# European Network of Homeless Health Workers (ENHW)

## Issue N°7 – Autumn 2008

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The articles do not necessarily reflect the views of FEANTSA.
Stefania Del Zotto, Policy Officer, FEANTSA

Dear Readers,

This issue of the ENHW newsletter is extremely rich and broad ranging. Topics include: the relationship between health problems, poor treatment compliance and low self-esteem among rough sleepers; the findings of a study conducted in London on resilience of people who are homeless; an overview of medical problems observed in an intermediate care service in Rotterdam; as well as the presentation of the Rauxa Association, which is based in Barcelona and provides a holistic treatment to homeless people faced with alcohol problems.

The forum section includes a contribution on the reasons why one commits to providing care to the most vulnerable as well as several reflections on the importance and benefits of sharing information and experience with other homeless health professionals. The resources section contains a summary of a review on effective services for substance misuse in Scotland as well as the results of research concerning the impact of users’ choice on the outcome of intervention. We hope that these examples will stimulate further reflection and interaction, be it in the form of articles for the Winter issue or on the online forum, which is now fortunately up and running again!

As you might have noticed from the index, this issue contains an article in Spanish, which is accompanied by a summary in English in the form of a Powerpoint presentation. The main aim of ENHW is to be a forum for exchange and mutual learning among healthcare professionals working with people who are homeless in Europe. In this context, we feel that one way to overcome the language barrier (and the lack of resources for translation) and to facilitate exchange is to give an opportunity to interested people to contribute in other languages, including Dutch, French, German, Italian and Spanish. The article should be accompanied by a paragraph summing up the content of the article in English.

Also, readers might be interested in knowing that FEANTSA is currently setting up a Resource page on homelessness and alcohol addiction: if you are aware of any relevant research in this context, we would be very pleased to hear from you.

To conclude, I would like to extend my warmest thanks to everyone who has contributed to the present issue. Please do not hesitate to send your answers, comments, questions and contributions for the next issue of the newsletter (by 15 December 2008) to stefania.delzotto@feantsa.org.

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?

NB: Depending on the number of responses received, we will publish an overview of ENHW Newsletters readership in one of the coming issues.
Homelessness: It Makes You Sick

Peter Cockerell*
St Mungo’s, London, UK

St Mungo’s recently ran a press campaign headed ‘Homelessness: It Makes You Sick’, designed to highlight the health problems faced by homeless people in general, and rough sleepers in particular. It was built around some research we did on the health needs of rough sleepers coming into our hostels, and on a Health Strategy document which proposed a way forward for health and voluntary sector agencies to work together to resolve some of the problems (both available on our website, www.mungos.org). The basic premise is simple: being homeless, and especially being a rough sleeper, is bad for your health – it makes you sick.

The findings of our research were not surprising, perhaps, to anyone who has worked with rough sleepers: high levels of physical health problems such as respiratory diseases, liver and kidney problems, abscesses and ulcers, blood borne viruses, with individuals having 6-13 different treatable conditions going untreated; high levels of substance misuse, in the majority of cases poly-substance use, with people injecting opiates, using crack and drinking heavily on a chronic lifestyle basis; and high levels of psychological disturbance, notably personality disorders, anxiety and depressive disorders, post-traumatic stress disorder, and (still, and this figure has remained constant in the last 15 years I’ve been working with rough sleepers) around 30% with longterm psychiatric conditions. Of those who died after coming into our hostels, the average age was 41.

Our proposals are also, perhaps, in a way not surprising: we need more cooperation between health professionals and those with expertise in working with this client group, with two-way training; we need more pro-active primary care interventions. (we’ve proposed a comprehensive health check for every person coming into our hostels, with support to complete follow-up treatment programmes); we need a residential facility for people discharged from hospital but not fit enough to cope on the street or in hostels where the capacity to provide nursing care is minimal; we need more flexible substance use treatment, better able to work with people with multiple needs (especially mental health issues), and more varied treatment routes (especially for poly-substance users); and we need far better mental health provision, with psychological therapies easily accessible, including for those with substance use problems, and with non-medical crisis houses for people experiencing psychoses or other mental health events.

As far as we can, we are going to pilot what we consider to be excellent primary health care for rough sleepers in three of our hostels, using charitable donations to fund it. We hope this will produce a good body of evidence that will convince commissioners of the human and cost benefits of effective proactive primary care provision for this client group.

However, what I would like to concentrate on in this article is an aspect of the ‘problem’ of health and homelessness that causes a lot of frustration and leads to a cycle of poor treatment and poor treatment compliance – the difficulty that many of our clients experience in caring for themselves. They let conditions deteriorate so that a cut turns septic, an abscess leads to amputation, a drinking habit leads to death; they begin treatment and don’t follow it through, or walk out of hospitals before treatment begins; they don’t seek treatment for all the other parts – teeth, feet – that might be wrong, just the one that’s causing them pain right now; they medicate with all sorts of drugs and alcohol, and don’t think their psychic pain is in any way unusual or treatable. Health professionals often end up regarding them as irritants, and as somehow undeserving of their expert and patient attention; and our clients often end up feeling that health professionals are antagonistic and useless. This lack of self-care is not because our clients have some kind of learning difficulties (which are rare in our experience); our clients have the same range of intellectual abilities as any other section of society. I think this is another aspect of ‘homelessness makes you sick’ that rarely gets the attention it deserves.

It is widely recognised that many homeless people suffer from low self-esteem. This is exacerbated significantly by the experience of homelessness or rough sleeping. As one rough sleeping client eloquently said to me “I am rubbish. Set out by the black binliners which are put out for the dustmen, and people don’t even notice me as they pass by; the
only difference between me and the rubbish bags is that someone comes to take the bags away”.

The depth of this low self-esteem is perhaps less widely recognised - and certainly it does not seem to be appreciated how this impacts on our clients’ behaviours. Hazardous injecting (in the neck, in collapsing veins), regularly using to overdose levels, ‘straightforward’ self-harm, suicide attempts, violence-provoking behaviours, and actions known to get you banned or otherwise excluded are commonplace – they are all attacks by clients on themselves. And non-compliance and non-engagement (or, more accurately, transient engagement, for most of our clients partially engage with a multitude of services) are both actions which protect against forming deeper, never mind dependent, relationships – they protect our clients from being found out as worthless or being attacked, which for many is the pattern of experience they have of previous relationships. This is key – our clients are repeating patterns learned, often in childhood, that they are worthless (unloved or worthy of attack or abuse). Homelessness and rough sleeping confirm and reaffirm this paradigm – and frequently the institutional treatment of individual homeless people by the services supposed to support them confirms and reaffirms this too.

For these reasons, the key aspect of tackling the health problems facing homeless people and rough sleepers is not just better trained, coordinated and targeted primary health care services. The real key to raising good health levels is in raising self-esteem.

