

European Network of Homeless Health Workers (ENHW)



Issue N°8 – Winter 2008

Editorial

- 2 Editorial, by Stefania Del Zotto

Sharing Experiences: News from Health Professionals across the EU

- 2 The Homeless Mental Health Service in Leicester, by Philip Johnson and Julia Middleton
- 4 The potential for evaluation of community arts groups that enhance the life of people with mental health issues and social inclusion needs, by Sue Hacking

Resources

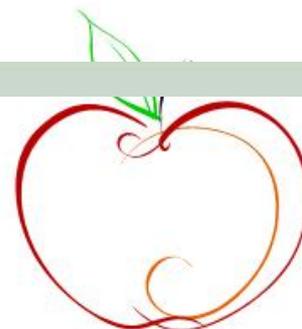
- 6 European Journal of Homelessness, Volume 2
- 6 Nursed or Mauled by the Tiger? by Austin O Carroll and Fiona O Reilly
- 8 Prevention of evictions in Amsterdam: evaluation of the assistance for households at risk, by Igor van Laere
- 9 No one left out: Communities ending rough sleeping, by Angela Jones
- 10 Eurocare and alcohol on the EU agenda, by Emilie Rapley
- 11 Update on relevant EU and international reports and documents

Forum

- 12 Toward an “academic” approach to homeless healthcare delivery: An Oxford Experience, by Wayne A. Centrone
- 13 Finland: addressing homelessness is also a question of public awareness and support, by Annie Mutema
- 15 Christmas with the homeless in Amsterdam, by Katia Maas

Events

- 16 MASH conference: Advances in Clinical Education, Liverpool, 3 March 2009
- 16 Hudson Year Urban Health Conference, Amsterdam, 6 April 2009
- 16 QNI Homeless Health Initiative Conference, London, UK, 12 May 2009



The articles do not necessarily reflect the views of FEANTSA.

Stefania Del Zotto, Policy Officer, FEANTSA

Dear Readers,

First of all, let me take this opportunity to wish you all the very best for 2009!

This issue of the ENHW newsletter contains a variety of articles and resources, which cover several topics of interest. These include: an example of homeless mental health services in England; an article concerning the potential for evaluation of community arts groups in the area of mental health; findings on how the health and welfare of homeless people had changed while Ireland was generating unprecedented wealth; an evaluation of the support provided to households at risk of eviction in Amsterdam; a review of the UK Government's revised plan for tackling rough sleeping in England from a health perspective; an overview of Eurocare and of the EU Health and Alcohol Forum; a link FEANTSA recently published European Journal of Homelessness, which contains articles related to health; as well as links to relevant reports published at EU and international level.

The forum section includes a contribution relating to the Oxford Postgraduate Certificate in the Provision of Health Care to People Experiencing Homelessness, a reflection on how the new Finnish strategy could address stigma and the "NIMBY" attitude, as well as a contribution on how important it is making people feel at home, especially at Christmas time.

We hope that these examples will stimulate further reflection and interaction, be it in the form of articles for the next issue or on the [online forum](#). We also would be pleased if you decided to share with us relevant research you are aware of, which might fit either in the next issue of the Newsletter or in our [Resource page on homelessness and alcohol addiction](#).

The main aim of the ENHW is to be a forum for exchange and mutual learning among healthcare professionals working with people who are homeless in Europe. As mentioned already, 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 people who are interested to contribute in other languages. The article should be accompanied by a paragraph summing up the content of the article in English. Please do not hesitate to contact us on this!

I would like to extend my warmest thanks to everyone who has contributed to the current issue. Please do not hesitate to send your answers, comments, questions and contributions for the next issue of the newsletter to stefania.delzotto@feantsa.org.

Sharing Experiences

The Homeless Mental Health Service in Leicester, England

Philip Johnson and Dr Julia Middleton *

Homeless Mental Health Service, Leicester, UK

The Homeless Mental Health Service (HMHS) provides assessment, treatment and support, to homeless people or those living in temporary accommodation aged over sixteen with mental health difficulties in Leicester city.

Leicester City is a highly urbanised and culturally diverse city with a population of 289,700 (2006 mid-year estimate based on Census projections). It is the

largest city in the East Midlands and the tenth largest in the country. Within this number there are approximately 586 people who are statutory homeless and 1001 non statutory (hidden homeless). It has a relatively high percentage of black and minority ethnic (BME) residents, currently estimated at 40% (The Diversity of Leicester: A Demographic Profile May 2008). A wide variety of ethnic communities have been living in the City for a number of years supplemented by asylum seekers, refugees and migrants from within the European Union. Leicester has a reputation of being a culturally diverse and safe city.

In the year April 07- March 08 the team had contact with 358 people for a total of 1357 occasions. As a service we aim to bridge the gap for homeless



people unable to access the full range of mental health services. Some services may focus on severe and enduring illness, others may be reluctant to see people with substance use issues in addition to their mental health problems, but we find it possible to assess all those people who approach us (regardless of diagnosis) including people with dual diagnosis, and who are still using substances.

We accept self referrals, or referrals from anyone supporting a homeless person. We also identify and engage people who have lost contact with mainstream mental health services. There is an 'open door' policy, with access to the service being offered exclusively on the criteria of the person being homeless. We have a flexible definition of 'homelessness' and 'mental health', to facilitate easy access to the team.

In addition to providing direct mental health services the team aims to promote and improve access to all mainstream social and health care, through advocacy and education. We provide teaching / education to hostel staff at their request and accommodate trainees on placement.

We operate within an outreach, assessment and contact model. This means that the team spends a significant amount of time where homeless people are known to frequent; e.g., hostels and day centres. We provide a daily "drop in" service at the 'Dawn Centre', which combines emergency accommodation, day centre and health care facilities. We also visit direct access hostels weekly and other appointments by flexible arrangements, therefore working times are relative to opening times of day centres / hostel routines. We are involved in weekly multi-agency forums, to facilitate resolution of problems preventing specific service users from improving their immediate situation. We are also involved in local authority homelessness strategic planning and development.

