European Network of Homeless Health Workers (ENHW)

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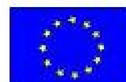

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Editorial

Welcome to the third issue of the ENHW Newsletter!

Dear Readers,

This latest issue of the ENHW newsletter brings together a range of interesting experiences and pieces of work from across Europe and indeed beyond, with a contribution from as far afield as Australia. The ENHW would like to express its sincere thanks to those who have shared their work in this issue of the newsletter and helped to enrich it as a resource. Also in this edition are several warm messages of the support for the ENHW, which are included below in the Forum section. I would also like to take the opportunity to emphasise once again that all readers are welcome to send along contributions to the newsletter. If you would like to do so, or even simply discuss the possibility of writing an article, please get in contact using the email below.

The ENHW had a small launch event on the occasion of the Second Oxford Health and Homelessness Conference in Oxford on the 25th of September. This interesting and well-attended conference was a good occasion to highlight the aims and resources of the ENHW and to raise awareness about its existence. The speech made by Dr Igor Van Laere on that occasion is included below. The ENHW was also presented at FEANTSA's International Information Day on the 18th of October in Zaragoza Spain, in order to inform FEANTSA's extended membership about the initiative.

Your comments, feedback and contributions are welcome: simply send them to dearbhal.murphy@feantsa.org

Integrated care for homeless people is sharing knowledge and experience

Dr Igor Van Laere
Doctor for homeless people in Amsterdam

Dinner speech at the opening of the second Oxford 'Health and Homelessness' conference, September 24th, 2007 for the Launch of the European Network of Homeless Health Workers at Oxford University UK

Mother Theresa said: "*Everything we do, is a drop in the ocean. But, if we don't do it, that drop will be lost for ever*"

Ladies and Gentlemen, Dear Friends,
It is an honour and privilege to stand here before you, to echo the unheard voice of poor and homeless people in our societies. I am very pleased that you give me the opportunity to unfold the mission of the European Network of Homeless Health Workers (ENHW).

Before I unfold our mission, I will try to answer three questions. Why do we need a network of homeless health workers? Why do we need to share our knowledge and experience in practice, education and research? Why do we need to reach in?

In daily practice we are confronted with homeless people in extremely ill health who are in need of two sorts of care. These are *social care* for housing, income and activities, and *medical care* for addiction, mental and physical health problems. These six problem areas are to be addressed simultaneously, while making rules and infrastructure for integrated care for those in highest need.

As homeless health workers, we are all aware of the complexity of rules, infrastructure and budgeting of services to support our homeless patients. Services are organised and managed in such an extremely complex manner that policy makers and managers tend to think that poor and homeless people do have complex needs. This is not true. Needs are not complex at all.

The amount of attention paid to *homelessness and health* in practice, academic centres and research institutes can be considered as marginalised as the attention paid to homeless people in general. Consequently, among service providers, homeless health workers are the poor and homeless professionals in highest need for support. For re-socialisation an recognition, we ourselves are in need for an identification card, benefits and health insurance, in order to deliver state of the art integrated care.

To provide care for prevention of homelessness and interventions to improve health of homeless people, broad and integrated knowledge and experience of a network is needed. As homeless health workers, we need to show *how* to disentangle the assumed complex needs of poor and homeless people. By sharing our knowledge and experience, we need to help policy makers and managers to ask simple questions.

To find and help poor and homeless people, integrated social medical care in practice, education and research is needed to answer the following questions:

What do we need to know to find people at risk?
How do people become homeless? We need to look for pathways to find people at risk. Who is at risk to become homeless? To reach out, we need to know who to find to target activities.

What knowledge and experience do we need once we find people at risk?
What are the problems of people at risk to become homeless? We need to bring the right tools to assess their problems. What integrated data should be collected during the first contact? (we need to know what problems we are looking for to target services.

How do we organise care?
What pathways should to be taken to organise problem oriented care? We need an effective network of many services. We need to know how to reach them and how long it takes before help arrives. Who are our friends in our care network? We need to know the attitudes, rules and red tape, to reach out for their attention and help.

How can social and medical outcomes be measured?
What common data do all services have to monitor? For a baseline, we need to define and collect a

simple and clear set of data of people and their social and medical problems, and record the amount of time needed before help is realised? What data does a central monitor need to measure outcomes? For follow up, we need to provide a simple and clear set of data on people, problems, the timing in the care process and the effect of help.