There are many ways to raise self-esteem, and they will be different for each individual. It requires individual journeys of self-discovery and self reconstruction to achieve stable and high self-esteem. Things that might help individuals to make this journey include greater self-determination and more democratic projects, giving greater responsibility; the opportunity to explore their own experiences, feelings and thoughts in a safe space, perhaps with trained guidance; the opportunity for self-expression; the opportunity to form non-abusive relationships; the opportunity to participate in wider social relationships; and the opportunity to earn an honest living.

At St Mungo’s, we have embraced the Recovery Approach as our guiding principle for work with clients; we are doing as much as we can to support real user participation; we have been fortunate enough to be funded as a pilot which enables us to offer psychotherapy to any of our clients that want it; and, largely through charitable funding again, we offer a wide range of pre-vocational training and educational opportunities. These, sadly, are not things much funded by health service commissioners, but, we think, they will make a big difference in the lives of our clients, enabling more of them to make their own recovery journey – and they will lead to the better health outcomes we all seek.

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Valuable Lives: Capabilities and Resilience amongst Single Homeless People

Dr Joan Smith*
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The ‘Valuable Lives’ study interviewed 87 people in Spring 2007 drawn from two homeless services run by Crisis in London; and traced 53 of them in Autumn 2007. Crisis is not an accommodation provider therefore the study included people living in their own accommodation, in temporary accommodation, with friends or squatting, or in hostels or rough sleeping.

Crisis services are not restricted and people in our study came from across the world; 60% of them were from the UK/Eire but 40% came from 23 other countries – from Africa, continental Europe, the Middle East and further. This was true for both male (64) and female (23) participants.

Capability among people in the study

The study used Amatyas Sen’s ‘capability’ approach, focussing on the lives people had led in the past, as well as their homeless experience and their use of homeless services. It focussed on whether, before they became homeless, people had lived lives they

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valued, and how current services could enhance their well-being, helping them re-create lives they valued.

In Sen’s argument a person’s well-being is bound up with their freedom to live a life they value to and to achieve their self-defined goals; in order to assess someone’s capability or potential it is necessary look at how they function in society (i). People in our study were in a difficult situation: they were, or had been, homeless and for most this had changed the course of their life. Therefore, to understand people’s capability we had to consider how they had functioned before they became homeless.

Interviews were undertaken by co-researchers who themselves had been homeless and part of the interviews were recorded. From the Spring 2007 interviews it was possible to create life summaries of each person and to identify a range of capabilities in the lives of people in our study before they became homeless.

We found that in the past men and women had similar educational profiles whilst people born in other European countries had the highest educational qualifications. But educational qualifications do not tell the story of whether people had been able to live lives that they valued; men in our study born in the UK had no educational qualifications but had work qualifications or work skills that had supported working lives they had prized. The greatest difference in past capability was among men in the UK, from those with work skills/experience and those who had never worked.

Work skills/qualifications allowed half the men in our study to have led lives they valued in the past – having extensive working lives and, for the most part, having brought up families – compared with a quarter of women. Women were more likely to have led lives with some value (their children, interests) but ones in which they had little control; 35% of women had lived in abusive domestic partnerships but women were less likely to have work skills/qualifications or work experience. A minority of men and women had led lives without work or domestic partnerships (20%, 30%).

The different capabilities of people in our study were summarised in three broad categories:

- People who had led lives with value for them but not the lives they would have chosen (33%).
- People who had led lives in which they did not achieve their potential or achieve what they would have desired to achieve (24%).

We found that being homeless damaged people’s capability through loss of skills, a lack of current certificates or damaged health. Hostel dwellers were unable to work because lost benefits lead to a loss of their accommodation; street homeless people often couldn’t work because of the stress of being homeless.

However, many were engaged in creative/learning activity. More than half were actively engaged or interested in creative arts (fine arts, crafts, writing, music). Many men described their engagement with physical activities, particularly walking, which helped them deal with mental health issues such as depression and anxiety.

### Resilience among people in our study

From our Spring interviews we knew that more than half the people in our study had experienced adverse childhoods that could have damaged their resilience. Before they were 16 years old, half had experienced the death of a parent, or had to move to live with relatives or friends, or were taken into care, or were living with an abusive parent. Others reported a happy childhood that was disrupted by having to leave their own country. Only a third of people (35%) reported having a happy childhood without major disruption. Recent studies of resilience have argued for the possibility that young people and adults can overcome poor childhoods and rebuild their resilience through supportive relationships later in life (Rutter, 1993)(ii).

Again using the life summaries developed from the Spring interviews we could identify whether people we spoke to been able to live resilient lives as adults. We approached resilience in relation to whether they had achieved an independent and mostly stable private life with people who cared for them (iii). Over a half of the people in our study had never established an independent home. The other half of the people in our study had either been most settled in their own home with their own tenancy (23%) or in their own home with a partner and children (25%).
Considering both whether they had ever settled in an independent home and the pattern of their relationships in the past (with parents, siblings, children, friends, and ex-partners) gave us a way of assessing whether they had been able to live resilient lives prior to becoming homeless - making relationships and living in ways that could enhance their self-esteem and self-image. Again we could summarise people’s backgrounds into three broad categories:

- Adult lives of independently sustained relationships that they viewed as positive and were mostly settled (33%).
- Adult lives of supportive relationships (often family) that were mostly settled (24%).
- Adult lives of violent, unstable or no relationships (43%).

We found that two thirds of the women in our study had lived in violent and/or unstable relationships or with no adult relationships compared with one third of the men (65% vs 34% men) whilst men were more likely to have lived in independently sustained relationships (40% men vs 13% women).

Half of the people in this study said that being homeless was the worst experience of their lives. Homelessness damaged men’s resilience in particular. Two thirds of men reported that being homeless had led to a loss of self-confidence and self-esteem; others that it had led to depression or anxiety. Only a minority of women reported being similarly affected by their homeless experience; this was partly because many were escaping abusive relationships.

The reasons they became homeless also varied between men and women. Men reported the reasons they were homeless were the loss of their domestic partnership, substance abuse, loss of employment, leaving an institution, leaving their own country or the death of a supportive relative. Women were more likely to report health problems, domestic violence (including substance abuse), loss of a relative that had supported them or leaving their own country.

Outcomes over six months

We traced 53 people in Autumn 2007. We were interested in how far they had moved towards living a life they could value rather than whether people had met a particular target of having a job or accommodation etc. Two-fifths were establishing a life they could value or moving towards that (22 people), 16 were coping despite their situation, and 15 were not coping or at high risk.

Most of the people who established a moving on pattern were born in the UK and had a network of family support as well as services. However most of the people who were at high risk were also born in the UK. People who weren’t born in the UK but were progressing had family support outside the country and some had support through their local church.

Family support was important. Over half said they would contact family if they needed support, and over half would contact friends. But 12 would contact their religious organisation and 5 a community organisation. Twelve people would contact their key worker and 17 an agency.

Accommodation was the basic service which most people needed in order to move on in their lives and make a life they valued. With rare exceptions, people in our study who did not receive accommodation support could, at best, cope with their homeless situation but they could not move on; at worst they gave up on the efforts they had been making. However accommodation did not ensure that people made a capable life; some who had been resettled still had mental health or alcohol problems that put them in the ‘high risk’ group, all but one born in the UK.

