European Network of Homeless Health Workers (ENHW)

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Editorial

A revamped ENHW Forum will start 2008 on a high note!
Dearbhal Murphy, FEANTSA

Dear Readers,
I am delighted to inform you that the online ENHW discussion Forum has been thoroughly re-vamped and a lot of great new resources have been added to it. The "Articles" Section has been greatly expanded and now contains a wealth of think-pieces, reflections, creative writing, messages of support for the ENHW and reports on a range of areas. Some of the topics covered include alcohol-related harm; outreach work in Palestine; new developments from the US, including the recent meeting of the Global Street Medicine Network in Houston; and Diogenes Syndrome. There are also some creative pieces reflecting the experience of homeless health workers, including a poetic testimony to outreach work and an imagined meeting between a homeless Santa and a little boy. Finally, a series of European Updates has been added, highlighting recent, relevant policy developments on health at European level. At present there are some updates on mental health, the European health strategy and the planned European action plan on TB. This section will be regularly updated.

In addition, some of the authors in this Winter Edition of the ENHW Newsletter would really like to get your feedback and to gather information on similar experience from across Europe. Where this is the case, a corresponding post has been made in the ENHW Forum, where you can give feedback or post any information that you may have. These online postings for continuing the discussion are highlighted in a box at the end of the relevant articles.

So, if you haven't done so already, why not check it out?! It is very easy to sign up from the forum homepage, or indeed to retrieve your password, if you can't remember it. However, if you still have a few doubts or feel a bit unsure about how it should work, you can read some further explanation and instructions relating to the Forum on the FEANTSA website.

As always, I would like to extend my warmest thanks to all of the contributors who have made this such a rich and interesting edition of the Newsletter, as well as our online contributors who have helped renew the ENHW discussion forum. I would like to remind you that you are welcome to contribute to the ENHW newsletter. You can contact me to discuss or send a contribution at dearbhal.murphy@feantsa.org.

Finally, I would like to take this opportunity to wish you all
A wonderful Christmas and a peaceful and happy New Year

Sad News from Amsterdam:
A testimony to Dr Bart Leewens

Dr Igor Van Laere

Doctor for homeless people in Amsterdam

Our dear friend and colleague doctor for people who are homeless in Amsterdam, Dr Bart Leewens has passed away, aged 54, last December 12, 2007.

We in the outreach team are all very sad about this terrible loss. Dr Bart had been an outreach doctor for the last 24 years. Dr Bart was a pioneer in outreach care in the fringes of Amsterdam, a hero for his patients and service providers, a great singer and musician, a rock 'n roll guitar man, a philosopher and great man, full of life.

A true friend has left us. Bart's death has a major impact on his wife and two children, family and friends, our homeless patients, our outreach team, and many friends in support services in Amsterdam.

The funeral was overwhelmingly attended by hundreds of people. This Christmas will be different. We miss him deeply.

Sharing Experiences

A way is made by walking: 10 years of the Caritas Marienambulanz

Bernadette C. Bruckner, Researcher

Poverty makes people sick. Yet, we all have to spend more and more money on health care. The consequence is another growing gap between "rich" and "poor". Personal living conditions, social inequality and exclusion lead on one hand to substantial burden and on the other hand to fewer chances of fulfilment and achievement. A vicious circle of problems such as homelessness, loss of work, debts, alcohol and drug addictions etc. can develop. This in turn has a direct effect on physical and psychological conditions of the people concerned. The Austrian health care system is one of the best in the world, but there are still gaps. The Caritas Marienambulanz is an institution which has

been trying for ten years now to close some of those gaps.

According to the mission statement, since opening in 1999, the Marienambulanz offers a low-threshold general medical primary health care for those people without health insurance (Austrians and people of foreign origin), undocumented migrants in Austria and insured people (Austrians and people of foreign origin), who cannot overcome the barriers to the public health care system for different reasons (alcohol- and drug addiction, shame, wish for anonymity, bad experiences, knowledge gaps, language barriers, social inequalities etc.) The Marienambulanz offers health care as needed.

Considering the cultural aspect and the holistic physical-psycho-social treatment approach, one focus of the work in the Marienambulanz is the prevention and early diagnosis of diseases before they become chronic and cause not only pain, but also high follow-up costs. To minimize costs through need-oriented prevention among the

target group, identification, treatment and follow-up of the patients is important. The catchment area of the Marienambulanz was the city itself in the first years, but now also people from other regions are coming to use the target-group-oriented services.

In April 1999 the ambulance opened their doors at Mariengasse 12, a part of the fraternity "Barmherzige Schwestern" and it was financed through the social services department of the city of Graz, through Caritas and through donations. Seven voluntary doctors offered their services from Monday till Friday between 12 a. m. and 2 p.m. Christine Anderwald was at this time the only full-time Caritas employee and responsible for the organisation, co-ordination and medical assistance.