How much do poor and homeless people cost?
What knowledge and experience is needed to take the shortest pathways to find people at risk and the shortest pathway to realise effective help? For efficiency and cost saving, we need to minimise the number of steps in an integrated care process, time is money. What political instrument is needed to measure costs? We need simple and clear financial pathways for provision of integrated social medical care, we need to show data of effective help and cost saving that points towards an integrated Ministry of Social Medical Affairs.

Ladies and Gentlemen, Dear Friends,

As homeless health workers, we actively have to reach out to find people in highest need, and we actively have to reach into services, academic centres and research institutes to make many friends in practice, education and research to better deliver integrated care. As a network, *our mission is to improve the social and medical condition of people with none or insufficient social and medical basic needs provided.*

Together we can keep and bring more people home. We stay close to the mission and aim for basic help: integrated, simple and clear. Just for what poor and homeless people need us most.

Mother Theresa said: *"you must never be afraid to be a sign of contradiction for this world"*

Let us join our hands. We have work to do.
Thank you.

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Sharing Experiences

Homelessness in North and West Belfast: the findings of a needs assessment

Jennifer Collins and Ruth Freeman

This work presented here[1], prompted by the recommendations of the 2004 British Dental

Association 'Dental Care for Homeless People' report[2], aimed to assess the *oral health needs* of a homeless population residing in North and West Belfast. Essentially the objective of the survey was to determine levels of unmet need, in order to target the delivery of dental care for this socially excluded group.

Methods
A cross-sectional survey was conducted. A convenience sample of 317 single homeless people was gathered across 14 hostels, both residential and rough sleepers drop in centres, located throughout North and West Belfast. Participants were asked to complete a questionnaire pertaining to their medical and social history. They were also asked to complete

the Oral Health Impact Profile (OHIP-14)[3] and the Modified Dental Anxiety Scale[4]. All participants who consented received a full dental examination of the extra- and intra-oral features. Obvious decay experience (DMFT) was recorded using BASCD criteria[5] standardized for the collection of epidemiological data throughout the UK. Periodontal status was recorded using the Community Periodontal Index (CPI)[6].

Results and discussion
Two hundred and sixty seven (84%) were male and fifty (16%) were female. The ages of those examined ranged from 16 years to 91 years. The most common stated reason for becoming homeless was alcoholism. Other reasons included relationship breakdown; family conflict; intimidation; recently prison release and drug/gambling addictions. The medical and social history data gathered illustrated the special requirements of this group, with a significant percentage (33%) suffering from psychiatric illness, addictions or complex medical health problems. 80% of the respondents stated that they smoked tobacco.

The results showed that this homeless population had more missing teeth, more untreated decay and poorer periodontal health than the settled, general population in Northern Ireland[7]. Their high dental anxiety status was found to be related to their

experience of dental disease, which was in turn found to impact negatively on oral health-related quality of life. Interestingly nearly 50 percent of the sample was to some degree 'ashamed' or 'self-conscious' about the appearance of their teeth.

The widespread use of smoking and abuse of alcohol marks this population out as a high-risk group for oral cancer. In the population surveyed, sixteen participants were observed to have soft tissue lesions. Of these, three participants were referred, for urgent specialist investigation; two of the lesions were found to be squamous cell carcinoma. In essence this meant that being homeless increased the risk of developing oral cancer by 95 times compared with the Northern Ireland population as a whole[8].

Conclusions

This survey supported the view that the homeless are a varied dynamic group of people, a disparate population of individuals who are difficult to stereotype or neatly categorise. The members of this group of homeless people experience a range of levels of social exclusion linked with the variety of degrees with which they interface with society. The scale of exclusion is reflected in their experience of disease, including dental disease.

It also highlighted the difficulties and barriers faced by the homeless when trying to access healthcare services including dental services. Oral health factors, such as the greatly elevated risk for oral cancer and high obvious decay experience, and psychosocial factors, such as dental anxiety, must be taken into consideration when planning the delivery of context-sensitive oral healthcare for homeless populations.

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Supporting the needs of older homeless Australians with an extended history of alcohol abuse.