Day Centres and creative/ learning services were places in which homeless and ex-homeless people had essential needs met (food, medical services), developed their skills and socialised. These services were essential for most men in this study – even for those who had been re-housed – and they wanted them extended. The women in our study wanted more personalised services within Day Centres and Creative Arts/ Learning Services and had a wider network of friends with whom they socialised.

People used services in different ways. Some needed services as a stop-gap in their lives, some as a springboard. But others needed them as a safe haven or a life-line and they could not be expected to leave services quickly even after being accommodated. Those who could not access services because they did not fit the criteria
(nationality/eligibility, local, rough sleeping) were at risk.

We found that services (both statutory and voluntary) need to address resilience issues and not further undermine self-esteem and self-confidence; respect really is central. They also need to address capability issues, building cvs with people so that they understand their skills. Some people knew exactly what they needed to get back on their feet and the issue was one of how quickly they could access services. Some were told they were not ‘vulnerable’ enough only to be made vulnerable by the lack of services. Major issues in services were those of hours of opening and boundaries between services.

The short report will be published on the Crisis website (www.crisis.org.uk) and a full report at the website of the Cities Institute London Metropolitan University/ Centre for Housing and Community Research. (www.citiesinstitute.org).

References

(ii) The approach to resilience in these studies is summarised in a study of runaway youth in Williams et al, 2001.
(iii) In each person’s life capability and resilience are interlinked but not the same and we have sought to give them equal weighting in this study rather than concentrate on someone’s employability, or on someone’s personal relationships.

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Intermediate Care for homeless adults in Rotterdam, the Netherlands

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CVD Havenzicht Rotterdam, NL

Rotterdam (population 600,000) is one of the biggest sea ports of the world. The city harbours 3,712 homeless people, of whom 1,773 night shelter users, 90 rough sleepers, 271 general shelter users and 1,578 day centre users in 2006 (1). Among the homeless, specifically the night shelter users and rough sleepers are most susceptible to multiple medical problems that need shelter and care (2). In this article we aim to describe the Havenzicht intermediate care service that caters for unwell homeless people in Rotterdam.

Havenzicht intermediate care service

Since 1993, Havenzicht has been a shelter-based intermediate care service, situated in the east part of the city, neighbouring one of the well to do areas in the city. Havenzicht provides a night shelter for 42 homeless people and 15 intermediate care beds for homeless people who are too ill or too frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital (3). Ten intermediate care beds have been available between 1993 and 2007, and were increased up to 15 beds last year. This specific service fills a gap in the care system for those people discharged from residential clinics and/or general hospitals, that are “supposed to recover at home” but have nowhere to turn to. This might be people that are discharged from other institutions and/or who were not admitted for secondary care in the first place. Therefore, for homeless people who are unwell in our community, Havenzicht intermediate care service aims to provide access to care, continuity of care and recuperation on one hand, and orientation and guidance of next steps to be taken to achieve rehabilitation on the other.

Intermediate care is delivered by a full staff of nurses, social workers and a general practitioner on call. Moreover, a pedicure, a dentist and a “street doctor” attend weekly during fixed hours. The medical doctor supervises the care process and proceedings (2,4).

Referrals

The largest referral source is the Municipal Public Health Service (GGD), as the director of the ‘street doctor project’, as part of the GGD Safety Net department, and local hospitals. Officially since 2004, the ‘street doctor project’ has been operational by a group of doctors that provide outreach medical care at various shelters in Rotterdam (4). During outreach care, homeless people who are not well can be seen by one of the outreach street doctors and be referred for intermediate care.

Furthermore, the GGD Safety Net department provides outreach care coordination in the community and plays a pivotal role in detecting

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vulnerable people and guide them into the public health domain, intermediate care included.

**Users and medical problems**

In 2004, most of the 99 intermediate care users were male (84%), Dutch (57%), or born in Surinam/Netherlands Antilles (14%), in the age group 20-50 years (84%), range 18-75 years. For admission physical illness and/or injury are the criteria, among which pulmonary disorders (22%), fatigue and exhaustion (15%), wounds (14%), tramps’ feet (14%) and gastrointestinal disorders (9%) were most prevalent. Ten people were known with a HIV infection, and 6 with diabetes. Moreover, 69% were drug user, 32% alcohol user, and 28% had a mental health problem (5).

**Undocumented migrants**

The city of Rotterdam does not provide shelter for irregular immigrants, however, intermediate care admission for a maximum of 5 undocumented migrants who do not feel well at a time, is allowed. In case of lack of legal documents, they have no where to turn to, other than churches and volunteer or charity organisations. During admission, we can only provide care for the (post) acute medical condition and often they are discharged too early due to lack of a place for long term recuperation. As a result of lacking alternative care, half of our clients, that are admitted twice or more often per year, consist of irregular immigrants who make up one fifth of the total intermediate care users. For the multiple admitted undocumented migrants a nursing home is suggested.

**15 years experience**

Through the years, we have gained experience with approaching and working with this specific and special group of people. Per year, we have 100 admissions of homeless people. Although about three quarters of the patients is discharged within two months, at the moment we host patients longer than six months or even years. Their long stay is due to multiple problems, for which it is difficult to find a place in general services. Furthermore, we feel the need to care for irregular immigrants who are too frail to be discharged and who are faced with problems due to their status.

The average length of stay has increased from 26 days in 2003 up till 50 days today. Last years’ increase of the number of beds (from 10 to 15) has not increased the number of admissions significantly. Due to an increase of the average length of stay we felt the need to expand our service, to give access to other homeless people in need for shelter and care. Through the years we have seen that the average age of the homeless population not feeling well rose: from 43 years in 2003 to 51 years today. Cocaine has become a major problem, more than the use of heroin, with underweight as a severe “side-effect”. Furthermore, we witnessed a revival of tuberculosis (6). Also, more patients were diagnosed with serious mental health problems.

In conclusion, the shelter-based intermediate care users in Rotterdam are mainly aging homeless men in need for prolonged intensive care, who present with “trimorbidity”: physical ailments (pulmonary, trauma and skin disorders), addiction (cocaine, alcohol) and mental health problems.

**References**

(2) Quispel F, Stockers MT. [Medical care for the homeless]. Medisch Contact 1985; 40 (51/52): 1593
(6) Vries G de, Hest R van, Sebek M. [Tuberculosis among drug users and homeless people in Rotterdam]. Infectieziektebulletin 2003; 14(10): 357-62.

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**Artículo en español (presentación PowerPoint disponible en inglés)**

**Asociació RAUXA – tratamiento integral de alcoholismo para transeúntes crónicos sin hogar**

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**Introducción**

Muchos autores coinciden en destacar la alta proporción de problemas sanitarios entre las personas sin hogar, siendo el alcoholismo el de mayor incidencia. Incluso hay investigadores que consideran la dependencia del alcohol la causa principal de la situación de indigencia y marginación callejera.

