

# FEANTSA POLICY STATEMENT



**Meeting the Health Needs of Homeless People**

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## Meeting the Health Needs of Homeless People

*FEANTSA calls on policy makers at appropriate levels to take account of the special health needs of homeless people and to create a health policy framework that makes it possible for these needs to be met.*

The fact of being homeless and, all too often, socially excluded and marginalised has direct consequences for the health of homeless people. Being homeless means living under a great deal of physical and psychological stress, which has far-reaching health consequences. Generally, mainstream health services are not adapted to the specific needs of homeless people and they can easily become the victims of stigma and of health inequalities. For homeless people to enjoy their right “to live in conditions favourable to their proper development free from physical and psychological overload, social isolation, psychosomatic symptoms related to stress and other forms of handicap”<sup>1</sup> there is a need for health and social services to provide services beyond their normal sphere of activity, in order to meet the needs of this vulnerable group. A proactive approach to meeting the health needs of homeless people should be a fundamental part of health promotion by the state. Such an approach constitutes a recognition of the state’s responsibility to reduce health inequalities and promote equity of access to healthcare. The EU has repeatedly called on its member states to take action to reduce health inequalities, as part of a public health shift from treating bad health to promoting good health. This notion is central to the Programme of Community Action in the Field of Public Health:

“People in the EU are living in better health than ever before. But good health for all is far from a reality. The health gap across the EU between those in good health and those in ill-health is widening. Good health still depends on where you live, what you do, how much you earn. The poor, the socially excluded and minorities are particularly affected by ill-health... To achieve good health, we need to look at the grass root problems – poverty, social exclusion, healthcare access. We need to understand how different socio-economic and environmental factors affect health. And then we need to make all these factors work together for good health. Good health must become a **driving force behind all policy-making.**”<sup>2</sup>

### *The duties of States towards socially vulnerable citizens*

It is also worth recalling how the Council of Europe frames the duties of states toward their more socially vulnerable citizens in the field of health. On the basis of commitments made in international rights charters, the Council of Europe has called on its member states to adapt health care services to the demand for health care, and health care services of people in marginal situations. It made the following recommendations in Recommendation Rec (2001) 12 of the Committee of Ministers to member states:

“i. develop a coherent and comprehensive policy framework that:

<sup>1</sup> Council of Europe Recommendation Rec (2001) 12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations, para 8.

<sup>2</sup> Former European Commissioner for Health and Consumer Protection David Byrne: “Enabling Good Health for All: A Reflection process for a New EU Health Strategy” 15 July 2004, Pg 3.

- secures and promotes the health of persons living in insecure conditions;  
- protects human dignity and prevents social exclusion and discrimination;  
- ensures supportive environments for the social integration of persons living in marginal situations or in insecure conditions;

ii. strengthen and implement their legislation in order to ensure human rights protection, social solidarity and equity;

iii. improve multisectoral co-operation to increase the ability of their social systems to participate in preventing health problems for persons living in insecure conditions. This approach should clearly specify the role, responsibilities and co-ordination of the various agencies and social institutions involved in order to prevent these persons from falling into marginal situations;

iv. develop comprehensive, effective and efficient health systems for a timely and adequate response to health needs in order to ensure equity and equal access to health care services, taking into account health needs and available resources, and to be able to identify, assess and treat health problems of persons living in marginal situations;

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In this Recommendation, the Council of Europe seeks to give guidance to states on how to meet their commitment to ensuring the full enjoyment of human rights by their citizens, in accordance with the international human rights instruments that they have ratified and agreed to be bound by. The commitment by states to safeguard the human rights of their citizens creates a duty and a responsibility towards all citizens, without exception. This notion resides at the very heart of European political culture, where the concept of the welfare state is deeply entrenched. In light of their exceptional vulnerability, states need to adopt a proactive stance in relation to homeless people. Having recognised their responsibility towards them, they need to transmit this duty to the relevant authorities, whether they be regional, local or municipal authorities. A sense of duty and a recognition that they are a part of our community must exist between the community and homeless people. This is the first fundamental step towards meeting the needs of homeless people.

