

# European Network of Homeless Health Workers (ENHW)



## Issue N°16 – winter 2012-2013

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HOME-less & home-FIRST, Dignity and Belonging, Health and Well-being

Rome, 6-7-8 March 2013

[http://www.smes-europa.org/PROGRAM\\_RMConf\\_EN.htm](http://www.smes-europa.org/PROGRAM_RMConf_EN.htm)

Homelessness, Health and Inclusion: Improving the health of the poorest fastest

London, 27-28 February 2013

<http://www.neilstewartassociates.com/sh303/speakers.php>

#### [Housing First Europe](#)

Final conference

Amsterdam, the Netherlands,

13-14 June 2013

Dear Readers,

We are pleased to share with you the winter edition of the ENHW newsletter, which covers a wide range of topics from all over Europe. The first article shares the results of a unique research carried out by King's College London that examines the link between homelessness, residential mobility, and the length of stay for mental health inpatients. The second article describes a European multidisciplinary pilot project which aimed at sharing experiences and practices relevant to the work on health and wellbeing of homeless people. The third article presents the results of a research on knowledge about homelessness and attitude towards homeless people of medical doctors in the Czech Republic. Finally, the fourth article summarises and analyses an international literature review on the access barriers to health care faced by homeless people. It also includes recommendations for the provision of adequate care for homeless people.

In the resources section, you will find information on reports and research, which are related to health and homelessness and might be of interest to you. You can also join our LINKEDIN discussion group: <http://www.linkedin.com/groups?gid=4361852>

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](mailto:dalma.fabian@feantsa.org).



### Homelessness, Residential Mobility and Length of Stay among Psychiatric Inpatients in South London: a Summary of Recent Research

Dr Alex D. Tulloch, PhD MRCP MRCPsych

#### Background

In a recent linked series of studies, a research team at King's College London attempted to answer three questions:

- (a) What are the characteristics and associations of homelessness among mental health inpatients?
- (b) What are the characteristics and associations of residential mobility in that group, that is, of movement from one residence to another?
- (c) What is the relationship between homelessness and residential mobility and the length of stay of mental health inpatients?

Taken on their own, homelessness, residential mobility and length of stay are all well researched topics, but research that properly examines the interface of these three phenomena is less common. For example, in a systematic review of studies of length of stay in the United States, we found only two studies which had examined the relationship between homelessness and length of stay. Studies of residential mobility among users of mental health services have consistently found a relationship between medium- to long- term mobility and a history of inpatient admission, but have generally not examined the timing of these moves, making it difficult to tell whether residential mobility is actually more common around the time of a hospital stay. Similarly to homelessness, the relationship between residential mobility as such and length of stay has rarely if ever been researched. Instead, research into the relationship between any aspect of housing and length of stay has generally taken the form of studies of delayed discharge—that is, of admissions which are judged to have been extended unnecessarily. While this method has some merits, it makes it hard both to gain an overall estimate of the effects of homelessness and residential mobility on length of stay and also to judge the importance of that effect relative to other influences on length of stay. Nonetheless, there is a clear sense on the part of many researchers and clinicians that the three phenomena are linked, and, in particular, that

homelessness may often occur around the time of admission, perhaps due to eviction, leading to residential mobility, in anticipation of which discharge is delayed and length of stay therefore increased.

Difficulties in looking at the relationship between homelessness, residential mobility and length of stay are likely to have arisen in part from the limited housing data recorded in those health data to which researchers have access. We were fortunate to be able to create a dataset from the electronic patient record database maintained South London and Maudsley NHS Foundation Trust—a large English mental health services provider which serves the London Boroughs of Croydon, Lambeth, Lewisham and Southwark. The Trust makes its records available to researchers in fully anonymised form as the BRC Case Register (Stewart et al. 2009).

#### Results of the study

Our methods are described in full in the three publications referenced at the end of the article (Tulloch et al. 2011; Tulloch, Fearon, et al. 2012; Tulloch, Khondoker, et al. 2012): we performed some descriptive analyses and used regression analyses to determine the relationships among variables. Here we concentrate on the results that we obtained.

We studied 4485 individual hospital stays. All of these began on one of South London and Maudsley's adult acute general psychiatric wards and ended in 2008 or 2009. The median length of stay was 22 days, which is somewhat longer than the English median of 17 days, possibly reflecting the greater social adversity and psychiatric morbidity found in inner-city populations. As is typical, most hospital stays were short, but there was a long tail of extended admissions. An examination of the dates at which recorded periods of homelessness began indicated that these clustered clearly around the date of admission. Of the total 4386 patients with address data, 719 patients (16%) were either recorded as homeless at the time of hospital admission or as becoming homeless during the admission, and 70% of these were recorded as homeless within seven days of admission. An examination of dates at which residential mobility was recorded demonstrated a different pattern. A total of 646 patients (15%)

moved into a new address during the admission or up to 28 days afterwards. There was a clear clustering of newly recorded addresses around the date of discharge, with many new addresses not being recorded until shortly after discharge.

Homelessness was associated with younger age; male gender; ethnicity other than White British or Black African/Caribbean; being single, divorced, separated or widowed; diagnosis of drug and alcohol disorder; detention under a forensic section of the Mental Health Act; having no previous admission or alternatively having a longer previous admission; having a low score on the depressed mood or hallucinations and delusions items of the Health of the Nation Outcome Scales (HoNOS); and having a high score on the HoNOS relationship difficulties and occupation and activities items. The most important effects were those observed for age and for marital status. The odds of homelessness (probability of being homeless divided by one minus the probability of being homeless) were around three times higher among 16-25 year olds than among 56-56 year olds and were around three times higher among those who were divorced, separated or widowed than among those who were married.

The strongest association with residential mobility was homelessness: the odds of residential mobility were around seven times higher among those who were homeless than those who were not. However, the association was not invariable: only 50% of homeless patients had a new address recorded in the period up to 28 days after discharge—a finding which surprised us, but has been described in an American population (Rosenheck & Seibyl 1998). Residential mobility was also clearly associated with younger age and with detention under the forensic sections of the Mental Health Act.