Este tipo de población es un grupo heterogéneo, difícil de conocer y de censar. Suelen estar al margen de las estructuras normalizadas sanitarias. Si bien hacen uso de los servicios hospitalarios de urgencias, produciendo elevados costes, una gran mayoría no han sido atendidos jamás.

Por todo ello es fundamental introducir nuevas fórmulas de búsqueda y aproximación, es decir adaptar nuestros servicios a la idiosincrasia de este colectivo, como mínimo en las primeras fases de contacto. También es absolutamente necesario el dar respuestas a largo plazo, hasta haber alcanzado unos mínimos de autonomía.

Ante esta grave temática se crea en julio de 1989 la Associació RAUXA, una ONG sin ánimo de lucro formada básicamente por voluntariado, con el objetivo primordial de paliar la situación de los indigentes o transeúntes crónicos sin hogar de la ciudad de Barcelona.

**Asociació RAUXA (1989)**

La Associació Rauxa es una ONG sin ánimo de lucro, formada básicamente por voluntariado, con el objetivo primordial de paliar la situación de los indigentes o transeúntes crónicos sin hogar, prioritariamente alcohólicos.

Objetivos: detectar la población sin hogar. Establecer relación interpersonal. Dar información. Inicio tratamiento alcoholismo crónico en las siguientes fases:

- Primera: furgoneta Rauxa, con seis literas y mantas para pernoctar. Fase de motivación para convencer a los indigentes alcohólicos de la necesidad de realizar tratamiento de alcoholismo. Se mantiene una relación interpersonal con los voluntarios de la Asociación, algunos alcohólicos rehabilitados, logrando poco a poco cambios que determinarán la toma de decisión y el comienzo de la segunda fase. Se ha atendido a más de 800 personas.
- Segunda: Comunidad Terapéutica Urbana (albergue Rauxa), consiste en el inicio real de un programa libre de drogas con énfasis de alcoholismo y tabaquismo. Es un recurso socio-sanitario de 14 camas en la ciudad de Barcelona. Se practica desintoxicación, deshabitación y rehabilitación. Aproximadamente la estancia media es de 6 meses, pasando a la tercera fase aquellas personas preparadas para la misma.
- Tercera: Pisos terapéuticos Rauxa, requiere que los pacientes distingan bien los signos o síntomas de desestabilización de la enfermedad. Precisan diferentes grados de tutela. Hay 9 pisos.
- Cuarta: De reinserción laboral, se ofrece a aquellos pacientes que necesitan desarrollar o renovar los hábitos laborales en un ambiente protector sin alcohol. Se han creado dos cooperativas que están unificadas desde abril de 2001 y se ha puesto en marcha un comedor social “La Terrasset” donde se ofrecen 152 cenas diarias a personas indigentes, confeccionadas por los pacientes en reinserción.
- Quinta: Alta con abstinencia total a drogas y conductas adictivas y cambio de estilo de vida.

**En concreto:**

1ª Fase: FURGONETA RAUXA (1989-1990) (Fase de Motivación). Objetivos:

- Oferta de 6 literas y mantas para pernoctar.
- Contacto y relación interpersonal.
- Mejora higiene personal (ducha y cambio de ropa dos veces por semana).
- Documentación en 불구a.
- Revisión médica completa: (Anamnesis, exploración física, analítica, RX Torax. PPD, Historia OH con criterios DSM IVTR).

*La inclusión en este documento de materiales de FURGONETA no necesariamente refleja las opiniones de FEANTSA.*

**Issue N° 7**
• Motivación para iniciar tratamiento de dependencia OH.

2ª Fase: ALBERGUE RAUXA (Febrero 1991) (Comunidad adaptación un individualizada, Se
interpersonales
Objetivos:
• Oferta de recurso sociosanitario de 14 camas.
• Programa libre de drogas y de conductas adictivas.
• Tratamiento del alcoholismo. Fases: Desintoxicación, Deshabituación y Rehabilitación.
  - Adquisición conciencia de la enfermedad. Prevención de recaídas.
  - Mejora de los hábitos higiénicos.
  - Desarrollo hábitos de vida cotidiana (limpieza, cocina y lavandería).
  - Inicio de actividades pre-laborales en taller Albergue y otros.
  - Formación adaptada a cada caso.
  - Administración de dinero.
  - Estímulo actividades lúdicas y de aficiones personales.

3ª Fase: PISOS RAUXA (Diciembre 1992) (Fase de reinserción social)
Objetivos:
• Oferta Pisos de alquiler para 3-4 ocupantes, temporal o permanente. Actualmente 8 pisos. Se inicia 1 piso de 9 plazas.
• Convivencia de apoyo terapéutico: Los pacientes deben tener capacidad para detectar y comunicar síntomas de desestabilización de la enfermedad en ellos mismos y en los compañeros.
• Optimización recursos económicos.
• Integración al barrio.
• Reinserción social.

4ª Fase: Reinserción laboral (Octubre 1994)
Se trata de conseguir una capacitación laboral individualizada, entendiendo como terapéutica la adaptación a situaciones laborales, relaciones interpersonales y afrontamiento de contingencias en un medio sin alcohol, para evitar recaídas.
Itinerario terapéutico laboral:
• Taller prelaboral en la comunidad terapéutica (CT), de dibujo y marquetería.
• La Terrassetta, restaurante sin alcohol abierto al público en general y comedor social donde se dan 152 cenas diarias a personas indigentes.
• Cooperativa Rauxa que realiza trabajos de pintura, albañilería y restauración.
• Preparación y búsqueda de trabajo externo.
• Trabajo independiente: incorporación al mundo laboral.

Cooperativas Laborales:
a) Cooperativa laboral RAUXA S.C.C.L. Septiembre de 1994
• Restauración.
• Gana por concurso la explotación del Comedor Social del Clot en abril de 1995, hasta diciembre de 1998.
• Gestionó la cantina del IES Salvador Seguí de la ciudad de Barcelona desde septiembre de 1998 a 2002, actualmente gestionada por ZAGUAN SCCL, Cooperativa independiente creada por tres rehabilitados.
• Gestionó desde marzo del 2000 la cantina del IES Berenguer de Palou, actualmente Escuela Superior de Música de Cataluña.


5ª Fase: Restaurante La Terrassetta
La Terrassetta, es una cafetería-restaurante gestionada por la Asociación Rauxa, inaugurada en mayo del 2000 como 4ª etapa del tratamiento del alcoholismo crónico (reinserción laboral). Esta cafetería-restaurante ofrece:
a) Al público en general:
Menús caseros diarios. Menús especiales de fin de semana.
Cenas para grupos por encargo.
Zumos naturales y batidos variados. Otras bebidas alternativas al alcohol, etc.
b) A la población indigente 152 cenas diarias de 18h a 21h. En convenio con la Administración local.

