drugs and alcohol, mental health and so on, they (the patients) are seen as the problem (Bevan 2006).

² <http://register.consilium.europa.eu/pdf/en/10/st16/st16319.en10.pdf>



Humphreys (2007) again sees utilitarianism as being akin to such medical models of health.

A second dimension is to recognise that clients are multifaceted, and there is rarely one solution to their issues, but this complexity may be our issue, not theirs. In the focus group, Homeless Link had an interesting perspective, both for front line workers and policy makers. This was that we should stop thinking of multiple needs as an exception for homeless people. This follows the thinking of Rorstad et al (1996) who see the defining distinction between the British and the American approach to multiple needs as being that the American model starts from the premise that most homeless people will have multiple needs, and designing services on that basis. Perhaps we could take this further and recognise that there is a truth in this for all of us. I prefer the word "multifaceted" because "multiple need" places the need within the person, when, as Rostad propounds, that is not necessarily where the complexity lies.

In reality, this group has a number of simple needs: a home, friends, income, meaningful daily activities, health needs and so on, which necessitate co-ordinated responses from several agencies. It is in realising this co-ordination that the complexity lies (Rostad et al: 1996 p45).

A third dimension is the need to develop autonomy in homeless people. Rankin and Reagan (2004) say that in order for care to be truly effective, users of social care services need to be recognised as co-producers of their own care (Kendall and Lissauer 2003). However autonomy needs to be developed, it cannot be assumed, particularly in homeless clients. Valesco (2001) notes that while service-user involvement is very well established in many areas of health and social services, it is only in recent times that the concept has risen to prominence in the field of homelessness. I have noted elsewhere (Seal:2008) that this history has legacies in the form of engrained cynicism, a lack of participatory cultures, and a lack of confidence on behalf of both staff and clients.

On a wider level, Friere (1972) believed that oppressed groups are socialised not to believe in themselves, not to analyse their predicament and not to ques-

tion wider issues. People need to be educated to be able to examine their situation, to understand what has happened to them and why. For him, it is in the State's interest for the poor not to think of their situation, or healthcare, lest they want to do something about it. In our context it means that you cannot just ask people what they want, people have to learn how to ask, analyse and question what they have first. As Godfrey says, services need to be '*underpinned by a philosophy that clients are more capable, resourceful, gifted and enterprising than they themselves, and often others, realise.*' (Godfrey et al: 2003 pp29), but they also need to develop the mechanisms that make this possible, an issue I will return to in the conclusion.

Again, the EPSCO conclusions offer us a starting point to shape, in training and in practice, what we mean by client-centred. It says that services must be '*designed to respond to vital human needs, in particular the needs of users in vulnerable positions*'. More specifically it says that services '*must be comprehensive and personalised, conceived and delivered in an integrated manner; They should 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.*'

CONCLUSION

I have argued that training for practitioners providing healthcare for homeless people needs to tackle some of the fundamental frameworks that they are operating within, namely a utilitarian philosophy and a reductive notion of client-centeredness. However, once in practice this needs to be sustained, which may be particularly difficult in the case of the need to develop autonomy. As a parting thought, the EPSCO conclusions also call for social services to '*involve a personal relationship between the recipient and the service provider*'. In two pieces of research I have been involved in, looking at homeless people's views on the health services designed for them, a common theme was the valuing of the time that services gave to them, the personal relationships that were built that allowed them to explore their issues. Given this, and the difficulties many homeless people have in establishing trust (Seal:2005), is the current average UK GP consultation time of 11.7 minutes enough? (BMA:2007)

We should stop thinking of multiple needs as an exception for homeless people.



[T]raining for practitioners providing healthcare for homeless people needs to tackle some of the fundamental frameworks that they are operating within.

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A Snapshot of Health Issues Experienced By People Who Are Homeless in Ireland

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INTRODUCTION

There are many different reasons why a person becomes homeless, but generally the explanation lies in a combination of structural factors (such as poverty or unemployment) and personal factors (such as family breakdown or health problems). What is clear is that once a person becomes homeless, the deterioration in their physical and mental health can be both rapid and debilitating. The Simon Communities believe that every person has the right to enjoy the highest possible standard of health. The experience of homelessness may result in serious and persistent violations of this fundamental right.

