European Network of Homeless Health Workers (ENHW)

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Editorial

Sharing Experiences: News from Health Professionals across the EU

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Editorial

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Dear Readers,

We are pleased to share with you the latest edition of the ENHW newsletter, which covers a wide range of topics. The first article reports a study carried out in Cork and aiming at indentifying the needs of homeless people attending mental health services, with a special focus on risk factors associated with suicide and homicide. The second article presents the results of an integrated model for risk management of tuberculosis, based on a research on sheltered population in Rome. The third article presents the results of a European project, which assessed service provision and quality of care for homeless people experiencing mental health problems. The fourth article describes how the use of mobile technology and social media can help homeless people to engage and seek answers to problems, reducing their social isolation and consequently improving their access to services. It might give you an inspiration to further adapting this model to the health area. Finally, the fifth article presents a study carried out in Catalunya: it considers the lack of coordination between health and social services, proposing some possible solutions.

In the resources section, you will find information on guides, reports and research, which are related to health and homelessness and might be of interest to you.

We hope that this newsletter will stimulate further reflection and interaction, which could take the form of articles for the next issue. We would be pleased to receive information on any relevant research or events you might be aware of.

We would like to extend our warmest thanks to everyone who has contributed to the current issue. Please do not hesitate to send your comments, questions and contributions to dalma.fabian@feantsa.org.

Mental Health Services for Homeless in Cork: Patient profile and Factors associated with Suicide and Homicide

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The article is based on a paper published in The Irish Medical Journal, March 2012 Volume 105 Number 3

This study aimed to establish a profile of users of the mental health service for homeless in Cork, Ireland, comparing this group with those attending a local General Adult Mental Health Service. It is estimated that there are currently at least 4,176 adults and 1,405 children experiencing homelessness in Ireland. Despite this little is formally known about the extent of the problem and certainly about its relationship to mental illness.

Homeless people with mental health problems are exposed to all the same difficulties that other homeless people encounter but have more trouble meeting their needs because of their mental health condition. Estimates of the prevalence of severe disorder among the homeless in other countries range from 25%-50%.

The prevalence rates of suicide in the homeless population range from 1-3%, this is compared to approximately 0.0001% in the general population. Given the high risk of suicidal behaviour in patients suffering from mental illness (up to 15% lifetime risk of suicide in those suffering from severe mental illness), it is recommended that particular care be given to identifying service users most at risk in order to intervene with strategies that reduce the likelihood of proceeding to suicidal behaviour.

In the UK, around one third of those convicted of homicide between 1997 and 2006 had a diagnosis of mental disorder. 3% of homicide perpetrators with mental illness were homeless.

According to the national homeless census which was carried out in 2008, 472 individuals availed of the homeless services in Cork City at the time of the survey. The purpose of the current study was to provide a detailed profile of service users attending the mental health services for homeless in Cork, including demographic and clinical data and, in particular, to focus on factors which are known to be associated with suicide and homicide, making a comparison of the study group with service users of a local general adult mental health service.

54 people were attending the Mental Health Service for Homeless in Cork City at the time of the study. In comparison to the General Adult Service patients, the homeless group were:

- more likely to be male (89% v 46%), unmarried (98% v 75%), unemployed (96% v 68%) and under 65 years of age (94% v 83%)
- more likely to have a diagnosis of schizophreniform disorder (50% v 34%), personality disorder (37% v 11%), alcohol (61% v 14%) and drug (31% v 5%) dependence; and less likely to have a mood disorder such as depression and bipolar affective disorder (33% v 54%)
- more likely to have a history of deliberate self harm (54% v 21%) and physical violence (48% v 10%)
- more likely to have a history of alcohol (74% v 27%) or drug (61% v 11%) misuse (i.e. any mention of alcohol or drug misuse in the history not necessarily meeting criteria for dependence)
- more likely to be non compliance with treatment (37% v 10%), miss appointments with mental health team members (41% v 17%) and have active symptoms (57% v 37%)
- seen more frequently by the psychiatrist (average of 3.3 weekly v 10.4 weekly) and had more input from multidisciplinary team members (74% v 37%).

The profile emerging from this study draws attention to the complexity of this minority group of mental health service users. Levels of unemployment and lack of a marital relationship are high in those attending mental health services in general but were significantly higher again in the homeless group, highlighting the potential issues of social isolation and lack of occupation which may exacerbate or maintain symptoms and add to risk of

relapse and suicide. There was a high prevalence of severe mental illness in the homeless population, with particularly high levels (50%) of schizophreniform illness in comparison to general adult mental health services. This is compounded by the especially high rates of dual diagnosis (70%), i.e. those suffering from both a mental health diagnosis and substance abuse, and almost half (48%) of the population studied suffering from a secondary mental health diagnosis, resulting overall in a particularly difficult group to treat.

In looking solely at twenty four features which have been seen in those who died by suicide or committed homicide, the group of homeless patients displayed many of these, with 39% having more than ten factors associated with homicide and 43% having more than ten factors associated with suicide compared to 8% and 9%, respectively, of those attending the general adult services. In addition to the high levels of complicated mental illness demonstrated by the high prevalence of severe symptoms, secondary diagnoses and dual diagnoses, this group also had higher numbers with more than five admissions to psychiatric inpatient units, had higher levels of active symptoms or symptoms at their last contact with the team and appear to be high risk. They were also more likely to be non compliant with treatment and required more intensive input from the multidisciplinary team.

One of the motives for carrying out this study was to identify the needs of the homeless population attending mental health services. From the findings it is clear that, in addition to the physical and social needs of any homeless person with issues such as isolation and lack of occupation, this group have the additional burden of severe and complex mental illness, addiction and are at risk of suicide and possibly violence. To aid in signalling those who may be at risk, all medical, social and voluntary workers involved in the care of homeless individuals should be educated in the risks and in the identification of those with mental illness or who may be at risk, and encouraged to refer to the appropriate services e.g. primary care teams or mental health services for assessment if they are concerned. Findings of studies such as this should therefore be taken into account in planning of services for mental health and homeless individuals to ensure that those most at risk are recognised and receive appropriate input form well resourced multidisciplinary teams to ensure there is intensive treatment of any underlying mental illness as well as dealing with addiction and social issues in order to reduce morbidity and risk.