Problemas encontrados y soluciones
El primer problema fue la aceptación del recurso inédito: la furgoneta Rauxa. Se resolvió al convencer a los patrocinadores de realizar la experiencia, y en caso de no ser positiva, siempre podría ser útil para la Asociación como simple furgoneta. Los resultados fueron fantásticos, de tal forma que favorecieron la donación posterior para la compra
del edificio donde está ubicada la Comunidad Terapéutica.

El problema de integración al barrio de la Comunidad Terapéutica se solventó implicando al vecindario en diferentes actividades como aportación de ropa, muebles... e invitándoles a las celebraciones de puertas abiertas, así como participando en las fiestas populares del barrio, colaborando con el Ayuntamiento de Gracia en las fiestas y realizando trabajos de restauración, limpieza, etc.

El conseguir que la Asociación alquilara un piso para que vivieran tres pacientes fue complejo. Inicialmente se planteó no explicar para que se destinaba; pero se decidió que facilitaría la continuidad el ser honestos con la inmobiliaria. Solo se exigió la presentación de un aval. La experiencia fue un éxito que propició la contratación de nuevos pisos con la misma inmobiliaria y con otras. Incluso el estudio que las inmobiliarias realizaban de una manera discreta para asegurarse de que alquilar un piso a la Asociación no comportaba ningún problema, ha sido útil para tener una valoración objetiva de la integración de los ocupantes de los pisos en la vivienda, vecindario, etc.

La primera cooperativa creada fue un fracaso, al no tener en consideración que los pacientes precisaban de un control externo y objetivo. La segunda cooperativa incluyó voluntarios o profesionales de la propia Asociación, con lo que se aseguró una dinámica correcta. Las dos últimas cooperativas creadas se han unificado para evitar la complejidad administrativa.

Un problema grave se suscitó al denegarnos el Ayuntamiento de Barcelona la gestión del comedor social del Clot que se había ganado por concurso y llevado durante cuatro años. Se hicieron campañas de prensa, recogida de firmas, presentación del caso ante el defensor del pueblo, y finalmente se interpuso un recurso. El Ayuntamiento decidió dar una compensación económica con la que se pudo comprar el restaurante "La Terrasset" y firmar convenio de cenas diarias para indigentes durante cuatro años que continuó hasta hoy.

Se detectó un alto índice de tuberculosis entre los sin techo, y en los años que se gestionó el comedor social del Clot, se implantó en el protocolo de entrada la detección de tuberculosis y derivación a centro de tratamiento, que desde entonces es un procedimiento protocolizado en nuestro Comedor Social "La Terrasset" y en todos los comedores públicos.

Se han establecido reuniones con otras entidades dedicadas a los sin hogar para hacer propuestas de cambio a la administración como son: Operación frío; salario social; viviendas dignas; cursos de formación; cooperativas sociales; cláusulas sociales en concursos públicos; información y formación sobre alcoholismo, etc. haciéndose realidad algunas de ellas.

Hemos colaborado con la Síndica de Greuges (defensora de los ciudadanos de Barcelona) a fin de defender todas estas propuestas (2005). Se ha sustentado la representación del Colegio de Médicos de Barcelona en el consejo municipal de pobreza, sin resultados prácticos.

El contacto con los medios de comunicación es constante para aumentar la sensibilización sobre pobreza, indigencia callejera y alcoholismo y para defender sus puntos de vista ante situaciones injustas. Se han efectuado reuniones con jueces, abogados y fiscales para potenciar la pena alternativa de aquellos pacientes en tratamiento condenados por algún delito.

Los problemas actuales fundamentales son:

- Financiación: desde el año 2003 se están manteniendo reuniones con la Generalitat y el Ayuntamiento para lograr convenios plurianuales y adecuados a las necesidades reales del proyecto. Finalmente se han conseguido convenios plurianuales con el Departamento de Salud y el Departamento de Benestar i Familia de la Generalitat de Cataluña (2006) y lo mismo se está planificando con la Administración Local (que se hará realidad en el 2008). Esto conlleva un aumento de plantilla con el consiguiente incremento de presupuesto. Se continúa tratando de multiplicar las fuentes de financiación. La relación con Europa a través de FEANTSA nos permitirá conocer otras entidades con las que compartir algún trabajo y así podernos beneficiar del conocimiento y ayudas europeas.
- Recursos humanos: Gracias a los convenios con la Universidad de Barcelona y Universidad Oberta de Catalunya, disfrutamos de la presencia de un número
Homeless people and the calm movement of the hand

Igor van Laere, MD
Doctor for homeless people in Amsterdam, NL

Once in a while, people ask me about my work: ‘Why do you work as a doctor for homeless people? ’Isn’t your work in vain, a drop in the ocean, do you see any results?’ and ‘Why didn’t you choose to be a specialist and make good money?’ I find these questions difficult to answer.

For more than thirteen years, I have been trying to guide homeless people through the pathways of ever changing services, helpers and red tape. I have learned lessons of street lives. During over ten thousand consultations I have been meeting homeless people, and their social and medical problems, who have found themselves fallen through all safety nets. I have been trying to find my way through the labyrinth of public services as well. And often, like the homeless, I felt lost and lonely.

My good parents showed me hospitality and care. They stimulated curiosity and adventure. At medical school I learned about disease and therapy. Though lectures about people and needs were lacking. After medical school I have worked in hospitals. Here, I was taught about disease and therapy in practice. And again, little about people and needs. I left the hospital to work in the field, of public health. Being raised in the rural fields amidst the harvest of social health, I moved to the urban fields to find my way through the ruins of social disease.

Through exploring the outdoor fields and problems of homeless people and services, I believe I have come to understand that life is about communication and behaviour. Success lies within attitude and presentation. We all try to navigate on our pathway of life, in our own way, to avoid punishment and exclusion. Many homeless people have been misfortunate by the lack of the calm movement of the parental hand. Instead of the guiding hand of appraisal and embracement, for homeless people, hands of punishment and exclusion have become existential barricades to internalise skills for communication and behaviour. And mostly, the attitude and presentation of homeless people are not welcomed by the general population and (health) services (1). Regarding the drifting away from socialisation, to avoid punishment and exclusion, mother Teresa said: “The most terrible poverty is loneliness, and the feeling of being unloved.”

For homeless people, to their pertinent misfortune, services have too often proved a barrier to recovery, and, as a result, contribute to a downward spiral of deteriorating health and decreasing choices (2). In the Western world, facts show us that homeless populations have a life expectancy of around 45 years, comparable with premature death rates among the general population in African and Eurasian countries (3,4). Western world’s donations are being send to lighten the burden of poor populations in poor countries and homeless populations in rich countries. Doctors without borders operate in all the people’s countries. For relief, in both rich and poor countries, services are occupied with begging and collecting budgets (5). It seems that occupational services have increasingly been drifting away from the needs of the helpers, who are given toys that serve to treat budgets more than skills and tools that are needed to support those in highest need (6).

Para más información véase: www.rauxa.org.

* Contact: asrauxa@rauxa.org
No matter the wealth of a country or service provider, their leaders are responsible for the attitude and presentation of the helpers. Moreover, the helpers depend on education and lessons to be learned of people and needs, based on hospitality and caring hands. Like in all the arts, to help poor and homeless people, the helpers need to learn the calm movement of the hand.