The legal status of the Marienambulanz was of a second ordination of the medical management. The ambulance was run for half a year as project to carry out a survey of demand. At this time 820 treatments

were given and an extension of medical assistance was necessary. Many stationary specialist and medical institutions offered their free medical assistance. At the present time the ambulance covers with their employees eight languages. Furthermore, if necessary, interpreters from Caritas and from our co-operation partner OMEGA are available and can be called in. Equally important is an ongoing learning and assimilating of medical care, due to the fact that the patients of Marienambulanz are all from socially disadvantaged groups of our society. Those people need to experience again confidence and continuity to identify themselves as part of this society. Since they do not visit or only go very late to a doctor, they need special offers with low-threshold access and without bureaucracy.

An overview of the evolution of the ambulance in data:
Between 1999 till 2006 the general medical care including psychiatry, hypertension and diabetes treatment were continuously evaluated. Between 2003 till 2006 development of the complete frequency including all treatments:

Frequenzentwicklung Ordination 1999-2006
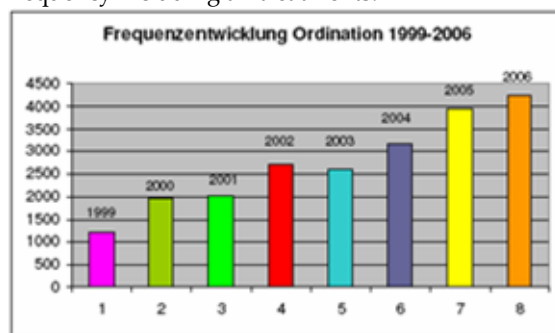
Evolution of employees in data:
1999 1 full-time employee; 9 voluntary; 2 employees of OMEGA
2004 2 full-time employees; 15 voluntary; 2 employees of OMEGA
2005 2 full-time employees; 22 voluntary; 2 employees of OMEGA
2006 4 full-time employees; 23 voluntary; 1 employee of OMEGA
2007 5 full-time employees; 25 voluntary; 1 employee of OMEGA; 3 contractual employees
The voluntary employees of the ambulance provide an average approx. 2500 hours per year.
22 specialised doctors, medical institutions as well as hospitals offer their services for free to the ambulance!

Evolution of the treatment offer:
1999   general medical health care
2001   "on-going medical health care"

2002	Follow-up social-psychiatric work, Diabetes and psychiatric ordination
2003	Hypertension and follow-up medical health care at the "Kontaktladen" of the streetworkers at the drug area
2007	Women's consultation and patient's training

Evolution of the financial framework:

1999 to 2002:	Social services department of the Caritas, donations
2003	Health office of Graz, Caritas donations, basis subvention for refugees
2004	+ subvention social-medical assistance
2005	+ subvention of Federal Ministry f or Health, Family and Youth
2006	+ service level agreement with the Styrian Health Insurance
2007	+ 2 year-treaty with Health Fund Styria

Development of co-operation in studies and intersectoral co-operation:
2002 to 2007:
➢ Study of Austrian Federal Institute for Health Care (2004, 2005, 2006, 2007) by order of the Federal Ministry of Health Care to "Survey of prevalence of infectious diseases"
➢ Study of the Styrian Health resort and the Health Office and Youth Office of Graz, for "Analysis of the needs of psycho-social accompanying measures for youth with problematic consumption of drugs in Graz"
➢ Study of the European Centre for Welfare Policy and Social Research by order of Federal Ministry for Social Security and Generations, with the aim to acquire people without health insurance qualitative and quantitative
➢ Study of the Federal Ministry for Health and Women to survey people without health insurance in Austria (both qualitative and quantitative research)

2006 to 2007
Marienambulanz managed a TB screening of all relevant risk groups in Caritas and Graz (asylum seekers, homeless people, people with high drug consumption and drug-addicted people). In co-operation with the Province-Sanitary-Office Styria. A Roentgen-bus was utilized.

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Evolution in the public perception:

2005 SozialMarie, award for innovative social projects
2005 3rd place – poster competition – EUPHA – European Public Health Congress
2006 National Strategy Report/ BMSG (Federal Ministry for Social Security and Generations) cited the Marienambulanz as a good practice example

2006 Award of Human Rights of Styria

1999 to 2007
Reports in radio, television (Report, "Heimat fremde Heimat") and newspapers on the topic.

In the ENHW Forum!
The Marienambulanz would like to make contact with similar outreach projects in other European countries. To share your experience, just log on to the ENHW forum and answer the Marienambulanz post!