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Tuberculosis in sheltered homeless population of Rome: an integrated model of recruitment for risk management

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Together with other social factors, homelessness is one of the greatest risk factors for the acquisition of

Latent Tuberculosis Infection (LTBI) and active Tuberculosis (TB). [1] In recent years, a few surveys have been carried out in Europe to evaluate the LTBI and TB prevalence in homeless people: the existing data (Rotterdam 29%, London 0.5%) show that adequate screenings and treatment pathways are needed to reduce the spread of *Mycobacterium tuberculosis* in overcrowded shelters and in the community. [2, 3]

In Italy, the incidence is extremely low in the general population. In 2008, crude incidence rate was 3.8/100,000 for those born in Italy and 50-60 /100,000 for those born abroad. In recent years the incidence of pulmonary tuberculosis seems stable and around 5-6 cases per 100,000 residents. However, the concentration of the majority of TB cases was observed among certain risk groups: alcohol abusers and drug users, homeless people, HIV-infected people, young migrants. [4, 5, 6]

In Rome, in the time-period 1996-2007, an annual average of 382.5 TB cases were notified (11.55 % of the total notified in Italy). A considerable increase of people living on the road has been reported in recent years: in 1998, a figure of 5,000 homeless people was estimated in Rome, but nowadays the expected number is about 23,000 [7], and the numbers alone could probably be a contributing factor explaining the increased rate of TB cases reported in the period 2002-2005 (409 cases in 2004 and 460 cases in 2005, up from 341 in 2002).

Epidemiological studies of homeless populations have reported the prevalence rate of 1.2%–6.8% for active TB. [8, 9] No data about the incidence of TB in homeless people are to date available in Rome.

Better understanding of the characteristics of homeless people with TB disease is important for creating strategies to reduce TB incidence in this high-risk population. [10]

Based on these assumptions, we enrolled homeless people from two shelters in Rome. A cross sectional study was carried on with the following aims:

1. to assess acceptance to came back for TST reading in a sample of homeless people recruited from two shelters in Rome [subjects who returned for Tuberculin Skin Test (TST) reading, after 72 hours],
2. to measure the prevalence of skin-positive results, assumed as LTBI
3. to investigate the associations between social risk factors and TST positive results
4. to evaluate the access to a public specialized outpatient clinic for initiating an early therapeutic pathway.

The protocols of this research were cleared by the local ethical committee.

The eligible individuals – male and female, Italians and foreigners, adults ≥18 years old – were recruited from two homeless refuges in Rome (named Caritas and Acisel) in the time-period November 2006-November 2007.

These two shelters were selected by convenience among all the others in Rome. A detailed anamnesis was collected using a form to record data about markers and risk factors. Previous *Bacillus Calmette et Guerin* (BCG) vaccination was investigated. The TST was performed by medical physicians in the surgery at the refuges, after informing the subjects about the study and obtaining their understanding and written consent by a translated form.

TST was read after 72 hours. According to the American Thoracic Society standards, a reaction with an induration diameter >10 mm and with normal chest X-ray, was considered as positive and we classified this as LTBI to send the subject towards a clinical pathway, managed by a specialized hospital [11].

Only positive subjects were invited to undertake a chest X-ray with portable equipment for radiography and to provide three sputum samples on alternate days.

The positive subjects to TST were referred to INMI (National Institute for Infectious Diseases "Lazzaro Spallanzani") in Rome for clinical evaluation.

Results

Among all recruited subjects, 259 came back for the TST reading, with an acceptance rate of 89.93%.

Out of the 259 compliant subjects, 141 (54.44 %) were TST negative and 118 (45.56 %) were positive, therefore suffering from LTBI. Among these, 18 (15.4 %) were over 60 years old, 16 (13.6 %) were females and 102 (86.4 %) were males.

No chest X-ray, sputum and culture sample, was positive respectively for TB and Mycobacterium tuberculosis.

Most people were Italians (33.2%) and Romanians (32%), as regards the TST-positives, 27.1% were Italians and 39.8% Romanians.

All TST-positive subjects were referred to a specialized outpatient clinic and 70 of them (59,32 %) accessed the health facility and completed the diagnostic pathway to receive the appropriate therapy.

The others 48 were lost to the study because of their homelessness condition, as all homeless were not stably residential in the shelter.

One subject (3.86 ‰) showed clinical suspicion of active disease and was promptly referred to hospital.
The results for LTBI risk, according to the multiple logistic regression analysis performed in order to discover the relationship with the risk factors, show that immigrant status, male gender, older age (over 60 years) and obesity were significant risk factors for developing LTBI, as shown from the OR and CI values.