Once in a while, I sit down and think of the questions people ask me about my job. For the answers I need help of great teachers. Why do I do my job? I consult Mahatma Ghandi: “Almost everything you do will seem insignificant, but it is important that you do it. The best way to find yourself is to lose yourself in the service of others”. What are the results? I ask Friedrich Nietzsche: “On the mountains of truth you can never climb in vain: either you will reach a point higher up today, or you will be training your powers so that you will be able to climb higher tomorrow.”

It is my dream to become a specialist of hospitality and care, to teach students and helpers about people and needs. One day, I hope to realise an academic chair of the streets to lecture and study integrated care for those in highest need.7 For now, I shelter aside W.B Yeats whispering: “But I, being poor, have only my dreams. I have spread my dreams under your feet; tread softly, because you tread on my dreams.”

References
(4) Gostin LO. Why rich countries should care about the world’s least healthy people. JAMA 2007; 298(1):89-92.
(5) Gostin LO. Meeting the survival needs of the world’s least healthy people: a proposed model for global health governance. JAMA 2007;298(2):225-8.
Bristol medical students attend Health and Homelessness Conference

Alice Edwards and Katharine Nowlan
HOMED, Bristol, UK

Bristol HOMED is a newly formed group of Bristol medical students who were brought together by our shared interest in homelessness and healthcare issues. HOMED is a nationwide organisation, which is affiliated with Medsin. Our Bristol group is made up of students who have varying degrees of knowledge and experience with regards to homelessness and healthcare. However, all are united in trying to raise awareness amongst medical students and campaign for greater provision of homelessness and healthcare education on medical curricula.

Such ideals provided the stimulus for some preliminary research we carried out over the summer. Our aim was to assess the extent to which homelessness and healthcare issues are specifically included in the curricula of English medical schools. Although our research methods have not been validated, the preliminary findings suggest that very few English medical schools include specific teaching on homelessness and healthcare. In addition, those schools which do provide an education into homeless healthcare issues generally provide little more than 2 hours’ teaching (usually not compulsory). An enthusiastic member of our group, who attended last year’s conference, suggested designing a poster outlining our research for this: the 3rd health and homelessness conference in Oxford. Two representatives from the Bristol HOMED group were able to attend the conference with the finished poster.

The conference provided us with an invaluable opportunity to meet health professionals from every corner of the world, whose experiences with homeless populations helped to provide greater perspective and challenge our views on health and homelessness. The conference reiterated to us that the health of homeless people is not always prioritised by governing bodies. However, we both feel truly inspired by the enthusiasm shown by everyone we met, and feel a strong sense of hope that changes can be made to the way that medical education and health systems view issues surrounding homelessness. We were struck by the dedication of many of the health professionals we spoke to and, given our relative lack of knowledge, feel privileged to have had our ideas so generously welcomed and listened to. As a result of kind offers from delegates at the conference there are now opportunities for us to gain clinical experience with homeless patients, something we often struggle to find as medical students.

Following the conference we feel empowered and re-energised to achieve HOMED’s goal of raising awareness amongst medical students regarding homelessness and healthcare. This year, in conjunction with Shelter, we are offering volunteering opportunities to Bristol medical students. We hope that this is just the start of HOMED’s advocacy work. If nothing else we hope that the insight we gained from the conference will help us in the future, to positively challenge both our own conduct and that of service users, and remind us to appreciate that everyone has their own story to tell. We strongly recommend the conference to both health professionals and students as an opportunity to gain further insight into the issues surrounding homelessness and health and to be inspired by and learn from the great work many people are already doing.

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Medical students and their passion for Street Medicine

Kevin Hoffman (USA), Lucie Potter (UK) et al.*

In September 2008, the 4th Annual Street Medicine Symposium was held in the beautiful city of San Juan, Puerto Rico. Street Medicine programs from Norway, Chile, India, the United States and many other locations met to strengthen relationships, share expertise and identify new ways to serve the vulnerable populations to which they have dedicated their career. As students interested in Street Medicine we were invited to participate in the conference, learning and obtaining a clearer grasp of the intricacies of Street Medicine (1).

Over the 3 days the conference took place, we not only learnt from pioneers of street medicine, but also joined together to develop a new found international team of students in Street Medicine, to become stronger advocates for those that live on the streets (2). Each of us that attended the conference had in our own way chosen to work with the street community. Some used art to reach out and display the disparities that homeless people encounter. Others included medical students whose work in
hospitals, clinics or medical outreach programs provided insight to the social injustices homeless people face. But we all left the conference undivided in our goal to do our part to improve the marginalized care that the street community receives.

The first day of the conference we heard presentations from different outreach programs; each providing inspiration from the different successes and challenges they face. This overview highlighted common problems experienced by several programs despite coming from vastly different contexts and countries. Crucially, this also afforded the opportunity to learn from innovative solutions that may be replicable, such as the simple but successful use of book clubs to connect with previously un-engaging homeless people (Donna Kelly, Cleveland, OH). We realized such sharing and collective learning was also possible at the student level.

Day two provided us with the opportunity to visit different sites of the local program, Iniciativa Comunitaria (3). We spent the afternoon assisting with needle exchange programs and clinics, again noticing not only the passion of the volunteers, but the communication, bonds and willingness to rely on each other to provide the best possible care for the street community. The final morning, the conference chose to give us the spotlight even against our protest out of angst. But as each of us presented, our fear and anxiety to speak in front of a room of people we hold in such high esteem gave way to the fire we possess to serve the community. A fire that would not be possible without a few key people, including Dr. Jim Withers (Pittsburgh, PA), Dr. David Buck (Houston, TX), Dr. David Deci (Morgantown, WV) and Dr. Angela Jones (Oxford, UK), encouraging our involvement and challenging us to think outside the social norm.

The conference reminded us that education is never ending and strength comes with the bonds of teamwork, devotion and dedication to the cause. Our current goals include strengthening communication between existing student groups, locating more students that share our interest and advocating for the improvement, or development, of a Street Medicine curriculum in our universities (4-6). As the Street Medicine Symposium begins to organize formally as the Street Medicine Institute, we are honoured to be included as one of the key principles. In return for the investment that the Street Medicine Institute has placed in us, we have challenged ourselves to become the next leaders in the field of Street Medicine, devoting our education, and quite possibly our careers, to reaching out and serving the health and well-being of some of the most marginalized members of our societies.

Thank you to all those who have supported and encouraged student involvement in the Street Medicine Institute and to Dr. José A. Vargas Vidot, known to most as Chaco, and Iniciativa Comunitaria for hosting the conference.

* The “Street Med Students”: Joanna Adkins, Will Bemben, Julio Bracero-Rodriguez, Lola Burke, Kevin Hoffman, Ben King, Emma Lo, Steve Lindauer, Alvaro Morales, Nabihah Mahmood, Nneka Nzegwu, Lucie Potter. Contact: Kevin.L.Hoffman@uth.tmc.edu, luciepotter@hotmail.co.uk.