*Why it is in the interest of States to engage with homeless people*

What is outlined above is, in a sense, the rights-based, moral argument for States to assume their responsibilities in relation to the needs of homeless people, but it can be complemented by a rather more pragmatic assessment of the situation. Simply put, can states afford not to engage with homeless people and other vulnerable groups? To meet and treat the needs of these people is very much in society's interest. There is a multitude of links between the functional "centre" of a given society, and its margins, where one finds vulnerable fringe groups. There are visible links, such as crime, and certain infectious diseases that go untreated in these vulnerable groups, like tuberculosis and hepatitis. There are also invisible links, like currents of violence. On a practical level, there is also a substantial economic cost for society. It pays for expensive, frontline, emergency services for these vulnerable groups, but it would be more cost-effective to help them move towards reintegration, so that they can become active and contributing members of society once again.

Adequate healthcare is one of the primary services that states must ensure for their citizens. The experience of FEANTSA's members on the ground is that homeless people do not have equal access to adequate healthcare and that chronic mental and physical illness is rife among the homeless population across Europe. FEANTSA calls on national policy makers to take

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<sup>3</sup> Council of Europe Recommendation Rec (2001) 12 of the Committee of Ministers to member states on the adaptation of health care services to the demand for health care and health care services of people in marginal situations: Recommendations.

account of the special health needs of homeless people and to create a health policy framework that makes it possible for these needs to be met. FEANTSA sees the following as fundamental elements of a health strategy to meet the health needs of homeless people:

(i) The promotion of a greater understanding of the complex and interdependent nature of the health needs of homeless people;

(ii) Integrated and accessible health services;

(iii) A broad rights-based approach to the provision of health services that incorporates a holistic notion of care that goes beyond simple health needs to a greater conception of general mental, physical and social well-being. Targeting health problems is a starting point from which the person can be supported through a transition to a more stable life-style. Assuring the individual's holistic well being through mental and physical good health, but also access to adequate housing, access to work or to meaningful occupation and a stable income should be the ultimate goal of health policy. Thus the integration and cooperation of social and health services is fundamental.



### *(i) The complex health needs of homeless people*

The health needs of homeless people are directly related to the often chaotic and unhealthy living conditions associated with homelessness. Rough sleeping and staying in inadequate and unhealthy shelters or temporary accommodation mean that chronic respiratory and cardiac ailments are highly prevalent among the homeless population. Asthma and tuberculosis are also common and worryingly, a drug-resistant form of tuberculosis has emerged among homeless people and other marginalised populations across Europe.<sup>4</sup> The real scale of the tuberculosis epidemic is unknown, but it seems to be on the increase all over. The highly infectious nature of the disease brings with it a whole set of problems. To allow persons suffering from tuberculosis to remain in circulation is a public health risk and yet hostel conditions do not allow for isolation. If a person does not follow treatment in a rigorous manner, the disease can quickly become drug-resistant, but the chaotic lifestyle of homeless people makes this almost impossible to ensure. This is a pressing problem across Europe and it needs careful consideration.

The living conditions of homeless people also give rise to a great many types of skin disease, both infectious and non-infectious. Many of the less serious skin conditions found among homeless people could be treated successfully and relatively easily, but unfortunately homeless people are unlikely to seek medical attention until they become disabling. Poor foot hygiene and exposure to moisture also mean that foot problems are common, particularly among rough sleepers and those spending a lot of time in the streets. Most prevalent are superficial fungal and bacterial infections<sup>5</sup> Certain severe and contagious diseases are found to a higher degree among the homeless population than among the general population, for reasons related to inadequate access to healthcare, malnutrition, unsanitary conditions and lifestyle factors such as drug use or other addictions. These include hepatitis B and C, HIV, and diabetes.<sup>6</sup> Dental health among homeless people also tends to be below the norm for the general population and research suggests that this type of care is particularly difficult to access for homeless people.<sup>7</sup>

Many of the severe physical ailments associated with homelessness also have a psychological dimension that cannot be neglected. The stress of dealing with severe disease such as HIV or hepatitis, in an environment where there may be little support, is extreme. The living conditions and social exclusion of homeless people is very stressful and this stress is undoubtedly among the primary factors that cause depression, schizophrenia, personality disorders and anxiety disorders to be common.<sup>8</sup> It would seem that among homeless people, mental health can be both a cause and an effect. People with previous mental illness histories may find themselves homeless and their illnesses may be further exacerbated by that fact. Drugs are a factor that impact greatly on both the mental and physical health of homeless