Dr Alice Rota-Bartelink

At present the most frequent drug of abuse among the elderly is alcohol(i). Long term alcohol abuse, particularly among the elderly can result in complex physical, psychological and social problems such as premature ageing, depression and social isolation. In a recent study in Melbourne, 43% of an elderly (50+YO) homeless population reported having issues with alcohol(ii). In another Melbourne study, 75% of older homeless service clients were reported to have a cognitive impairment; the majority being alcohol related brain injuries (ARBI)(iii). There is evidence that older people with multiple needs may be particularly unwilling to use specialist or mainstream services(iv). In providing care and support to these individuals, there remains a difficult balance between human rights and intervening where the client is unable to make a "rational" decision about their own welfare or poses a risk to others. Wintringham is a specialised welfare company established in 1989 to support elderly homeless people in accessing mainstream aged care services. By focussing on the age-related aspect of their client's need rather than their homelessness, Wintringham today has grown to provide a wide range of aged care services including housing, low and high care residential care, community based services, outreach and advocacy.

Many of Wintringham's clients suffer the effects of long term alcohol abuse and homelessness and in response; the Wintringham model of care has evolved to support the consequent complexity of need. It would be naive to believe that the issue of alcohol abuse is isolated to the older homeless population with the incidence among the older population being grossly under diagnosed (v). This is due in part, to the awareness of ARBI being low among frontline workers in health and social care resulting in alcohol problems not being identified(i). Other factors contributing to an under diagnosis include; the symptoms of ARBI being masked by dementia or other age-related conditions, the social stigma attached to ARBI – eg hidden by relatives, and the inaccuracy or inappropriateness of currently available generic assessment/evaluation tools.

In Australia, there is a distinct lack of statutory provision for the older homeless population and there continues to be a lack of higher level

supportive accommodation, i.e. 24 hour staffed hostel. Most rehabilitative projects within the community have an emphasis that can overlook the needs of homeless people, particularly with coexisting complex mental health issues resulting from ARBI. There is a shortage of services with the skills-base and expertise to manage the complexity of need associated with advanced ARBI.

The difficulty in case management and providing appropriate accommodation for elderly homeless persons with high and complex needs has posed a problem for health care providers, social support agencies and housing agencies for decades, especially since the introduction of social policies involving deinstitutionalization and the promotion of community-based living. The people to whom we refer somehow fall in the jurisdictional cracks created by division and structure of funding for health and social care. These people tend to transiently shuffle between organizations that cannot provide long-term care management solutions. Their mental well-being and chronic health status incrementally deteriorates to such a point that the increased reliance on hospital and emergency services reaches crisis level at which stage institutionalization remains as the only viable option.

In Australia, complex funding processes mean that resources are spread over Commonwealth and State and Territory portfolios, non-government organisations and service providers, creating practical obstacles to agencies comprehensively addressing an individual's complex needs(vi). Specialised services often have restrictions on the longevity of their care, minimum age of eligibility and the degree of behavioural disturbance that they are capable of facilitating. When dealing with older people with complex needs, services need to be more flexible, accessible and creative when supporting those with enduring mental illness particularly in association with older age and homelessness. They need to recognise that a person's mental health needs can and do change over time, and therefore require ongoing assessment. Interventions should not be short-term, as potential "change" is often a long-term process and they need to take into account that homeless people may have multiple needs and therefore are not suited to inflexible systems and working practices.

Wintringham advocates for elderly homeless people ensuring equal access to services and that the voice and needs of the individual are respected and heard. Wintringham in partnership with arbias, have recently commenced a four-year project funded by The JO & JR Wicking Trust which is managed by ANZ Trustees. This project will investigate, design and trial a purpose-designed 'Specialised Model of Residential Care' specifically aimed at providing long-term care and support to older homeless people with severe acquired brain injury.

The major aims of The Wicking Project are to; develop and trial a psychosocial model of long term residential care for older people with advanced ARBI; determine the most effective & appropriate tools of assessment and evaluation of this population group; influence government and policy makers with a view to changing the systemic response to older people with ARBI; and to provide an information platform from which other service providers can develop appropriate service delivery responses to older clients with ARBI.

The trial will recruit four individuals with severely affected behaviours arising from ARBI who will be housed and supported together in a dedicated Wintringham hostel. The participants will be selectively recruited for a history of unsuccessful tenancies arising from challenging or anti-social behaviours. Individualised and specialised care, support and behaviour management strategies will be provided by highly trained and skilled personnel eg arbias case management. And all participants will be supported to maximally utilise intensive recreation and diversional activities. This project presents us with the opportunity to extend Wintringham's philosophical principles of "Options, Rights and Dignity" to a group of impoverished people who have been existing outside mainstream services.

A successful trial will provide us with evidence and hopefully enough leverage to influence a change in policy and funding structure to allow us to continue to provide this much needed support to a disadvantaged and marginalized client group. If you are interested in finding out more about this project, just visit our research site at www.wintringham.org.au.