We have developed a service which is able to respond to clients needs as they arise and when the client is ready to engage. Often Homeless people have become mistrustful of services. By being accessible and approachable in places where homeless people frequent, we have been able to build trust and mutual respect. The challenges of supporting homeless people have changed in accordance with the developments in changing legislation and logistics of accessing scattered services. Homeless people can be very chaotic, our clinical practice has to adapt accordingly.

The service began in 1990 during the closure of long stay wards at two local mental health hospitals, funding was obtained for a mental health nurse to address the homeless problem that was anticipated as a result of the closures. A local GP, Dr Hewett also started working with homeless people (Dr Hewett 2007). Gradually over the following years other members became involved with the mental health team including nursing, Psychiatry and Psychology (funded in part by DOH Homeless Mentally Ill Initiative).

Dr Hewett established a Personal Medical Service (PMS) pilot. The Homeless Mental Health Service developed as a separate service, but continued to work closely with the Homeless PMS.

In 2000 an additional nursing post was seconded to enable the team to undertake a six month pilot project, to measure the effectiveness of providing a managed care model including inpatient assessment, treatment and follow up. The pilot project was successful; however it identified gaps in resources which could not be overcome at that time.

In 2001 a sessional Associate Specialist Psychiatrist was employed who also works part time as a GP with the PMS improving liaison between the two services.

The team's current compliment consists of 1 senior nurse practitioner, 2 outreach mental health nurses, 1 Support worker, 1 psychologist, ½ Associate specialist Psychiatrist, sessional input from a Consultant Psychiatrist and 1 part time team secretary.

Our service was one of five case study areas featured in the Department of Communities & Local Government (DCLG) national research into Homelessness and Mental Health ('Getting Through' 1st January 2007).

The nurses have been involved in the implementation of the Homeless Nurses Group UK, which has amalgamated with the Homeless Health Initiative (Queens Nursing Institute). This is a networking / peer support group for nurses



working with people who are homeless or vulnerably housed in the UK.

In April 2008 the team were successful in winning the 'Mental Health & Wellbeing' category of the 'East Midlands Regional Health & Social Care awards' and went on to become one of a final three projects in the same category of the National Health & Social Care Awards in July 2008.

The team has developed to its current provision, following years of negotiation with providers and purchasers. Practical resources have taken time to be resolved including a city centre team base which was only achieved in February 2007. Prior to the opening of the Dawn Centre in Jan 2006, the logistics of providing a dispersed service was very challenging. The development of the 'one stop shop' concept has facilitated our communication with other agencies (statutory / non statutory) as well as the obvious advantages for the homeless clients.

In Summary we have developed a mental health service which is easily accessible, non exclusive, quickly responsive and flexible for homeless people. In doing so we promote dignity and respect for our clients and have listened to their experiences and needs to shape our service. We have tried to adapt to the changing needs of our clients and the needs of other homeless services trying to help the same clients. Our service has adapted to the holistic aims

of the Dawn Centre (one stop shop), organisational changes within the trust, and has benefited from improved coordination and communication with partner agencies. We have emphasised the plights of homeless people within our own NHS Trust, and their mental health issues amongst other homeless services. The overall benefits of providing our service far out weigh the service costs. As we are a small team the yearly costs are only £303,000, this includes contribution to our team base, administration, manager, travel/mileage, telephones, as well as salaries with on costs.

References

"Getting through" Access to mental health services for people who are homeless or living in temporary or insecure accommodation - DCLG, DOH, and CSIP - 1st January 2007

Primary Healthcare for Homeless People in Leicester, England - Dr Hewett - ENHW Newsletter, Issue No3, Oct 2007

The Diversity of Leicester: A Demographic Profile May 2008 cited in Leicester City Council - Homeless Strategy 2008 (awaiting publication)

* Philip Johnson is Senior Nurse Practitioner and Dr Julia Middleton is Associate Specialist Psychiatrist at the Homeless Mental Health Service in Leicester. Contact: Philip.Johnson@leicspart.nhs.uk

The potential for evaluation of community arts groups that enhance the life of people with mental health issues and social inclusion needs

Dr Sue Hacking*

University of Central Lancashire, Preston, UK

It is now common in the UK to find a range of third sector projects working alongside statutory services to help people build or maintain valued social roles and relationships in the community. Specialist arts projects are amongst the handful of funded community services for people who feel excluded from society because of their mental health or social needs. Arts projects are said to help people improve their confidence and attitudes to life, improve their wellbeing and mental health, develop self esteem, help others, perhaps develop skills that are transferable to employment, help socialisation and

interaction with other people and help people develop new interests or nurture old ones, but in the UK there has been little robust evaluation of these claims until now (Hacking et al 2008).

Outcome research for health-related community arts projects has been rather limited and thus there has been much speculation on what constitutes evidence (Hacking et al 2006, Spandler et al 2007, Secker et al 2007b, Hacking et al 2008). Competing frameworks around quality of life in recovery, the process of recovery and how social inclusion is situated and thought about (Spandler et al 2007) has meant there are no consensus and few general guidelines and instruments for good evaluation of social outcomes, particularly practitioner led measures (Hacking and Bates 2008). Arts projects in the UK have traditionally had a culture that encourages equity between individuals, focuses the primary interest in the activity to the exclusion of other considerations, those with participants referred who have mental health needs tend to see



FEANTSA

The articles do not necessarily reflect the views of FEANTSA.

themselves as social and community groups that empower individuals, that focus on self defined goals rather than 'illness' and typically prefer not to collect or seek to share data about individuals referred to them. Our UK study of over 200 arts projects that claimed to support participants with mental health needs found only a handful that were collecting consistent basic information about their participation that could be used as supporting evidence; many projects did not even collect descriptive information (Secker et al 2007a). Such projects are increasingly seeking ways to evidence their work sympathetically; many produce brochures showcasing work by participants and other quality and satisfaction outcomes but this does not really satisfy the evidence base needed for funding health interventions.