Discussion and Conclusions

The results of our study indicate a prevalence of LTBI of 45.56% among the homeless and of 3.86 ‰ for active TB.
The low rate of active TB, compared to other experiences, could be interpreted as a sign of protection and full immune-competence of this group of subjects. It may be hypothesised that the incidence of active TB in this cohort of LTBI positive homeless persons may be explained by the good quality of conditions available for the homeless living in Italian shelters, which warrant good nutritional status and, therefore, low risk of progression to active disease. On the contrary, being homeless or belonging to a poor community may not necessarily increase the conditions leading toward active TB (healthy migrant effect against TB too). Indeed, historically active TB has affected mostly young adults, which are supposed to be the healthiest age group. The lack of immunological correlates of protection, and the fact that many steps in the mechanism of pathogenesis of TB are still missing, prevent us from properly addressing these issues.
Nevertheless, the remarkably high LTBI prevalence observed may indicate that the homeless may have a higher risk of contracting *M. tuberculosis* infection because of overcrowded environments or because they shelter in a community where the greater chance of an active TB patient transmitting the microorganism is not promptly recognized.
In this perspective, finally, immigrants should not be considered as spreaders of the disease but as persons at risk, and appropriate public health approaches should be oriented towards them, aimed at inclusion and at the promotion of barrier-free prevention and care measures. [12]
In Italy, health is a constitutional right for everyone, migrants included, independent of their judicial condition. Nevertheless, in practice, a high level of inequality affects access to healthcare services, as this is noted when we compare the Italian population with migrants. Available data reveal a substantial failure of health and social policies for integration. [13]
In 2008, ECDC (European Centre for Disease Control) published a Framework Action plan to fight TB in the European Union (EU), which recognises the concentration of TB in "hard to find" and "hard to treat" populations as a major challenge to TB control efforts across the EU and encourages EU institutions to collaborate with partners to identify and disseminate good practice models for TB control. [14]
On these foundations, our study applies this model of TB control in advance and for the first time in Rome, and produced a high compliance amongst the homeless population. In fact, a high adherence to screening was observed (89.93 %) if compared with a 65 % adherence to TST reading registered in a preventive therapy programme carried out in an inner city population in Atlanta in 1994-1996 [15] and with a maximum adherence rate of 84 % using economic incentive strategy to encourage test reading adherence in a high-risk population. [16]
Our data confirm that active surveillance is an excellent tool for prevention. Active research in crowded areas gave the possibility to 59.32% of the positive subjects to access health care facilities and to complete the clinical pathway.
The strength of our experience was the opportunity to reach people in shelters (where people sleep and eat) and to start a clinical activity within the same place, with highly motivated staff, in order to facilitate access by the most disadvantaged persons.
Nevertheless, the compliance to the TST reading decreased from 89.93 % to a 59.32 % clinical compliance when health and social support was missing and people were invited to go to hospital by themselves. The active role of a social network also should be strengthened with the aims of prevention, diagnosis, treatment and follow-up. For example, the Dutch TB control model is based on close collaboration between hospitals and municipal public health TB. [17]
Moreover guidelines should take into account the peculiarities of risk groups for whom health is not a priority. [18]

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Service provision and quality of care for homeless people with mental health problems in Europe

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The following report is based on a paper submitted to BMC Health Services Research

Introduction

Mental health problems are disproportionately higher amongst homeless people than the general population [1-6] yet homeless people encounter many barriers when attempting to access treatment.

Homeless people often have difficulty registering with health services and often seek mental health care through accident and emergency services, where they may not receive appropriate care and treatment [4,6]. Entitlement to health care does not always mean access [7,8]. Issues around opening hours, inflexible appointment procedures and location of services can make it difficult for homeless people to access services [6,8]. Negative attitudes towards homeless people may also exist in health services and there is often an unwillingness to accommodate the multiple and complex needs which homeless people tend to present with [7,8,9].

Despite the issues outlined above there is little information available on the characteristics and quality of service provision for homeless people in

Europe [9]. This article draws on findings from the PROMO project (DG Sanco: 2007 – 2010). The aim of the PROMO project was to assess current service provision and quality of care across 14 European capital cities for people from socially marginalised groups, including homeless people, who experience mental health problems. The findings in relation to homeless people are presented here.

Methods

Two highly deprived areas in 14 European capital cities were selected to participate in the study. The participating capital cities were Vienna, Brussels, Prague, Paris, Berlin, Budapest, Rome, Dublin, Amsterdam, Warsaw, Lisbon, Madrid, Stockholm and London. The research areas (28 in total) were identified by using the relevant local indices of public health and social deprivation. The target population size for each area was between 80,000 and 150,000 inhabitants, with some flexibility to accommodate different local contexts.

The Promo project sought to asses within each research area (i) all mental health, social care and general health services which potentially serve homeless people with mental health problems; and (ii) the overall quality of care for homeless people with mental health problems. Homelessness was defined according to the first two categories of the existing ETHOS typology [10], i.e. roofless (people sleeping rough or in emergency accommodation) and houseless (people in temporary accommodation).

Assessment of services

Services in each area which potentially provide health and social care to homeless people were identified. Each service was contacted and asked to participate in the study. A structured questionnaire was developed specifically for the assessment of services and covered the following aspects of service provision. (1) provider and funding information, (2) characteristics of staff, (3) service accessibility, (4) characteristics of clients, (5) programmes provided to clients from target groups, (6) co-ordination with other services and (7) service evaluation.

The assessments were carried out by PROMO researchers in each capital city with either the manager of the service or a designated member of staff. Each service was classified according to the following typology: (i) homeless specific or generic; (ii) mental health, social care or general health. While the assessment was focused on the selected areas, services located outside these areas but used by marginalised people from the selected areas were also assessed.

Overall quality of care

Semi-structured interviews with were conducted with 'experts' in mental health care for homeless people in order to assess the overall quality of care. One interview took place in each research area (n=28). The professional backgrounds of the experts who participated in the interview were - Social workers (8), Psychiatrists (7), Psychologists (5), Teachers (2) Psychiatric nurse (1), Medical Doctor (1), Lawyer (1), Nurse (1), Homeless service manager (1) & Therapist (1).

The interview consisted of (i) two case vignettes which described patients with different mental health problems and with contrasting attitudes towards seeking care. The experts were asked about the possible pathways into care, the barriers to receiving care and ways to overcome these barriers; and (ii) general questions in relation to the strengths, weaknesses and co-ordination of services for homeless people with mental health problems in the area, and how service provision may be improved.

Results

Assessment of Services

The results in relation to services identified as homeless specific are presented here. In total 111 homeless-specific services were assessed - 19 homeless-specific mental health services, 84 homeless-specific social care services and 8 homeless-specific general health services. 38% of services reported engaging in active outreach while 27% reported engaging in case finding. 64% of services reported some form of exclusion criteria, with aggressive behaviour (44%), lack of motivation (25%) and addiction (22%) the most prominent. 52% of services were open outside office hours from Monday to Friday and 60% were open any times at weekends.