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Without Prejudice: Homeless Health Care should be integrated in the mainstream medical curriculum

Lucie Potter, Third year medical student from Bristol University, England
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Being a medical student and spending the first two years on a close-reign being spoon-fed education, the opportunity to "undertake a period of independent work" for a month as a Student Selected Component is one that excites some and terrifies others. Determined take advantage of this freedom I applied to spend my time in London with homeless healthcare services.(1)

My idea was met with a mixture of resistance, admiration and bemusement: "why do you want to work with a load of smelly no hopers?". The negative opinions only gave me more reason to do the placement; if healthcare students hold this prejudice about homeless people, and their training fails to address this ignorance, understanding and treatment of this vulnerable and often difficult to engage group will remain poor.(2)

My month was spent observing clinics with the Homeless Health Team of Westminster PCT, Great Chapel Street Surgery and Dr Hickey's Surgery, speaking to residential patients in Wytham Hall, outreach work with the Joint Homeless Team and reviewing literature on homeless health. On my placement I was very fortunate to have excellent teaching from dedicated staff in specialist services to provide for the healthcare needs of homeless people. Their enthusiasm and passion for their work inspired and enabled me to explore many aspects of this interesting and challenging area of medicine.(3)

To highlight a few key concepts I have learnt and will stay with me:

- The importance of multi-disciplinary teamwork and communication between healthcare, housing and social work. Also an overlap in knowledge of the other teams, for example basic training in identifying mental health needs so that an individual can be referred to healthcare and needs addressed before the tenant leaves or tenure is threatened.
- The importance of holistic care, particularly in homeless people with multiple needs which interact and cannot be treated alone.
- The importance of treating the patient with respect and an open mind. This is particularly important in gaining their trust and empowering them with involvement in their healthcare.

My placement has developed my skills academically and personally in a way that will benefit me in my future career.(4) These skills are also valuable in mainstream medicine, such as an improved knowledge and understanding of poverty and health, mental health issues, drug and alcohol dependency, and social marginalisation. Despite my choosing homeless healthcare being a desire to do something different, my time with homeless healthcare services has highlighted to me the need for homeless healthcare to be integrated into the mainstream curriculum, so that doctors of the future better understand the specialist healthcare needs of homeless people and can address them without prejudice.

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Addicted to Attention

Gerdien van de Geer
Social nurse Salvation Army Amsterdam

As a social nurse for homeless people in Amsterdam, I felt honoured to be asked to write a few words for the ENHW about my job. I work for the Salvation Army, an organization that does not need further explanation. At two locations I try to help and assist formerly homeless people in Amsterdam. The first location is a nursing home for elderly drug addicts. Their average age is above 50. This location gives a roof to men who are not able to find their way in "normal society". They are addicted to drugs, often have psychic problems, and are in need of medical and social help. The other location I'm employed is a social boarding house. It gives a roof to homeless people of all ages and with all sorts of problems.

My job at both places is to observe the medical condition of the clients. Due to their life style I need to provide skin care for injuries and wounds, pulmonary and diabetic care and e.g. I measure their blood pressures and weight. I collect medical problems and help present the clients and problems to the doctor during weekly consulting hours at both locations. After doctors hours I take care of referrals and appointments with specialist care, I have contact with the pharmacy for medication arrangements etc, and if needed I discuss advice and treatment within the team.

Most of the time however, I'm feel I have to act not only as a nurse but also as a psychiatrist, a social worker, a mother, a friend, a lawyer and so on. To me the most important thing is to realize that I am not working with one part of a human being. I work with human beings. I work with persons who often over-ask a professional when they find one. In my perception this is the result of their experience in life so far. Often my clients are used to being ignored by society and excluded from all sorts of support in many ways.

For me it is a challenge to be a good listener and also to watch over my own boundaries as a health professional. I want to do whatever I can within my professional capacity and to activate other professionals to do what they can. In that way I try to make the clients feel that they are being listened to.

My inspiration to do this job is the following perspective: "Being an addict doesn't only mean the addiction to drugs, but also the addiction to attention." If society provides only the first, who am I not to provide the last.

How much right …?

*By Dr. I. Heath, general practitioner in London**

In his peerless book, *A Fortunate Man: the story of a country doctor*, John Berger asks "How much right have we to go on being always patient on behalf of others?" Nowhere is this question more important than in the healthcare of those who are homeless or whose housing is inadequate. In his later book, *And our faces, my heart, brief as photos*, he writes:

- the naming of the intolerable is itself the hope. When something is termed intolerable, actions must follow. These actions are subject to all the vicissitudes of life. But the pure hope resides first and mysteriously in the capacity to name the intolerable as such.

