

European Network of Homeless Health Workers (ENHW)



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Editorial

Stefania Del Zotto, Policy Officer, FEANTSA

Dear Readers,

This issue of the ENHW newsletter is extremely rich and broad ranging, with a series of articles from Europe and beyond. Topics include tuberculosis control among people who are homeless in the European Union, an overview of the first year of activities of the QNI Homeless Health Initiative in London, the relationship between adolescents and alcohol in the Netherlands, the presentation of a quality assessment model currently implemented in Denmark, and the use of the “Housing first” approach in addressing the needs of mentally ill homeless adults in the United States.

The forum and resources sections bring additional “food for thought”. These include articles on issues such as the effective access to health care, a reflection on behaviours towards people who are homeless, and in particular on the role educators can play in changing attitudes. Other contributions give further examples of initiatives, studies and good practice. We hope that these examples will stimulate further reflection and interaction, be it in the form of articles for the next issue or on the online forum once it is up and running again.

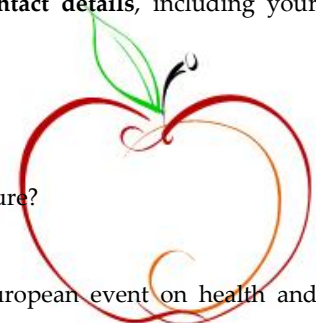
I would like to extend my warmest thanks to all contributors to the present issue. I would also like to take this opportunity to invite all subscribers to help us better identify who they are and which are the areas, where there is scope for progress. Please do not hesitate to send your answers, comments, questions or contributions for the next issue of the newsletter (by the end of September) to stefania.delzotto@feantsa.org.

I wish you all a very pleasant summer time!

SURVEY - We would be pleased to **know more about you** in view of further potential cooperation. We would be very grateful if you could send to the above mentioned address your **full contact details**, including your profession/area of specialisation and living place.

We would then ask you to answer the following **questions**:

- 1 How did you hear about the ENHW newsletter?
- 2 Have you already contributed? Would you be interested in contributing in the future?
- 3 Would you like to have feedback on general EU initiatives in the field of health?
- 4 What improvements would you suggest for future issues?
- 5 Would you/your organisation be prepared to/interested in co-organising a European event on health and homelessness?



Thank you for your time!

What is social medical care about?

Igor Van Laere, MD

Doctor for homeless people in Amsterdam, NL

Over the last decades, welfare states have been witnessing growing homeless populations in their communities. In response, alongside the mainstream services that address the housed population, a separate and growing community of services have appeared to dim the noise and to repair the damage caused by homeless people. I consider noise and damage as symptoms of underlying social and medical problems. But these symptoms are not only caused by those who live in our streets and shelters. A growing housed population seems to have difficulties not to make noise and/or not to cause damage, at home or in the public domain.

Are noise and damage a result of unguided freedom and independence without borders? And in response, to alleviate the symptoms, have public services become services without borders? In the public service arena, are social and medical helpers operating without borders? Are the public helpers educated and skilled as craftsmen to repair the damage? And public managers, are they, in response to the social medical problems in the community, guiding the upbringing of the craftsmen needed?

Before, the mayor, priest and family doctor were friends who shook hands upon an agreement to fulfil the formidable task of social, spiritual and medical leadership. Parents were parents and children were children. Craftsmen were building homes, teachers were teaching, social workers were working socially, nurses were nursing and doctors were caring. Helpers in the community performed tasks and responsibilities within clear borders. Care by knowing each other through personal contact in good community practice.

Today, who responds to noise and damage, as signals of alarm? I tend to think, rephrasing Orwell, that we are all equal, but a growing population of children is more equal than their parents. Within a growing number of families and generations without borders, unguided in communication and

behaviour, children will need a growing number of public helpers to repair the damage in later life.

Noise and damage in poor and underserved populations, as symptoms of poor and underserved communication and behaviour that is often guided by mental poverty, is in high need of reparation efforts. But today, who, with what knowledge and experience with underlying social and medical problems, reaches out to the noise to systematically estimate the damage? Is it fear for the unknown among the helpers, to face the battlefields at the bottom of society, that chains the helpers to desks and computers to treat red tape? Are the helpers imposed by impersonal activities that in response are symptoms of fear among politicians and managers, to face unguided communication and behaviour among the helpers without borders?

Over the last decades, in welfare states, the public assistance services and their helpers have been growingly occupied with tasks and responsibilities without borders. As a result welfare states are in need for doctors, nurses and social workers without borders. As family doctors, the gate keepers for addiction, mental and physical health problems, hardly visit their patients at home, who is able to assess the social medical damage beyond a desk and computer? And nurses who have to report every nursing minute? And social workers who are lost in stacks of forms? Who, in the bureaucratic and finance driven battlefield, is the director in the process of repair and reconstruction in bottom care?

Social medical care is about parents being parents and children being children within borders. And helpers being helpers to assist the poor and underserved with *social care* for housing, education, income and activities, and *medical care* to guide problems of addiction, mental and physical health. It is up to the academic world to train *doctors, nurses and social workers without borders* to learn to know the borders of social and medical care for those in highest need. It is up to local leaders to be a role model by reaching out and shake hands.

Social medical care is about good community practice!

Tuberculosis control among homeless persons in the European Union: more than words alone

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Introduction

The changing epidemiology of tuberculosis (TB) across the EU is characterised by a concentration of disease in certain sub-groups of the metropolitan population. Large cities harbour a disproportionate number of socially excluded inhabitants belonging to risk groups for TB, specifically immigrants, homeless persons, illicit drug users, alcoholics, street dwellers with psychiatric co-morbidities and persons with a history of imprisonment. Some of these risk factors commonly overlap and are especially over-represented in prison populations.¹ The prevention and control of TB among these risk groups is complicated by delayed diagnosis, onward transmission and poor treatment adherence leading to the development of drug resistant forms of TB. A recent international study on risk factors for TB transmission in low-incidence countries highlighted homelessness, injection drug use and alcohol abuse as the main factors associated with uncontrolled TB transmission in the community.² In 2002 and 2003 one out of six of all notified TB patients was homeless, illicit drug user or (ex)prisoner in Rotterdam, the Netherlands, and London, United Kingdom, respectively.^{3,4}

Homeless persons have poor access to health care or delay seeking help and their lifestyle may also camouflage TB-related symptoms. Therefore TB in homeless persons more frequently progresses to advanced and infectious forms of disease before it is diagnosed. Homeless people commonly share confined air spaces in poorly ventilated congregate settings such as hostels, day centres, methadone dispensing posts or safe drug consumption rooms. The problem is further compounded because their general health is poor, compromising immunity to TB. Collectively these factors exacerbate one another resulting in major outbreaks of TB involving homeless persons. Such outbreaks have been documented in many EU countries where extremely high rates of TB have been consistently

demonstrated (between 500 and 3000 TB patients per 100,000 homeless persons). This makes TB a common pan-EU problem,^{1,3-15} and also a problem for future EU member states.¹⁶