In the analysis of length of stay, we replicated previous well-established associations of diagnosis, legal status and older age with length of stay; we also showed that length of stay was associated with having a long admission in the past and with several HoNOS items. As we had hypothesised, length of stay was 99% higher among those who moved home and was 45% higher among those who McCoy, D. et al., 2007. Carrot and sticks? The Community Care Act (2003) and the effect of financial incentives on delays in discharge from

were homeless. These effects were some of the largest observed, and because of this, despite both homelessness and residential mobility applying only to a minority of those admitted, they together explained as much of the total variance in length of stay as did the patient's diagnosis.

### Implications of our research

Homelessness and residential mobility remain fairly common parts of the experience of mental health inpatients. They are strongly related to each other, and to length of stay, and the times at which they occur in relation to hospital stays are also characteristic. Many of our findings support the common supposition that a common pattern is for an admitted person to become homeless before or shortly after admission and then to move home, and for this to increase the length of time that they spend in hospital. However, homelessness also appears to increase length of stay regardless of whether the affected person is immediately rehoused—indeed, what happens to those homeless inpatients that are not recorded as being rehoused deserves further investigation.

It is both inefficient and inhumane for those with housing problems to spend longer in hospital than would otherwise be required and we suggest that policy attention be refocused on this long-standing problem. Cross-charging local government for “delayed discharge”—a policy developed in Sweden—was implemented several years ago in acute hospitals in England, although with unclear effects (McCoy et al. 2007). It may be one possible solution. An alternative, and perhaps more elegant, solution might be for an affected individual's housing budget and the responsibility to provide housing to be transferred from local government to the health provider for a defined period, giving a clear incentive for the health provider to arrange suitable accommodation in a timely fashion. However, any approach must not lose sight of the essential importance of choice of accommodation as the means by which people attempt to satisfy their housing needs—forcing recently discharged inpatients to take unsuitable accommodation may be little better than the current situation.

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**SAFYA: un progetto pilota su homelessness e salute.**

**Anna Filoni and Marco Iazzolino, fio.PSD**

#### *English summary*

#### **SAFYA: a pilot project for homelessness and health**

*In 2010, fio.PSD promoted a European pilot project with the aim to link different experiences and good practices at EU level, in order to better study issues related to the health and psychological wellbeing of homeless people.*

*The project involved 20 researchers from four different European cities and had the following partners: fio.PSD, the NIHMP, the National Institute for Health, Migration and Poverty, the Sundheds Team (Health Team for Homeless) of Copenhagen, St. Mungo's Hospital of London and the Galliera Hospital of Genova.*

*The main objective was to share and test a multidisciplinary model, able to take into account both social and health elements and involve different professionals.*

*The Safya project set the basis for future projects, having established common, sharable and comparable procedures. Now fio.PSD would like to develop another project to be tested in different European and Italian cities. Using the multidisciplinary model, appropriate screening*

*instruments should be developed in order to better understand and improve the psychological wellbeing of homeless people.*

Pensare cambiamento, promuovere percorsi che non si accontentano di rispondere ad una molteplicità di bisogni è il desiderio di ogni studioso del sociale. La centralità della relazione e della vulnerabilità psicologica nello studiare questa popolazione non rappresenta solo un ambizioso obiettivo scientifico, ma anche la necessità di pensare nuove forme di lettura, studio e ricerca che provino a mettere in dialogo chi opera con chi è chiamato a leggere i processi e gli esiti dei processi di marginalizzazione. Safya ha come oggetto un progetto pilota che partendo da un approccio multi e trans-disciplinare, vuole porre al centro la persona, non solo come somma di bisogni a cui rispondere, ma come risorsa vitale anche se sofferente per la sua vulnerabilità.

#### **Le ragioni e la genesi del progetto pilota Safya**

Studiare il fenomeno dell'homelessness dal punto di vista della salute e del benessere psicologico rappresenta una sfida importante da cogliere nella



sua complessità.

Per questo nel 2010, la fio.PSD si è fatta carico di promuovere un progetto pilota europeo che andasse, in primo luogo, a connettere esperienze e buone pratiche a livello di Unione Europea.

Gli studi e le politiche di intervento svolte sino ad oggi sono incentrate su una lettura prevalentemente sociologica del fenomeno, gli organismi che operano sul territorio sono spesso schiacciati dal fronteggiare situazioni di emergenza e di risposta ai bisogni primari. La necessità di confronto tra le varie forme di intervento, per gran parte portate avanti singolarmente sulla base delle competenze acquisite sul campo, di ricerca di punti di riferimento comuni e di protocolli strutturati e sistematici di presa in carico totale di queste persone.

Il primo draft del progetto pilota è stato oggetto di confronto nel gruppo europeo di Feantsa che si occupa di salute nel novembre 2010 a Milano. Una vera e propria peer review che ha coinvolto esperti di health and homelessness provenienti da nove paesi (Germania, Olanda, Inghilterra, Francia, Belgio, Finlandia, Danimarca, Austria oltre che Italia) in un lavoro di revisione approfondito sul senso e sulle modalità del progetto sperimentale.

Crediamo sia opportuno riportare due elementi di criticità che hanno caratterizzato la discussione e che hanno accompagnato il percorso che ha portato ad individuare i partner ed i principali indicatori del progetto. La prima criticità rilevante affrontata nella peer review è stata il focus sulla multidisciplinarietà. Il pensare di avviare un processo di sperimentazione multidisciplinare, ha sortito un dibattito interessante che ha sostanzialmente evidenziato il gap esistente fra la necessità "strutturale" di un intervento sanitario di emergenza (dal first aid allo screening sulla tbc) e il desiderio di promuovere percorsi di salute bio-psico-sanitari capaci cioè di prendere realmente in carico la salute integrale della persona. Non è questa la sede per approfondire questo tema ma l'articolarsi del dibattito sulla multidisciplinarietà è stato certamente la premessa della seconda questione di interesse del presente lavoro: la centralità della relazione ed in particolare di un contributo psicologico nel lavoro sul tema della salute.