However, the results of a final survey of participants of 23 arts projects across England show many of the elements that go into an arts project can be assessed and measured and showed positive gain. Mental health, empowerment (self esteem and confidence related issues) need not be very different from those in other areas and we were able to classify many elements of social inclusion that showed evidence of improvement (Hacking et al 2008).

This does not mean that all projects should adopt full health care evaluation measures and indeed for many projects, clashes with their prevailing culture and concerns about intrusion in their participants lives, were too great for them to participate but the study has provided fuel for debate on the potential and need for evidence of effect and best practise that may resonate with the budget concerns of many care managers in the social care sector working with arts projects.

Outcome definition

The suggestions here are for a basic information set as a minimum fit for most health care agencies needs. To be able to provide evidence that a project works, a systematic set of data is needed; it is not necessary to collect extensive information, especially if there is no-one who can easily evaluate it.

To start, it would be helpful to have the aims of the project clearly expressed in relation to how participation in the project will help people. A staff meeting is often a useful arena to explore the potential of the project to fulfil its aims. This exercise may provide the project manager with better specification. In our 2008 study, we looked primarily for evidence of change in these fields, but many projects would not be aimed to increase all

these aspects and some may aim for steps along the way:

- Mental Health (Wellbeing, life functioning, risk and symptoms)
- Social Inclusion (isolation, relations with others, acceptance)

Empowerment (self worth, self efficacy, mutual aid and positive outlook)

Data

Data includes a variety of social and health related information that helps measure what your project aims to achieve. For instance, if you decide that your project aim is to help your participants gain confidence, you may need to decide what kind of confidence your participants will gain, select a measure of it on entry and on leaving the project and ask them if the project helped in any way that related to confidence to establish what it was that the project did for them. An analysis would help relate the figures before and after the project to what the participants said helped them. Demographic data will help readers of the analysis assess the kind of population the project was useful to. If the data was kept consistently on every participant, after a few years a useful data set would support the project in funding bids.

An individual data set should ideally consist of a skeleton of measures that describe the participants and their situation:

- Demographics (gender, age of participant, location)
- Housing (including who the participant shares accommodation with)
- Somatic and psychiatric health (obtained from referring agency)
- Medication or other treatment
- Social support status
- Stakeholders, including other health service -providers

A data set should be included about the participation in the project

- Attendance
- Description of the intervention selected by the participant (if the project has a number of different activities)
- Start date and projected end date

Other data should be collected that evidences the project aims.

- Measure on entry to the project and at regular intervals afterwards (for example, a depression scale)
- On exit from the project and if possible at an interval afterwards.

The file could also contain

- Observations from the team and the participant about their participation

- Consent from the participant to use the data for research
- Photographs or copies of work

It is very important to consider how and when this data is to be analysed as part of the system. For new and innovative methods of practice, ideally feedback directly to project staff at relatively short intervals. It is important to see practice and evaluation as mutually developing because of the risk of doing work that has no real effect in the long term but simply contributes to paperwork leading to cynicism and burn-out. Among small projects working with marginalized people, it is really important to keep paperwork down, develop practice in a humane and challenging way and allow staff to give feedback and refine practice quickly to become a direct agent of change (Hacking and Bates 2008).

This kind of data set, analysed at six monthly intervals, allows the project to self monitor in that changes in demographics, performance and other aspects of project are apparent. Actions to correct or discuss are accessible to the team and if done in a sympathetic way, the participant can be involved too. It is also possible to introduce new data-sets into the system and get a quick response if the situation requires it and is an invaluable aid to reports and funding bids for project managers.

References

Hacking S., Secker J., Spandler, H. Kent L., Shenton, J. (2006) Mental health and arts participation: the

state of the art in England. *The Journal of the Royal Society for the Promotion of Health* 126, 121-127.
Hacking S., Secker J., Spandler, H. Kent L., Shenton, J. (2008) Evaluating the impact of participatory art projects for people with mental health needs, *Health and Social Care in the Community*, 16(6):638-648

Hacking, S., Bates, P. (2008) The Inclusion Web: a tool for person-centred planning and service evaluation, *Mental Health Review Journal* 13 (2): 4-15.

Secker J., Hacking S., Spandler H., Kent, L., Shenton, J. (2007a) *Mental Health, Social Inclusion and Arts: Developing the Evidence Base*. National Social Inclusion Programme, Care Services Improvement Partnership, London.

Secker, J., Spandler, H., Hacking, S., Kent, L., Shenton, J., (2007b) On the trail of the holy grail: empowerment and arts participation for people with mental health needs, *Journal of Public Mental Health* 6 (4):14-23.

Spandler, H., Secker, J., Kent, L., Hacking, S., Shenton, J. (2007) Catching life: the contribution of arts initiatives to recovery approaches in mental health, *Journal of Psychiatric and Mental Health Nursing*, 14: 791-799.

* Dr Sue Hacking is Senior Research Fellow at the Department of Nursing and Caring Sciences, University of Central Lancashire, Preston, UK. Contact: shacking@uclan.ac.uk.

Resources

European Journal of Homelessness, Volume 2, Effectiveness of Policies and Services for Homelessness, December 2008

FEANTSA is pleased to announce the publication of the second volume of the European Journal of Homelessness, which contains also articles devoted

to health related issues. The electronic version can be downloaded free of charge from: <http://eohw.horus.be/code/EN/pg.asp?Page=1112>. Printed copies (20 euros including postage) can be ordered from research@feantsa.org.

Nursed or Mauled by the Tiger?

"Health of Homeless People in Ireland: has anything changed in context of Ireland's economic boom?", by O'Carroll A, O'Reilly F, *European Journal of Public Health*. 2008 Oct; 18(5):448-53.