**Resources**

(1) [www.streetmedicine.org](http://www.streetmedicine.org)


(3) [www.iniciativacomunitaria.org](http://www.iniciativacomunitaria.org)


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**Request for information**

Dr. Jim Frankish from the University of British Columbia, Vancouver, Canada, is looking for data on the prevalence of homeless people (no fixed address) in outpatient, emergency department or inpatients populations at major European hospitals. If you would like to share with him relevant information, e-mail: frankish@interchange.ubc.ca.

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To keep Ministers informed of progress and report any relevant findings.

1.4 The group spent some months considering the range of issues that needed to be considered in order to move towards recommendations and concluded that there is a real need for a good evidence base in this field. As a result research was commissioned from the Centre for Housing Policy at the University of York. The researchers were asked to:

- Identify and review available evidence on service models and approaches that produce positive outcomes for people with substance misuse problems who are either homeless or at risk of homelessness.
- Outline and assess how positive outcomes in effective services are recognised and measured.
- Develop potential outcome measures for services.

1.5 The research was published in July 2008.

1.6 The research comes at a highly opportune moment as it coincides with:

- The launch of the Scottish Government’s drug strategy, „The Road to Recovery”
- The Scottish Government’s consultation on „Changing Scotland’s Relationship with Alcohol”
- The Scottish Government’s development of new guidance on Preventing Homelessness and research into service barriers affecting people with multiple and complex needs.

2. Key points from the research

2.1 There are clear cause and effect relationships between substance misuse and homelessness. That is not to say that everyone with a substance misuse problem will become homeless but people with substance misuse problems are at higher risk of homelessness. This research also evidences that homelessness can lead to substance misuse and that existing substance misuse problems are likely to become worse once a person becomes homeless. Paragraph 2.39 states that “these studies paint a picture of homelessness and substance misuse as mutually reinforcing conditions that are the result of sustained, multiple, compound disadvantage
through childhood and adult life. There is evidence of sustained socioeconomic exclusion, isolation and alienation among homeless people with a history of substance misuse. There is also evidence that it is lone homeless people and young homeless people, rather than all groups of homeless people, who are characterised by high rates of substance misuse.” Hence adults in homeless families appear less likely to be involved in substance misuse.

2.2 The research considers 5 key models for working with homeless people with substance misuse problems, as follows:

- Joint working and case management;
- Fixed site detoxification services;
- Staircase, continuum of care and transitional models;
- The Housing First model;
- Permanent supported housing.

2.3 The conclusion is that there is no one approach that works for all and each model works for some people. However, on the whole, approaches that consider a person's housing needs and aspirations alongside substance misuse issues seem to have more success. The most positive evaluations come from the Housing First model in the United States. This model provides people with mainstream housing that they want to live in and provides services within that housing. Linked to the same principle, models where people do not access permanent or mainstream housing until they have demonstrated 'improvement' in their substance misuse seem to be less effective. However Housing First has demonstrated less success in ending substance misuse or promoting access to paid work.

2.4 In the UK, the most common approach to providing substance misuse services to homeless people is through a care management/joint working approach. This is different from the Housing First model which provides housing that the service user values from the start and provides support through one keyworker undertaking all support tasks. There is limited evidence as to the success or otherwise of joint working/care management approaches largely because no systematic evaluation has been undertaken. However, there is a generally expressed belief that when it does not work well it is due to a failure in joint working, rather than a failure in the principle of the approach – that the services are not available or are unable to work together effectively.

2.5 The research does suggest that for many areas of Scotland the most useful and cost effective approach may be to look at how existing services could be adapted in the light of the research: for example, using one post from a substance misuse or housing support team to focus on providing appropriate housing and realistic support to individuals affected by both homelessness and substance misuse. It may also be helpful to consider the sharing of a resource across authority or area boundaries.

2.6 The review found that on the whole responses requiring or promoting abstinence are not particularly effective in working with homeless people with substance misuse problems. Interventions adopting these approaches tend to have a high drop out rate of 60 to 80% and low success, although there is evidence that they do work for some people.

2.7 However harm reduction approaches were found to have more success which provides a clear implication that expectations for ‘improvement’ should not be set too high. The evidence suggests the need to be realistic and look for ability to sustain accommodation and a reasonably stable lifestyle rather than expect people to achieve complete abstinence and a fully independent lifestyle. The research also highlights that services based solely on treatment which offer no other support and do not coordinate with other services, such as stand-alone clinics offering detoxification, tend to be largely unsuccessful. Services that offer a range of supports, including housing related support, tend to be more successful at retaining service users and keeping them in accommodation. Therefore the more comprehensive a service is the more effective it is likely to be at retaining formerly and potentially homeless people in accommodation or settled housing.

2.8 The research notes that all mainstream service models have some successes. However there is no strong evidence that any service intervention is consistently effective at achieving independent living and an end to substance misuse for most of its users. While a permanent end to homelessness, independent living, paid work and an end to substance misuse is an attainable goal for some service users, this is not true for all. Promoting harm reduction and ensuring that someone is in settled housing is all that may be achievable for some service users.

The articles do not necessarily reflect the views of FEANTSA.
2.9 In Scotland there is already a requirement to provide housing for all unintentionally homeless households in priority need. By 2012 this will extend to all homeless households, therefore one of the key elements of the successful Housing First approach is already met. However, it may be necessary to think further about:

- When housing is provided – the research suggests that holding off on permanent (settled) accommodation until a substance misuse or other problem is dealt with, is not the most successful approach, and
- What housing is provided – again, the evidence suggests that it does need to be housing that is desirable or at least acceptable to the person in order for them to be able to invest in it.

2.10 The review found little evidence of any concerted attempts at preventing homelessness among people with substance misuse problems and, consequently, no real pointers for what might work. The research suggests that the problems faced by people with substance misuse problems who are at risk of homelessness are so complex that it would be difficult to know where to start. However, it does suggest that it may be useful to begin to highlight people with substance misuse problems as a key risk group alongside, for example, people leaving care, prison, or long stay hospital. This reflects an additional key finding that the higher the level of need, for example among people with long experience of street homelessness, long term addiction and severe mental illness, the less the chances are that services will be successful.

2.11 An additional finding of the review is that there is a global tendency to see the problems of homelessness and substance misuse as largely resulting from individual moral failure. Services in the US designed on these assumptions saw poor results but more recent services have adopted new models based on different assumptions. Moving beyond ideas of homelessness and substance misuse as simply being the results of individual moral failure is therefore essential if services are to be successful.

2.12 The issue of effective outcome recording and reporting was considered at some length and numerous problems highlighted. It was identified that substance misuse outcome measures such as TOPS and CISS rarely include any focus on housing or homelessness issues and outcomes so would not really be useful. It considered a number of broad outcomes models used in homelessness or housing support services and felt that these may be more useful although they still have problems in terms of consistency, organisational/worker focus or bias, relativity of positive outcomes for individuals (e.g. one person’s outstanding success may be another person’s backward step) and applicability over periods of time (i.e. sustainable outcomes).