70% of services reported that they do not have any professionally qualified mental health staff. 21% of services reported that they provide some type of addiction treatment programme. Only 8% of services reported that former clients are involved in direct delivery and contact with clients in a paid

role and 14% in an unpaid role. 54% of services reported that they have routine meetings at least once a month with other services concerning the care of homeless clients.

In comparison to the more generic mental health, social care and general health services assessed as part of the wider project (n=350), the homeless-specific services were significantly more likely to be provided by 'not for profit private organisations', to engage in case finding, to provide some type of social care programme and were less likely to report have a waiting list. The generic services were significantly more likely to report providing addiction programmes, individual psychotherapy and to have a higher number of paid staff.
The generic services were also significantly more likely to report having doctors, psychiatrists, psychologists/psychotherapists and occupational therapists as part of staff, while the homeless specific services were significantly more likely to report having social workers as part of staff.

In comparison to the generic mental health services assessed as part of the wider project (n=221), the homeless-specific mental health services assessed were significantly more likely to report providing active outreach and support around housing. However the homeless specific services were significantly less likely to report having psychiatrists, psychologists/psychotherapists and occupational therapists as part of their staff, and significantly less likely to provide psychotherapy.

Overall quality of care
The most common themes in relation to barriers to care for homeless people with mental health problems and ways to overcome those barriers are presented here.

Barriers to care
The difficult and chaotic life circumstances of homeless people were a common theme, including alcohol and substance abuse problems and difficulties with medication compliance. An unwillingness amongst homeless people to engage with health services was seen as a barrier to care, which is often related to a lack of trust in health professionals.

Not having health insurance or not being registered with a GP was identified as a barrier to care. Admission and discharge procedures in the health services, mainly a lack of clear responsibility in relation to the treatment of homeless people and complex catchment area procedures, were also highlighted. A lack of collaboration between mental health, social welfare and homeless services was highlighted frequently. The issue of prejudice by health professionals towards homeless people was also regularly highlighted.

Ways to overcome barriers
Building a relationship of trust with homeless clients was frequently highlighted, mainly by being respectful and ensuring regular contact. Helping homeless people to overcome administrative barriers such as lack of health insurance and complex admission procedures was also seen as important. Taking a comprehensive approach to treatment, e.g. helping homeless clients with issues such as accommodation and employment was regularly highlighted. Greater provision of mental health outreach was also seen as a positive step.

Conclusions
The results from the PROMO project bring attention to a number of issues relating to service provision for homeless people with mental health problems in Europe. Levels of active outreach and case finding appear low while the prevalence of exclusion criteria across services is high. Overall the level of input from mental health professionals was reported as low. The problem of substance abuse was highlighted yet addiction programme provision in the assessed services is low. Prejudice, a lack of co-ordination amongst services and difficulties in relation to health insurance were identified as major barriers to for homeless people in accessing care.

The results of the PROMO project suggest that homeless-specific services are better equipped to deal with the initial needs of homeless people. They are more likely to provide outreach, case finding and support on issues such as housing and social welfare than the generic services. On the other hand the larger generic type services provide more addiction programmes and psychotherapy, are more likely to employ mental health professionals and have a multidisciplinary team, and therefore may be more appropriate for long term care. Further research in determining the effectiveness of both delivery models, including the most effective coordination of homeless specific and generic services, would be useful.

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Further information
Further information on the PROMO project is available at www.promostudy.org.

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Homeless SMS: the information support service for homeless people using text message and social media

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Introduction of the project

Homeless SMS is a project investigating how simple mobile technology can help homeless people in the European context, reducing their social isolation and encouraging their engagement in positive activities. The project was founded in 2010 in London, explored how mobile technology could benefit the UK's homeless community through a social innovation incubator called Bethnal Green Ventures. Specifically the project has shown how text messaging can be used to help this group, as a persuasive tool for

securing their attention, distributing valuable information and positively affecting their behaviour.

In 2011, the project began to develop a pilot service working closely with homeless people and several high profile homeless service providers in London.
The pilot service used Twitter as a communication platform between homeless users and relevant parties such as service providers, other homeless and general public. Homeless SMS makes use of the free text messages sent from Twitter to account followers with mobile phones, as a free and effective channel to reach out to and engage with homeless users. The pilot service performed for three months, with 25 homeless people in London, proved that the service encourages homeless users to engage, seek answers to problems and to express themselves, in so doing reducing their social isolation. As a result, service providers have an improved opportunity to engage with them further.

The problem of failed engagements

Homeless people have complex needs, often caused by the compounding of multiple problems such as mental illness, substance abuse and relationship breakdown. Furthermore, homelessness leads to increasing isolation and disengagement from society, which reduces their ability to cope and overcome problems.
In the UK, there are extensive statutory-funded services available, ranging from professional support intervention to the provision of temporary accommodation, however many homeless individuals are hugely frustrated with these services because of complex restrictions and requirements for access. This leads many to mistrust institutional services and to disengage from them. For those that do access services, many over time increase their dependency on them, prolonging their homeless state and making them lose the motivation to solve their problems. These issues can be very destructive as these services are often essential to help an individual resolve their problems and escape the cycle of homelessness.
The problems involved in the homeless people's engagement with services turn toincreasing of service costs. For instance, homeless people less likelihood attend outpatient appointments, only managing 34% of meetings [1], whereas the average non-attendance rate of psychiatry out-patient appointments is 19.1% in England (2002-2003) [2].The failed tenancy is another significant cost factor. Between 25 to 50% of homeless people who moved in a private accommodation lose their tenancy within one year [3]. Each incident of the failure is estimated as £2800 [4].
There is an urgent need to assist homeless people to navigate the homeless services relevant to their specific status and needs while at the same time discouraging dependency on them. In addition, encouraging social and psychological re-engagement is a critical approach if people are to move on from homelessness. Homeless SMS is designed to compliment existing services and to support this process.