Once suffering is expressed, it becomes tangible and demands redress. This is one of the fundamental processes of medicine and healing; it applies no less

to social injustice. If we simply hear the story of suffering but make no move to work alongside the sufferer for redress, we abandon our task. Health and social justice are inextricably linked.

There is a long and fine tradition of using the provision of social housing as a deliberate intervention to improve health or to mitigate the effects of ill-health. Tragically, in Britain, this tradition all but disappeared under the sweeping monetarist policies of Margaret Thatcher, who declared, memorably, that there is no such thing as society. Existing tenants benefited hugely from the right to buy their housing but this has been to the detriment of those coming after who are now confined to a much more limited range of less saleable accommodation. Those with chronic health problems and particularly with a combination of mental, physical and social problems all of which exacerbate each other are to be found in what are in danger of becoming marginalised ghettoes of disability and failure.

Those with the most severe problems struggle to maintain their tenancies and the routes from inadequate social housing in a hostile environment to street homelessness are all too easy. In his book *The Good Society: the humane agenda* JK Galbraith wrote:

Under the best of circumstances, there are some men and women who cannot or do not participate. In the good society no one can be left outside without income - be assigned to starvation, homelessness, untreated illness or like deprivation. This, the good and affluent economy and polity cannot allow.

The continuing prevalence of homelessness condemns our societies. Only a rediscovery of the enormous benefits of a robust social housing sector, which is more than last-ditch provision for the most desperate, can begin to resolve the enduring problems of homelessness and its disastrous heath consequences. Doctors can only work effectively if they are prepared to acknowledge the full human dignity of each patient in turn. This recognition brings with it the responsibility to speak to the powerful on behalf of those on the losing side of social injustice, because we have no right to go on being patient.

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Primary Health Care for Homeless People in Leicester, England

Dr Nigel Hewett, general practitioner

"Nothing in the world can take the place of persistence. Talent will not. Genius will not. Persistence and determination alone are omnipotent."
Calvin Coolidge, 30th President of the USA, 1872-1933.

Leicester is a City of 280,000 people in the East Midlands. I first began working with homeless people here in 1990, taking up a contract to provide two half-day GP clinics a week, while continuing to work the rest of the week in my general practice partnership in the leafy suburbs. The morning clinic started at 7.30am in the night shelter to catch the residents before they were put out on the streets at 9am. The rest of the sessions were spent in a nearby drop-in centre. In 1998 I took some study leave to carry out a needs assessment, which confirmed considerable unmet need for healthcare amongst homeless people, and identified appallingly high rates of morbidity and mortality.[1] To try and overcome these problems I proposed an outreach service with clinics provided in drop-in centres and hostels across the city with the aim of making primary health care more accessible. A survey of the opinions of homeless people in Leicester endorsed this provision.[2]

In March 2000 a Personal Medical Services Pilot was set up. This was a new and experimental method of funding primary care that allowed services to be set up that would not have been economically viable under traditional funding arrangements. I left my GP partnership and since then have worked full time as a salaried employee for the homeless service.

We began entirely on an outreach basis. The service has gradually grown through joint working with

partner agencies, mainly in the Local Authority Housing Department, and the voluntary sector. We meet weekly with the other statutory and voluntary agencies that work with homeless people, to coordinate care for those whose needs are most hard to meet. Because of this long history of joint working we were able to obtain funding for a new building, called the Dawn Centre, which opened in December 2005. This unique building combines a health centre, with a voluntary sector run drop-in and local authority run night shelter. It is a Beacon Site generating national interest in our joint working arrangements and providing a model to which other services aspire.

Over the past seven years the team has grown from just me and a mobile phone, to twelve full and part-time staff. A Consultant Nurse, with part-time Practice Nurse and Health Visitor provide a full range of treatments, chronic disease management and health promotion. I have part time GP colleagues, so that together we have nearly two whole time equivalent doctors. We also have a full time drug worker who helps us provide substitute treatment (mainly methadone and buprenorphine) for about sixty homeless drug users. Our administration and reception team has grown to support the increased activity. Last year we treated 1,074 patients in 9,143 consultations and we have treated 3,659 patients over the past seven years. Working alongside us we also have three community psychiatric nurses and two part time psychologists with sessional psychiatric support.
We have won a variety of regional and national awards, and try to reassure ourselves that our high profile will make it hard to cut our service as the NHS undergoes yet another round of reorganisations.