ABOUT SIMON

The Simon Communities of Ireland is an affiliation of local Communities in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East. In addition, the National Office performs a coordinating role in campaigning in the areas of housing/homeless policy and the wider poverty and social inclusion agenda; best practice in service delivery and working with people who are homeless; and in the area of full time volunteering promoting excellence and providing accredited training.

The Simon Communities throughout Ireland provide the best possible care, accommodation and support for people experiencing homelessness and those at risk. Together, with people who are homeless, Simon tackles the root causes, promotes innovative responses and urges the government to fulfil their commitments. Simon delivers support and service to between 4,500 and 5,000 individuals and families who experience - or are at risk of - homelessness on an annual basis.

SNAPSHOT – A METHOD OF DATA COLLECTION

General

A snapshot is a 'point in time' picture during a particular sample time period, in this case one week. Snapshot studies can be a very useful tool when time and resources are limited allowing information to be

gathered and analysed fairly quickly and reported in a relatively simple manner. They are particularly suited to purposeful sampling methods. Given the 'point in time' nature of such studies it is critically important that such studies clearly state up front what they measure and report on, and indeed what they do not, inclusive of a comprehensive limitations section.

This Study

This snapshot study² focuses on the profile and health needs of some of the people using Simon projects and services during a one week period. It is important to note that the number of people who participated in the study is a sample and cannot be used to estimate the total number of people using Simon services during the week in question or a longer period of time such as a calendar year. It is however a significant sample and thus can be used as a basis to generalise about the health and support needs of people who use Simon services nationally. The research has used a form of sampling called "convenience sampling". This is a type of sampling which involves the sample being drawn from that part of the population which is close to hand; i.e. a sample population selected because it is readily available and convenient. The questionnaire for this study was designed internally utilising in-house expertise. It was not designed or administered by health professionals and thus the findings are indicative. Although the form does ask about drug and alcohol use, it does not ask about the extent, frequency or quantity of drug or alcohol use. Thus, this information is also indicative and might be considered a gap in the data restricting the extent of conclusions that can be drawn about problematic drug and alcohol use.

STUDY AIMS

In Ireland there is a lack of specific information about the health of homeless people. This is the first ever National Health Snapshot study which was undertaken by Simon, building on local studies which had been undertaken in Dublin and Cork previously. This Health Snapshot Study attempts to address this deficit in relation to some of the people who use Simon

The Simon Communities believe that every person has the right to enjoy the highest possible standard of health.

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² Health and Homelessness: Health Snapshot Study of People Using Simon Services and Projects in Ireland (2010) Simon Communities of Ireland <http://www.simon.ie/index.php?page=research>



Responding effectively to the needs of people who are homeless requires a person-centred response and [...] accessible and flexible services.

projects and services around the country. It explores health status, both physical and mental health; drug and alcohol use and the health implications; and access to medical services, amongst other issues. Understanding the health needs of people who become homeless is critical to developing, designing and improving, not only homeless services, but also health and other related services. This is critical in addressing long-term homelessness in Ireland.

Specific Aims

- To identify some the range of health issues experienced by people who use Simon services in Ireland.
- To inform the policy and campaigning work carried out by Simon nationally, regionally and locally.
- To address the data deficit and to add to the existing body of knowledge.

There are generally 3 groups of people that the Simon Communities work with and who were met for this research: people who are homeless; people who were previously homeless and need ongoing support; and people who are at risk of becoming homeless. These groups all fall under the ETHOS definition³ of homelessness and housing exclusion which has been adopted by the Simon Communities of Ireland and integrated in the National Homeless Strategy 'The Way Home: A Strategy to Address Adult Homelessness in Ireland 2008-2013'.

STUDY PARTICIPANTS

This National study is based on information collected by the eight Simon Communities across Ireland. This study was conducted during a one week period from July 26th to August 1st 2010. Seven hundred and eighty eight (788) people participated in this research, a sample of people using Simon Community projects and services during this one week. It is important to note that this is not all of the people who were in contact with the Simon Communities during the week in question.

- Seventy-eight percent (78%) were male and twenty-two percent (22%) were female.
- Thirty percent (30%) of people in this study were under 35 years of age.
- Fifty-four percent (54%) were aged between 36 and 55 years.
- Twenty-six percent (26%) were aged between 56 and 75; of these, three percent (3%) were aged between 66 and 75 years of age.