There has been no new drug for the treatment of TB for almost half a century and, while highly effective, current treatment is long and can be complicated by side effects to medication. Once diagnosed, poor adherence with treatment and loss to follow-up care is common among homeless persons. Poor treatment adherence leads to further transmission and is the cause of drug resistant strains of the disease. The concentration of TB in socially excluded and vulnerable groups also affects staff working with these groups and the general population.^{5,6}

Framework Action Plan to fight tuberculosis in the European Union

In February 2008, following consultation with FEANTSA and other relevant organisations, the European Centre for Disease Prevention and Control (ECDC) published the "Framework Action Plan to fight tuberculosis in the European Union", providing directions and proposals on what needs to be done in EU member states to decrease the burden of TB.¹⁷ The report recognises the concentration of TB in "hard to find" and "hard to reach" populations as a major challenge to TB control efforts across the EU, besides problems such as multi- and extensively drug resistant TB and TB-HIV co-morbidity. The report states that "tackling the TB situation in vulnerable populations must be a key element in any comprehensive strategy to reduce and eventually eliminate TB".

The Action Plan is built on four principles:

1. *ensure prompt and quality care for all*, e.g. through developing services tailored to the needs of vulnerable populations. This requires a sustained commitment of resources that reflect the complexity of delivering tailored interventions such as outreach services for Directly Observed Therapy (DOT).
2. *strengthen the capacity of health systems EU-wide*, e.g. health systems must be accessible, flexible and patient-centred without cultural, social and economic barriers.
3. *develop new tools, such as tools that enhance the operational components of TB control*, e.g. proper evidence-based public health interventions that

can cut the chain of TB transmission as early and effectively as possible, such as active case-finding in vulnerable groups.

4. *build partnerships and collaboration with countries and stakeholders*, e.g. the Action plan states that EU institutions in collaboration with partners can support the identification, development and dissemination of good practice models in TB control.

Realising these principles are essential to effective TB control among “hard to reach” groups throughout the EU, and FEANTSA welcomes the explicit references to this cause within the Framework Action Plan. The publication of this report provides for the first time an opportunity to re-think TB control among homeless and other vulnerable populations across the EU. We see this as a call to action to strengthen TB control across Europe through the exchange of experiences, collaborative research, advocacy and co-operation.

FEANTSA’s views **

1. TB is a key public health challenge for the 21st century that demands co-operation and concerted action across the EU.
2. TB treatment is one of the most cost effective health interventions.^{18,19}
3. TB remains highly stigmatised and strongly linked to poverty, poor housing and social exclusion.
4. TB cannot be tackled without addressing the social causes.
5. Those groups with the highest burden of disease in the EU are those same groups who have poorest access to health services and are least likely to complete treatment.
6. Standard approaches to TB control, such as contact tracing, and self supervised treatment are largely failing “hard to reach” groups.
7. TB services that are not geared towards the needs of urban hard to reach groups carry a future risk of higher rates of TB and drug resistant strains, rendering the disease once again untreatable.
8. There is an urgent need for more accessible and flexible TB services with capacity to proactively engage those most at risk.
9. TB cannot be controlled at a population level without specific targeted efforts to tackle the disease among “hard to reach” groups.

TB control models

TB is not only a medical disease but has strong social roots and components.²⁰ The evidence to date suggests it is not possible to control TB among homeless persons and similarly vulnerable populations through a solely biomedical hospital based approach. Hospital services must be complemented by public health community based TB initiatives tailored to the needs of homeless persons and other vulnerable groups. The success of the Dutch TB control model provides an important example where TB is controlled through close collaboration between hospital based services and public health TB clinics in the community. These services are complimented by two former TB sanatoria, now acting as tertiary in-patient TB treatment centres for patients with complex medical or psycho-social needs and where the consultants provide a daily telephone expert advice service to TB professionals and medical specialists in the field. The hospitals concentrate on in-patient and clinical care while the public health TB clinics work through a network of local health and social care agencies to provide contact tracing, preventive treatment, out-patient care and DOT; and active case finding among homeless and other vulnerable populations with appropriate targeted interventions, such as mobile digital X-ray screening.^{3,5} The public health clinics also have epidemiological responsibilities for surveillance and outbreak investigation. In the Netherlands TB control physicians, specialist nurses (who often also act as social workers) and practice assistants work under one roof and the TB clinic is a one-stop-(TB)-shop for all basic diagnostic (tuberculin skin testing, chest radiography and smear microscopy) and treatment facilities. This model is especially beneficial to socially excluded groups who often require intense case management and DOT to prevent lost to follow-up. The Netherlands has one of the lowest TB rates in the EU despite a significant concentration of homeless people and illicit drug users in the major cities of Amsterdam and Rotterdam where all vulnerable groups are periodically and successfully screened.^{3,20} The Action plan states that EU institutions in collaboration with partners can support the identification, development and dissemination of good practice models in TB control. The Dutch model is only one of such examples that is likely to be applicable and beneficial to other EU countries.

Exchange and research

There is an urgent need to develop the knowledge base on optimal strategies for effective diagnosis and treatment of “hard to reach” groups in the EU. There is some experience in different countries – often emerging from pilots – but more has to be done in order to translate this expertise into effective policy and practice. Here there is a clear role for the EU to add value, by fostering exchange and mutual learning in this area, supporting the dissemination of ‘best practice’ and helping member states drive forward their TB strategies. Exchange visits and development of educational material and courses aimed at multi-disciplinary staff (medical, nursing, social) working in public health TB control and with people who are homeless and illicit drug users in the EU should be established. TB among people who are homeless and illicit drug users, especially in urban settings, should be one of the key areas in the EU context for basic, applied, and operational research. For example, the EU can help to identify specific areas for action, supported through bilateral and multi-lateral EU and non-EU organisations or mechanisms, to promote early diagnosis among these vulnerable groups and ensure that the subsequent treatment is available, accessible, affordable, appropriate and most importantly successful.

EU Action

International borders are no barrier to TB. Increasing population mobility means that TB control is now a common responsibility across all EU countries. Uncontrolled transmission among “hard to reach” groups, coupled with the threat of emerging drug resistant TB is a major public health challenge, especially in urban centres across Europe. TB in the EU cannot be controlled without specific provision to reach and fully treat vulnerable communities. There is a clear role for the EU to protect the health of citizens against TB. FEANTSA hopes that the “Framework Action Plan to fight tuberculosis in the European Union” is more than words alone and results in real action, specifically regarding one of its key elements, i.e. tackling the TB situation in vulnerable populations. We call for an EU supported collaboration of partner organisations across member states to provide leadership and strategic direction, the evidence to inform policy and practice, and advocacy and support for those most at risk from TB today.

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** for more details, see FEANTSA's [Response to the Stakeholder Consultation](#) on the "Proposal for an Action Plan to fight Tuberculosis in the European Union", December 2007.