2.13 An effective system for measuring outcomes for this group could clearly be developed, however this needs more detailed work and needs a debate on whether to go with a new system or to adapt an existing one. Key issues that would need to be considered are:

- Not being too ambitious in terms of anticipated outcomes
- Incorporating some form of longitudinal measure to check sustainability of outcomes
- Identifying forms of data collection that are robust but not too resource intensive.

2.14 The findings from this research are now being used to inform government and stakeholders planning in addressing this important policy area. The full research can be found at: http://www.scotland.gov.uk/Publications/2008/07/24143449/0

* Contact: sue@sueirving.co.uk.

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**“Investigation into the Impact of Choice in Intervention, and Recommendations for Future Practice within Homeless Occupational Therapy Service”, by Susan Holmes, Margaret Hunter, Mary McCoo, Sharon Rae, Joanne Reilly, Debra Wolfe, Christine Work.**

**Sharon Rae*  
NHS Greater Glasgow and Clyde - Glasgow Homelessness Partnership**

**Abstract:** The Homelessness Task Force was set up in 2001 to advise the Scottish Executive on prevention and alleviation of homelessness. It was recommended that Glasgow close its large hostels and from this the Hostel Re-provision programme was established. This is a mandatory process and, as such, the residents have no choice but to leave. Occupational therapists (OTs) are an integral part of this re-housing process and must therefore help facilitate clients’ transition, irrespective of any desire the clients may have to remain within hostel accommodation. However, the College of Occupational Therapists Code of Ethics states that OT services should be client-centred and needs-led (COT, 2005). With this in mind, a review of the research was undertaken on the topic of how choice impacts on the outcome of intervention in order to recommend best practice for the service and for others who practice in restricted settings. 3 main issues emerged as particularly relevant for OT practice. Firstly is the suggestion that increased choice may have little or no impact on treatment outcome or in certain cases can impact negatively. Secondly is an understanding of the manner in which clients weigh evidence in order to make choices; often basing choices on unrealistic or irrelevant information. Lastly is the relationship between client choice & motivation, whereby motivation is informed not just by choice but by incentive, expectancy and success.

**Recommendations for OT practice within Glasgow homeless services:**

<table>
<thead>
<tr>
<th>How do clients make choices about their treatment?</th>
<th>Suggested action</th>
<th>Example</th>
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</thead>
<tbody>
<tr>
<td><strong>Issue identified</strong></td>
<td><strong>Suggested action</strong></td>
<td><strong>Example</strong></td>
</tr>
<tr>
<td>Culture of homelessness limits choice-making opportunities and can leave individuals feeling unable to make choices (Miller and Keys 2001).</td>
<td>OTs must strive to empower clients, encouraging them to take an active role in their treatment and building a sense of self-efficacy.</td>
<td>Encourage active participation in setting realistic and achievable goals</td>
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</tbody>
</table>
| Clients make choices by weighing evidence (Sosin and Grossman 2003). Often, process of judgement can be skewed by:  
  - Clients own view of their needs/insight.  
  - Basing judgement on past experience.  
  - Lack of information.  
  - Placing too much value on short-term goals over long-term consequences. (Morse et al 1996, Sosin and Grossman 2003, Tsembens et al 2004) | OTs should support clients through “weighing” process, paying particular attention to the following factors:  
  - Individualising choices presented to highlight how they relate to client needs.  
  - Ensuring judgement is based on information, not stereotypes.  
  - Working to improve insight to ensure goals are realistic.  
  - Providing information in a variety of forms.  
  - Setting timescales to highlight how goals will be reached. |  
  - Arrange appointments, at time, and in an environment, suitable to both client and Therapist.  
  - Occupational Therapy information leaflet sent with initial appointment letter.  
  - Clarify clients understanding of role of Occupational Therapy on initial meeting and give further verbal description, if required.  
  - Therapist to reflect back on assessment and observations, with client, in an open and honest dialogue. |
| Clients are likely to disengage if choices made do not lead to expected outcome within expected timeframe (Morse et al 1996, Sosin and Grossman 2003). | OTs should ensure larger treatment choices are broken down into smaller, achievable tasks to reduce feelings of frustration and increase sense of achievement. | Use of positive encouragement to take ownership of treatment plan, at pace and frequency agreed by both client and Therapist |

The articles do not necessarily reflect the views of FEANTSA.

Issue N° 7
Does offering choice have benefits for treatment?

<table>
<thead>
<tr>
<th>Issue identified</th>
<th>Suggested action</th>
<th>Example</th>
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<tbody>
<tr>
<td>Research does not support notion that increased choice leads to improved treatment outcomes, especially for people with more serious health issues (Calsyn et al 2003).</td>
<td>OT staff should feel reassured that they are not acting unethically by presenting clients with only limited choices. OTs should consider the culture of homelessness and how this can impact an individual’s capacity to make choices when planning treatment.</td>
<td>Be aware of client’s stage within Cycle of Change (Page 10) and how this may impact on treatment plan.</td>
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<tr>
<td>Too many choices can reduce participation (Sosin and Grossman 2003)</td>
<td>OTs should ensure only relevant choices are presented and should assist with the decision making process.</td>
<td>• Limit range of choices, if appropriate.</td>
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<td></td>
<td></td>
<td>• Ensure options are relevant and valuable to clients.</td>
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<tr>
<td>Lack of insight can lead to poor decision making (Humfress 2002, Sosin and Grossman 2003)</td>
<td>OTs should work with clients to ensure they understand their needs and abilities before making choices.</td>
<td>Provide feedback on outcome of assessment, adhering to the 5 principles of Motivational Interviewing</td>
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How do choice, engagement & motivation interlink?

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<tr>
<th>Issue identified</th>
<th>Suggested action</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cycle of change and motivational interviewing (MI) techniques are both highlighted as evidence based tools to facilitate productive choice-making by clients (DiClemente 2003, Rollnick and Miller 1995)</td>
<td>Consider means of incorporating MI and cycle of change into practice. Access training in MI techniques where necessary.</td>
<td>Use of therapeutic discussions, with clients, to ascertain why behaviour continued and help to clarify the good and less good consequences of these actions.</td>
</tr>
</tbody>
</table>

References

• www.alcohol-drugs.co.uk

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Events

Mental Health & Homelessness, Joining up to Improve Access, Aberystwyth, UK
Date: 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 third event will be held 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

2nd European Scientific Conference on Applied Infectious Disease Epidemiology (ESCAIDE), Berlin, Germany
Date: 19-20 November 2008


MASH conference: Advances in Clinical Education, Liverpool, UK
Date: 3 March 2009

Draft programme available here. For more details, please contact Dr Joseph O’Neill:
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QNI Homeless Health Initiative Conference on homelessness and nursing, London, UK
Date: 12 May 2009

For details, please contact kate.tansley@qni.org.uk

FEANTS

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This programme was established to financially support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields.

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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
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