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<sup>4</sup> World Health Organisation Europe, 2002 Fact Sheet 07/02, page 2, paragraph 2:  
<http://www.euro.who.int/document/CMA/rc52fstb0702e.pdf>

<sup>5</sup> "Medical and Cutaneous Disorders Associated with Homelessness" Alexander J. Stratigos, MD, Andreas D. Katsambas, MD, SKINmed 2(3):168-174, 2003. Abstract and Introduction: pg 4-6

<sup>6</sup> Ibid

<sup>7</sup> Homeless Link: "Health Inclusion – The First Evaluation Report" June 2004, pg 7

<sup>8</sup> Homelessness and health: what can be done in general practice? Nat M J Wright MB MRCGP, Charlotte N E Tompkins BA PGDip, Nicola S Oldham MSc, Debbie J Kay. Journal of the Royal Society of Medicine, Vol. 97, April 2004 pg: 171.

people. Drug-induced psychosis is prevalent and of course there are multiple health risks attached to drug-injecting, especially when homeless people are forced to inject in unsanitary conditions. Mental health problems may make it difficult for homeless people to access healthcare in an organised way according to an appointment system. This may mean that a homeless person will need extra support in order to follow a prescription or course of medication. Mental health problems often occur in conjunction with substance abuse problems. Doctors refer to this as “dual-diagnosis” and these problems present in a person tend to aggravate each other. Thus where a person may be suffering from a disorder such as depression, which, alone might be relatively straightforward, the complicating factors arising from substance abuse and probable physical ailments may together amount to extreme vulnerability. None of the conditions might be serious and enduring, but together they create an “aggregate of vulnerability” that often leaves the person chaotic and vulnerable.

What emerges from this rapid overview of common health problems associated with homelessness is a clear picture of complex and interdependent needs. Workers in the area of healthcare provision for homeless people have tried to come up with a health definition that truly captures the multi-dimensional nature of the health needs of homeless people. Below is a definition that was elaborated by NGOs in consultation in the UK:

#### **A DEFINITION OF MULTIPLE NEEDS**

A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services:

- mental health problems
- misuse of various substances
- personality disorders
- offending behaviour
- borderline learning difficulties
- disability
- physical health problems
- challenging behaviours
- vulnerability because of age

If one were to be resolved, the others would still give cause for concern.<sup>9</sup>

Thus severe physical illness cannot be treated in isolation from mental illness that may both contribute to, and arise from, physical ill-health. Equally, one cannot hold off from treating mental or physical illness until the homeless person deals with substance abuse problems, which is often the policy in mainstream health services. Substance abuse cannot be addressed without due consideration of the mental illness it may have provoked, or contributed to, and the physical illness that may also directly arise from it. This type of “multi-dimensional” care is generally not available to homeless people, as they usually access healthcare through emergency services, which are seldom equipped to offer this kind of care. Nor do structures commonly tend to exist whereby homeless people would be referred and transferred to the necessary services, within an overall framework of support.

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<sup>9</sup> Multiple Needs Briefing, Bevan P, Homeless Link 2002

## *(ii) Integrated and accessible health services*

Given the complex nature of the aggregate health needs of homeless people described above, it is clear that an adequate health care response will also need to be necessarily complex and take into account several forms of ill-health that may be present in a single person. When considering how to improve current healthcare for homeless people, one must ask two fundamental questions. (1) How to ensure that homeless people overcome the barriers to accessing mainstream primary health care services that at present stop them from using existing services to their full potential? (2) How to go beyond the treatment of pressing visible symptoms to ensuring that homeless people receive treatment for all of their needs, whether mental, physical or substance-abuse related?

First of all, what then are the barriers that block access to healthcare for homeless people? Homeless people themselves have identified the following as factors that prevent them from accessing primary healthcare:<sup>10</sup>

- **Stigma:** Homeless people tend to encounter negative reactions when they try to access healthcare services. Trying to deal with administrative personnel can be particularly difficult;
- **Discrimination:** Homeless people find it harder to register with a General Practitioner than members of the general public. Requests for a permanent address and other details can constitute a real or a psychological barrier;
- **No continuity of care:** The lifestyle of homeless people tends to be a mobile one, but there is frequently no flexibility in the healthcare system in this regard. A move from one district to another may mean that a homeless person finds himself or herself outside the system again;
- **Difficulty accessing drug and alcohol services:** services may be insufficient and often have very long waiting times, but they are crucial for the health of homeless people;
- **Lack of knowledge about entitlements:** some homeless feel that they don't know what they are entitled to in the line of healthcare and services. If they were better informed they would be more confident about trying to access them;
- **Financial obstacles:** in many countries there may be cost associated to accessing healthcare that makes it inaccessible to homeless people.