First year of existence for the QNI Homeless Health Initiative in London

Kate Tansley*

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The QNI Homeless Health Initiative (HHI) has recently had its first birthday. HHI provides tailored support to nurses, midwives and health visitors working with homeless people.

Many community nurses, both homelessness specialists and mainstream practitioners, will have homeless and insecurely housed patients on their caseload. Yet too frequently practitioners can be unsupported in meeting the needs of this highly vulnerable group – lacking the support, knowledge and skills required. The Queen's Nursing Institute's (QNI) Homeless Health Initiative (HHI), funded by the Big Lottery Fund, offers a way forward for practitioners and service users.

HHI and its members have much to celebrate this summer. HHI offers free support to nurses, midwives and health visitors working with homeless people, and turned one year old on 6 June 2008. We were delighted to find two new nurses to join us on that day – bringing our membership up to 400 for the first time. Since that time, numbers have continued to increase. Several of our members have won awards for their work this year, showing the vital importance of their work and the quality of their care.

Health practitioners working with homeless people are committed, highly skilled professionals. Yet they

face many issues: caring for a highly vulnerable population, often with multiple health issues and

sometimes chaotic lives, presents its own challenges - and add to that institutional challenges, such as lack of understanding of homeless health issues by providers. Like their clients, homelessness specialist practitioners are often unsupported and marginalised, sometimes feeling stigmatised and undervalued. These conditions include lack of support and resources, restricted career opportunities, and of appropriate supervision.¹

Practitioners can face lack of understanding of, and resulting low priority given to, homeless health issues in their local health economies – which means homeless services may be vulnerable to cuts. In addition practitioners working in generic services may be unsupported in addressing homeless people's health needs. When there is a local lack of analysis of the health needs of homeless people, this can lead to invisibility of many local needs.

HHI carried out a survey of new members in 2007, which revealed the difficulties which nurses working in the field of homelessness may encounter – this led to the HHI launch report – available at: www.qni.org.uk/hhi.htm

The majority of practitioners working with homeless people are unlikely to have received training on homeless health issues and thus lack training vital to their roles – overall, two thirds of HHI's survey respondents had ever had any training on homelessness and health, although the majority were specialists in the field. There are a

number of specialist services which offer a range of flexible, accessible services (including outreach) to meet needs.

However the nature of provision may be patchy, due to lack of specialist services in many areas, and lack of knowledge of homelessness in generalist services. Many mainstream providers, who also have a key role, lack knowledge on homeless people's health needs, as demonstrated by the HHI launch report – for example only 8% of this group had received any training in homelessness and health issues, and 71% did not feel confident in their ability to care for homeless people.ⁱⁱ These issues can impact adversely on care provided.

74% of survey respondents, most of whom were homelessness specialist practitioners, were 'lone workers' at least sometimes,ⁱⁱⁱ and so potentially face risks to personal safety. Some could not access appropriate clinical supervision and support.

Due to the complexity and severity of homeless patients' needs, and the fact that they may present with several different problems, appointments frequently take longer than with the general population. Patients are very mobile (often not attending again) which creates difficulties for continuity of care and means practitioners have to be opportunistic and creative.

Community practitioners working in disadvantaged areas, or even affluent areas with pockets of deprivation, will be able to benefit from the free support the QNI's HHI can offer. HHI offers a free support service to enable them to better meet the needs of homeless and vulnerably housed people. HHI is offering support to meet practitioners' professional needs such as: tailored professional development, peer support, networking opportunities, updates on homeless health care, developing specialised resources such as practice guidelines and health promotion resources tailored to homeless health care.

HHI recently launched a new section of its website to enable HHI members to share information more easily, with sections for profiles of practice (homeless health care in action) profiles of learning, and a Members' Q & A Forum section. Please see www.qni.org.uk/hhi.htm and click on 'Information Sharing' for more details.

To date, HHI has published several newsletters, a briefing on homelessness and health, a launch report mapping homeless health care, guidance on commissioning services for homeless people for both practitioners and commissioners and a resource on benefits and homeless people. We will launch our service user involvement resource pack in early July.

HHI is committed to service user involvement – and as such, published a report on homeless people's experiences with health care.^{iv} HHI commissioned Groundswell, a leading user involvement organisation working in the field of homelessness, to research homeless people's experiences of health via focus groups with 25 homeless people in Grimsby, London, and Gloucester, conducted by professional facilitators with personal experiences of homelessness.

Key findings included the most important factor in a health service being people and their attitudes: 'respect, good people, tolerance, care, compassion, friendly, no general rudeness.' Homeless people identified their key health issues according to circumstances – e.g. rough sleepers identified cleanliness, safety and foot care.

A number of barriers to access were noted, including: waiting times and lack of time with professionals, opening times, and lack of information. Service users expressed varied experiences with staff attitudes but frequently felt these to be more negative due to their homelessness experience: 'I was homeless and he [the GP] didn't want me around...he's a lot better now I've got a stable address and all that, he treats me with respect.'

Different problems with Accident and Emergency were noted – for example, difficulties due to gate-keeping experience from front line staff. Around 38% stated their first port of call for health care would be a 'one stop shop' – centres offering homelessness services and health care. This may be partially due to the fact that most of those participating used one stop shops. In an emergency most would go to Accident and Emergency or dial 999.

Some people reported being discharged from hospital onto the streets: "they didn't find me anywhere to live even though they said they would if I've been discharged on the streets.' One extreme case was reported as: 'I was beaten up and had



stitches. 2'o' clock in the morning they're throwing me out. The following day I was vomiting blood.' Positive experiences include being discharged with enough medication for a week. Some hospitals may be unaware of the national guidance on hospital discharge for homeless people.

Recommendations include: training for health/reception staff on health and homelessness, training for homeless people about health services, increase awareness of hospital discharge guidelines and audit use, improved signposting by A & E for homeless people, adopt protocols to be adopted regarding intoxication, clear protocols for GPs on registering homeless people and clear protocols on access to health records.

The full service user report (and all HHI resources) is available at: www.qni.org.uk/hhi.htm

Over the next year, HHI will be offering nurses small grants to increase service user involvement. Our new service user involvement resource pack will also improve practice in this vital area.

HHI is now completing a survey of its members to determine the success of the first year of the initiative, and to plan next year's support for members, supporting them to improve services with and for homeless people. The results of this survey should be announced in July/August on our website – but early results are extremely positive.

HHI is planning the 'nursing and homelessness' conference on 12 May 2009: to our knowledge, this is first ever conference for nurses working in this field. It will have a wide range of topics and key note speakers: from improving access to health care

for homeless people, to sexual health, pregnant homeless women, self harm, substance misuse, blood borne viruses, and more. The costs will be affordable for nurses. Please join HHI (becoming an HHI member is free) to receive more details.