Stress and coping in mothers who experience homelessness

By Victoria Tischler
University of Nottingham, UK

I have been working on research with homeless mothers in England for the past six years. My interest is in stress and coping theory and how helps to describe and understand the process of homelessness and resettlement in this population. In this piece I will reflect on my experiences of this research and outline some of the main findings. I have included a list of relevant publications for those who wish to find out more about my work.

I have completed a number of studies in the Midlands region of England with my collaborator: Professor Panos Vostanis, Chair in Child Psychiatry at the University of Leicester. The design has been prospective and involved interviewing women when they were homeless and four months later, when they had usually been re-housed and begun the process of resettlement. I used mixed methodologies to examine issues including mental health, child behaviour, coping, social support and physical health status. I interviewed women using a semi-structured approach. These interviews were narrative, thus allowing women to 'tell their stories'. This method has elicited rich data which revealed the multiple stressors and deprivations that many of these women have experienced before and during homelessness. Themes included poverty, childhood abuse, intimate partner violence, substance misuse and social isolation. I used this method to help validate the women's experiences and to promote empowerment. This is particularly important when

working with individuals who are vulnerable and marginalised.

There is very little research to date on this population in England and I considered it important to highlight and publicise the situation of these socially excluded women and children who are a 'hidden' population. English law defines this population as in 'priority need' therefore they do not live on the streets but in hostels or shelters. Because of this they do not receive the same attention and resources as those who sleep rough even though they constitute a significant proportion of all those who are homeless.

Although sheltered, the women and children that I have spoken to have often experienced serious trauma such as domestic violence, war and harassment and attacks from neighbours. The majority of mothers become homeless because of violence inflicted by a male partner. This has often continued for many years and women may have made multiple attempts to leave their abuser. Mental health problems were commonly reported by women and also behavioural difficulties in their children. Mental health problems often persisted after homelessness which suggested that the mental distress was related to issues aside from homelessness. In addition, families often lost contact with previous services, children were moved from school and contact with health and social services was fragmented. Social isolation was common as many of these women were estranged from their social networks because they had moved to a different area or relationships had broken down due to conflict or over-crowding. I have noticed a reluctance by some agencies to 'take responsibility'

for this population. Many services are allocated according to address and these families have no fixed abode therefore whose core business are they? I found that, aside from statutory housing responsibilities, a few dedicated agencies or committed individuals have developed services for this population. Therefore, specialist provision across the country is inconsistent. Because of the multiple and complex needs presented it is necessary to have a range of agencies involved in the care of these families which requires commitment and co-ordination.

Although hostels appeared to be a temporary respite, for many, the conditions there compounded their distress. For example, families had to share living spaces and facilities with other traumatised families, substance misuse was common, and there was a lack of child care and play areas and a lack of specialist services such as counselling. Good practice is being developed in some areas, for example, Leicester has a team of family support workers who provide input for parents and children whilst homeless which includes parenting advice and child care and referral to specialist services if necessary. The support continues after re-housing to ensure that families successfully resettle in the community.

This research programme has been challenging. Attrition was high. This is common in prospective studies but was especially so with an indigent population. It was difficult to engage women with services and in the research. In understanding this I found it useful to consider Maslow's hierarchy of needs which suggests that individuals cannot address higher level needs such as cognitive and psychological exploration before their basic survival needs for safety and shelter have been met. I was moved and inspired by the bravery and resilience of the women I met. Despite the trauma they had experienced, they had made an important step towards a new, better future for themselves and their children. When I spoke to women at follow up, after most had been re-housed, many spoke of the positive outcomes of homelessness such as newfound confidence and social support networks established whilst homeless. Such outcomes are associated with post-traumatic growth and I plan to pursue research on this topic in future.

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A New Joined-up Health Service for People who are Homeless in Dublin – "Safetynet"

Lynda Haran, Safteynet Team

The purpose of this short article is to introduce and explain the Health and Homelessness service "Safetynet". This is a new health service for homeless people that has been running in Dublin since last May. This article provides a description of the health issues which the homeless population experience and further describes how these multiple heath needs are compounded through difficulties in accessing mainstream care. It outlines how the Safetynet service has evolved, its composition, aim and objectives and importantly how by adopting a team approach the service endeavours to respond to health

Health Needs of the Homeless:

As we are well aware those who are homeless experience multiple health needs. A typical homeless or ex homeless person with multiple needs will often present with three or more of the following:

Mental health problems, misuse of various substances, personality disorders, offending behaviours, borderline learning difficulties, physical health problems, challenging behaviour (Feantsa, 2006; RCSI, 2000; Focus Ireland 2000).

These multiple health needs challenge the structure of the medical model of working in separate specialised areas.