Dr Austin O'Carroll and Fiona O'Reilly,



FEANTSA

Safetynet Healthcare for Homeless People, Ireland

The period between 1995 and 2008 saw the rise and demise of the Celtic Tiger. This period was characterised by huge economic growth which between 1990 and 2002 was the highest in the world (1). The prevailing economic philosophy promoted

by the Government parties was a liberal free market one whereby taxes were lowered and attempts were made to cut public spending and privatise public enterprises. This was described as the 'Boston versus Berlin' debate with Government parties promoting the individualistic liberal US approach over the social democratic European model. The Celtic Tiger did result in higher relative poverty with Ireland achieving second place on the relative poverty scale. Criticism of the increase in relative poverty levels was rebuffed by the argument that absolute poverty levels were reduced and that all socio-economic groupings would benefit from the economic boom. This is known as the trickle down argument typified by the phrase 'a rising tide lifts all boats'.

We conducted a census in 2005 of 356 homeless adults in the North Inner Dublin city which was a repeat of a previous study of 192 homeless adults that was carried out by T Holohan in 1997 (2). By comparing both studies we were able to gain some insight into how the health and welfare of homeless people had changed over that same period.

This comparison demonstrated that:

- The homeless population was becoming younger with 81% under 45 years in 2005 versus 70% in 1997.
- Homeless people were more likely to be long term homeless (i.e. > 1 year) in 2005 than 1997 (i.e. 66% vs 44%).
- There were more women becoming homeless (39% were female in 2005 versus 29% in 1997).
- Along with the 356 adults there were 120 children living in homelessness.
- Drug Usage had increased dramatically with 64% having used illicit drugs in the 2005 census versus 32% in 1997.
- Eighty-four percent in 2005 said they had at least one physical or mental health problems compared to 65% in 1997.
- In terms of general physical health problems there was little difference between 2005 and 1997. However, in 1997 Holohan did not ask if respondents had HIV, Hepatitis B or C. In 2005 6% had HIV, 5% had Hepatitis B and 36% had Hepatitis C. This reflected the rise in drug usage amongst homeless people.
- There was a worsening in mental health with 51% reporting been diagnosed with depression and 42% with anxiety in 2005 versus 35% and 32% respectively in 1997.
- There was also worsening dental health with 53% reporting dental problems in 2005 versus 37% in 1997.

- Self rated health was also worse with 44% saying their physical health and 47% saying mental health limited their daily activities versus 25% and 24% respectively in 1997. Self rated health has been validated as a good measure of general health. Self report of fair to poor health status had increased since 1997 and was twice that of the general population (3).
- Access to primary health care had not changed with 45% and 46% in 2005 and 1997 respectively not possessing a medical card to entitle them to free primary health care.
- Homeless people were high users of secondary care services with 37% having attended and Accident and Emergency Unit, 27% a hospital outpatient department and 19% having been a hospital inpatient in the previous 6 months in 2005. This reflects findings in the international literature (4).

These findings indicated that while the Celtic Tiger was generating unprecedented wealth for the Irish nation and reducing absolute poverty, the situation for the homeless population was worsening in terms of duration of homelessness, morbidity, self assessed health and drug usage. There had been a shift in population demographics towards a younger more female population with significant numbers of children ending up in homelessness. It could be argued that if the numbers of homeless people were reducing that those left in homelessness would have worse social and health indicators i.e. the negative selection theory. However, examination of demographic trends in the homeless population fails to support this hypothesis. The finding that the health and welfare of homeless people worsened over an economic boom period replicates similar findings in a US study by O Toole (5).

This study shows a changing disease profile among the homeless population consistent with a growing drug using population. It confirms that the homeless population in terms of health in Dublin remain excluded from the benefits of an economic boom despite a Government policy aimed at redressing social exclusion.

The full article can be accessed in the European Journal of Public Health.

References

1. UN Human Development Report 2004
2. Holohan T. Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin. Dublin RCPI 1997

3. Kelleher C, Friel S, Nic Gabhainn S, Tay JB. Socio-demographic predictors of self-rated health in the Republic of Ireland: findings from the National Survey on Lifestyle, Attitudes and Nutrition, SLAN. *Soc Sci Med.* 2003 Aug;57(3):477-86.
4. Mandelberg JH, Kuhn RE, Kohn MA. Epidemiologic analysis of an urban, public emergency department's frequent users. *Acad Emerg Med.* 2000 Jun;7(6):637-46
5. O' Toole TP, Gibbon JL, Seltzer D, Hanusa BH, Fine MJ. Urban homelessness and poverty during economic prosperity and welfare reform: changes in self-reported comorbidities, insurance, and sources for usual care, 1995-1997. *Journal of Urban Health,* 2002, 79(2):200-210.

* Dr Austin O'Carroll is the Chairperson of Safetynet Healthcare for Homeless People and Ms Fiona O'Reilly is Researcher in Homelessness and Addiction. Contact: austinoc@hotmail.com and fiona.a.oreilly@nuim.ie.

Prevention of evictions in Amsterdam: evaluation of the assistance for households at risk

"Evaluation of the signalling and referral system for households at risk of eviction in Amsterdam", Health and social care in the Community, Volume 17, Number 1, February 2009, pp. 1-8(8)

By Igor van Laere, MD, Matty de Wit, Msc, Niek Klazinga, MD, Netherlands*

Igor van Laere* MD,

Doctor for homeless people in Amsterdam, NL

Background

In Amsterdam, the Netherlands, over 1,400 households are evicted from their homes each year. Evictions are associated with rent arrears, housing related nuisance, addiction and mental health problems. We describe the results of an evaluation of the functioning of the signalling and referral system, set up for households at risk of eviction, through a qualitative and quantitative study.

Methods

Documents, interviews and questionnaires completed by employees of all 12 housing associations (for rent arrears) and by employees of all 13 nuisance control care networks (for nuisance), were used. Data on households with rent arrears, for which a court eviction order was requested, were collected prospectively in September and October 2003, and retrospectively on households causing nuisance and/or who were known to be evicted due to nuisance in the period 2001-2003. Functioning of signalling, of the 'alarm' of problems underlying rent arrears and/or nuisance, was evaluated by the extent of problems that were identified by the employees. Functioning of referral was evaluated by comparing the identified problems with the assistance contacts.