WHAT THIS STUDY DEMONSTRATED

Long-Term Homelessness

Long-term homelessness, which according to the Irish government is more than 6 months, was high in this study, with 80.5% of people reporting being homeless for more than 6 months. Of these, 35.5% reported being homeless for 5 years or more.

Homelessness Makes You Sick

This study demonstrates the complex needs⁴ (many related needs) experienced amongst people using the Simon Community projects and services around the country; with 56% of people experiencing at least one diagnosed physical health condition, 52% experiencing at least one diagnosed mental health condition and 28% of people experiencing a combination of one or more diagnosed physical and mental health conditions. In addition, people reported alcohol use (66%), drug use (30%), self harm (15%) and attempted suicide (23%). In short, people who are very sick and very vulnerable.

Homelessness Is About Health As Well As Housing

This study also highlights the fact that homelessness is not just about housing; health is a significant factor and needs to be addressed in tandem with housing. Access to appropriate healthcare is critical to ensure that people remain as healthy as possible and that they get the supports that they need. To support people to move out of homelessness, accommodation must be provided with appropriate housing, health and social care support based on need and also high support housing for those who need more intensive, ongoing support.

RECOMMENDATIONS

Responding effectively to the needs of people who are homeless requires a person-centred response and the provision of accessible and flexible services that address the person's care, accommodation and support needs.

Recommendations in this National study focus on the following areas:

- Improving access to health care for people with complex needs
- Improving access to drug and alcohol services for drug /alcohol users who are homeless

³ For more on the ETHOS definition, visit www.feantsa.org

⁴ The term, "complex needs" is "...a framework for understanding multiple interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to stable housing or meaningful daily activity. As this framework suggests, there is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services" (Rankin and Regan, 2004).



- Improving access to homeless services for drug and alcohol users
- Reducing Accident & Emergency service usage and hospital and prison stays
- Ending inappropriate discharge practices
- Achieving standardised needs assessment
- Training for front line staff
- Access to services for those affected by the Habitual Residence Condition⁵
- Further research on the pathways out of homelessness

Some of the key recommendations include:

- **Maintain existing specialist services and expand them into areas where they are required:** Specialist services working in conjunction with mainstream services have been proven to be effective when working with people who are homeless, supporting them to manage and overcome their combination of health problems. This improves diagnosis, interventions and, critically, outcomes.
- **Alcohol and Drugs Services:** Drug and alcohol services across the whole spectrum must be expanded. These should include harm reduction, access to substitution treatment,⁶ detoxification, rehabilitation and aftercare all-around the country. Where possible these should be tailored and targeted to the needs of people who are homeless with alcohol and/or drug related problems.
- **Housing with supports and high support housing:** To tackle long-term homelessness and to support people to move out of homelessness, the provision of accommodation with appropriate housing, health and social care support based on need is critical. In addition, high support housing for those who need more intensive, ongoing support must also be an option. The provision of both housing with supports and high support housing works and is working in Simon Communities all around the country.

CONCLUSION

As stated, this was the first ever National Health Snapshot study undertaken across all eight of the Simon Communities in Ireland. The Study has been very positively received across the board by politicians, policy makers and people working in the area. In addition to the National Report, each Simon Community received a localised report focusing on the users of their services, which they can use for service development and enhancement, and localised lobbying. The briefing papers circulated to TDs (MPs) and Senators as part of the *Simon Week 2010* Political Briefing event focused on the findings of this study. The study provides a national baseline of the health issues experienced by those using Simon services and projects around the country which can now be used for comparative purposes. Furthermore, the findings support Simon's campaigning efforts in the area of complex needs (many related needs). This exercise will be repeated in 2011 allowing Simon to begin mapping trends in relation to the health status of people using services around the country. Planning for the National Health Snapshot 2011 is underway.

[T]he provision of accommodation with appropriate housing, health and social care support based on need is critical.

5 A "proven close link to Ireland" http://www.citizensinformation.ie/en/social_welfare/irish_social_welfare_system/social_assistance_payments/residency_requirements_for_social_assistance_in_ireland.html

6 This is the procedure of replacing a drug, usually heroin, with a medically prescribed substitute e.g. methadone or buprenorphine.



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