Access to Health:

The multiple health needs are compounded by the fact that client's access to medical services is poor. It is well established that those who are homeless

experience difficulties accessing mainstream services for many reasons including the healthcare system, being homeless and attitudes of healthcare staff (RCSI 2000, Feantsa 2006).

As a result mortality rates and morbidity rates are higher among those who are homeless.

In 2006, the European Federation of National Associations working with the Homeless, (Feantsa) in their annual conference, drew on the expertise of

over one hundred members across the EU, in relation to Access to Health for those who are homeless. Their findings indicated that while the

mainstream healthcare services are the ideal and goal for all, specialist low threshold services, can be tailored to meet the needs of the homeless and can help to bring them into mainstream care.

Irish Context:

In Dublin City area, medical support services, particularly nurse-led services, within homeless services have been developing and growing over the last few years. Each clinic had developed as a separate entity, and as a result used separate chart and recording systems and separate policies and protocols. While they had provided a valuable and necessary service, much of the care provided had been reactive. There was no formal communication between agencies that often had the same client base. The lack of a centralised patient information database meant that continuity of care across the service was a problem.

The Safetynet Service

The Safetynet service was set up in May 2007 to address and develop these and other issues. It is currently operating in over ten locations throughout Dublin. It was developed by collaboration between the HSE, General Practitioners and Nurses working in the Voluntary Sector. **Picture of all**

It is described as "Safety net" because it offers essential medical support to people who are homeless and who may not be in contact with mainstream services. Therefore the service is primarily targeted at people experiencing homelessness, which is not linked into, or in contact with medical services. Thus, the service acts as a "Safety Net" by "catching" those who might not access mainstream services and allowing easier access to health in a specialist homeless service. However the service also works to improve links and access to mainstream health for those who are experiencing homelessness.

Aim:

The aim of the Primary Care Safety Net service is to offer a comprehensive primary care service targeted at people who are homeless in Dublin. The service endeavours to make health services more accessible to people experiencing homelessness by locating

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medical services in the agencies and service where homeless people attend for support and live.

The Safetynet hope to achieve this by:

Computerisation: All the clinics will operate with computerised records on a single network. This gives the advantage pf having more comprehensive files, avoids double scripting and enables better continuity of care. This is currently being piloted and will be rolled out before end of year. This will also provide a useful database for statistics and emerging trends in the community.

Co-ordination with other services as a unit. A unified voice will bear more influence on other medical services in the community than individual services.

Shared protocols and policies. A policies and protocol committee has been set up to develop these, based on best practice. Again this will standardise the service provision.

Linkages with hospitals specifically Accident and Emergency and Out Patients. Many service users inappropriately self refer to A and E as they have no medical card. The Safety Net Service bypasses this problem as clients can be seen without medical cards. Safetynet also endeavours to improve relations and provide fast track services by improved communication and referral system.

Preventative services. Both primary and secondary preventative measures can be developed in the services.

Services provided include:
General nursing assessments – Vaccinations - Wound management/skin problems - General health problems - Mental health assessments and referrals – Phlebotomy - Pre-test and post test counselling - Sexual health - Men's health - Women's health - Harm reduction - safer injecting information - Referrals to hospitals and other services - Health promotion – Counselling – Chiropodist – Dentist.

Client Feedback:
For the launch we asked clients for their feedback in relation to the services, here are a few comments…..
"It is very difficult to look after your health when you're on the streets and without the doctor, dentist, nurse a lot of people on the Dublin streets would suffer ….. They showed me that there are some people who care and won't judge you on your appearance or your living arrangements"

"I am very grateful for the chiropody services that are available at the centre. Only for her I would have a lot of problems with my feet"

"The nurses in here are great. They help with everything you need off them. …..They don't look at you different"
"The nurse and doctor are so helpful with everyone; they get treated all the same"

Conclusion:
While the Safetynet service is still in its developmental stages, it has a vital role in the fight against homelessness. Only with continuing teamwork among it participant's and other primary, secondary and tertiary service can we hope to improve health service provision.

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Some Thoughts on Helping People who are Homeless – towards a rights and empowerment based approach

By Isolde Daiski, York University, Toronto

Seeing homeless people on the street is all too common place these days in North American cities like Toronto. Rents are very high and therefore affordable housing is out of reach for many people.

Twenty-five years ago there were homeless people on the street. However they were much fewer in numbers and mostly adult males (Gillis & Singer, 1997). Then, in the early eighties, mental health institutions opened their doors to 'reintegrate' their populations 'into the community' (Harris, Mowbray & Solarz, 1994), while the community support promised by governments that was needed for successful reintegration never came forward.