As I began this work I could not imagine that the Dawn Centre and our multi-agency team would be the result. Now, when I emerge dispirited from yet another finance meeting, I am encouraged by the heroic persistence of my patients, struggling on against the odds, which inspires me now as it always has done.

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Forum

Have your say: some messages of support for the ENHW

About the necessity of an integrated concept of homelessness

By prof.dr.Paul Heydendael, emeritus.
Nijmegen, the Netherlands

The "ENHW Newsletter" is a necessary one. Just because I am retired, I see and understand the necessity of an integrated concept of homelessness. In 1965, I started to work as a social psychologist and researcher on the patterns of and relations between health and the behaviour of "normal" people. I have worked with sociologists, epidemiologists and doctors of any kind. My special

interest has been the behaviour of the homeless and of the so-called "misfits". Furthermore, as a clinical psychologist, for more than forty years, I met and tried to treat many homeless -, addicted - and handicapped people. Therefore, I am convinced of the necessity of continued sharing of knowledge and research based on an integrated concept. Indeed, an integrated concept.

New facts and more results about the health(-behaviour) of the homeless are needed. But, these facts can only be useful if a integrated concept is accepted by multidisciplinary teams of practitioners and researchers. In my opinion, the causes of homelessness must be explored based on the hypotheses of "selection", more than on the idea of causation. This means that most of the homeless can not be "treated" successfully by e.g. psychiatrics or psychologists who consider homelessness as a disease, a temporary situation, or a result of addiction, mental health problems, houseless-ness and so one. The combination of all these underlying factors and causes are the result of selection. The main approach of treatment should be: relief and alleviation of the pain caused by the

state of homelessness. This target should be reached for and might be more realistic than trying to replace the homeless into "non-homeless".

It might be hard to believe and accept, but homelessness is and will be of all times and all places. Politicians and policy makers tend to approach the phenomena of homelessness as a state of houseless-ness, that simply can be removed in a couple of years. But those responsible for decision making have to understand what homelessness means to people and those who try to support them. It is a pity, and more than that, that most public services, and even doctors(!), tend to approach homelessness as a matter of own responsibility by choice.

Therefore, the efforts of a European Network of Homeless Health workers, and spreading the word by the ENHW newsletter is a very necessary one. Moreover, the newsletters have the potential and mission to remove ideas that drift away from reality. Ideas and solutions based on knowledge and experience from both practice and research have to be integrated to better serve homeless people.

I wish Igor van Laere and his companions a very successful continuation of this remarkable and very good Newsletter!

Message of Support from John Lozier, Executive Director,

National Health Care for the Homeless Council
Nashville, Tennessee, USA www.nhchc.org

The creation of the European Network of Homeless Health Workers and related initiatives of FEANTSA have greatly encouraged your colleagues in the United States. As our worsening political economy leaves more people dispossessed and without health care, our heartiest efforts seem only to staunch the flow. In your work, however, we see a seriousness of purpose and a commitment to bedrock values of human rights that recall for us our own raison d'etre and strengthen our resolve. We struggle against the same morbid realities everywhere, and we are informed by your work and emboldened by your friendship. Thank you for being there.

Resources

Book Review: Sher L, Kandel I, Merrick J, eds. Alcohol and suicide: Research and clinical perspectives.

Alcohol use disorders are a major medical and social problem facing many countries. In the United States today, more than 15 million Americans are estimated to suffer from alcoholism. In the United Kingdom, the number of dependent drinkers has been calculated as over 2.8 million.

The consumption of alcoholic beverages has risen steadily since World War II and drinking begins at an earlier age. The steady increase in alcohol production and consumption is related to the broader growth of commodity production in industrialized societies in which alcoholic beverages are consumed in tandem with other new forms of commodities and foods. In the business world misleading and confusing information is often used to win consumers without considering the effects of the product on the health of the user. Alcohol advertising is countered by warnings from the health professions, but the individual is expected to sort out the contradictory information and make a rational decision. Seeking the causes of alcohol abuse within the person diverts attention from the invisible economic, political, and social parameters that promote the lucrative industry of alcohol production and consumption.

Alcohol use is a major contributing factor for head injuries, motor vehicle accidents, violence and assaults. It has been estimated that alcohol is involved in 45 percent of violent crimes, 45 percent of episodes of marital violence, 20 percent of nonfatal industrial accidents and 15 percent of nonfatal traffic accidents. The cost of alcohol-related mortality and morbidity in the United States is

estimated at $136 billion per year. Beyond money, there is also the pain and suffering of the all individuals, family members and friends, besides the alcoholic affected.