HHI wishes to offer support to as many community health practitioners as possible. Nurses, midwives and health visitors working in England are our key priority. We encourage such health practitioners to join us free of charge, whether homeless and vulnerably housed people are a large or small part of their caseload – we wish to support both homelessness specialists and mainstream providers to meet the needs of homeless people. This initiative can support practitioners to better meet homeless people's needs. For more information, to access our resources, our programme of events, and to join, contact Kate Tansley via 0207 549 1402 or kate.tansley@qni.org.uk.

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Adolescents and Alcohol: Exploring Borders and Crossing Lines in the Netherlands

Denese van Poppel*

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Alcohol abuse among adolescents and young adults is currently a hot topic in the Netherlands. Quite rightly so, as a recent study illustrates.¹ In this summary, this very real problem within Dutch society is discussed and illustrated by an individual case to provide insight into the train of thoughts amongst adolescents and young adults.

Adolescence is the period during which a child matures into an adult, and often experimentation goes along with this transition. This experimentation includes exploring borders and

crossing lines which include the use (or abuse) of alcohol. Alcohol can serve as a means to express solidarity between peers, to identify with youth culture, or to confirm personal identity. There is a thin line, however, between experimenting with alcohol and crossing lines. What happens if it turns out that adolescents do not learn from the negative consequences of alcohol consumption?



FEANTSA

The articles do not necessarily reflect the views of FEANTSA.

The aim of the study was two-fold. Firstly, to clarify the prevalence of alcohol related injuries and accidents among adolescents and young adults (aged 12 - 30) in South-East Brabant, during weekends. A distinction in alcohol related injuries and accidents is made in traffic accidents, violence and assaults, minor accidents (e.g. falling), alcohol poisonings and other kind of accidents (e.g. injuries caused by broken glass). Secondly, to profile the adolescents and young adults involved in order to provide a clear overview of the problem.

A total of 172 adolescents and young adults under the influence of alcohol were registered with an alcohol related injury or accident during the data collection period of eight weekends. Males formed the majority in the total number (64%). Furthermore, most involved adolescents and young adults aged 17 to 25. The impact of alcohol related injuries and accidents on the adolescents themselves are nil. This is probably best illustrated by the individual case of a girl aged 17, who suffered from alcohol poisoning for the second time in her life. Remarkable is her unfazed attitude and the reaction of her friends. Although this was her second experience with a life threatening situation, she was not bothered at all. She stated that she will be 'more careful' with drinking in the future. Keeping in mind that she normally drinks 20 alcoholic beverages, she does intend to drink less in the future. The social control of her friends was missing. Although they were frightened by her poisoning, they were surprised as well, because they drank the same amount of alcohol and did not experience any

problems. Instead of admitting the seriousness of their own drinking behaviour, they were more or less blaming the girl for her poisoning!

Drinking (excessively) is culturally embedded in the Netherlands. As the data collection period included the Queen's Birthday, a national holiday, the number of alcohol related injuries and accidents peaked that weekend. The question is what should be done in order to prevent adolescents from going off the rails? Who takes responsibility for this problem? It cannot be the intention of Western society to forget about the wellbeing of their younger generation.

1. Poppel DGH van. Alcohol related injuries and accidents among adolescents and young adults in south-east Brabant during weekends. [Dutch]. University Maastricht, Samenwerkingsverband Regio Eindhoven (SRE), the Netherlands, 2007. www.sre.nl/alcoholenjongeren.

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STAP is a member of Eurocare, an alliance of agencies set up to tackle problems associated with alcohol use at a European Level. www.eurocare.org

Documentation and quality assessment in health-related outreach work in Copenhagen, DK - A potential model?

Dr Henrik Thiesen*

In the Copenhagen-based Health Team we have worked systematically with data collection, guidelines and quality assessment since the team was implemented in mid-2005.

Quality assurance in health-related out-reach work is not very different from what is seen in other medical specialties.

There are no general guidelines for good medical treatment in street-medicine but when looked closer at, the medical work is comprised of well-known

methods that all can be done by properly trained professionals. Each of the elements can be assessed and collected in a clinical database.

This means that the health-work can be divided into functions which are used in many places and where there is an evidence base for effect and best practise.

Where out-reach health service separates itself from other kinds of health-service is that it integrates methods from an array of different specialties, including psychiatry and addiction and aims to integrate this with social work.

When many different specialties and treatment modalities are incorporated it becomes necessary to use very simple norms for treatment quality and



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these norms have to grow out of the daily practise. To implement standards of care or treatment directly from in-patient treatment in hospitals would be very complicated and probably counterproductive.

Data

To be able to set standards of quality of care, a systematic set of data is needed and we aimed to get an extensive, easily accessible data-collection on each patient using mobile standardized chart.

Data includes a variety of social- and health-related items:

- Demographics
- Housing (FEANTSA - ETHOS-coding)
- Somatic and psychiatric health (ICD 10)
- Substance use (lifetime and present)
- Earlier and on-going treatment
- Physical data (including blood-screening)
- Social support status
- Stakeholders, including other healthservice - providers
- Response time for contact and treatment

The data-set can be divided into data which are relevant in immediate treatment and data which may have relevance in development of "better practise" based on:

- Evidence in other settings and specialties.
- Clinical observations in the team and in the literature
- Casuistic observations in the team and in other clinical settings.

Method

Every nurse is responsible for clinical data-collection described in an internal clinical guideline. We use a simple pre-printed chart and guidelines for additional data collection which mostly is physical data from blood-sampling. The nurse who is case manager of the individual patient is also responsible for the completeness of the individual data-set and she decides which data it is possible to collect during contacts with the patient.

All data are collected in a common data-sheet and from that data-processing is done every 6 months. This data-processing supplies data which can be used for:

- Quality control = focus on internal and appointed quality goals
- Demographics
- Processing of health- and social data

On top of that an annual quantitative and qualitative report, is made consisting of:

- In-depth analyses of data
- Description of clinical methods which may be well-known methods implemented into out-reach health
- Development of a new evidence base in out-reach health service.

By processing the data with such short interval we are able to see changes in patient demographics and we are able to keep an eye on our performance data and implement actions to correct if there are dysfunctions in the way we have set up as a goal for the team. It also makes it possible to implement new data-sets into the chart and get a quick response to whatever the data seeks to enlighten. A good example of the latter is the casuistic information that Vitamin D status in the general Danish population is unexpectedly low¹. The team implemented vitamin D status in the general blood status and found a severe deficiency at first status in 2007. Next step has been the establishment of a protocol for intervention and clinical improvement of symptoms.

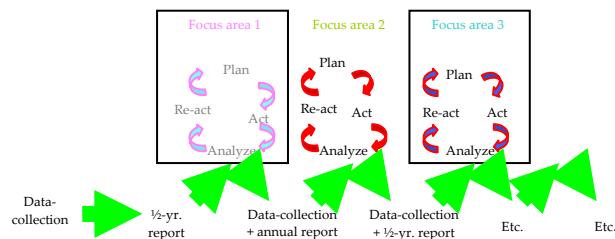
Assessment, description and action on health-related problems this way makes it possible to improve the general health-service in a fast-paced way and to re-assess how and if, changes in treatment brings about better outcome. At the same time it is possible to assess how a new treatment modality or data- catch can be done without interfering with what already is implemented in the daily work or how it, on the other side, may change the general practice of the team.