Per segnare il percorso nelle sue criticità/opportunità la scelta del titolo ha avuto un ruolo importante. Il voler validare la multidisciplinarietà dell'approccio, il porre la centralità della relazione, la constatazione che ci trovavamo a lavorare in uno scenario segnatamente multiculturale ha portato quasi naturalmente a scegliere come titolo una parola che in qualche maniera rimandava a queste accentuazioni: Safya. Un termine swahili che significa salute integrale, olistica intesa come benessere pieno, globale, in altre parole una grande sfida per si occupa di persone senza dimora.

### I partners di Safya

Il partner primo e fondamentale con cui si è strutturato il percorso è stato l'INMP<sup>1</sup>. L'istituto fondato e diretto sino allo scorso anno dal prof. Aldo Morrone ha rappresentato negli ultimi anni un vero laboratorio di ricerca sul tema della salute legato al mondo della grave emarginazione.

In particolare l'INMP aveva sperimentato un modello analogo alla nostra idea iniziale che poteva essere oggetto di lavoro del progetto. Il problema era quindi cercare luoghi diversi in Europa che rispondessero alle criticità evidenziate ed in più fossero selezionati per provenienza (dal punto di vista socio-geografico) e per tipologia (dal pronto soccorso dell'ospedale ad attività di cura e accoglienza, diagnosi destinata alle persone senza dimora).

La ricerca dei potenziali partners a livello europeo è stata indirizzata non solo alla collaborazione di quelle che sembravano le migliori expertise del settore ,ma anche di realtà che avessero voglia di puntare a creare realmente dei processi nuovi, ponendosi in un atteggiamento di apertura nei confronti dei percorsi di lavoro e del team tenendo anche conto di quelli che ci sembravano i prerequisiti del progetto (la differenza geografica e la tipologia di intervento).

Il Sundheds Team (Health Team for Homeless) di Copenhagen si inserisce in una cornice di assistenza primaria, creando un ponte tra i servizi sanitari e

<sup>1</sup> INMP Istituto Nazionale per la promozione della salute delle popolazioni Migranti e per il contrasto delle malattie della Povertà di Roma.



L'individuo e quindi di accesso all'assistenza secondaria.

Il St. Mungo's Hospital di Londra è stato scelto come realtà significativa per la sua rete, infatti opera sia a Londra che a Reading, Oxford e Bristol. Fornisce ospitalità, centri diurni, unità di strada e servizi nelle carceri, servizi sanitari, di salute mentale e disintossicazione, così come servizi di reinserimento ed impiego, addestramento e sviluppo delle capacità.

L'ospedale Galliera di Genova E.O. Ospedali Galliera si inserisce nel progetto Safya con una propria specificità relativa sia alle origini della sua fondazione sia alle particolarità della realtà territoriale in cui opera. Il Galliera rappresenta inoltre l'Ospedale di riferimento per aree della città ad alta presenza di immigrazione e forme di disagio sociale,

### **L'obiettivo principale del progetto ed il ruolo di Fio.PSD**

Il ruolo dello staff fio.PSD è stato quello di assicurare il coordinamento necessario, la direzione scientifica oltre che l'importante azione di empowerment in grado di orientare il processo nelle naturali fasi di criticità.

Le finalità del progetto, il disegno e gli obiettivi concordati hanno portato alla composizione di staff multidisciplinari orientati a condividere il Modello proposto (un medico, uno psicologo, un mediatore culturale ed un antropologo).

L'obiettivo principale inizialmente concordato era la condivisione sperimentale di un Modello socio-sanitario multidisciplinare inerente ai fattori socio-sanitari rilevanti e prevalenti nella popolazione senza dimora secondo la classificazione Ethos mediante un approccio transdisciplinare e transculturale, attraverso un'azione di supervisione e formazione sistematica e sistemica degli staff delle tre U.O. coinvolte.

Le risorse a disposizione ed il percorso concertato hanno creato le condizioni per individuare un target complessivo di 21 persone senza dimora su cui operare il processo di esportazione del Modello con una chiara attenzione procedurale. Si è deciso in itinere di non definire il target concertato con ulteriori connotazioni (per esempio immigrato, ospite di un servizio, etc.) volendo diversificare il campione.

### **Le precondizioni per l'uso del Modello**

La consapevolezza di dover orientare un processo complesso all'interno di uno scenario che avesse caratteristiche analoghe e misurabili proprie di lavoro scientifico ha reso necessario esplicitare alcune precondizioni per l'uso appropriato del Modello.

Per questo alle singole Unità Operative delle città coinvolte è stato chiesto di riconoscersi nei seguenti assiomi:

- 1) Professionalità, efficienza e continuità dell'assistenza sanitaria, evitando interventi secondo logiche residuali dettati dalla scarsità delle risorse.
- 2) Accompagnamento ai servizi territoriali, che svolgono il ruolo di "ponte" con il sistema sanitario, che sia in grado di strutturare alleanze e strategie (tra persona e servizi ed anche tra i servizi stessi), ed educare alla salute come bene comune.
- 3) Agevolazione di una rete di interventi in grado di promuovere l'evoluzione dell'integrità psicofisica della persona.
- 4) Possesso di competenze socio-culturali da parte degli operatori socio-sanitari da affiancare a quelle medico-sanitarie.

### **Le fasi del Modello oggetto della indagine**

In presenza di queste precondizioni, che hanno certamente contribuito a selezionare il numero dei partners, abbiamo finalmente indicato il processo che sostanzialmente lo svolgimento progettuale. Le fasi qui descritte sono state luogo di confronto e dialogo costante, al di là dei differenti setting all'interno dei quali si sono effettivamente articolate, e sono state in buona parte oggetto di implementazione progressiva da parte delle singole U.O.:

- a) L'accoglienza (mediatore culturale o professionista individuato).

E' necessario che il mediatore culturale rappresenti il primo contatto della persona senza dimora nella struttura sanitaria. Egli parla la stessa lingua e appartiene allo stesso contesto socio-culturale della persona da accogliere, se straniera. Inoltre, egli descrive alla persona accolta (straniera o autoctona) gli operatori con cui entrerà in contatto, mostra i luoghi (le stanze) dove sarà sottoposta alle visite mediche e psico-sociali, indica e spiega tutte le procedure nelle quali verrà coinvolta e l'accompagna nel percorso dello screening psico-fisico dai vari specialisti.