Over 30,000 people commit suicide each year in the United States. The rate of attempted suicide may be as much as ten times higher than the rate of completed suicide. Of community-residing persons, 4.6% admit to attempting suicide at least once in their lifetime. Alcohol use is associated with suicide risk. It plays two different roles. Ongoing alcohol use disorders can contribute to suicide risk by effects on mood and impulsive-aggressive traits. Acute alcohol consumption at the time of a suicide attempt can have a disinhibiting effect. Alcohol is involved in 40 percent of suicide attempts. Some reports have found that lifetime mortality due to suicide in alcohol dependence is as high as 18%. Individuals with alcohol dependence have a 60–120 times greater suicide risk than the non-psychiatrically ill population. Drug abuse, alcohol abuse and homelessness can also result in a higher rate of suicide as has been found by several research studies.

Sher L, Kandel I, Merrick J, eds. **Alcohol and suicide: Research and clinical perspectives**. Victoria, BC: Int Acad Press, 2007, 205 pages, US$19.75. Website link:
http://www.trafford.com/07-0486

This book is a collaboration between researchers from Columbia University, Department of Neuroscience, New York, United States (Leo Sher), Department of Behavioral Sciences, Ariel University Center, Samaria, Ariel, Israel (Isack Kandel) and the National Institute of Child Health and Human Development in Israel (Joav Merrick) together with researchers from Denmark, Spain, Israel and the United States and recommended for people in the field of alcoholism and suicide as stated in the forword by professor Danile TL Shek from the Department of Social Work at the Chinese University in Hong Kong.

The medical consumption among users of facilities for the homeless in Ghent, Belgium

By Mieke Van De Walle and Tine Verdée et al.*
Sixth Year Medical Students at Ghent University, Belgium

This survey describes the medical consumption among users of facilities for the homeless in Ghent. This is being compared to the medical consumption of the Belgians who were questioned by the health enquiry in 2004. To verify the need for medical consumption, health indicators of the homeless are first compared to health indicators of the average Belgian. Secondly, the medical consumption and the effect of different indicators on the medical consumption (general practitioner and urgent care) are being analyzed. Lastly, the prevention of barriers and their effect on the medical consumption (general practitioner and urgent care) are being investigated.

Methods: To question the important determinants of medical consumption the appropriate questions of the health enquiry 2004 were copied. Other questions were added to these on the basis of the sticking points described in the literature. In total 122 surveys were taken in the facilities for homeless people in Ghent in the period between 15 March and 6 July 2006. The data were analyzed with bivariate and multivariate analyses.

Results:
Health indicators: Very significant to extremely significant differences between the homeless and the average Belgian were determined for the four questioned health indicators: 'subjective health experience', 'limitations for at least six months because of a health problem', 'usage of prescribed drugs' and 'usage of substances'. For the health indicator 'having a long-term disorder' no difference was shown. The differences indicate that homeless people are in a worse condition than the average Belgian.

Usage of medical care: The usage of medical care of the homeless is very significantly to extremely significantly higher than the usage of medical care of the average Belgian (with the exception of dental care). *Determinants of the contact with the general practitioner:* The contact with the general practitioner is generally determined by three health indicators, being 'limitations for at least six months because of

a health problem', 'minimum one contact with the specialist in the past two months' and 'usage of prescribed drugs in the past two weeks'. These variables are significant in the multivariate analysis and are directly proportionally correlated to the contact with the general practitioner. *Determinants of the contact with the urgent care:* The contact with the urgent care is mainly determined by the variables 'subjective health experience' and 'do you have someone from whom you can obtain information'. In the multivariate analysis, a reasonable to very bad subjective health experience is correlated with more contact with the urgent care. The homeless who can count on someone for information, visit the urgent care less frequently.

Barriers: Barriers that are most cited by respondents are financial barriers, barriers specific to the survival strategy of the homeless and barriers specific to their disease behavior. Barriers originating from the organization of the health care system and from the relation doctor-patient are reported less frequently. The only barrier in the field of the organization of the health care system that deserves attention in this study is the long waiting time at the doctor's office. The only three considerable barriers (experienced by 14,9%) in the field of the relation doctor-patient are the fact that people do not trust the general practitioner, find that the doctor poses cumbersome questions and find the contact with the general practitioner too distant.