The break-through model

The described model is known as the "break-through model" and it can be used to identify any problem in clinical practice and most kinds of health-related issues if there is a basic set-up for data-collection. In the Health

¹ Leif Mosekilde et al. Vitamin D deficiency: Definition of and prevalence in Denmark, Ugeskr Læger 2005;167:29-33

Team we have used this model to identify problems in daily practise, implement changes, evaluate the changes and correct if the results were not in accord with the goals we set out to reach.



Example 1: In mid-2006, when the team was 1 year old, data showed that an unacceptably low percentage of the patient charts were systematically filled. 28 % had a full chart and the goal was 75%. The team nurses made a complete review of the chart, including the same data but with an extensive reshaping of lay-out. 6 months later the percentage of fully completed charts was 57 and by the end of 2007 it was 86%, vastly exceeding the initial quality goal.

Example 2: From the beginning it has been a goal to find standards for the best possible treatment. We set out with a set of simple goals for response time and based on the fact that we are not an emergency service we wanted:

1. 80% of patients to be seen by a nurse within 7 days from contact with the team. In 2007 this was accomplished for 98.5% within 7 days and average response time was 1.4 days;
2. If treatment is needed, 80% of the patients should be offered treatment within 7 days from the point in time when treatment is decided. In 2007 98.5% were seen within 7 days and average response time was 0.5 days.

Based on these data we were able to set up a new goal for response, including a “good practice” in the course of treatment so that

3. 80% of all treatment and blood sampling must be reviewed within 14 days of treatment initiation.

The goal for this chain of events is to secure that once a treatment is implemented, it is also followed through by the team and secondarily to get a picture of which barriers there are to treatment.

Development in concurrence with practice

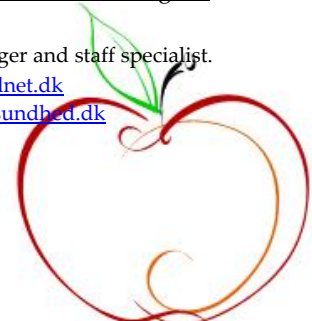
One of the most important learnings we have gathered from this practise of on-going quality assessment is that it has to be done in concurrence with the daily life and practice to support development of a professionalism that is felt understandable and necessary by each member of the team.

For a new method of practice or a new data-catch to be part of what is conceived as “the way we do things to do them as well as possible” it is necessary that data are evaluated and lead back to the staff with relatively short intervals so that the individual team member can see directly what the results of a changed method or behaviour are. At the same time the team member can give feed back to refine the method and that way become a direct agent of change. It is important to see practice and development of quality as two sides to a satisfying development. If one doesn’t have an eye for the effects of ones methods all the time, there is a huge risk that one ends up doing work that has no real effect in the long term. Methods and practices that are not developed obviously become obsolete and evaluation and control that doesn’t feed into daily practice may lead to cynicism and burn-out among staff members – a trend that unfortunately is seen in many hospital-treatment settings throughout Europe.

Among small intensive teams working with severely ill or marginalized people, it is of utmost importance to avoid the negative trend by keeping practice humane and challenging in a never ending development.

Parts of this article have been published in Danish in the Health Team annual report 2007, available at <http://www.hjemlosesundhed.dk/?English>.

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“Housing First” as a Model for Serving Mentally Ill Homeless Adults in the United States

Dr. Deborah K. Padgett*

Professor at New York University

In 1992, a psychologist named Dr. Sam Tsemberis decided to take action on what he was hearing while conducting homeless outreach for New York

City’s Project Help. Put simply, the homeless men and women he encountered did not want to go to a

hospital or city shelter, insisting they preferred to have an apartment of their own first (or at least concurrent with the treatment and supervision being offered to them). The 1990s were a time of growing concern about the persistence and visibility of homeless persons in the U.S., among whom one third were seriously mentally ill adults who also abused alcohol and/or drugs.

The prevailing service ethos then (and now) was to place the homeless mentally ill on a continuum of services which gradually became less restrictive as consumers showed the ability to maintain abstinence, behaviorally comply with treatment recommendations and manifest ‘housing readiness’ as judged by program providers. Tsemberis’ newly-found organization, Pathways to Housing, Inc., reversed this continuum by providing homeless mentally ill persons with immediate access to an apartment of their own. Pathways also enacted consumer choice, a policy most evident in its approach to substance use, i.e., harm reduction rather than strict abstinence. Support services were provided by Assertive Community Treatment (ACT) teams along with an array of programs (health care, job training, harm reduction support groups, nutrition, exercise, photography, painting and the like). Treatment access and use were not linked to retaining one’s housing, but payment of the rent to a private landlord depended upon ‘money management’ to reserve one-third of tenants’ disability income. Additional funds for rent and other services provided by Pathways were procured primarily through government grants and contracts.

In the ensuing years since Pathways began, concerns about its approach centered on the wisdom of placing of mentally ill substance-abusing persons in the community without supervision and restrictions. Interestingly, public resistance surfaced

only once, when Pathways was asked to extend its services to a neighboring suburban county. That opposition, which received attention in the local media, was almost entirely organized by shelter providers, in particular those associated with churches.

Some non-profit programs serving the same population argued that their approach was little different from Pathways. However, no organization replicated the unique ‘package’ of Pathways to Housing—immediate access to independent housing, harm reduction, the absence of on-site supervision, consumer choice re: use of medications, etc. A few of these elements might be present, but there was invariably a catch, e.g., a curfew, mandated treatment attendance, or a ban on illicit drug use.

This uniqueness of the Pathways approach—and its transferability to other cities in the US and abroad—is being put to the test as Pathways-like programs are up and running in Washington D.C. and Philadelphia and are being developed in several other U.S. cities, from Denver to Fort Lauderdale. As this is being written, a colleague from the University of York (Dr. Carol McNaughton) is visiting the US to learn about how Pathways works in order to bring it back to her British colleagues and potentially interested service providers. A number of visitors from the Netherlands and other EU countries have visited Pathways’ home offices in New York City to learn more about this innovative approach.

In 1997, Dr. Tsemberis and colleagues were able to obtain Federal funding to experimentally compare Pathways’ ‘housing first’ approach to usual care, or ‘treatment first’. Quantitative results from that four-year trial, which are published in several journals (see Appendix), have shown that Pathways consumers manifest greater housing stability, sense of mastery and choice than their usual care counterparts living in congregate settings. These empirical findings, along with clear evidence that Pathways is less costly than a bed in a jail, hospital or shelter, have led to high-level Federal endorsements (see Appendix) and to media attention ranging from the field of medicine (*The Lancet*) to the business world (*Fortune Magazine*) to leftist advocacy (*Mother Jones Magazine*). This attention, timed perfectly to coincide with the “recovery paradigm shift” currently sweeping through the world of services for persons with



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serious mental illness in the U.S., points to the potential for a profound change in how an especially vulnerable group - the homeless - might be treated in the future.