Therefore many of these former residents ended up on the street, unable to afford housing or to find landlords willing to take them in, due to the stigma attached to mental illness. Then, in the nineties after incisive social cutbacks and removal of rent controls by the governments of the day, more and more people in low-paying jobs were unable to afford housing. They began living in the shelters, parks, ravines and on street corners. Families with children are now the fastest growing segments of the homeless population (Sunnak, 2004). Churches started to offer their basements for mass sleeping quarters in the wintertime one day per week, while their members prepared meals and helped out with cleaning and other tasks associated with these 'out-of-the-cold programs'. As rents got more expensive food banks began to open to provide food for those who were unable to afford the necessities of life. Another outcome, in the late eighties, was an outreach program called the 'health bus' (Daiski, 2005). It is staffed by paid outreach workers and volunteer nurses and provides counseling and nursing services at various stops once a week, to deliver some basic healthcare. It remains a very needed service for people who are on the fringes of society and often have no health card to access the mainstream healthcare services. Homelessness had expanded exponentially and problems included to prevent people from dying on the street.

While the services described above were designed as stop-gap measures to prevent people from dying, they did nothing to reverse the trend of homelessness. Based in a charity model they maintain the status quo, while easing the consciences of those who were doing well in our affluent society. Ultimately they do not solve the larger problem of inequitable distribution of societal resources. In a rich country like Canada nobody is supposed to be homeless. That lack of housing contributes to ill health and even premature death in a major way is supported by research (Bryant, 2004; Hwang, 2000; Hwang et al, 2003; Shapcott, 2003). Further, it is well documented that subsidized housing can cure homelessness (Shapcott, 2005; Sunnak, 2004). Some authors, such as Culhane, Metreaux, & Hadley (2002); Walker (1998) and White (1998) claim that many people have been on the street for so long that they forgot what it is like to be confined to an indoor place and to have to deal with the inevitable obligations, such as cleaning up, paying rents, and in general, having the responsibility of occupancy. Therefore they need supportive housing, at least in the beginning, to get comfortable again.

The principle of social justice is the basis for good public health (Drevdahl, Kneipp, Canales & Dorcy, 2001). In a rich country everybody should have access to the necessities of life, including a roof over one's head. And this roof should be proper housing that provides privacy and security, not a crowded shelter where people are warehoused, or sub-standard housing (Nutbeam & Simpson, 2001). A community based approach to housing the homeless starts bottom-up with the people's wants and needs (Raeburn & Rootman, 1998). Instead of 'doing for' workers are in a partnership with their participants (Bottomley, Bissonnette, & Snekvik, 2001; Bunkers, 2004, 1998, Zerwekh, 2000). The underlying assumption is that the lived experiences of people who are homeless make them the experts of their lives. Therefore they know what they will need to achieve health and quality of life (Daiski, 2007). This assumption leads to a model of empowerment. The first role of the helper then is advocacy for the necessary resources at a policy level, not charity. Helpers work in collaboration with their helpees, who lead the way, as they are the most knowledgeable about their own needs and situations. Drevdahl et al (2001) claim that feeling connected is a prerequisite for social justice. Helpers are knowledgeable about the possibilities and advocate for resources that exist or should be provided. Together helpers and helpees envision and create situations that improve health and quality of life, while respecting human dignity. Of course the situation at hand has to be dealt with. In the short term, more immediate needs, such as healthcare, food and temporary shelter have to be provided. The first and foremost goal, however, should always be to end homelessness, fair livable wages and equitable distribution of wealth.

When caught up in the immediate needs that have to be met, I believe that there is an inherent danger of losing sight of the larger picture. Crisis management strategies can then become permanent solutions. An example are the food banks that started off as temporary relief measures and now have become institutionalized. These charities are financed and run by volunteers and thereby absolve governments and societies from their obligations towards their citizens. Being eager to help by providing what one knows, might be with the best intentions, yet it can dis-empower rather than empower. It often creates learned helplessness rather than sustainable abilities in the other person. It also divides the ones who give and those who receive and thereby creates an 'otherness'. Let us acknowledge our common humanity as, with some

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bad luck, many of us could end up homeless on the street. Let us respect the dignity of those people who are homeless and make sure that policies get created that redistribute wealth in a way that people can provide for themselves and their families, without having to rely on others' charity. In the meantime, yes, we need to help as best we can. We need to provide the services that help people through the immediate crisis and to obtain necessary healthcare. However, this is only a beginning. Our real aim should be to provide conditions that these services are no longer needed. Based on the principle of social justice, together with those we want to help, we should advocate for governmental legitimate resources to ensure that they are appropriate for them and meet their needs. Only the ones who experience these services can judge their appropriateness.

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Care Avoidance and Care Paralysis

By Gert Schout, PhD, Groningen, the Netherlands*

Professionals in the Public Mental Health Care (PMHC) are confronted with clients who avoid the care they need. This study is addressed to the competences and organisational conditions that professionals need for the work with clients who avoid the care they need, and for that matter are helped within the PMHC. The aim of this study is to understand the dynamics that bring forth the production and reduction of care avoidance and care paralysis. Care avoidance and care paralysis not only coincide, they reinforce and recall each other.