Le visite mediche specialistiche (personale medico)

Il mediatore culturale, previo appuntamento concordato con l'équipe, accompagna la persona dal medico e gli consegna la cartella clinica cartacea che comprende già i dati anagrafici. Il medico specialista effettua le visite di controllo, prescrive gli esami ematochimici e strumentali necessari al fine della realizzazione dello screening, e contestualmente o posteriormente alla visita.

I colloqui psico-sociali (psicologo, antropologo, mediatore culturale della lingua e della cultura del paziente)

- b) Il mediatore culturale, previo appuntamento con l'équipe, accompagna la persona al colloquio e gli consegna la cartella clinica cartacea già comprensiva dei dati anagrafici.
- c) L'équipe effettua il colloquio al fine della realizzazione dello screening psichico e contestualmente o posteriormente la visita, compila la sezione psico-antropologica della cartella clinica cartacea e informatizzata condivisa da tutta l'équipe multidisciplinare.

### Il Modello ed il protocollo di sperimentazione

Un lavoro di ricerca che ha coinvolto complessivamente oltre 20 ricercatori in 4 città diverse in Europa, in un breve arco di tempo ed in matrici culturali certamente non omogenee ha necessitato di un protocollo chiaro e definito.

La base del lavoro è stata la scheda da compilare<sup>2</sup> da parte del team in un lavoro comune. Questo è stato un elemento innovativo per le unità, abituate a lavorare separatamente per poi discutere i singoli casi in riunioni periodiche mettendo insieme le varie prospettive. Il Modello proposto, invece, prevede un lavoro che va oltre all'approccio multidisciplinare, lavorando sul caso insieme, in colloqui svolti alla presenza delle varie figure professionali, in una costruzione del caso che, pur avvalendosi delle singole competenze, le mette insieme per arrivare ad un livello di analisi più complesso.

La scheda in particolare ha offerto un percorso guida per i colloqui e la costruzione della relazione terapeutica, pur non limitandosi a questo. I 122 item che la compongono, sono stati quindi "una porta privilegiata" del lavoro d'insieme.

Provo qui a percorrere in sintesi le sette parti con l'obiettivo di evidenziare i limiti ed potenzialità di

<sup>2</sup> Vedi allegato 2 – Scheda Transdisciplinare Safya.

ogni gruppo di items.

#### a. Anagrafica (1-39)

La dimensione anagrafica, al di là delle ordinarie informazioni sulla persona, contiene indicazioni per una analisi antropologica, sociale e relazionale, che in sede di discussione ha evidenziato interessanti e sorprendenti opportunità di approfondimento. L'uso della cartina geografica ha permesso di lavorare in una sorta di cammino alle radici della desaffiliazione.

#### b. Anamnesi condizione alloggiativa e relazionale (40-51)

Questo gruppo di items contiene informazioni importanti sullo stato della persona non solo inteso come condizione alloggiativa ma anche in merito alla sua dimensione relazionale. In particolare gli item 50 e 51 sono stati utili nel cercare di avviare un percorso di comprensione degli eventi che hanno causato la condizione di homelessness, indagando la percezione soggettiva della causa della condizione confrontandola con la visione dell'équipe.

#### c. Anamnesi condizione lavorativa e istruzione (52-62)

Capire il quadro delle competenze dell'individuo significa scoprire non solo i titoli, ma anche le potenzialità su cui lavorare in un percorso di cura.

#### d. Anamnesi salute percepita ed osservata (63-96)

Questo gruppo di items raccoglie informazioni e osservazioni cliniche su aspetti diversi. Attraverso domande che indagano il rapporto con le istituzioni, sia sanitarie che giuridiche, si possono fare osservazioni di carattere puramente psicologico e cogliere elementi di psicopatologia, così come evidenziare risorse e potenzialità. È stato veramente molto proficuo, per esempio, il lavoro sul delta esistente fra salute percepita ed osservata. Il medico e lo psicologo con l'aiuto dell'antropologo e del mediatore hanno fatto non poca fatica a trovare significati e letture comuni rispetto a questi items.

#### e. Anamnesi area delle relazioni e sessuale (97-115)

Questa parte della scheda, che raccoglie informazioni sulla sfera relazionale e sentimentale, mentre è stata vista come naturale parte del processo da parte del team dell'Ospedale Galliera di Genova, era un elemento innovativo per le unità straniere. Nonostante l'approccio psicologico alla persona che vive in strada le domande sulla vita

personale di relazione erano da queste viste come intrusive e imbarazzanti.

Dopo un lavoro impegnativo di confronto e analisi su questo tema, una volta applicato il protocollo, il riscontro è stato più che positivo, le persone intervistate si sono sentite accolte e questo ha facilitato la creazione di un'alleanza terapeutica.

f. Aggiornamento sezione relazionale, elementi base per esame obiettivo dello stato psichico (116-119)  
Questa parte puramente clinica comprende elementi di base diagnostici articolati che potrebbero richiedere più incontri per essere raccolti e un'ipotesi diagnostica iniziale.

g. Prestazioni (120-122)

Gli items 119-120-121 hanno il fine di tracciare il lavoro dell'antropologo all'interno dei setting multidisciplinari.

### Conclusioni del progetto pilota Safya

Il progetto si è concluso con una restituzione da parte delle singole U.O. sugli esiti raggiunti, utilizzando la swot analysis

Non è stato possibile, come previsto all'inizio, fare un'analisi dei singoli casi o trarre delle conclusioni generalizzabili. Il lavoro si è articolato nell'adottare il modello proposto, che mette al centro la persona e la relazionalità, una modalità di colloquio iniziale con la persona senza dimora, utilizzando una scheda clinician report, comune per tutte le U.O., da parte del team transdisciplinare. Attraverso incontri di tutti gli staff a Roma, Genova, Londra e Copenahgen, cercando faticosamente di superare le barriere culturali, sono stati analizzati uno per uno gli item della scheda con le loro declinazioni, adattato le procedure alle diverse realtà, analizzato il contributo delle singole professionalità, alla

gestione dei casi.