Results

For 275 households with rent arrears, housing associations reported social problems in 196 (71%), of whom 94 (48%) were in contact with social assistance, and medical problems in 62 (23%) of whom 18 (29%) were in contact with medical assistance. House visits by housing associations resulted in a much higher identification of problems, and were associated with a reduced eviction risk (relative risk 0.57 (95%CI: 0.43 to 0.75)). For 190 nuisance households, nuisance control care networks reported social problems in 103 (54%), of which 13 (13%) were in contact with social assistance, and medical problems in 155 (82%), of which 142 (92%) were in contact with medical assistance.

Conclusion

To prevent evictions in Amsterdam, housing associations should improve their signalling role by conducting more house visits, and they should refer more households to medical assistance. Nuisance control care networks should refer more households to social assistance. Households at risk of eviction should be guided hand in hand by local networks providing housing, social and medical assistance. Only an integrated approach can keep more households at home.

Keywords

rent arrears, nuisance, evictions, homeless, public health strategy, preventing homelessness.

* Igor van Laere is MD for homeless people at the GGD Municipal Public Health Service Amsterdam, Matty de Wit, Msc, PhD works as well in the same service, while Niek Klazinga, MD, PhD works also at the Academic Medical Centre, University of Amsterdam, Department of Social Medicine. Contact: ivlaere@ggd.amsterdam.nl.



No one left out: Communities ending rough sleeping, UK, November 2008

Dr Angela Jones*

GP and Independent Consultant, UK

This document was published in November 2008 and represents the UK Government's revised plan for tackling rough sleeping in England. In the executive summary it states: "This new strategy signals our intent to work with our partners to end rough sleeping by 2012." The summary of 15 main actions and responsibilities highlights the fact that, to tackle rough sleeping effectively requires action across the full range of disciplines and thereby across government departments. Cheeringly, for the audience of this newsletter, one of the 15 action areas is devoted to health.

Action 5 states that the Government departments will further improve access to health and social care services for people with multiple needs by a number of actions to be taken jointly between CLG (the department in charge of local government) and DH (Department of Health) :

- to strengthen the economic case for commissioning more integrated health and social care services for homeless people
- to develop the joint health and social care needs assessment (JSNA) which local authorities and health bodies undertake in their areas, such that it includes factors relevant to rough sleepers
- to promote and evaluate their jointly written Hospital Discharge Protocol which advises on how to develop a system in each acute hospital whereby homeless people are identified and offered appropriate help and discharge packages
- to ensure that the local managers in the NHS improve services to homeless people in key targeted areas
- to look at developing effective responses to people who have experienced childhood trauma and now have complex needs and the most chaotic lives
- to see how health trainers (an existing DH programme) can help rough sleepers
- to develop a health and homelessness website to promote good practice
- to work with the public health observatories to develop tools for needs assessment of rough sleepers.

This list of actions (paraphrased by me) certainly represents a better understanding of the link between ill health and homelessness. It also constitutes a considerably larger programme in the field of health and homelessness than in "Coming in from the Cold", the first rough sleeper strategy, published in 1997. If all the actions are undertaken, there is a possibility that health care for homeless people will improve substantially, as it allows for improvements in funding through the economic work and the enhanced needs assessment.

There is a theme of 'piggy-backing' rough sleepers into existing programmes, such as the JSNA and the health trainers programme which represents a sensible and pragmatic governmental response. Likewise, promoting the implementation of previously released guidance on hospital discharge is a logical action.

Slightly disappointing to those of us in the health and homelessness sector has been the lack of an explicit guarantee within this document that rough sleepers can register with a primary care practice and receive an appropriate integrated package of care, commensurate with their needs, including intermediate care if required. This is vital in the UK context as access to most health care is currently predicated on being registered with a general practice, and also because the continuity of care that such registration can provide, has the potential of offering an anchor of security and stability in the often chaotic world of the person who sleeps on the streets.

Perhaps the locality managers will be aiming at commissioning such integrated primary care services. Hopefully this is what the economists will be modelling and investigating. If so, there is a possibility that rough sleepers' health needs will begin to be met. It is to be hoped that this is the case, otherwise, with ill health and homelessness as inextricably linked as the chicken and the egg,, the strategy is unlikely to achieve its target of eliminating rough sleeping by 2012.

Resources

UK Government web site:

<http://www.communities.gov.uk/publications/housing/roughsleepingstrategy>

* Dr Angela Jones is GP for people who are homeless in Westminster, London, and Independent Consultant, Inclusive Health, UK. Contact: angela.jones@inclusivehealth.co.uk



Eurocare and alcohol on the EU agenda

Emilie Rapley*

Eurocare

[Eurocare](#), the European Alcohol Policy Alliance, is a network composed of 50 voluntary and non-governmental organizations across Europe working on the prevention and reduction of alcohol related harm. Eurocare represents a diversity of views and cultural attitudes towards alcohol, and was created in 1990 as a result of growing concern of the impact the European Union could have on alcohol policy in Member States. Member organisations reflect the different strands of work in the alcohol field, and are involved in the provision of information to the public; education and training of voluntary and professional community care workers; the provision of workplace and school based programmes; counselling services, residential support, as well as research and advocacy activities.

One of Eurocare's main goals is to promote the prevention of alcohol related harm to decision makers in the European Union, and advocate the implementation of evidence based alcohol policies.

Alcohol related harm in Europe

Alcohol is a key public health concern in Europe, causing some sixty diseases and conditions, and inflicting an enormous toll on European ill-health from birth to the grave. Europe is now the heaviest drinking region in the world (1): harmful alcohol use is the third biggest cause of early death and illness behind tobacco and high blood pressure (2) and estimated to cost around €125 billion every year due to ill health, accidents and injuries, crime and lost productivity (3). More than one out of every four deaths among young men (aged 15 to 29 years) and one in every ten deaths among young women in the EU is due to alcohol, often caused by road traffic accidents, homicide, and violence. There is a significant problem of alcohol addiction and abuse among the homeless population in Europe; evidence suggests that 25 % to 73% (5) of homeless people suffer from alcohol problems.