These are problems that can be solved with political effort and investment. National policy makers should give consideration to measures such as those listed below, with a view to ensuring that homeless people can get the most out emergency and primary health services:

- **A mapping exercise** in order to get a clear picture of the existing health services for homeless people: their capacity and the structures that are in place. Mapping the degree of saturation and the demand placed on these structures will allow a good assessment of need in this area. This assessment of needs and of existing capacities to meet them can be a good starting point for policy-makers.
- **Training for staff and medical professionals** in order to ensure understanding and sensitivity towards homeless people. This will help to combat stigma and discrimination. For medical professionals, training would also help to raise awareness of the type of illnesses and health problems that a homeless person is likely to be suffering from. Medical professionals would be aware of the need to work opportunistically and holistically with homeless people, perhaps making certain tests available to them, though they may have presented with a separate medical problem

<sup>10</sup> "Listening to Homeless People: Involving Homeless people in Evaluating the Health Services" Groundswell UK, Healthlink, 2003

(tests for TB, HIV etc.) There could also be an in-depth assessment of overall mental and physical health;

- **Information leaflets** on the specific medical conditions associated with homelessness for the different branches of the medical profession (dentists, mental health workers, general practitioners, chiropodists etc.) This can help the medical professional feel more prepared and able to treat homeless people)
- **More flexible administrative procedures:** homeless people often find that they can not meet the, often substantial, administrative requirements to actually access healthcare and that this is a substantial barrier. Policy-makers need to ensure that the administrative procedures in the health sector in their country are sufficiently flexible to enable inclusion of all that need healthcare.
- **Free healthcare:** for those who cannot afford to pay. This is a fundamental provision for homeless people and other vulnerable groups. Finally, it is the only way that one can truly ensure that homeless people will not be prevented from getting the care they need through lack of money.
- **Make the medical records of homeless patients more easily accessible:** a procedure or mechanism could be put in place whereby the medical records of homeless people will still be easily accessible to doctors and healthcare professionals dealing with mobile homeless people, who may access services in changing geographic locations - e.g. handheld patient records, which the homeless person keeps with them. These hold the main health needs and the treatment interventions. Whatever system is adopted should seek to ensure continuity of care for homeless patients;
- **Investment in drug and alcohol services:** It should be borne in mind that the success of drug and alcohol treatment depends a great deal on patient motivation. The services need to give thought to the question of how to build and to foster motivation. Investment in these services would improve overall availability of detox and harm reduction strategies, and this in turn might help to build on the motivation to confront addiction problems when it arises by making a quick referral possible, if it is not already;
- **Information dissemination:** Information about healthcare rights could be made available through homeless services. A brief manual could be prepared and distributed.

These actions would remove some of the basic barriers that confront homeless people when they try to access health services and would improve the quality of the care that can be offered. However, policy-makers should bear in mind that there are other groups, that share many of the vulnerabilities of homeless people, and who face equally substantial barriers to accessing healthcare. Failed asylum-seekers and undocumented migrants often find it impossible to get even basic healthcare. Furthermore, they often have major health problems, both mental and physical. This group too, is often faced with the problems of homelessness. Their plight must not be ignored.

Having examined the question of barriers to access, consideration must also be given to the second question of meeting the complex and multiple health needs of homeless people. Specialist healthcare services for homeless people can be a solution to meeting their multiple health needs, as they are designed to take account of the complex health situation of homeless people and conceived to be easily accessible to them. There are drawbacks however. The most obvious is that specialist services are costly, and their long term funding is often not secured. They may be well thought of by a particular political party that is in power, but not by the next. Also, although they may work well in urban centres, homeless people in rural areas will still be dependent on mainstream services, which need to be adapted to meet their needs. Finally, there is a danger of "ghettoisation" of specialised health services for homeless people if they are segregated from mainstream services and remain so. A combination of specialised and mainstream services, with referrals between the two, can work well, where this is feasible. It is useful, however, to focus on how strong links and referral systems can be put in

place to ensure that “joined-up” services can be offered within existing mainstream services. There are a few elements<sup>11</sup> that should be borne in mind when formulating approaches and policies in this area:

- It should be ensured that doctors and healthcare professionals are aware of the need to try and address all areas of the health needs of homeless people, both by direct treatment and referral to specialised services.
- Doctors and other healthcare professionals should be involved in a care-planning process whereby they ensure that homeless people are integrated into the healthcare system and where possible they should try to oversee referral.
- It is vital to avoid the phenomenon whereby homeless people end up shunted from service to service, without the whole of their situation being treated in a holistic way. This can be avoided if there is a strong sense of partnership between the health services and a commitment to acting in the best interests of the patient. In Scotland, a system called 'single shared assessment' is under development. This means that a single, thorough assessment of all the health needs of the homeless person is carried out when they initially present and a care plan is made on this basis. The care provided is holistic and will involve other services, but these will have access to, and work on the basis of the initial assessment, which is 'shared' among all services. Thus healthcare is provided in an integrated rather than a piecemeal manner. (For more detail, see Appendix 4)
- Doctors and other healthcare professionals should ensure that a diagnosis of mental ill-health or dual-diagnosis does not lead to exclusion from other health and social services.
- There needs to be an adequate discharge procedure from hospitals and where possible, packages of appropriate care are brought together where an adherence to medication and treatment regimes should be strongly encouraged.

These procedures will help to ensure that the homeless persons' health needs are met in a more comprehensive way. However, even this broader approach to meeting complex health needs does not encompass a truly holistic understanding of what it means to be healthy. It is vital to look beyond the simple meeting of needs to a broader concept of health. Such a concept is enshrined in the World Health Organisation definition of health:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>12</sup>

The preamble of the World Health Organisation further states that:

“The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...”<sup>13</sup>

When considered in this light, combating the very state of homelessness and the physical, mental, socially excluded and unhealthy lifestyle that goes with it must form a part of a health policy that seeks to promote the health of homeless people.

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<sup>11</sup> Homelessness and health: what can be done in general practice? Nat M J Wright MB MRCGP, Charlotte N E Tompkins BA PGDip, Nicola S Oldham MSc, Debbie J Kay. Journal of the Royal Society of Medicine, Vol. 97, April 2004 pg: 171.

<sup>12</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946

<sup>13</sup> Ibid

*(iii) A holistic notion of care that goes beyond simple health needs to a greater conception of well-being*

When considered from this perspective, it becomes clear that a health policy that seeks to promote the good health of homeless people must address the wider questions of housing, employment and social reintegration generally. To provide such a wide range of services in an adequate fashion necessitates a very integrated system of health and social services, with a strong capacity to refer people and follow up on their needs. Links also need to be forged with the homeless service sector so that existing voluntary sector services can be easily accessed through the public social and health services. There needs to be strong partnership working between both the statutory and the voluntary sectors, that seeks to promote creative and brave new multi-disciplinary services that will seek to holistically support homeless people. It is also crucial that such a system be sustainable and productive in the long-term. For this there also needs to be a strong emphasis on prevention of homelessness. It is, therefore, worth considering what this entails.

*Prevention:*

In a truly holistic approach, some thought also has to be given to the question of prevention: that is prevention of recurring illness among homeless people; prevention of a relapse back into homelessness; and prevention of homelessness itself. Preventing future and recurring illness will be achieved by improving access to medical services and by supporting health professionals to offer holistic, opportunistic and preventive (eg: vaccines etc.) care to homeless people. As regards preventing the person from becoming homeless again in the future, long-term support and referral to social and voluntary services will certainly help to prevent the continuation and the recurrence of homelessness. Medical services can also help to prevent homelessness itself. An awareness of the warning signs of threatening homelessness has to be created among social and medical workers, so that they can act accordingly and refer the person in question to the help they need. Training of these professionals in relation to factors that may reveal recent or imminent homelessness will help to put strong preventative systems in place. Another avenue that is worth considering is the education of the young generation concerning homelessness. This can be done in schools with a training pack, but it might also be useful to consider the involvement of formerly homeless people in peer education schemes, giving the opportunity to come to terms with their experiences and helping others to learn from them.