In definitiva il progetto Safya ha creato i presupposti per una progettualità futura, individuando un vocabolario e delle prassi comuni, condivisibili e confrontabili che permetteranno ai progetti successivi di avere specifici obiettivi e risultati analizzabili.

La fio.PSD confrontandosi a livello nazionale ed europeo con homeless e salute mentale vorrebbe gettare le basi per il progetto successivo che verrà sperimentato in varie città italiane e successivamente europee.

Utilizzando il team multidisciplinare, con al centro la figura dello psicologo, verrà individuata un procedura di assessment, che si avvalga di una batteria di test specifica, che permetta di fare una valutazione iniziale, una sul processo e una sugli esiti.

Costruire adeguati strumenti di screening che aiutino a comprendere il percorso evolutivo del benessere psicologico della persona homeless. Se è vero che la quasi totalità delle persone in strada hanno dietro le spalle una molteplicità di eventi traumatici, oggi non ci sono adeguati strumenti in letteratura per misurarne gli effetti, comprenderne le cause ed individuare i fattori che possano facilitare i processi di cambiamento.

Gli strumenti attualmente utilizzati e validati scientificamente sono stati pensati per setting diversi che non rispondono alle reali esigenze di un fenomeno così complesso. Le modalità terapeutiche di intervento avranno come cornice teorica di riferimento il modello bio-psico-sociale e il concetto di resilienza, facendo leva sulle risorse e cercando di individuare gli elementi che possono portare ad un percorso stabile di recupero e di benessere.

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### The Awareness and Attitudes of Medical Doctors towards Homelessness in the Czech Republic

**Andrea Pekarkova MD**

Background

The aim of this research is to find out why doctors in the Czech Republic often do not want to treat homeless patients. Doctors were asked to answer

questions about their current awareness of and prior knowledge about homelessness and their opinions and reactions when confronted with patients who are homeless. It was discovered that doctors do not have enough information about homelessness, they are not interested in the issue of homelessness, and their attitudes towards homeless people are very negative. How they behave and respond in real-life situations is determined by the



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Articles from this publication can be quoted as long as the source is acknowledged.

ethical viewpoints and attitudes that they already hold.

## Introduction

After the Velvet Revolution the Czech Republic started to deal with the social problem of homelessness. Although many social projects have been started since that time society in general has not yet accepted homeless people as equal members of society. We can see this clearly in the case of healthcare provision. In the past there were very few cases of death reported among homeless people because they were not admitted to hospital. The aim of this research was to investigate the awareness and attitudes of doctors towards the homeless. I was interested in the ethical viewpoints they held, and in particular the preconceptions and prejudices they held towards the homeless. Another aim was to discover how much they already understood about homelessness, social work and healthcare entitlement for homeless people. I also wanted to know to what extent doctors are interested in the issue of homelessness and how they would deal with healthcare provision for homeless people.

## Methods

A questionnaire was used for this research. In March 2010 100 male and female medical doctors from different age groups and departments (internal medicine, dermatovenerology, neurology, ENT) were asked to fill in a questionnaire. 41 completed questionnaires were collected. The questionnaire was divided into three parts. The first part focused on their general ethical attitudes and their attitude towards the intrinsic value of the human being. They were asked whether human dignity is dependent on something or not. They were also asked to put into order their own priorities in life. The second part focused on the social and health problems of homeless people. The doctors were asked to assess the significance of different risk factors that might lead to homelessness. Other questions were about health insurance and a homeless person's right to healthcare, about the relationship between society and the homeless, about social work and about general interest among medics towards the homeless people. The third part of the questionnaire included questions connected with particular situations and solutions to the problem. Doctors were asked how they deal with homeless patients,

how much treatment they offer, whether they cooperate with social workers, and so on. They were then given the opportunity to comment further.

## Results

Most of the doctors did not agree with the statement that "human dignity is not dependent on anything, it is an intrinsic part of being human part of being human". They expressed the opinion that human dignity is dependent on a person's intellect, his or her abilities and life skills and whether he or she follows the rules of society. (see Table N.1)

The doctors responded that, in their opinion, the most important risk factors leading to homelessness were alcohol addiction and other types of addictions. Social injustice and the influence of the market economy were not seen as strong risk factors.

The following results were found from the second part of the questionnaire. 26.8 % of all respondents did not know that homeless Czech citizens still have health insurance although they do not pay for it. 34.1 % did not agree with the fact that homeless Czech citizens are entitled to full healthcare provision. 36.5 % expressed the opinion that it is a waste of time providing care for homeless people. 87.8 % of respondents thought that the homeless are a burden to society and they are a disturbance on public transport, on the streets and in parks. 34.1 % did not consider it a problem that many homeless people died of exposure last winter. 43 % of respondents were not sure about levels of hygiene at homeless shelters and whether it was possible to send patients with leg ulcers and other types of chronic wounds to these centres. Four people did not respond. Only two doctors replied that they have been in social centres, nightshelters and hostels for homeless people and that they have experience of the conditions there. 95.1% of respondents had not yet visited such facilities. Five doctors did not respond to this question. 87.8 % of respondents were not interested in further information about homelessness. 36.6 % of the doctors thought that healthcare provision for homeless people should be reduced to simple basic care. 34.2 % replied that when they have a patient who is a homeless person they try to cope with most of his problems. On the whole 36.6 % of respondents replied that when they have a patient who is a homeless person they contact social

workers and co-operate with them. 26.8 % thought that it is a good idea to send a homeless patient to a social centre instead of admitting him to hospital (in situations where another person might be admitted). 31.7 % of respondents thought that social centres should also take care of homeless people who are ill. 70.7 % of doctors agreed that better cooperation between the healthcare providers and social workers would help. 63.4 % of respondents replied that it would be good to build a specialised social-healthcare facility for rough sleepers who are ill. 51.1 % thought that it is the homeless person's own problem, because every person is responsible for their own health. 73.1 % of the doctors thought that further education for all the relevant parties (medical staff, social workers and homeless people) in this area would be useful.

### Discussion and conclusions

It is important to explain how we determined which departments to include in the research. Surgical clinics were not included. Although they were asked to co-operate they were not open to it. Some doctors did not fill in all the details about themselves and did not respond to all questions. They were probably worried that they might be identified. They did not show further interest and mostly did not give any further comments.