How Homeless SMS can help

Based on our field study, more than 70 percent of homeless people in London are estimited own a mobile phone and Homeless SMS is the first service to makes use of this untapped resource for their communication needs.
The Homeless SMS service provides an information network for the homeless that enabled by the SMS functionality of the Twitter platform. The service empowers homeless people to access information they need, when they need it; it makes them aware of opportunities to participate in, contribute to and enjoy whilst facilitating the exchange of information with their peers, service providers and the general public.*Figure 1* illustrates the parties involved in the service.

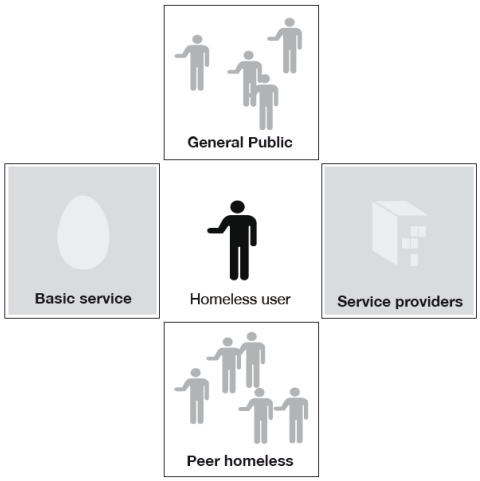

Figure 1. Involved parties in the Homeless SMS service

Homeless users are taught how to select the specific communication channels tailored to their unique needs and circumstances. Homeless SMS proactively manages these communication channels, distributing regular information-updates, and encouraging

engagement while at the same time guiding users' involvement in a positive manner.

How the service works

The service has been designed to minimise development costs. It is delivered via Twitter through SMS and so makes use of a commonly used and well understood, robust service. SMS messages can be sent and received from every mobile phone and so serves as a 'catch-all' for delivery.

Users are introduced to the service through traditional homeless service providers. They are signed up to twitter and their mobile phone is linked to their account. They can then interact with that personal account fully through their mobile phone.

Core Functionality:

A set of Twitter accounts are provided and understood as pipes for specific streams of information. Every tweet (message) sent from these accounts will be immediately received as an SMS on their phone. Useful messages can be stored for reference at a later date. Message types include:

- Regular updates on specific topics relevant to their circumstances.
- Alerts of new/temporary services in their area.
- Notifications of activities, opportunities and courses that may interest them.
- Weather alerts, useful contact numbers.

In addition users can also ask questions by texting the service. This can include information on local services such as facilities and opening times as well as souprun times and locations etc. The service will attempt to find the answers and will respond directly to the user at the time of need.

1) The service enables homeless service providers of all descriptions to manage their own accounts. By prompting their new and existing clients to 'follow' the service's account, they can send timely updates and reminders on specific meetings, courses, workshops and services and by so doing, reduce attendance, increase engagement and encourage positive outcomes
2) Homeless SMS also enables users to interact with other homeless users to foster an informal support network. They can ask and answer questions from their peers and share up to date, valuable information 'straight from the horse's mouth'. This can be done under pseudonyms or nicknames to avoid privacy concerns.
3) Importantly, the service provides a platform that enables homeless people to share their situations and voice their thoughts to outside world. This can encourage supportive comments from non-homeless twitter users interested in what they have to say. This serves as valuable emotional support, alleviating isolation and providing the confidence that someone is out there, that someone is listening.

What we have done

We began adding users to the service at the beginning of June 2011. We took a decision only to add users in small batches so we could effectively manage the service and get feedback from our users to improve it. We have signed up 25 users in the Connection day centre, so far and only three users have stopped the service. Each user is receiving 3 to 5 messages from the service per day excluding messages from other users. Picture 2 shows the prototype service. Below is an overview of the project highlights in 2011:

Positive outcomes of running the pilot service for three months:

1) One user received a message notifying him of a free eye test service at a specific location. He used the phone number in the message, booked an appointment and now has glasses.
2) One user tweeted about looking for odd jobs because he needed to raise a fund for his visa application. He got a wallpapering job offered from an individual follows the service. He worked for a few days and earned money. He managed to submit his application.
3) One user applying to be a Big Issue dealer decided not to when he was asked to pay £15 for the red jacket. He tweeted his frustration and one non-homeless individual responded that it was a deposit rather than payment. He returned and is now a Big Issue dealer.
4) Several users have had discussions about the best companies to approach for work if you are homeless and without references.
5) Positive and supportive conversations between homeless users were discovered such as messages to discourage one user to beg.
6) A number of users contributed their own content to the service. Several examples included users sending in quotes that had inspired them or even some they made up themselves. These were then used as quotes of the day and sent to other users.

Figure 2. Prototype service

Conclusions

From the experience of the pilot test, we learned positive effects of deploying the SMS based non face-to-face communication tool complementing the traditional engagement between service providers and their service users.In 2012, we intend to take the Homeless SMS project from a pilot to a fully realised service. We are aiming to implement the service in within multiple service providers refining the service through increased usage.

For more information about the project, please visit www.homelessSMS.com

And www.ohyoon.com/homeless.html

Acknowledgements

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Disfunciones entre los ámbitos de salud y social. Afectación sobre el abordaje de la enfermedad en las personas sin hogar en Catalunya

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English summary

Insufficient coordination between health and social services. How to approach the health needs of homeless people in Catalunya.

According to a census conducted in 2011, every day, an average of 2800 homeless people live in the city of Barcelona. This figure shows a 25% increase in the number of homeless people, if compared with the data available in 2008.

A study carried out in 2009 revealed a lack of coordination between health and social services, with a consequent negative impact on the health of homeless people. A second study, carried out in 2010 and 2011 and based on a semi structured survey administered to professionals and homeless people, confirmed these first results.

In the end, the article presents some proposal coming

from homeless people and professionals working in the health and social areas to improve this situation. Some of these proposals include a request for a better communication between health and social services and different departments, through the creation of agreements of collaboration, the necessity of an increased attention to mental health problems and larger efforts to understand the context in which homeless people live.