The EU Alcohol and Health Forum

The EU '[Alcohol Strategy](#)' was adopted in October 2006 after unprecedented, [aggressive lobbying on the part of the alcohol industry](#); it addresses the adverse health effects related to harmful and hazardous alcohol consumption, and highlights the social and economic costs caused by alcohol.

The European Commission's [Alcohol and Health Forum](#) constitutes the backbone of this Strategy. Launched in June 2007, the Alcohol and Health Forum is multi-stakeholder platform, bringing together over 59 members- both NGOs and economic operators (alcohol producers, retailers, advertisers, and publishers) pledging to take voluntary actions to reduce alcohol related harm in Europe. These actions will be monitored and evaluated against set objectives and targets, as well as overall relevance to areas of focus for the Forum:

- "strategies aimed at curbing under age drinking"
- "information and education programmes on the effect of harmful drinking and on responsible patterns of consumption"
- "possible development of efficient approaches throughout the community to provide adequate consumer information"
- "actions to better enforce safe limits for selling and serving alcohol"
- "interventions promoting effective behavioural change among children and adolescents and cooperation to promote responsibility in and prevent irresponsible commercial communications and sales".

European Institutions, the World Health Organisation, and EU Member States, will participate as observers. The Forum is chaired by the Director General for Public Health and Consumer Protection (DG Sanco), Robert Madelin. For economic operators, participation in the Forum is now crucial in order to promote corporate social responsibility, and above all, avoid the implementation of EU level legislation, for example in the area of commercial communications.

Eurocare welcomes the action oriented remit of the Forum and is committed to fully supporting DG Sanco, whose work has been pivotal in firmly establishing alcohol on the EU political agenda. Eurocare also welcomes the appointment of a [Science Group](#) of the Forum and looks forward to the conclusions of the Group's investigation of "the impact of marketing communication on the volume (and patterns) of consumption of alcoholic beverages, especially by young people", due in the spring.

Eurocare, as the only European Alliance of non-governmental organisations working on the single issue of alcohol, is investing considerable resources in the EU Alcohol and Health Forum, seeing it as an opportunity to further raise awareness of alcohol



issues in Europe. The Forum will certainly test the economic operator's ability to face their responsibilities and commit to effective actions aimed at reducing alcohol related harm.

Commitments

Over [one hundred commitments](#) have been put forward so far by stakeholders. For the first time, industry voluntary actions will be monitored in an open and transparent way, through systematic evaluation. Most commitments made by alcohol producers concern information campaigns, more specifically the promotion of 'sensible drinking' messages, whilst the retailers' focus appears to be on enforcing age limits for the sale of alcohol. A number of producers have also sought to develop in house workplace alcohol policies. Advertisers and publishers' commitments are, rather predictably, focused around commercial communications.

For civil society members, the Forum, though representing a demanding workload, has provided a new impetus for further focus on alcohol issues. Eurocare, is keen to take on a leading role in the Forum. Beyond efforts to coordinate NGO involvement in the forum (including eight of its own members), Eurocare has submitted three commitments: the creation of a new website; the organisation of an event to raise awareness of Foetal Alcohol Spectrum Disorders, and, jointly with the European Youth Forum, the creation of a pan European 'Alcohol Policy Youth Network'. The idea behind this, is to set up a capacity building network,

providing training courses, advocacy schools, seminars, and training, all specifically designed around alcohol policy, in order to empower youth organisations to be active and valid actors in the field. We hope to submit new commitments in 2009, in collaboration with other NGOs.

Above all, the Alcohol and Health Forum will enable the alcohol issue to remain on the European political agenda, an objective Eurocare has been pursuing for nearly two decades. This type of high profile initiative is also likely to receive increasing media attention, and will hopefully help raise public awareness of the growing problem of alcohol related harm in Europe.

References

- (1) Anderson, P & Baumberg, B (2005) '[Alcohol in Europe: A Public Health Perspective](#)', Institute of Alcohol Studies: London.
- (2) DG Sanco Factsheet '[Alcohol Related Harm in Europe: Key Data](#)'
- (3) *ibid.*
- (4) *ibid.*
- (5) (2003) *Addiction Research and Theory* Vol 11(4)
(1999) *European Archives of Psychiatry and Clinical Neuroscience* vol 249(1)

*Emilie Rapley is Policy & Public Affairs Officer at Eurocare. Contact: emilie.rapley@eurocare.org; web site: <http://www.eurocare.org>.

Update on relevant EU and international reports and documents

Below you will find the links to recent reports or documents, which are relevant to the area of health and homelessness.

Social determinants of health: the Final report of the Commission on social determinants of health published in August 2008 is available online: "[Closing the gap in a generation](#)". The report looks at how social (in)equity affects people's health.

European Pact for Mental Health and Well-Being: this is the main outcome of the EU High-level

conference "Together for Mental Health and Well-being" held in Brussels on 12-13 June 2008. Combating stigma and social exclusion is one of the five priority areas, which have been identified. The Pact can be found on the [European Commission's web site](#).

Drug addiction: the European Monitoring Centre for Drugs and Drug Addiction has issued a study on [Drugs and vulnerable groups of young people](#), which looks at youth homelessness as well. The EMCDDA has also recently published its [2008 Annual report on the state of the drugs problem in Europe](#).

Toward an “academic” approach to homeless healthcare delivery: An Oxford Experience

Wayne A. Centrone*

Outside In Medical Clinic and Health Bridges International, Inc., Portland, Oregon, USA

For many medical providers the experience of working with homeless populations can feel like trying to take a sip of water from a fire hydrant – very messy and a bit overwhelming. The day-to-day challenges of care delivery are awe inspiring at best and incredibly demoralizing at worst. The subtle modifications to general standards of care delivery are often a consuming element of the practitioner’s daily struggles. For some providers the skills and clinical techniques they learned in their health-professions training programs can leave them under-prepared to care for the multitude of complex medical, psychological and social issues facing a homeless population.