*Why Housing? How housing affects mental, physical and social well-being:*

There is a growing understanding of the complex way that stable housing impacts on the health of an individual. Housing, especially of a stable and safe kind, is an element that is glaringly absent in the life of homeless people. This affects their health in a variety of ways. From a physical point of view, the implications are obvious: a lack of housing means exposure to the elements and the hardship that goes with it. It also means increased vulnerability to occasions of violence from others. It essentially means living in a state of permanent, underlying stress. This, of course, takes its mental toll. A house can mean release from these stressors and so is beneficial, but the sense of mental well-being and security that comes from having stable housing runs much deeper than this:

“To live somewhere involves the development of a special relationship to space, time, luminosity, self and others. A house, in its concrete reality, brings support to certain aspects

of individual psychological structuring – it is the central reference point of human existence.”<sup>14</sup>

From a social point of view, a house can be the starting point for:  
“the structuring of a family group and its relations to the outer world with an opening towards a potential sense of belonging to a community.”<sup>15</sup>

Escape from the stigma and discrimination attached to the homeless lifestyle is also beneficial for mental and social well-being and is a positive step towards social reintegration and the building of new social bonds.

*Why employment? How employment affects mental, physical and social well-being:*

Employment brings with it many positive benefits for the health of a person. From a practical point of view, the greatest benefit is simply the fact of having a regular and sufficient income to meet one’s expenses. This in turn opens up the beneficial possibilities of good housing, good nutrition and enjoyable recreation. The greatest benefit of employment for homeless people is probably a sense of mental well-being. Employment can be an important source of feelings self-worth, which can be further enhanced by the acquiring of new skills. It also gives a time-structure to the day and ensures that the person concerned will be engaged in regular activity. Work also unites people in collective tasks for common goals and can be an important source of social bonds and interaction. Even when employment in the competitive labour market is not a realistic option, engagement in appropriate meaningful occupation can bring with it a very beneficial effect on the mental health of homeless people.

*Social Reintegration:*

In order to think about what social well being and reintegration mean, in a wide and holistic sense, it can be useful to start by considering homelessness as a very negative process of loss. It can span all kinds of loss – loss of employment, loss of housing, loss of family and social networks, loss of stability, loss of mental and physical health, loss of self-esteem, loss of hope and so on. From this point of view, we can think about social reintegration as a process of restoration that needs to be carried out on many fronts. Furthermore, the different elements that must be regained are interlinked in a complex way. For example, restoration of housing will help to restore physical health and a sense of control; restoration of mental health may go a long distance towards helping to re-enter employment, which in turn will reinforce mental and physical well-being. It is for this reason that a broad notion of health and health promotion must be applied when seeking to lay down policies for improving the health of homeless people. Health services, both primary and emergency, may be the point of contact for many homeless people. From there, they need to be integrated into the system of statutory social services and voluntary services that may be in place. Their needs must be met in as wide and holistic way possible that encompasses referral to housing services, to housing support schemes, to substance dependency schemes, to training, to counselling and finally, to social reintegration.

In some places, it has proved fruitful to give this framework of cooperation a written or even contractual basis. It can make the role and responsibility of each sector more clear and thereby help partnerships to function more smoothly. The idea is that the agreement should be established jointly by the hospitals, mental health units, drugs and alcohol services, the social services and any other relevant actors, recognising the competencies of each, laying down the modalities of the partnership and the responsibilities of all actors. The stringency of the observance of the agreement and the legal or contractual status of document will vary

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<sup>14</sup> World Health Organisation: “Review of Evidence on Housing and Health” prepared for the Fourth Ministerial Conference in Environment and Health, June 2004: pg 6

<sup>15</sup> Ibid

according to the culture and the customs in different places. Some groups may be more comfortable with an informal agreement, others will prefer it to be formal, but it can be a useful tool in all cases.

Overall, there is little doubt that brave and creative approaches with both political and financial investment are needed in order to build a social and health services system that functions in this joined up fashion.

*In the Appendices of this policy statement, you will find some good practices that have promoted different ways of meeting some or all of the health needs of homeless people and that have tried to ensure that these services are really delivered to homeless people.*

## APPENDICES

### **Appendix 1: Promoting Accessibility: The Marien-Ambulanz in Graz, Austria**

As was outlined in the preceding policy statement, the chaotic lifestyle associated with homelessness can make it very difficult for homeless people to manage to access healthcare through the usual channels. They may not be able to abide by the system of appointments and organising visits in advance. It is also clear that they may encounter stigma and discrimination in emergency services and that the care that they receive there may not take into account the full scope of their health problems. A further complicating factor is that, given their homeless status, their administrative entitlements are unlikely to be in order and they may not meet the administrative requirements in emergency services. Feeling unsure about whether or not one is entitled to healthcare is also a dissuasive factor.