Influence of barriers on the contact with the general practitioner: A significant influence on the consulting or not consulting of a general practitioner cannot be shown, not even for a single barrier. *Influence of barriers on the contact with urgent care:* There are four barriers that give reason to a significantly higher usage of urgent care: 'long waiting time', 'lack of transportation', 'because I move a lot, I have to find a new general practitioner each time again' and 'I find the health care organization far too complicated'.

Conclusion: In spite of the barriers, the medical consumption of the homeless is strikingly higher than the medical consumption of the average Belgian. This can be explained by the fact that the homeless score worse than the average Belgian for health indicators and by the fact that these indicators significantly coincide with the medical consumption.

Personal note

It was a captivating social experience to learn the vision of homeless people on health care through interviews. We also broadened our knowledge in the field of statistics. It was fascinating to expose surprising and significant differences by numerous statistical analyses.

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2007 Report: Homeless people's healthcare needs and access to healthcare provision in Wales

Led by Professor Susan Hutson for Cymforth Cymru

This document is a summary of the report *Homeless people's healthcare needs and access to healthcare provision in Wales*, prepared by Prof Susan Hutson. The full report is available from Cymorth Cymru.

The report describes the experiences, views and ideas of homeless people across Wales, and has been prepared with the support and involvement of fourteen homelessness organisations across the country.

This paper was commissioned by the Welsh Assembly Government following Homeless Link Cymru's 2006 report *Homeless People's healthcare needs and access to healthcare provision in Wales* (available from Cymorth Cymru). Whilst the 2006 paper considered evidence from homelessness service providers across Wales, the current study presents the experiences, views and ideas of a sample of homeless people.

We hope that this work will inform future health and homelessness policy in Wales, and support the development of improved service provision for homeless people. You can consult the document on FEANTSA's website.

Third International Street Medicine Symposium in Houston, Texas
By Suzanne Atkinson, MD
www.streetmedicine.org

This year's symposium will feature programs that demonstrate a Best Practice in serving those that are living in streets throughout the world. Symposium sessions will be energized by the discussion of different clinical methods used in the streets as well as the operational procedures to implement a street medicine program. In addition, new symposium faculty members from Los Angeles, San Francisco, Kathmandu and Oxford, UK, will present their street medicine programs, as well as the European Network of Homeless Health Workers.

We are exceptionally blessed to have *Jim O'Connell, MD*,* as our keynote speaker. Dr. O'Connell is the director of Boston's renowned Health Care for the Homeless and has been a true pioneer in the care of the homeless. He has authored numerous articles on homeless health as well as the landmark textbook on the Health Care of Homeless Persons. His insights should prove invaluable to all those involved in care for those living on the streets.

We are pleased to provide you with an exceptional opportunity to meet colleagues who are providing this unique care to the street homeless population. There is no registration fee to attend symposium sessions. Sessions will be held October 31st through November 3rd, 2007, at the Best Western Plaza Hotel and Suites at the Medical Center, Houston, Texas.

* O'Connell JJ. The need for homelessness prevention: a doctor's view of life and death on the streets. J Prim Prev 2007;28(3-4):199-203.

Play it Better - Conference on October 9th 2007

Birmingham Repertory Theatre, Birmingham City Centre
www.playitbetter.bham.ac.uk

We are proud to present the first Play it Better conference, a Dutch English day conference on the use of applied theatre techniques in health care! The theme for this conference is mental health and is therefore held on the day before International Mental Health Day, October 9th 2007.

Applied Theatre is the generic term for the use of drama-based approaches to improve communication and can be used to explore issues in health care contexts. Applied Theatre techniques are used internationally to promote change in attitude, behaviour and communication. It has been suggested that Applied Theatre is a particularly effective method for training professionals and promoting dialogue between service users and professionals in mental health settings.

Communication is extremely important in mental health care. Symptoms of mental health problems are not external, a fact which influences the diagnostic process. This means mental health professionals rely heavily on communication skills in order to get all the information they need to diagnose and help the patient. Secondly, patients with mental health problems may not be capable of communicating effectively. They may not comprehend their own emotions and might not always be able to control their behavior. Professionals in mental health care need skills in conflict resolution and mediation to deal with this. The conference will address these themes.

The conference takes place on October 9th 2007 from 09:00 - 16:30. Find out about our fees at www.playitbetter.bham.ac.uk Express your interest and book via playitbetter@contacts.bham.ac.uk

Your comments and questions about the ENHW are welcome!
Send them to: dearbhal.murphy@feantsa.org