It is a shame that most of the doctors did not agree that "human dignity is not dependent on anything, it is an intrinsic part of being human". This can lead to the attitude that people do not have equal value and that they must do something to prove their value or worthiness. It is interesting that for doctors the most important factor in determining human worth was "following the rules of society". Homeless people often do not follow the rules of society, and when it comes to the area of healthcare they have problems behaving themselves in

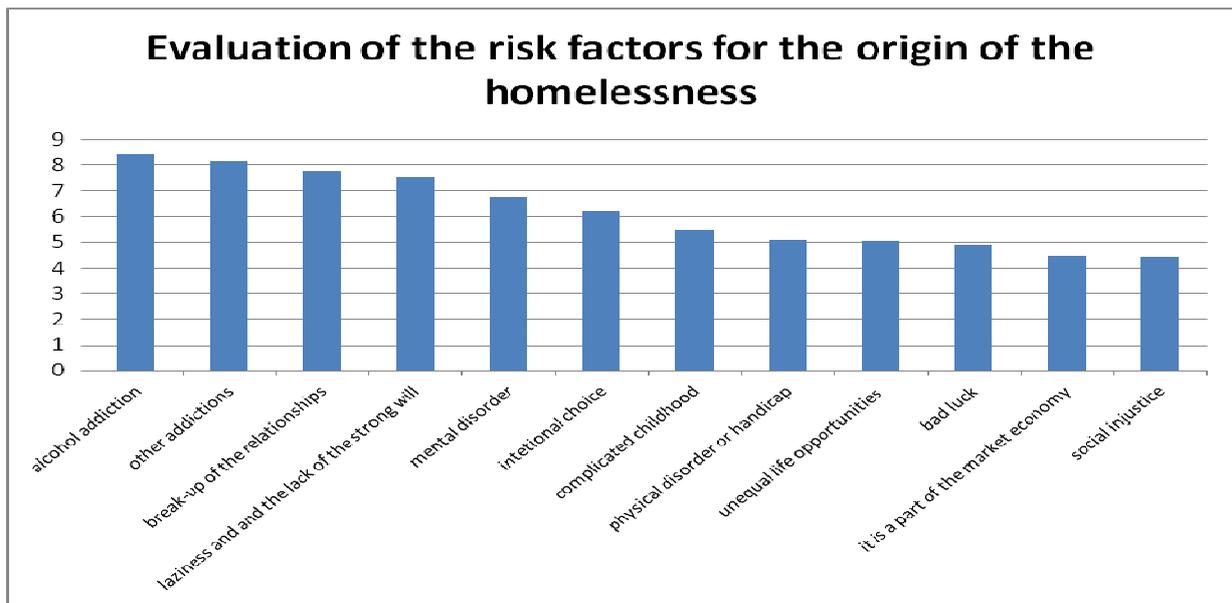
hospital and during medical procedures. These ethical opinions held by doctors might influence their behaviour, believing that homeless people are not entitled to healthcare, although this is in contradiction to their human rights.

Doctors in the Czech Republic see homelessness primarily as a result of alcohol addiction. All the homeless are seen automatically as alcoholics, especially when they are so often seen drunk on the street. According to Czech researchers alcohol addiction is not the most important risk factor leading to homelessness. Homelessness however, often leads to addiction (Hradecky I., 1996, Nadeje). The percentage of doctors who do not know that Czech citizens who are homeless have health insurance and may claim full care is too high. From other results we can see that doctors do not have enough information about homelessness, social work and social centres and about healthcare provision for homeless people. It is contradictory that most respondents replied that education in this area is important, but that most of them showed no interest in finding out more. There were some further comments confirming that attitudes towards the homeless are based on prejudice and are far removed from reality. Attitudes towards homeless people are generally very negative. On the other hand it is encouraging that the respondents would support the idea of a special social – healthcare facility for rough sleepers who are ill.

The most important conclusion of this research is that further education for medical staff in this area is necessary. We have already started to hold some lectures at the Medical Faculty in Prague and we try to provide further training for hospital staff through lectures and articles. We also realised that what is needed is not only further information and education, but also a deeper ethical understanding of the value of a human being.

Table N.1 – The assessment of the value of the human, the scale was 1-4 (1 – the least significant, 4 – the most significant)

the factors of the value of the human	following the rules of the society	abilities and skills	intellect	job	education	social status	success	external appearance	family background	wealth
n (the number of responses)	41	41	41	41	41	41	41	41	41	41
r (average)	3,195122	3,097561	2,804878	2,7317	2,512195	2,243902	2,1463	2	1,92683	1,634146
± (SD)	0,739793	0,820615	0,772058	0,9883	0,858869	0,81989	0,751	0,79633	0,89416	0,724353



### Access barriers to health care faced by homeless people - Recommendations for adequate care

#### Results of a literature review

Elisabeth Hammer, neunerhaus

#### Background

The neunerhaus association, a social organisation providing assistance to homeless people in Vienna (see [www.neunerhaus.at](http://www.neunerhaus.at)), offers – in addition to shelters – outreach general medical and dental care for homeless people. With these offerings, respectively combining medical services and social work, we see ourselves as the bridge between the health and social services. In 2013, our medical offerings will be extended to include practice-based general medical care. We have taken key findings from the report described below into consideration while developing this concept.

To increase our knowledge of the state of health and the use of standard medical care services by the homeless and to better understand the barriers the homeless face when using health services, we commissioned a literature review from the Ludwig Boltzmann Institut für Health Technology Assessment. The report, in German, is available and

can be downloaded from the neunerhaus website: [www.neunerhaus.at/medizinische-versorgung](http://www.neunerhaus.at/medizinische-versorgung).