In Graz, in Austria, a system has been put in place to provide emergency and basic medical care to those who need a system with easy access or who are without health insurance. It is run and organised by the charitable organisation Caritas and the rights organisation "Verein Omega", in cooperation with local authorities (regional and municipal) and with their financial support. It was created in 1999 in response to acute need.

In order to break down barriers to access, the health services are provided in a centrally located easy access unit that is open daily between 12h00 and 14h00. There is also an information telephone number. The idea is that those who are without medical coverage, whether natives or foreigners, are welcome to come and seek professional medical. In this way, the Marien-Ambulanz does away with many of the initial basic barriers to medical care. There is also a mobile unit that goes out to patients in need on Wednesdays to offer free and anonymous basic medical care. The Marien-Ambulanz offers a wide range of tests that take account of the needs of homeless people. This includes HIV testing, tuberculosis testing and urine testing.

In its work, the Marien-Ambulanz seeks to apply holistic principles, going beyond basic medical care to offer psychological support and social support as far as possible. It is certainly true that in order to be truly holistic, this type of emergency, frontline service must lead to access to other social and specialised medical services. Basic and emergency healthcare, particularly when it is easily accessible, is vital in order to avoid death and chronic suffering for homeless people, but it will not have an overall positive effect on the long-term health situation and overall well-being of homeless people, unless this frontline, low-level access is the first step in a process of healing and reintegration.

For more information on the Marien-ambulanz, visit the website:

<http://caritas-graz.at/home.php>

## **Appendix 2: Helping homeless people and other excluded groups towards reintegration: a “person-centred approach” in Porto, Portugal**

In Porto, there is a specific, highly marginalized homeless population of young adults, who are generally called “arrumadores” and identified with their practice of parking cars for drivers in order to get money. There are a significant number of these young homeless people in the city (a 2003 count showed some 750) and they are very excluded. Problems of poor-health, malnutrition, infectious diseases, AIDS, drug addiction and other severe health disorders are common. Crime and offending behaviour is also prevalent among this population.

An innovative approach has been put in place through Conde Ferreira Hospital Centre, which is known as a “person-centred help and support programme”. The theory underpinning this approach looks at each individual as an actor within a social network and in a specific geographic environment. The idea is that the intervention should take place in the geographical location where the excluded population is located (thus eliminating problems of access). It should be based on an understanding of the social network within which these marginalized young people operate: the groups operate on an internal system of norms and values that are at odds with society at large. This social system operates according to its own logic and tends to trap those who are a part of it in a repeating chaotic lifestyle that is in violent conflict with outsiders. It is isolating and creates a hostile attitude. At the outset, the project sought to gain an insight into self-perception and external perception of those living in these marginalized communities. It sought to understand the mechanisms whereby these communities are maintained. It did this through research and interviews.

The project seeks to reintegrate those marginalized in these communities through working with them at an individual level. The approach was based on the belief that changes to the individual’s attitude and ethos will change how he and she interacts with the community and that the intervention should lead to better social adjustment and reintegration. The intervention is centred around promotion of personal growth, self-determination, improvement of social relationships, employment, recreation and leisure.

Access to the programme is at street level through a mobile outreach unit that facilitates initial contact. The programme is based on the establishment of empathic one-to-one relationships between staff and the users of the programme. Working on this basis, the staff member helps the user to gain access to support services that may be available. Several strategies are followed to meet the holistic needs of each individual. These include: medical treatment, specific psychological treatment, individual and group counselling, social and professional skills training programmes, housing support, supported employment etc.

The programme itself is dynamic and flexible and evolves as the experience of the staff increases and in relation to the different communities that may be targeted. It incorporates training for staff (present and future) and ongoing research. The research seeks to offer greater understanding of social exclusion both of communities and individuals. It also has an evaluation function whereby it critically considers the programme and its effectiveness over time. Initial findings based on various indicators in relation to the arrumadores population show that the programme is managing to retain some 50 % of those that undertake it and that they are making slow progress towards better health, rebuilding social networks, independent living in autonomous housing and employment or supported employment.

For more information, contact Rogério Pastor-Fernandes, who works in this programme and who is a member of the FEANTSA Health and Social Protection Working Group.