De acuerdo con el diagnóstico de recuento llevado a cabo en la noche del 8 de Noviembre de 2011, que actualizó el anterior, llevado a cabo en 2008, cada día hay aproximadamente 2.800 personas sin hogar en la ciudad de Barcelona.

Supone un incremento de aproximadamente 700 personas (25%) de presencia diaria, en tan sólo tres años. Estos resultados, alejan a la ciudad del objetivo de erradicar la existencia del sinhogarismo.

Los resultados, definen un mapa en el que 838 personas fueron contadas en espacios públicos (un número parecido al de 2008), 695 en asentamientos (un incremento del 162%, que parece apuntar a una cierta reacción por parte del incremento de personas sin hogar por autoorganizarse, ante el escaso aumento de respuesta por parte de de entidades sociales y administraciones), y en recursos residenciales de la Red de Atencion a Personas Sin Hogar (XAPSLL), 1.258 personas (un incremento del 5,7%, que es el incremento de plazas residenciales de esta Red).

La metodología del recuento, que tenía como objetivo el no ser invasivo hacia las personas, no permitió recoger datos sobre porcentajes por género, origen, edad ni tempo de permanencia en la situación de sin hogar de las personas contadas.

Se constató, pues, un elevado incremento en números absolutos de personas en esta situación, así como de la supervivencia de estas personas en asentamientos y en espacios públicos. En cambio, el incremento de plazas residenciales, desde 2008, ha sido porcentualmente poco significativo.

En este contexto, el estudio realizado en 2009 sobre el estado de salud de las personas sin hogar, objetivó la existencia de disfunciones en la coordinación entre los ámbitos de salud y social, que se traducían en una atención sanitaria deficiente e insuficiente hacia las personas sin hogar.

Hemos profundizado en las causas y efectos de estas disfunciones, a través de un estudio qualitativo, realizado entre 2010 y 2011, a través del análisis de entrevistas semi dirigidas a cuatro grupos focales:

- grupo de personas sin hogar
- grupo de técnicos sociales
- grupo de técnicos de salud
- grupo de gestores sociales

Algunas de las conclusiones más relevantes, fuero la constatación por parte tanto de personas sin hogar como de profesionales de que los déficits de coordinación impactan directamente en la salud de las personas sin hogar.

También, que la falta de coordinación hace más lenta y difícil la obtención de plaza en los recursos sociales, mientras que el tiempo de espera es largo para ser atendidos por el sistema de salud en general y, especialmente, por el circuito de salud mental.

Las interrupciones y rupturas en el seguimiento de la enfermedad, pueden llegar a ocasionar rupturas con el sistema social, con lo que la persona sin hogar acabe desvinculándose de todo sistema de apoyo.

Los colectivos que se sienten más perjudicados por esta descoordinación, son:

- personas sin hogar con patologías globales o pluri patologías. También, las personas sin hogar con enfermedades no diagnosticadas
- Jóvenes con problemas de salud mental y/o drogo dependencia
- En general, mujeres que se encuentren en una o más de las situaciones descritas
- Personas inmigrantes con derechos de salud restringidos por su condición de migrantes
- Profesionales del ´ámbito social: por saturación, angustia, miedo y riesgo de agresiones, entre otras circunstancias, generadas por las consecuencias de esta descoordinación

Propuestas

A través del análisis llevado a cabo, surgieron una serie de propuestas de intervención, que aquí agruparemos en dos categorías, las realizadas por las propias personas sin hogar, y las realizadas por los profesionales en su conjunto (sociales y de salud; técnicos y gestores).

Las personas sin hogar, plantearon como principal:

- ofrecer expectativas reales y no ficticias al paciente. Se destacaba una insatisfacción por el gap entre las expectativas de la propia persona sobre el tratamiento de salud que va a recibir i que sus referentes sociales alimentan, y el que realmente recibe. A veces, acaba generando un efecto de rebote de rechazo del seguimiento médico que acaba repercutiendo en su salud.
- Comunicación fluida entre los sectores social y de salud. Las personas sin hogar consultadas, constataban las disfunciones de coordinación y

los efectos perjudiciales sobre su tratamiento y posible mejora

- Incrementar los recursos y apoyos a la atención a la salud mental de las personas sin hogar, un problema que dicen vivir como grave y ante el cual les parece que no hay vía de abordaje alguno, sino es el que puedan recibir en caso de una crisis, y sólo por TMS (Trastorno Mental Severo)
- Insisten en destacar que todas estas propuestas, no son sino oportunidades de apoyo a su inclusión social, a su plena normalización, e insisten en que la inexistencia de estos puentes, implican lo contrario: el fortalecer su perpetuación en la situación de sin hogar.

Los profesionales, señalaron como principal:

- La no creación de redes alternativas de atención a las necesidades de salud del colectivo. Las existentes, con suficientes mecanismos de coordinación y algunos protocolos de actuación concretos para el colectivo, son aparentemente suficientes para el correcto tratamiento y seguimiento de la salud de los pacientes
- La importancia de que el ámbito de la salud se apoye en el ámbito social, que suele dar seguimiento a las personas sin hogar, para conocer mejor la realidad contextual de la persona sin hogar y así pode realizar las micro-adaptaciones necesarias para un correcto tratamiento y seguimiento (compartir información; coordinación con los profesionales sociales de referencia; trabajo conjunto sobre determinados aspectos relacionados con hábitos de vida/higiénicos y/o de seguimiento de la enfermedad)
- La identificación de diferentes líneas de intervención para mejorar la eficacia del sistema, a través de la implementación de canales formales de coordinación, a nivel de acuerdos entre los departamentos/ministerios de salud y sociales:
  - Del ámbito de salud al ámbito social: contar con el profesional social referente de la persona sin hogar, como figura reconocidamente equiparable a la de familiar, a quien transmitir la información relevante necesaria para garantizar el seguimiento de la enfermedad
  - Del ámbito social al de salud: Facilitar al profesional de la salud, aquellas informaciones disponibles de hábitos de vida u otros que puedan ser relevantes para trabajar correctamente el abordaje de la enfermedad en la persona. Facilitar los acompañamientos a la visita médica, así como el ingreso y el alta hospitalaria, de manera que los equipos de salud puedan planificar tanto el tiempo de tratamiento necesarios, como el tener la seguridad de que el alta podrá producirse en el tiempo que clínicamente se considere necesario
  - El ámbito de salud, consigo mismo: Para las personas sin hogar con "patologías globales" o con "pluripatologías" –múltiples enfermedades, agudas o crónicas, que puedan afectar al conjunto del sistema de salud de la persona, o no-. Estas son atendidas por servicios diferenciados y herméticos, sin contacto ni coordinación entre ellos, del propio servicio de salud. Se desaprovecha frecuentemente el que una persona que por un determinado motivo accede a la posibilidad de un tratamiento, lo haga sólo por la afección que origina este, y no por la globalidad de patologías que pueda sufrir.
  - El ámbito social consigo mismo: No hay una red común de traspaso de información entre las entidades sociales en relación al seguimiento de cada persona sin hogar, con lo que una nueva intervención en un servicio social, implica comenzar de nuevo desde cero en el conocimiento y seguimiento le su estado de salud.
- Otra línea de intervención, se basa en los protocolos de colaboración:
  - Protocolos de circuito: estipular qué servicios del sistema de salud deben de dotar qué recursos y como, para que las dos redes, social y de salud, sepan cuáles son sus interlocutores cuando sean necesarios, y no tener que utilizar como única vía las redes informales
  - Protocolos de atención: definiendo can flexibilidad una sistematización alrededor de qué tipo de atención sanitaria y qué tipo de atención social necesita la persona, en relación a su enfermedad
  - Protocolos que permitan gestionar con los tiempos de urgencia necesarios, casos especiales
- Hacer más accesible la figura del médico/médica: normalizar la comunicación entre los dos profesionales e igualar la consideración entre uno y otro
- Normalizar la información al profesional social de referencia en relación a la persona atendida, por lo que respecta al diagnóstico, tratamiento y

coordinación del seguimiento de la persona. Ambos profesionales están por igual el secreto profesional, y con frecuencia, el profesional del ámbito social y la estructura social para la que trabaja, pueden ser un elemento sustitutivo del apoyo familiar, de primer orden.

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Resources

"Access to Health Care for Vulnerable Groups in the European Union in 2012"

Nathalie Simonnot*
Médecins du Monde/Doctors of the World International Network

Médecins du monde (MdM) – Doctors of the World International Network runs 180 health programs in Belgium, Bulgaria, France, Germany, Greece, Netherlands, Portugal, Spain, Sweden, Switzerland and United Kingdom. MdM started working in Europe in 1986.

MdM released various specific surveys on undocumented migrants' state of health and the barriers to access healthcare in 2007, 2009, and 2011. MdM International Network published a document, held a roundtable discussion and organized an event in front of the EU Parliament on April 10th 2012, following the World Health Day: MdM want to show how difficult access to healthcare is for various populations in Europe like destitute European citizens living in their own country, destitute European citizens living in another EU country, asylum seekers under the rule of Dublin II...

MdM wants to insist on the necessity to immediately improve access to vaccinations, antenatal care, prevention and treatment for infectious diseases just as much as we need to protect seriously ill foreigners, who cannot access care in their home.

The paper is available on Médecins du Monde website and can be downloaded from the following page:
http://www.mdm-international.org/spip.php?article1121

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EPHA Annual Conference 2012 - *Restructuring health systems: How to promote health in times of austerity?*

Anne Hoël*
EPHA – European Public Health Alliance

On June 6 2012 the European Public Health Alliance (EPHA) held a day-long conference entitled *Restructuring health systems: How to promote health in times of austerity?*. The debate, hosted by the European Economic and Social Committee (EESC), brought together for a first time more than 20 speakers from all across Europe health professions, experts and civil society along with the IMF, OECD, WHO, DG ECFIN, DG SANCO and Commissioner Dalli. Around 150 people joined EPHA to assess the impact of the current downturn in the continent's health systems and identify actions to move forward.

Based on a briefing highlighting facts and figures on the impact of the economic crisis on health, the Conference already resulted in a Open Letter to Heads of States, signed by 65 organisations & MEPs calling on EU leaders to stop cutting essential health and welfare systems and focus on ordinary people living in Europe coping with the dire impact of a financial crisis of which they are the first victims. FEANTSA was one of the signatories.

Useful links:
Conference documents:
http://www.epha.org/a/5080
EPHA briefing on the impact of the crisis on health:
http://www.epha.org/a/5192
Open Letter to Heads of States:
http://www.epha.org/a/5227

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Hidden health needs of homeless young people: key considerations for health commissioners

Homeless young people face important problems in accessing health services. That is why the homelessness charity Centrepoint, has drawn together information on homeless young people's health needs. Too often, homeless young people are not considered in the designing of local health services, despite having much poorer health on average than other young people.
Centrepoint, after having collected data on homeless young people health needs and services, has identified key recommendations for how local health commissioners could best work to support vulnerable and homeless 16 to 24 year-olds.

The report is available on Centrepoint website and can be downloaded from the following page:
http://www.centrepoint.org.uk/the-solution/influencing-policy/research/hidden-health-needs-of-homeless-young-people

Tuberculosis surveillance and monitoring in Europe 2012 – ECDC report

A joint surveillance report on Tubercolosis has been released by the ECDC (European Centre for Disease Prevention and Control) and the WHO Regional Office for Europe (WHO/Europe).
It analyses the data collected in countries throughout the European region. Data show a decrease in tubercolosis incidence since 2005 but with important diversities among countries.
Moreover, drug resistant tubercolosis represents an important concern that needs to be addressed.