With the help of the two sociological concepts 'anomia' and 'alienation', it is explained how these two phenomena interact. The avoidance of care seems to coincides with a general mistrust of PMHC-clients in society and the institutions within it. Clients for their part can call for such aversion that self fulfilling prophesies ('I told you, they never do something for you') are provoked which subsequently reinforce the world view that society or the assistance is good for nothing. These negative self fulfilling prophesies are nourished and repeatedly provoked and culminate into an unshakeable world view. A world view which must keep on distance the feelings of uncertainty and chaos that accompanies the lives of these people.

This process of rejection of the average society, the institutions and the services of care givers, can be reinforced by care givers who present themselves insensitively and bureaucratically. This insensibility is related in this chapter with the fragmentation, differentiation, rationalisation, myopia and decontextualisation of services within healthcare, public well-being, housing and public security. Myopia is the phenomenon that organisations can become caught up in and carried away by their own rhetoric and perceptions.

Organisations in this field of action have been powdered with protocols, directives, thresholds, indications and counter-indications that restrict the discretional space of professionals. The alienation - or in the words of Bauman 'the deconstruction of moral personality', or in the words of Schuyt 'bureaucratic indifference' – can be observed in shifting behaviour, the unnecessary referring of 'cumbersome clients', procedural behaviour and insensitiveness for the needs of people. When alienation processes of professionals and anomic processes of clients meet in assistance situations, there a mixture of self fulfilling prophesies arises ('you see, this client is not motivated' and on the other hand 'I told you, the assistance is good for nothing'), that end up in the avoidance of care and care paralysis.

Sometimes care workers can however create situations in which these phenomena are pushed back, situations in which trust and initiative - the opposite of care avoidance and care paralysis - appears. Pushing back care avoidance and care paralysis is linked to a style of work: establishing contact from a starting point of acceptance; looking for opportunities for affirmation; marking (small) progress. This study points out that care avoidance and care paralysis cannot thrive under conditions, as: the proximity between the local population and care facilities; the committed involvement of professionals to a fixed territory; a network wherein signals (of nuisance or deprivation) and actions can be linked; a small-scale service level so that key figures from the local population and professionals of the care facilities can axially know each other; discretional space for professionals to develop initiatives; and finally a moral framework where indifference is brought up for discussion.

Who will be the Health Advocates and Activists of Tomorrow?

By Dr Maria Stuttaford, University of Maastricht, the Netherlands

In terms of health and human rights, Europe has the advantage over other regions in the world in terms of international agreements, conventions and legislation; as well as institutions through the structures of the European Union, The Council of Europe and WHO Europe. With all these structures and mechanisms in place, why are we still asking: how and where do people who are homeless invoke their right to the highest attainable standard of health and who is acting to protect, respect and fulfil the right to health of people who are homeless.

When I first started writing this short article, I drafted a piece about research on the role of civil society organisations working with people who are homeless. Then I held an informal group discussion with students of the Bachelor of European Public Health at the University of Maastricht. They have no formal training in the area of health and human rights or of working with people who are homeless. What do the public health professionals of the future think about: the right to the highest attainable standard of health; what being homeless means; how being homeless impacts on the right to health; the role of public health professionals in protecting, fulfilling and respecting the right to health for people who are homeless; the possibility of pursuing a career which involves working with people who are homeless?

For the students participating in the discussion, the highest attainable standard of health meant: access to modern, innovative and quality health care as well as a healthy environment, opportunities to attain the highest standard of health and ability to participate in social and cultural life. In addition, to these entitlements, they said that the right also includes the duty of the state to create the conditions in which the right to health can be attained.

Being homeless was described by students as someone who has fallen out of the social net, is excluded, has inter-related health and addiction issues, and is stigmatized and marginalised. It was said that in theory they have the same rights to health as everyone else, but that the reality is different. The very fact that people are homeless is a barrier to the right to health.

Health professionals need to take multi-faceted, evidence based approach that take account of the complexity of health issues people who are homeless deal with. Students elaborated on how such approaches should focus on access to services, prevention of health problems, empowerment to make choices, education to raise awareness of services and support and building social networks. While some specialist programmes are required for people who are homeless, attention should also be paid to integrating them into society and integrating them into mainstream services and support as much as possible. This could lead to reducing stigma.

In terms of where public health professionals could work with people who are homeless, there was agreement that services should be provided at locations where people who are homeless already gather and/or meet. However, that services and support should not be forced on people. It was pointed out that health professionals can work at a number of levels: in service delivery, in raising awareness and reducing stigma to encourage integration of people who are homeless into day-to-day life and the workforce, and to lobby for greater equity.