Like so many people, I have been blessed to work with persons experiencing homelessness for a number of years. I feel very fortunate that a part of my formal training involved a structured fellowship specifically geared toward preparing me to work with homeless and underserved populations. Yet, in spite of this specialty level of training – I have continued to struggle with how to best serve homeless people.

In my role as the medical director of an outreach program that targets the hardest to reach homeless populations I get to work with a broad scope of patients – from commercial sex workers to young adults strongly incarcerated in substance abuse. I am continually challenged by the complexity of need; and at the same time, I am forever grateful for the opportunity I am offered in my interactions with these tremendous people. In my role as the director of an international healthcare outreach and advocacy organization, I am often faced with finding unique ways to deliver care and services in resource poor environments. The cultural, economic and physical challenges of care delivery require me to seek and utilize creative approaches. In both of my professional “worlds” I am stretched to consider all of the possibilities to better bring resources and care to underserved populations.

I have come to realize that the best method for me to increase my ability to serve is to broaden my knowledge and expand my insight. The skills and academic learning that I leveraged from my

enrollment and completion of the University of Oxford Postgraduate Certificate in the Provision of Health Care to People Experiencing Homelessness helped me to gain this greater professional insight. The level of critical appraisal that I can now bring to the delivery of care and the development of programs and projects is a direct reflection of my experiences in the Oxford program. Through my enrollment in the Postgraduate Certificate curriculum, I learned to reach out to a collective of professional colleagues around the world and to build collaborative bridges of experience and knowledge. Through my enrollment in the course I learned to truly consider the unique aspects of homeless healthcare delivery and work to bring these specialty skills to my patients every day.

The University of Oxford curriculum is the brainchild of Dr. Angela Jones and Mr. Mike Seal. The year-long course grew out of Dr. Jones’ ten-plus years of care delivery to homeless populations and the countless trial and error experiences that led to her current clinical practice. Mr. Seal provides a real academic backbone to the curriculum of study – as he is one of the U.K.’s most notable academics on homelessness and housing instability. Together, Dr. Jones and Mr. Seal bring the unique perspectives of well trained and knowledgeable professionals with the anecdotal experiences of over 25-years of care delivery to persons experiencing homelessness.

Throughout my enrollment – a portion of the course is taught through an on-line learning portal that allows for interactive discussions and discourse between students and their tutors and a portion of the course is taught in residential classroom intensives that bring the entire cohort together in Oxford – I was continually amazed at the level of thoughtfulness and academic proficiency that the instructors brought to the learning environment. Students were expected to digest a number of academic journal articles and to Socratically evaluate the impact of the didactic information toward their daily practice of care delivery to persons experiencing homelessness. Most of all students were encouraged to work together to consider current and future approaches to delivering the highest quality care possible to homeless populations.

Today when I serve my patients I feel confident in the knowledge that around the world people are working to bring the highest standards and the greatest insight into the care of homeless populations. I feel assured that my experiences and



learning from participation in the University of Oxford program have better prepared me to advocate for the complex needs of people experiencing homelessness. And, I feel hopeful that with greater academic investigation and more political will – we can someday end the human rights tragedy that is homelessness.

My enrollment with the Postgraduate Certificate in the Provision of Health Care to People Experiencing Homelessness was one of the most influential

experiences of my career – and an adventure that I encourage every clinician working with special needs populations to strongly consider.

* Wayne A. Centrone is Attending Physician and Medical Director, Outreach Program, Outside In Medical Clinic and Health Bridges International, Inc., Portland, Oregon, USA. Contact: Wcentrone@Outsidein.org and Wayne@HBInt.org; web site: <http://www.outsidein.org> and <http://www.hbint.org/>.

Finland: addressing homelessness is also a question of public awareness and support

Annie Mutema*

Student and Volunteer Worker, Helsinki, Finland

Introduction

Three issues are in the forefront with the homelessness issue in Finland:

1. The government embarked on a plan to half homelessness by eradicating shelters and replacing them with supported housing. This project would span three years 2008-2011 (1);
2. Entering the year 2009 this plan is stagnant. This is largely due to the NIMBY effect (“not in my backyard”) which is currently in full force reeling from the political and media backdrop of the recent Municipal elections in November 2008, and
3. The global state of affairs and the looming international threat to the Finnish economy is already starting to show effect to the homelessness issue.

Homelessness in Finland is an effect of multitude of causes, a complex web of health and social issues. It is therefore important to study carefully and implement measures that are likely to support and strengthen existing societal structures in these areas. The chronic homeless of Helsinki today are mostly men that fell out of the system during the previous economic depression and time of unemployment in the early and mid 1990’s when Finland suffered a recession (2). Should we now be worried that there is another generation of homeless coming from the current economic turn of events?

The support housing project cannot happen in a vacuum. The whole Finnish society needs to come together and support the project for it to be a success. Efforts to do this should first be done before embarking on a project of this scale. In writing this article, my aim is to highlight the issues that I think are important to reignite this project. This initiative is a much needed one and should be given all the

support it can so as to benefit not only the targeted group but Finnish society as a whole.

NIMBY effect – how to best deal with it

In 2005, Timo Kopomaa, in his study about the possible NIMBY (“not in my backyard”) effect on support housing plans in Finland, discovered that the successful endeavours have all managed to take care of the following issues:

- Suitable place
- Local dialogue
- Good planning
- Managed image
- Winning the fight with media
- Control and support, and
- Sensitive management of the environment issues (3).

He therefore concludes that taking care of these issues in the future should also lead to positive and easy integration of social housing into the already existing neighbourhoods feeling threatened by the potentially negative impact that might come along with the new housing plans.

The most important point to come from Kopomaa (2005) study is that the NIMBY effect in Finland is often met with the more educated and better off middle-classes than with areas that have had to deal more with the issues beforehand, namely poorer neighbourhoods; areas with houses rather than flats, areas with distinct borders and specifically areas where the residents can feel an invasion or a threat from outside to their neighbourhood. From this, it is therefore clear that if the government would carry out a sensitisation programme to counter the NIMBY effect, it would target this group of the more educated middle class.