Based upon this combination of positive empirical findings and high-level policy endorsements, momentum for housing first in the USA has become stronger than ever. It is inarguably a consumer choice-driven approach that can appeal to cost-conscious bureaucrats. Yet there are powerful incentives operating against this momentum. Even without overt opposition from providers or family members concerned about giving too much control and unsupervised autonomy to mentally ill individuals, the weight of the status quo is heavy. Much is at stake in a system predicated on the disbursement of many millions of dollars by Federal and state authorities (New York State's Office of Mental Health alone has an annual budget running close to \$5 billion). Mental health professionals, hospitals, clinics, shelters and congregate residential facilities may fear losing all or part of their funding if housing first gains favor (even if only as one of several accessible alternatives). Yet this writer remains cautiously optimistic that both the idea *and* the reality of housing first will be widely embraced in the future.

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Forum

ENHW online Forum facing technical problems

FEANTSA would like to apologise for the technical problems, which are hindering the effective use of the online forum at the moment. We are working on it and hope that the forum will be operational again after the summer break. We will keep you informed.

Dutch medical professional organisations speak out about the frictions in care to (undocumented) migrants

Evert Bloemen and Erick Vloeberghs*

Provision of medical advice and treatment to undocumented migrants and rejected asylum seekers had lead to a certain amount of tension and confusion within the care system. Medical doctors are faced with problems of continuity and of transfer of care in asylum seekers' centres as well as in cases of (threatened) expulsion. They are

involved in problems related to the quality of care in detention centres for immigrants, and when care is given to illegal immigrants there is a lack of clarity about what 'medically necessary care' means.

Doctors have recently been warning their professional organisations about these issues. The national organisation of general practitioners

(LHV), and of mental health professionals (GGZ Nederland) together with PH-inspectors have taken

the initiative to invite other medical professional organisations to participate in the Commission Medical Care for Aliens, known as the Commissie Klazinga in the Netherlands – named after Dr Niek Klazinga, professor of Public Health.

The commission has formulated its professional stance regarding the provision of medical care and medical advice in the reception of asylum seekers



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and undocumented migrants in the Netherlands. The commission has also further elaborated on the concept of 'medically necessary care' and presented practical recommendations.

The English summary of the report is available through the Pharos website, the Dutch knowledge and advisory centre refugees, (undocumented) migrants and health:

http://www.pharos.nl/uploads/site_1/Pdf/Documen/Arts_en_vreemdeling_Summary.pdf

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Touching lives, changing attitudes: using homeless outreach to ignite the passion for compassion

David M. Deci M.D.*

Goal/problem statement

Much has been written with regard to the elucidation of core attributes and skill sets that future physicians need to possess. Articulating and demonstrating these principles within the curriculum is a daunting task. Using a student-driven and street-based outreach to the homeless, key concepts such as healthcare access, coordination of care, compassionate non-judgmental and comprehensive care are brought to life in a ways that are both meaningful and visceral for students. This presentation outlines the manner in which this particular service learning can transform the lives of both students and homeless clients. The impact that community connectedness, peer mentoring, and role modeling in a collaborative environment has upon students is described.

A key challenge of predoctoral education is the fostering, guiding, and molding of caring, compassionate and collaborative physicians. This charge extends to all students, irregardless of intended specialty. Furthermore, this curricular and social mandate is underscored by recent findings and mandates of the Institute of Medicine, the Liaison Committee on Medical Education, and the Future of Family Medicine Project. Although course and clerkship objectives often reflect these principles, it is often difficult to transform these

objectives from passive, observational experiences into meaningful, active learning opportunities.

Many medical students enter the predoctoral curriculum with altruism and social commitment, fostered by a desire to "make a difference" through health care services. Unfortunately, the time demands of medical school and the tightly structured basic science and clinical courses prohibit both learners and teachers from fully exploring opportunities for reconnecting with the emotional motivators that can bring about not only personal awareness, but positive professional growth and development.

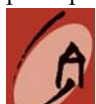
Through role modeling by faculty and trained student volunteers in the setting of providing street-based care, a complex agenda of cognitive and noncognitive skills are developed and enhanced through a meaningful and time-effective experience.

Description of project or intervention

Driven by student interest and a deep commitment to extend care and compassion beyond the walls of the West Virginia University School of Medicine, the Family Medicine Interest Group underwent a process of inquiry and training that led in June 2005 to the establishment of the Multidisciplinary UnSheltered Homeless Relief Outreach Of Morgantown (MUSHROOM). Patterned after the highly successful "Operation Safety Net" developed by James S. Withers, M.D. of Pittsburgh, the program's goals include:

- Providing basic life sustaining social, nutritional, and medical outreach to the unsheltered
- Serving as an advocacy and educational force for local homeless issues
- Coordinating care for homeless who enter the local healthcare system
- Fostering a sense of compassion and social commitment for health professional students
- Expanding service learning more broadly into the Morgantown community.

The targeted population served is that of the unsheltered homeless. These individuals often suffer from mental illness or have had social experiences that limit their ability or desire to access traditional care in formalized clinics, offices, and hospitals. Often mistrustful of the current health care system, they typically suffer from both chronic and acute conditions that are life threatening. Trained volunteer health professional students



accompany physicians and social workers on “street rounds” in Morgantown. They go where they are needed most to meet those individuals living under the bridges and along the riverbanks. Volunteers bring basic clothing items as well as deliver food and fluid replacements. In addition, they provide critical medical assessment and first aid treatment. Perhaps most importantly, volunteers bring compassion, caring and conversation to marginalized clients who often go unseen in today’s society.

Evidence of effectiveness

The Impact of MUSHROOM: since June 2005:

- 2200 client encounters
- 200+ medical services provided with value of \$65,000
- 250 volunteers with 2000 volunteer hours

Example of student reflection as a measure of promoting attitude change: “I would just like to enclose some of my reflections on participating in MUSHROOM with you on Tuesday night. First of all, the comment you made to me and the first year student about living in Morgantown all of our lives and never seeing the shameful poverty in the same town really hit me. Here I was, dedicated to public health, universal health care, etc. and yet they are all abstractions to me. I have not really seen what poverty does to a person. I have not imagined one of those old men we encountered as my own father, forced to live a life of indignity, forced to serve people half his age for a few scraps. MUSHROOM made all of the vital humanitarian issues that are important to me come to life, face to face.

What really hit me the most though, and I think the other students would agree, was the gentleman living by the river. While he was speaking about his ordeal, I kept trying to picture in my mind not interacting with any other human being for a week or two, let alone an entire month. The sense of total hopelessness that gentleman purveyed really stung.