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### **Appendix 3: Health and Homelessness: A Strategic Response by Government – the Scottish Experience**

In 1998, through the Scotland Act, legislative power in the areas of health, housing, social work, criminal justice and the court system was devolved to the new Scottish Executive. This has brought political, legislative and social change. It has also brought decision-making closer to home. Many politicians have a real interest in combating homelessness and this political will has made a strategic government response to the problem possible.

In 1999 the Homelessness Task Force was created in order to make recommendations on how to tackle the problem. It was a strong expert group chaired by the Minister responsible for social affairs. In 2001 the Housing (Scotland) Act was passed and the right to accommodation was enacted. The Homelessness (Scotland) Act was passed in 2003 laying down a responsibility to tackle homelessness.

Legislative power in relation to health and responsibility for the National Health System in Scotland was devolved to the Scottish Executive, who drew up a plan for development of the health system entitled “Our National Health – A Plan for Action, a Plan for Change”. Homelessness was a major theme and homeless people were identified as a priority group in the area of health. There was a recognition that the health needs of homeless people need to be tackled. In order to carry out this action, a Health and Homelessness Co-ordinator post was created to oversee implementation and Guidance was drawn up requiring the health sector to deliver services to homeless people. The health system is administered by Health Boards. These boards were asked to draw up action plans to reduce inequalities. The guidance outlined for them what elements the plans should contain. It included needs assessment of the known homeless population, which services were being used and which not etc. The aim was to get an overview of the situation. The next step was for the action plan to address the identified problems. Partnership working quickly emerged as a crucial element. The work with the boards was often difficult, as when launching any new concept. Working through these difficulties with the steering group has taken years.

15 Health and Homelessness Action plans were drawn up and are in place. Financial support of £18m was provided. An approach of ‘local solutions to local problems’ has been fostered and works well. A wide range of innovative services have come into being, some on the basis of very creative ideas. Some of the major challenges that have emerged are rural homelessness, mainstream versus specialist healthcare and the need for high-level support.

The system is assessed within the National Health Systems Scotland Performance Assessment Framework. This measures all aspects of healthcare delivery. Health of homeless people has become a key indicator. This places pressure on boards to deliver on their commitments. The Health and Homelessness Steering Group also contacts the boards every six months for an update on their progress towards implementing the Action Plans. Stakeholder feedback from NGOs active in the area is also a useful check on the reality of the situation on the ground. It is also vital to foster relationships within the sector between NGOs and health boards.

The progress that has been made is encouraging and the Scottish Health Boards have taken significant steps towards providing integrated and accessible services to homeless people.

For further information, visit website:

[http://www.show.scot.nhs.uk/sehd/healthandhomelessness/home\\_page.htm](http://www.show.scot.nhs.uk/sehd/healthandhomelessness/home_page.htm)

Or contact Sue Irving ( National Health and Homelessness Coordinator until March 2005 and Contributor to the FEANTSA Health and Social Protection Working Group.)

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#### **Appendix 4: Single-Shared Assessment: Facilitating Inter-agency working in Scotland**

Single, Shared Assessment is one of the key parts of the Scottish Executive's strategy to improve the results for people using community care services. Implementation began in 2002, starting with the area of service provision to the elderly. Single, Shared Assessment redesigns the assessment system that takes place when a person first accesses community care services, takes a more holistic approach to assessment, with benefits for people who use services, for agencies and for professionals. More particularly, it will streamline systems and speed up the delivery of services. In short, it will mean shorter routes to services, and faster passage along these routes.

Single, Shared Assessment is for people with community care needs seeking help from social work, health or housing authorities, and who may require the services of more than one professional discipline or agency. To ensure the most appropriate assessment response, whichever agency or professional is the initial contact, agencies will need an integrated system for receiving and acting on referrals, free from bureaucratic screening procedures. They also need to be clear on applying the Single, Shared Assessment principles where only one agency or professional / specialist is involved.

These arrangements are designed to improve results for people being assessed, partly through more focused inputs from professionals and by reducing the need for multiple assessments. Over time, therefore, they should be cost effective. Agencies may, however, incur short-term costs in training staff and developing new approaches.

Full details of the procedures and principles of Single Shared Assessment may be found on the website of the Scottish Executive:

<http://www.scotland.gov.uk/Topics/Health/care/17673/9484>