Finally, students were asked if they would be interested in working with homeless people. For them, this was the most difficult question to answer. While they all said they would feel comfortable working at the policy level, they all said they would struggle with working at the level of service delivery. The reason given for this, is that under current structures and ways of working they do not feel they would be able to implement the innovative care and support that people who are homeless would be asking for.

Group discussion with 1st and 2nd year students, Bachelor of European Public Health, University of Maastricht, 21st November 2007.

I was struck by their response to my final question to them: if you graduated next month, would you be interested in becoming a public health professional who works with people who are homeless. Their response was cautious. Yes, they said, but only at a policy level. Not in service delivery. Their reason: that they do not feel that the current political and societal structures would enable them to provide the innovative care and support that would be requested of them by people who are homeless.

Those states parties who have ratified the ICESCR (1966) have the obligation to protect, respect and fulfil the right to health. However, experience shows that we cannot rely on the state and we cannot rely on the judicial system in order to achieve wide scale implementation of the right to health. Complementing and integrating with legal processes and state obligations, we need collective action by civil society organisations (CSOs) who can: advocate, develop policies and programmes, hold government to account and seek redress for past violations (London 2004). Recent research in southern Africa has shown that collective action has the potential to increase the realisation of the right to health (London 2007). However, we also need to guard against CSOs, being expected to fulfil state obligations (London and Thomas 2006). It is necessary to work with health professionals to ensure the right to health is attained for everyone, without discrimination. Furthermore, we need to encourage health professionals who are entering practice, to engage with groups who are marginalised and we need to ensure that these new health professionals feel supported to innovate in the way they need and want to. What can we do, in practice and in education, to prepare and encourage students to take up this challenging work? How can we convince them, that their innovative ideas and enthusiasm will be embraced and nourished?

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In the ENHW Forum!
Do you agree that health professionals have a rold to uphold and advocate for Human Rights, particularly the right to health? To share your experience, just log on to the ENHW forum and answer the Health Advocate and Activists post!

Message of Support from Hungary : Together we can achieve more

Ria Benko, Edit Szentandrasi, MD, Magdolna Joo
University, GP office for the homeless and Social Work department in Szeged, Hungary

We would like to congratulate on the establishment of the European Network of Homeless Health Professionals (ENHW). Besides social workers, by profession, the health care workers are those who get in touch with homeless people. Hence, the role of doctors, nurses and pharmacists is outstanding. They can not only write, dispense or give the right medication for the body, but can say healing words for the soul. Doctors' office and pharmacies are and should continue to be places where homeless people can feel they are treated like "humankind". The ENHW is a gap filling organization, for which

separated national organizations and standalone health care workers aspired. Luckily, somebody recognized the need and power of collective struggle. Hippocrates would be proud…

Here in Hungary the homelessness explosion occurred right after the political change in 1989, it was unknown before. Meanwhile ambulatory health care facilities for homeless people (GP office) were set up, now they are available free of charge –for limited hours - in big cities. Now, with the help of the Hungarian Maltese Charity Service those homeless people - who would never go to the doctor's office themselves – are transferred there. Here in the

southern part of Hungary, in Szeged city, in the near future our long-standing dream will come true: a 24-hour health care service for homeless people. Such service has been already working in some cities.

Despite these developments, we still face huge problems. The only compulsory and continuous health care control for homeless people is the chest X-ray for tuberculoses screening. Addictions, and other psychiatric disorders are quite prevalent among homeless and with the cutback and close of chronic psychiatric institutions, the long-term care of homeless people with these illnesses is unsolved. Another problem is the compliance with follow up visits and drug treatment due to their chaotic lifestyle. We can only hope that the (right) medicine is taken (by the right time). We think that without establishing long-term residential care or nursing homes for homeless all our endeavors have limited effectiveness, and resembles to "fire-fighting", elimination of immediate threat.

We hope that joining the ENHW will gives us the opportunity to share difficulties, identify good templates to follow and to organize exchange programs for health care professionals. We believe that unity is strength, and our togetherness and cooperation will result in better health care for homeless people. Together WE can Achieve More.

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Resources

The Homeless Hub: research library on homelessness issues in Canada

Dr. Stephen Gaetz et al

The Homeless Hub is an innovative research library and information center focusing on homelessness issues in Canada, www.homelesshub.ca. Building on the success of the Canadian Conference on Homelessness, held at York University (2005), the Homeless Hub represents a new approach to sharing information and research on homelessness. We strongly believe that evidence-based research can and should have an impact on decision-making and solutions to homelessness, through helping to educate the public, and to inform policy and practice at all levels of government and in the social, health care and housing sectors.