The philosophy of MUSHROOM needs to be disseminated into the med school curriculum. I cannot help but think how many times I have heard the euphemism “lifestyle” or “cushy” to describe the choice of specialty that students are pursuing. It seems the medical profession has headed more and more in the direction of preserving social status, and “prominence” is the ultimate goal promoted in the

culture of the medical establishment today. Maybe a touch of social awareness is just what is needed to counteract this disturbing trend.

Thanks, Sammy Almashat, MS III April 3, 2007.”

Discussion and conclusions

The missions of MUSHROOM directly address the urgent need within our medical education systems to develop relevant learning experiences that bring to life the attributes, collective values, and the skill sets that future physicians will require.

The model of service learning and community outreach described is innovative in a number of ways. Most importantly, this model is student-driven. This allows for student ownership, engagement and growth. Students participating in this project have developed leadership skills as well as enhanced organizational and public speaking skills. They have boldly entered into the center of a community problem for which they have developed an effective, humanistic and holistic solution. Just as importantly, they have witnessed the delivery of compassionate and collaborative care rendered with openness and acceptance.

The power of role modeling is another aspect of this educational experience that has merit. Not only do medical students see faculty and residents engaged in this outreach, but they, themselves, rapidly become role models and teachers for new volunteers. In the intimate and visceral setting of the streets, back alleys, and riverfront homeless camps, medical students witness role modeling by other key partners including social workers, psychologists, nurses, graduate students, and community members. Most importantly, in a very touching way, they become “students of the street” and learn valuable lessons about life from the clients they are serving.

This model of learning is definable, powerful, relevant and time effective. Its elements, principles, and structure are transferable to other institutions and other forms of community or social outreach. It highlights the capacity for small extracurricular elements to serve as beacons of hope in the medical curriculum. Lastly, it emphasizes the astonishing ability of medical students to serve as change agents for a better future.

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“Working with drug users – Guidance for accommodation providers and other support services”, Cymorth Cymru, 2008.

Homelessness services across Wales and other areas of the UK report that significant numbers of their service users are dependent on illicit drugs and/or alcohol. However, in some cases services are unclear about how best to respond to this issue, and service users in different parts of the country are likely to have very different experiences.

The recent Cymorth Cymru publication discusses the range of implications that drug use has for homelessness services, including concerns around legislation, staff and client safety, neighbourhood relations, working with partner agencies, and promoting effective engagement with drug users. The Guidance proposes an inclusive, harm reduction approach to drug use which focuses on the key role that homelessness services can play in assisting people in addressing their difficulties, accessing specialist services, and making real, lasting changes to their lives.

The Guidance has been funded by the Welsh Assembly Government and is available in hard copy or to download.

Web site: <http://www.cymorthcymru.org.uk/>

Resources published by the QNI Homeless Health Initiative

They can be downloaded and include:

- Homeless People and Benefits: Signposting Tool for Nurses, click [here](#).
- On the Ground: Mapping Homeless Healthcare, the Homeless Health Initiative launch report, click [here](#).
- QNI briefing paper on Health and Homelessness, click [here](#).
- HHI's Service User Consultation Report, click [here](#).
- HHI's Commissioner's Guide, click [here](#).
- HHI's Practitioner's Guide, click [here](#).

“Homelessness and disorder: the challenge of the antisocial and the societal response”, by Scanlon, C

& Adlam, J (2008a), in C. Kaye & M. Howlett (eds.) *Mental Health Services Today and Tomorrow: Part 1 Experiences of Providing and Receiving Care*. Oxford, Radcliffe*

Overview: the chapter begins with a discussion of the psychosocial concepts of 'homelessness', 'dangerousness' and 'disorder' and then seek to re-define and re-locate both from the internal world of the individual sufferer to the psycho-social 'dis-memberment' associated with what we have called the 'unhoused mind'. We then explore the complex reciprocal relationship between the 'ordered' and the 'dis-ordered', the social and the anti-social, and consider some possible implications for individual workers, staff teams and organisations who are tasked with attempting *to house* or otherwise *to accommodate* such people. The chapter concludes with a challenge for policy makers to reframe the philosophical basis of their approach to the societal duty of care.

* Related article: Scanlon, C. & Adlam, J. (2006) 'Housing 'unhoused minds' – inter-personality disorder in the organisation?', *Journal of Housing, Care and Support*, 9 (3), 9-14.

“Souls in the Hands of a Tender God, Stories of the Search for Home and Healing on the Streets”, by Craig Rennebohm* with David Paul, Beacon Press, 2008.

Overview of the book: the Mental Health Chaplaincy began in 1987, as a response to an increasingly visible number of homeless, mentally ill individuals on the streets of downtown Seattle, Washington, USA. The chaplain walks a daily route through the city centre and nearby neighbourhoods, doing outreach and engagement with homeless, mentally ill individuals who have lost contact with care or who have no services. Outreach and engagement includes the four stages of approach, companionship, partnership, and mutuality. The aim is to share the journey from the street to stability within the community assisting individuals to find and use a variety of healing resources, and to foster the capacity for welcome and hospitality in the community, and to establish long-term, neighbourhood scale patterns of care.

Souls in the Hands of a Tender God is a tender and touching book with stories of the search for Home and Healing on the Streets. From an American street

chaplain's work with homeless people who suffer from mental illness come uplifting stories of hope and redemption, and a call to us all to build healing communities. In the United States, persons with brain disorders account for a large proportion of the homeless population. Craig Rennebohm approaches his task of helping these "souls" from a religious perspective, but he is always aware of the need for skilled medical treatment, the physical necessities of home and security, and the social need for companionship and understanding. *Souls in the Hands of a Tender God* does more than just tell inspiring stories. It points to workable models of community mental health care, and it challenges churches, non-profit organizations and governments to take steps toward caring effectively and compassionately for those in our midst who are suffering and marginalized. A must read for all homeless health workers!

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"Assessment of risk for substance use disorder consequent to consumption of illegal drugs: psychometric validation of the neurobehavior disinhibition trait", by Mezzich AC, Tarter RE, Feske U, Kirisci L, McNamee RL, Day BS *Psychol Addict Behav.* 2007; 21(4):508–515.

Overview of the article: given the relationship between substance use and homelessness, as well as the proportion of male population among people who are homeless, prevention among boys at risk is crucial. According to the study, which has been published in December 2007 issue of *Psychology of Addictive Behaviors*, a psychological trait called neurobehavioral disinhibition (ND) may help identify boys at risk of habitual drug abuse after experimentation with an addictive substance.

Web site: <http://www.drugabuse.gov/newsroom/08/NS-4.html>

Ongoing research: Undocumented children at the academic medical centre in Amsterdam

Background: Pharos*, conducted retrospective research concerning access to health and necessary medical care for the children of undocumented

migrants in the Netherlands. The aim of the research was to know:

1. How many uninsured undocumented children (from 0-18 year) were hospitalized between 2000 – 2005 in the Emma Children's hospital/AMC in Amsterdam, and
2. What medical illnesses these children were suffering from.