The report is available on ECDC website and can be downloaded from the following page:
http://www.ecdc.europa.eu/en/healthtopics/Tuberculosis/epidemiological_data/Pages/tuberculosis_surveillance_Europe.aspx

Alcohol in the European Union. Consumption, harm and policy approaches – WHO report

The World Health Organization Regional Office for Europe has published a new report on alcohol consumption, health outcomes and action to reduce harm across the European Union. Alcohol is one of the world's top three priority areas in public health. In Europe, alcohol is the third leading risk factor for disease and death after tobacco and high blood pressure. The report provides information to guide the future action of policy-makers and other stakeholders in reducing the harm done to health and society by excessive drinking. The report also has a chapter dedicated to the issue of alcohol and the workplace.

The report is available on WHO website and can be downloaded from the following page:
http://www.euro.who.int/en/what-we-publish/abstracts/alcohol-in-the-european-union.-consumption,-harm-and-policy-approaches

Making It Matter: Improving the Health of Young Homeless People

The homelessness charity Depaul UK and the pharmaceutical company AstraZeneca presented the report *'Making It Matter: Improving the Health of Young Homeless People'*. This research is part of the Young Health Programme, funded and developed by AstraZeneca in collaboration with Depaul UK. It aims at gathering evidence and obtaining a clear picture of the health and wellbeing experiences of homeless young people.

Some of the key findings presented in the report:

• 40% of young homeless people are likely to be experiencing depression compared 21% of non-homeless young people
• 27% of homeless young people have been diagnosed with a mental health condition by a doctor compared with 7% of the group of non-homeless young people
• Compared with peers Depaul clients have higher usage of walk-in clinics, ambulance and A&E services and are more frequently admitted to hospitals.
• 35% respondents said that they wanted more mental health support
• Long waiting times lead to a lack of timely care which is especially vital in this group where help, particularly for mental health issues, is sought at the point of crisis.

The report includes recommendations for commissioners and providers to ensure that the needs of young homeless people are at the centre of their care.

The report is available on Deapul UK website and can be downloaded from the following link: http://www.depauluk.org/newsandresources/research-and-publications/

The Prevalence of Traumatic Brain Injury in the Homeless Community in a UK City - a briefing

The study, launched by the charity The Disabilities Trust, shows how brain injury can lead to homelessness.
The results of the research showed that:
• almost half (48%) of the homeless participants reported a history of traumatic brain injury compared to just 21% in the control group
• of the homeless participants, most (90%) indicated that they had sustained their first traumatic brain injury before they became homeless
• the mean age at first injury was 19.9 years, indicating that for many people their first TBI was sustained at a young age
• over half (60%) of the homeless participants with a history of TBI said that they had experienced more than one traumatic brain injury, compared to 24% of the control group

The briefing is available in the website of The Disabilities Trust and can be downloaded from the following page:
http://www.thedtgroup.org/news-and-media/news/almost-half-of-homeless-people-say-they-have-a-brain-injury.aspx

Environmental health inequalities in Europe – WHO assessment report

Based on 14 environmental health inequalities indicators, the WHO Regional Office for Europe has produced an assessment report, identifying the main inequalities existing in the European region and possible recommendations and actions to be taken.
The main findings of the report show that socioeconomic and demographic inequalities as regards to risk exposure to environmental conditions are present in all country in the

European region, although some specific differencies between countries.

The report is available on WHO website and can be downloaded from the following link:
http://www.euro.who.int/en/what-we-publish/abstracts/environmental-health-inequalities-in-europe.-assessment-report

Improving hospital admission and discharge for people who are homeless

According to the report, 70% of homeless people end up in the streets once discharged from hospital. This report, produced by the homelessness charities Homeless Link and St. Mungo's, identifies best practices and advice for hospitals staff to understand what more could be done to ensure homeless people have somewhere to stay when discharged from hospital.

The report is available on the Homeless Link website and can be downloaded from this link: http://homeless.org.uk/news/hospitals-discharging-homeless-people-street#.T8SlArDrqri

Join the LinkedIn discussion group of the European Network of Homeless Health Workers!

A LinkedIn discussion group of the European Network of Holmeless Health Workers has been launched. The aim of this new tool is to improve collaboration and information sharing among the members of the network. This will be a new platform for exchanging knowledge and experiences among professionals working in the areas of health and homelessness.

Do not hesitate to join the discussion group, contributing to the debate or simply sharing information on interesting articles, reports, useful resources and events you may be aware of.

To join the LinkedIn discussion group, please follow this link:
http://www.linkedin.com/groups?gid=4361852

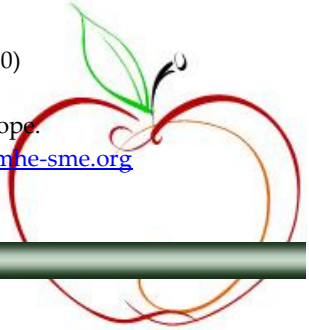
Events

Housing First: Challenging Perceptions
Glasgow, United Kingdom
11 September 2012

For more information and to register, please follow this link:
http://www.turningpointscotland.com/housingfirst2012/

Tackling Health Inequalities to Ensure Active Citizenship
Mental health, Exclusion and Homelessness
Brussels, Belgium
European Parliament, 13 November 2012 (14.00-16.30)

Conference organised by FEANTSA and Mental Health Europe.
For more information and to register, please contact paulina.banas@mhe-sme.org



European 13th conference SMES-Europa
HOME-less & home-FIRST
Pathways different & personalized accompanying
Rome, Italy
10-11-12 December 2012

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The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries.
To that effect, PROGRESS purports at:

- providing analysis and policy advice on employment, social solidarity and gender equality policy areas;
- monitoring and reporting on the implementation of EU legislation and policies in employment, social solidarity and gender equality policy areas;
- promoting policy transfer, learning and support among Member States on EU objectives and priorities; and
- relaying the views of the stakeholders and society at large.

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