The aim of the report was to systematically analyse the published literature on the health status, on barriers to health care and on utilisation patterns among homeless persons in urban area in order to support evidence-based planning of health care for homeless people. (Zechmeister-Koss/Reichel 2012: 7)

A systematic literature search was carried out to identify literature on health status of homeless people. According to pre-defined criteria, relevant studies from 2006 onwards were selected in a step-wise approach. Barriers to access were qualitatively summarised from international reports that had been identified via hand search. Studies on utilisation characteristics were identified via hand search and analysed according to the service level utilized and professions involved. (Zechmeister-Koss/Reichel 2012: 7)

The article summarises several key findings on barriers to using health services by homeless people and discusses the relevance of the results for Austria. All the statements have been taken from the report that was carried out under the direction of Ingrid Zechmeister-Koss, published at the end of 2012. What has not been summarised here, are those

findings related to the state of health or typical symptoms of homeless people or their behaviour in relation to services.

### **Barriers to the use of health services**

In international literature, various access barriers faced by homeless people are described in addition to the lack of entitlement to services encompassing formal, organisational, financial and social barriers.

#### **Social barriers – not dependent on country of origin**

Homeless people run into social barriers regardless of where they come from. Despite existing legal rights, there are subjective barriers, such as fear, shame, and distrust, as well as negative experiences with doctors and care attendants. Studies also point out that there is prejudice of the medical personnel against homeless people, for example, that they are violent or anti-social or do not deserve any help. The lack of respect as well as scorn and stigmatisation on the part of the health service provider subsequently has a negative influence on the health-seeking behaviour of homeless people: they tend to distrust diagnoses and question the aptness of medical prescriptions. An additional barrier named in the literature is self-assessment of one's state of health. Despite significant morbidity, homeless people have a relatively positive self-assessment of their own state of health<sup>3</sup>, which can be attributed to a tendency to repress reality as well as a certain optimism that facilitates survival in extreme conditions. As a result, symptoms are ignored longer and orientation to other homeless people change their concept of "healthy" and "sick". A further social barrier comes from low health literacy – the knowledge of health and the

<sup>3</sup> Data regarding the self-assessment of the state of health of the homeless in Vienna can be found in the 2012 report "Evaluation of the Viennese Assistance Programme for the Homeless", carried out by L&R Social Research (online at: <http://www.lrsocialresearch.at/sozialforschung/archiv-de/547-Evaluierung+der+Wiener+Wohnungslosenhilfe>)

ability to process and understand such related information. Additionally, language and cultural barriers arise from problems of understanding due to foreign language or technical jargon. (see Zechmeister/Reichel 2012: 47ff)

#### **Access barriers in Austria I: Lack of entitlement to services and financial barriers**

In Austria, there is statutory medical insurance that is primarily linked to gainful employment. The insurance system is set up in such a way that practically the entire population is covered. Nevertheless, an estimated 1-1.5% of the population (some 80,000-120,000 persons) lives in exceptional circumstances and transitional states do not fall under the protection of the insurance system. Those concerned are primarily people with low income and those who are not legally employed. Many of them are homeless.

For part of the population living in poverty – especially homeless people, who in Austria do not have regular protection in the national insurance system – coverage is foreseen through the tax-funded, welfare-based needs-oriented social assistance scheme.

If a person is not insured through the statutory system or through the needs-oriented social assistance scheme, then they themselves must pay all costs related to the use of services in the health-care system. An exception is made, however, with emergency care, in which every medical service provider is obliged to give first aid in an emergency situation, without regard to financial status. If the costs cannot be offset or paid for by the patient, then the medical service providers must cover the costs themselves. Opportunities arise from this obligation to carry out treatment that goes beyond the acute emergency case or to agree on a broader definition of what constitutes an emergency case, in order to care, for example, for the uninsured. Financial means for the medical care of uninsured (homeless) patients, through NGOs however, are very limited. (see Zechmeister/Reichel 2012: 49ff)

## Access barriers in Austria II: organisational barriers

The fragmentation inherent to the Austrian health-care system is an organisational barrier that presents an additional hurdle, particularly for homeless people, in terms of the availability of services. On the one hand, various cost units and regional authorities create a divided care structure that hampers integrated care, e.g. follow-up care after hospitalisation or treatment of chronic diseases, which is crucial to ensure adequate care for homeless people. On the other hand, the financing structure prioritises hospital-centred care, whereby the use of general medical services by homeless people is further complicated. An additional key organisational access barrier is the lack of residential address – without which diagnosis, bills or information cannot be fully received. (see Zechmeister/Reichel 2012: 51ff)

**Recommendations for the organisation of adequate health care for homeless people** (see Zechmeister/Reichel 2012: 67ff)

### Regarding the place of care:

– A broad general health and specialist care in the practice-based sector has higher priority than tertiary hospital care. Professional support for those concerned in the use of primary health care has to be ensured. Complementary to the traditional institutional settings of health practice, outreach help would facilitate the use of services.

– Primary health care should be particularly low-threshold with regard to accessibility, office hours, waiting time and formal conditions of entitlement, in view of the fact that because of the numerous individual barriers, services are either little used or late used, resulting frequently in unnecessary hospitalisation.

– Specialised services for homeless people make it more likely that the necessary services will be used in due time and that personnel can provide better care for the special needs of homeless people. There are certain drawbacks to this system; are that because of the reduced contact homeless people

have with the regulatory system, existing stereotypes are reinforced; service providers and cost units in the regulatory system feel less and less responsible for the care of these people. Moreover, such services, due to their costs, are possible only in an urban environment and access barriers to the regulatory system still prevail.

### Regarding treatment:

– It seems practical to provide care across the practice-based, outpatient and inpatient sectors in order to improve continuity of care, particularly for homeless people who are chronically ill.

– Treatment guidelines for specific diseases should be checked as to how they can be applied to homeless people and their specific circumstances.

– Adequate treatment of many health problems of homeless people includes calls for an improvement in living conditions.

### Regarding the occupational groups involved:

– Many studies confirm the necessity of interdisciplinary, organised care. In addition to medical personnel, professions specialising in the care of homeless people are required. Extensive language skills are an advantage.

To improve the health of homeless people, the social determinants of health should be addressed on levels of society as a whole, e.g. in the areas of education and the labour market. Health must be more strongly anchored as an interdisciplinary issue, which would allow the financing of certain health care services through various sources, including the social as well as the health care system.