Methodology: the research was conducted by looking at the children's medical reports. The inclusion parameters were: the diagnosis at discharge, patient – doctor delay and the follow-up care.

Conclusions: During the prescribed period, 47 children were hospitalized on 69 occasions. The intakes (31) were predominantly postpartum.

Patient - doctor delay didn't play an important role. Most children were hospitalized perinatal (22), referred by another hospital (14) or via the first aid post (10).

The most common diagnoses were: perinatal problems (24) and maternal HIV- infection (7). The polyclinic follow-up care changed from 'never seen again' to regular check-ups in the case of HIV-infected children. 37 children were born in the Netherlands.

Remarkably, older children are hardly hospitalized. They only go to hospital as teenage mothers to give birth, or just after a suicide attempt. Also, the patients or doctor's delay needs closer examination at the general practitioner's level (referrals).

Since the number of children is low, there is a suspicion that the children and their parents face constraints when entering the hospital. Additional research is needed and will start in The Netherlands in July 2008.

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*Pharos is the Knowledge and advisory centre for refugees, migrants and health. Last May, at the European Public Health Association (EUPHA) 2nd conference of Migrant Health in Europe, Malmö, Sweden, Pharos had a chance to present the findings of the research. For more information: <http://www.pharos.nl/supernavigatie/english/85?pagina=2>

Studying homeless health care in Oxford, UK – Come and join our learning community

Dr Angela Jones, Course Director

Since October 2007, the first cohort of students have undertaken the Postgraduate Certificate course in Provision of Health Care to People Experiencing

Homelessness at the University of Oxford UK. This course is unique in many ways. It is currently the only accredited postgraduate course covering homeless health care in the world. All professional groups dealing with this complex area are encouraged to participate and non-graduates with extensive experience in the field are also able to apply.

Study takes place over a full calendar year, starting with an intensive 10 week course which is delivered via an interactive online learning environment which enables the group of students from all over the world to work together over an extended period, sharing their views and expertise as well as the learning experience through online discussion forums and live web chat.

Students then attended an intensive face-to-face teaching week in the beautiful city of Oxford.

The course work, as well as being assessed, is also designed to be useful in the student's everyday work and to enhance practice in the locality in which the student works. Students are required to produce original information resources for their locality, service reviews and case studies on which they reflect in the light of the available literature. Reflective learning is integral to the course and hopefully becomes second nature by the end of the course for those who were not already engaged in reflection through their professional training. Louise, an independent advocate from Scotland, said:

The course work is specific to daily practice whether you are a practitioner in health or homelessness. The assignments are work based and the investigative work is relevant and useful providing expertise and tools to assist practitioners to work towards improving service provision to this very needy, marginalised group.

Throughout the year, certificate students have access to the world famous Bodleian Library at Oxford, either online or via personal visit. They also have access to the facilities at Rewley House,

Oxford, the home of the University of Oxford Department for Continuing Education, which hosts the course. There are two main course tutors, Angela Jones, a family physician from the UK and Mike Seal, an experienced trainer, author and academic in the field of homelessness. Numerous guest tutors from UK, the USA and Europe participate both during the face to face week and online....in fact , many enjoyed the teaching so much that they stayed on to join the learning group!

Perhaps most special of all is the atmosphere of camaraderie that builds up among the students, beginning with the online exchanges and confirmed when they all meet in person in the Spring.

Our students are now studying towards their final assignment, which will be presented as a poster at the Third Oxford Health and Homelessness Conference on 16th September and as an oral presentation with discussion on the previous day.

For those not able to undertake the whole course in one year, a two year option is available. People who already have a postgraduate qualification or who for some other reason do not wish to take the course for credit are welcome to enrol for the online course or one of the study days, all of which are available as stand alone courses. Here is a comment from Lynn, a nurse team leader who took the online course last year:

This was a fantastic course with huge amounts of useful information and a really good buzz among the students. On the basis of the knowledge I gained, I have managed to attract a large additional grant and am expanding my service.

It is the intention that alumni of the course can maintain contact and dialogue via the annual conference and via an online forum within the Oxford Health and Homelessness Forum. <http://cpd-online.conted.ox.ac.uk/> We are also considering whether to extend the course towards a Diploma or full Masters over the next years.

I will leave the last word to Louise:

I have worked closely with people who are experiencing homelessness for fifteen years. My present remit is advocacy and the promotion of the rights of the homeless. On a daily basis I encounter the discrimination and the difficulties that people who are homeless have in accessing adequate housing and essential health care. In Scotland,



government interventions have made it a requirement that health services take responsibility to actively seek out individuals from this group with health issues and devise pathways to care. A great deal of my responsibility is to ensure that these pathways are indeed accessible but also relevant and sustainable. Working on my own I was aware that multi-agency working is essential to assist this client group. I also believed that a holistic approach is required if progress is to be made to meet their often very diverse needs. I would strongly recommend that given the

opportunity all practitioners at all levels in the field of homelessness whether in housing or health provision should be given the opportunity to attend this very relevant course.

For further details, see our website:

<http://cpd.conted.ox.ac.uk/healthsciences/courses/homeless>

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Events

Third Oxford Health and Homelessness Conference, UK

Date: 16 September 2008

This autumn, the Third Oxford Health and Homelessness Conference will also be a first – to our knowledge it is the first conference devoted to showcasing and sharing research into health and homelessness to be held in Europe. Entitled “Learning from each other: cross-cutting perspectives on health and homelessness”, this event aims to bring together front-line workers, provider organizations and academics across many disciplines to share insights with a view to improving practice.

For further information:

<http://cpd.conted.ox.ac.uk/healthsciences/courses/homeless/researchconf.asp>

Home, homelessness and community Turvey Abey, UK

Date: 26 September 2008

The workshop aims at exploring the meaning of home and community through in-depth consideration of the experience, and the meaning of homelessness and “unhoused” states of mind.

For further information:

http://www.feantsa.org/files/ENHW/July08/Conf_HomeHomelessness.pdf

Mental Health & Homelessness, Joining up to Improve Access, Wales, UK

Dates: 30 September and 19 November 2008

As a response to the growing evidence that homeless people in Wales experience particular barriers in accessing mental healthcare, the Welsh Assembly Government is funding a series of three regional events to bring together professionals from across the various support sectors to consider how mutual understanding and joint-working can be improved. These events are aimed at frontline staff working in homelessness and mental health services.

The first was held in Cardiff in June, the second will be in Bangor on 30 September and the third will be in Aberystwyth on 19 November 2008. Cymorth Cymru will produce a report outlining key issues raised and recommendations for future policy.

For further information:

<http://www.cymorthcymru.org.uk/events.html>

QNI Homeless Health Initiative Conference on homelessness and nursing, London, UK

Date: 12 May 2009

For more information, please contact

kate.tansley@qni.org.uk



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

For more information see: http://ec.europa.eu/employment_social/progress/index_en.html