As a one-stop-shop, the Homeless Hub is a place where community services providers, researchers, government representatives, people who have experienced homelessness and the general public can access and share research, stories, and best practices. Based on a partnership between York University, the Government of Canada and a range of community partners from across the country, The Homeless Hub provides an opportunity for people and organizations to better understand,

develop and promote creative and collaborative responses to homelessness and housing instability.

The Homeless Hub is:
Easy to use – multiple ways to search; simple search engines; sophisticated browsing menus; simple forms and multiple ways to submit documents or join the Hub Network. A time and cost savings vehicle to making informed decisions when creating effective solutions to homelessness. A forum for sharing research and disseminating information. A vehicle to finding peers and other stakeholders across Canada to collaborate with. Up to date with the latest research, strategy, policy and resource information.

Call to Action - We invite you to:
Search or browse the library, experiences, resources and Hub Network areas to get the information and contacts you need. Share your knowledge by submitting your documents or citations of works, and permit us to include them in our library. Join the Hub Network and allow us to make your core contact information visible for other stakeholders to contact you for collaboration purposes. Recommend and refer other stakeholders to The Homeless Hub as the first place to start to get connected to homelessness information and people

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Provide feedback on our website functionality, usefulness and ease of use.

If you wish to comment or ask questions about The Homeless Hub, you can contact us by email: thehub@edu.yorku.ca.

*Dr. Stephen Gaetz, Principle Investigator; Alice Broughton, Co-applicant; Bill O'Grady, Co-applicant' Christine Brooks, Project Manager; Birgit Armstrong, Research Coordinator Asetha Power, Knowledge Mobilization Coordinator.

Access to Health Care for Undocumented Migrants in Europe: New PICUM report
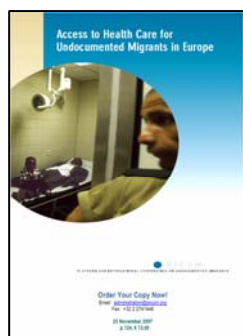
The result of an intensive two-year project co-funded by the European Commission, the new PICUM (Platform for International Cooperation on Undocumented Migrants) report identifies the legal and practical barriers encountered by undocumented migrants when trying to access health care within eleven EU Member states.

It gives visibility to the problems arising from inadequate access to health care. The situation facing undocumented migrants in terms of law and practice is provided through the country profiles; each providing an overview of the most common problems and obstacles preventing a realization of the right to health. Good policies and practices within each of the eleven countries are highlighted to provide inspiration for new health care strategies and actions which can continue to address the problems facing undocumented migrants in Europe.

The information contained in this publication will be useful in convincing the governments of EU member states to speak more, to do more, and to take on their responsibilities and comply with international human rights obligations instead of continuing to rely upon civil society as an alternative provider of health care for undocumented migrants. Making a strong case for action, this report may be used as a tool of influence, pressure, empowerment and innovation. Ten practical recommendations are provided to help national and European policy-makers to better address the problems arising from a lack of or an insufficient access to health care for undocumented migrants in the EU.
Read the report online

Events

Mental Health and Social Exclusion, 15 years on…what has changed?

10th SMES-Europa Conference, Rome, 23-25 January 2008

The extent of poverty and of social exclusion in Europe is unacceptable.
             European Council Lisbon 2000
The true causes of poverty and exclusion are far from being eradicated in Europe.
             Cons. EU – Rapp. Comm. 2006
The stigma and discrimination, related to the mental disease, are long-lasting.
             European Year "Equal opportunity" 2007

The 10th European Conference will take place 23-25 January 2008, in Rome, Italy, where SMES

organized its first Conference back in 1992, and founded the Association SMES-Europa (Santé

Mentale Exclusion Sociale – Mental Health and Social Exclusion).

SMES-Europa, has been focusing the attention on people who live in situations of extreme poverty and suffer because of mental illness and social exclusion. Discrimination and stigmatisation are on the increase. Marginalisation and poverty affect increasing numbers of people. Extreme exclusion claims an increasing number of victims. The European Community, for all its rhetoric on social exclusion, has failed to address these problems effectively over the last 15 years.

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The conference is aimed at those who work for the mental health and social rehabilitation of mentally ill homeless and socially excluded people. It will be a form to review the ideas and experiences developed, especially as regards community care and outreach, work and social inclusion, and migration and citizenship.

The aim is to look back - what has changed in the last 15 years, for better or worse? And to look forwards - perspectives and proposals for future

establishment of effective rights and access to health and social services.

All the information concerning the conference can be found on the SMES website. For any query you may have or any additional information, contact: **Luigi Leonori**, President of SMES, e-mail: smeseu@smes-europa.org or Read the Programme online

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