Reference: Zechmeister-Koss, Ingrid/Reichel, Markus (2012): Gesundheitszustand von wohnungslosen Menschen und deren (Zugangs-)Barrieren zum Gesundheitssystem. Eine Literaturübersicht. HTA-Projektbericht Nr. 63. Wien: Ludwig Boltzmann Institut für Health Technology Assessment.

[www.neunerhaus.at/medizinische-versorgung](http://www.neunerhaus.at/medizinische-versorgung)

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## Resources

Setting standards – Discussing health inequalities in the context of European Year of Citizens- mental health and homelessness –conference materials including presentations of speakers

The hearing – organised by Mental Health Europe and FEANTSA - discussed inclusive citizenship from the viewpoint of one of the most excluded groups – homeless people with mental health problems. It raised awareness on health inequalities and issues of access experienced by this group, explore ways to promote it, and present tools to prevent mental health problems and promote mental well-being homeless people. It also explored the role the EU can play in tackling this problem. Most importantly, the hearing underlined the idea that the European Year 2013 cannot be developed in a vacuum – active citizenship depends on active inclusion, and a fair democratic society cannot be achieved without the guarantee of a minimum standard of living. With one in four EU citizens experiencing mental health problems over the course of their lives, a rate even higher in homeless people, it is time for the EU institutions to further recognise and address the issue of health inequalities equalities. You can find the background document and the presentations at: [http://www.mhe-sme.org/news-and-events/setting\\_standards.html](http://www.mhe-sme.org/news-and-events/setting_standards.html)

EU Compass for Action on Mental Health and Well-being

EU Compass is a tool for sharing information on mental health situations and activities across the EU. The information is divided in four categories: Policies and good practices, reports/studies/projects, policy documents/Stakeholder statements, Events. You can search the database and upload information at: [https://webgate.ec.europa.eu/sanco\\_mental\\_health\\_public/form/list.html](https://webgate.ec.europa.eu/sanco_mental_health_public/form/list.html)

The psychological sufferings of homeless people (in French)

According to a survey on the prevalence of mental health and addictions among homeless people in France, 32 percent have severe mental health problems. Among young people this number augments to 40 percent. Major depression and

anxiety are also much more common than in the general population. The book of Alain Merceul (psychiatrist and chief of Hospital Sainte-Anne) describes the psychological sufferings of homeless people and the double exclusion and stigma homeless people with mental illness face.

<http://www.franceculture.fr/emission-l-essai-et-la-revue-du-jour-souffrance-psychique-des-sans-abri-revue-du-mauss-2012-11-15>

European Action Plan to reduce the harmful use of Alcohol 2012-2020 (WHO)

The action plan was endorsed by 53 European Member States at the Regional Committee for Europe in September 2011 in Baku, Azerbaijan. It includes a wide range of policies and programmes that are relatively easy and cheap to implement, can reduce the harmful use of alcohol, promote health and well-being, improve productivity, and enhance human, health and social capital across the life course from birth to old age. This action plan proposes a range of options for the 10 action areas of the global strategy to reduce the harmful use of alcohol that all European Member States can engage in. The action plan is available at: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0008/178163/E96726.pdf](http://www.euro.who.int/_data/assets/pdf_file/0008/178163/E96726.pdf)

WHO – Health policy responses to the financial crisis in Europe

The global financial crisis that began in 2007 can be classified as a health system shock – that is, an unexpected occurrence originating outside the health system that has a large negative effect on the availability of health system resources or a large positive effect on the demand for health services. This policy summary aims to address a gap in the literature by presenting a framework for analysing health policy responses to economic shocks; summarizing the results of a survey of health policy responses to the financial crisis in the European Region's 53 Member States; and discussing the potential effects of these responses on health system performance. The policy summary is available at: [http://www.euro.who.int/\\_data/assets/pdf\\_file/0009/170865/e96643.pdf](http://www.euro.who.int/_data/assets/pdf_file/0009/170865/e96643.pdf)



### Understanding the relationship between mental health and bedsit in a seaside town (University of Essex)

This report looks at the experiences of bedsit residents in a seaside town and how living in a bedsit has impacted on their well-being and mental health specifically. It also looks at how the bedsits are managed using data from interviews with landlords. The difficulties of accessing other types of housing and the importance of bedsits in meeting future housing needs are also considered. The report is available at:

[http://ukehrnet.files.wordpress.com/2012/10/bedsit-report\\_bklt\\_web1.pdf](http://ukehrnet.files.wordpress.com/2012/10/bedsit-report_bklt_web1.pdf)

### 'My voice has to be heard' - Research on outcomes for young people leaving care in North Dublin

One-in-five young people surveyed for a study into leaving the care system had experienced a period of homelessness in the 21 months after turning 18. The report was carried out by EPIC (Empowering People in Care) and it aims to contribute to the better understanding of the issues facing young people when they leave care. It looks at the needs and circumstances of young people aged 17-18 who leave care and the factors associated with positive outcomes for young people. The

young people interviewed highlighted the various challenges that they faced such as multiple accommodation moves and mental health needs. The full report is available at:

<http://www.epiconline.ie/research-report-on-outcomes-for-young-people-leaving-care.html?PHPSESSID=5c3d360b7f05c6e9145ec12dd5783ce8>

### Use of medical evidence in homelessness cases in UK (University of York)

This study by the University of York examines the use of medical evidence in homelessness applications in England. It does so by examining the decision-making practices in three different local authorities: London Borough, Northern City and Eastern Town. The study is available at:

<http://www.york.ac.uk/media/chp/documents/2012/ESRC%20Medical%20Evidence%20Research%20summary.pdf>

## Events

HOME-less & home-FIRST, Dignity and Belonging, Health and Well-being  
Rome, 6-7-8 March 2013

[http://www.smes-europa.org/PROGRAM\\_RMConf\\_EN.htm](http://www.smes-europa.org/PROGRAM_RMConf_EN.htm)

Homelessness, Health and Inclusion: Improving the health of the poorest fastest  
London, 27-28 February 2013

<http://www.neilstewartassociates.com/sh303/speakers.php>

### [Housing First Europe](#)

Final conference

Amsterdam, the Netherlands,  
13-14 June 2013



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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.

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- 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.

For more information see: <http://ec.europa.eu/social/main.jsp?catId=327&langId=en>.