The study on NIMBY effect was ordered by the Ministry for Environment for the new housing plan year 2005. The action plan on support housing was then prepared and issued in January 2008. Now



local observers say that the NIMBY effect has slowed down the program for supported housing (4). It therefore appears that resistance was foreseen but nothing was done to counteract this phenomenon such that the project would run smoothly.

Stigma

Stigma fuels the NYMBY effect in Finland. It could be said that actually the Finnish societal view on homelessness is that, it is a self inflicted condition. This is because the individuals who suffer from homelessness are normally unemployed alcoholics, in their fifties and they are viewed as rejecting the social welfare state.

The presence of stigma or the fear of stigma by an individual suffering from homelessness has a catalyst effect into chronic homelessness. Stigma can be life threatening. Outi Lithén, the former executive director to AIDS Tukikeskus - the biggest AIDS support centre in Finland - says that during the years of the AIDS scare in the 1980's more people were killed by the stigma than the disease itself (5). This unfortunately applies to homelessness as well. It is stigma that prevents the homeless from accessing much needed social and health services not to mention housing itself. There are currently 2500 chronic homeless in Finland and 60% of them live in Helsinki.

The importance of housing within an interdisciplinary approach

The complexity of homelessness has led to a lot of research and practical trials and projects on how to best deal with different homelessness cases around the world. The University of Oxford course on homelessness targets professionals working with the homeless. Two things that stand out about this course are the fact that there is no other course on homelessness enrolling professionals ranging from doctors to nurses to lobbyists to social workers to volunteers, in exchanging ideas and experiences together with world class experts. Secondly, the course provides a platform to gain knowledge and skills on how to better employ our existing working methods to suit the target group. This is facilitated by inter professional interaction and debate among the various professionals.

As professionals, we all agree that the only way to avoid the 'revolving door syndrome' which plagues the chronic homeless is to provide them with more suitable accommodation to allow stability and therefore better access to social and health care, including in terms of better conditions for treatment compliance. Also, it is important that professionals are aware of stigma and combat it. A year into this

much anticipated plan, "Oskari" is still on the streets moving from shelter to street to shelter, while temperature reaches -15 degrees Celsius.

Conclusion

The Finnish government Support Housing Project 2008-2011 is a much needed initiative to fight against chronic homelessness, but to be successful, it needs to address the NIMBI effect and gain a broader public support too. Next steps could be:

1. Having media as your partner

It is quite evident that private media is less likely to support social welfare efforts such as the Support Housing Plan because they live off ratings and papers sold (6). Public media, such as Finnish Broadcasting Company (YLE) for example, could make partnerships to promote the cause. It is a two way stream, if the YLE wants to survive they need to make partnerships with civil society and causes that justify their existence among private media.

2. Training responsible professional against stigma.

It is important to highlight the value of anti stigma campaigns among professionals that deal with this vulnerable group of homeless. To break the cycle of stigma and social exclusion, we must begin with the professionals that work with this group ranging from doctors to nurses to social workers to hostel wardens to receptionists. It is also evident that to be of better service to this group, all professionals involved should work together.

This would clearly have an effect as we belong to this group of the educated that are so much against the support housing programme in their neighbourhoods. The stigmatisation of this group primarily by the professionals that are in contact with them is the biggest enabler of chronic homelessness. The more we shun this group, the deeper they get engrossed into homelessness they are, which not only puts a strain on themselves, but on society as well primarily at the health system. As their problems become more complex, so do their health needs.

3. Inter professional networking to combat the revolving door syndrome

Assertive outreach programmes and community work based methods would yield more results in fighting homelessness. At VVA ry (Vailla Vakinaista Asuntoa), there is an outreach bus project (Yökiittäjä) which has proved to be very successful. Yökiittäjä is a nightly support centre for the homeless, offering information services on social benefits and a warm café with snacks. Also some nursing services and first aid are available. The bus has certain stops during the night in Helsinki and the near district. This is the only such project in the city of Helsinki.

One of the vices of the Social Welfare system in Finland is the bureaucracy and no community work based methods, therefore leaving this responsibility to 3rd sector organisations like VVA ry. We clearly need to adopt new working methods. Either the Social Welfare system should adopt new working methods and employ a more hands on approach or then the 3rd sector should be met with much increased funding.

The revolving door syndrome needs to be addressed and the University of Oxford Programme offers a unique example on how to plan and execute strategies considering all the complexities related to homelessness.

There is a Ndebele proverb that says good luck does not come twice. We are in a very fortunate position to have a national plan to eradicate long-term homelessness. And thanks to existing research and practice, we have also the means to make sure that this opportunity is not lost.

References

- (1) Ohjelmatyöryhmä AHKERAT Report, (10.1.2008) "Pitkäaikaisasunnottomuuden poistaminen vuoteen 2015 mennessä - Pitkäaikaisasunnottomuuden vähentämishjelma", Helsinki.
- (2) Unemployment rate rose from 2% to be higher than 12% for 5 years between 1992-1997 (Wikipedia - Internet)
- (3) Timo Kopomaa, (2005) Naapuruussuvaitsevuus - Tuetun asumisen ja palvelutoiminnan yhteys lähiympäristöön, asukasvaikuttamiseen ja kaupunkisuunnitteluun, Ympäristöministeriö, Hankintakeskus, Helsinki.
- (4) Interview, Executive Director Saana Lehtonen, VVA ry, Helsinki, 30.12.2008.
- (5) Lithén, Outi (2 Jan. 2009), YLE Teema. YLE Television, Helsinki, (television program).
- (6) This conclusion was made in Council of Europe meeting on discrimination and media, Strassburg, 20.11.2008.

* Contact: tsvakayi@yahoo.co.uk.

Christmas with the homeless in Amsterdam

Katia Maas*

Salvation Army, Amsterdam, Netherlands

I started to work at the Salvation Army in Amsterdam in December 1995. Just after finishing my social studies, I was hired as a social worker in a shelter. In 1995 the winter was very harsh, so besides the 70 regular residents, the winter cold brought us 20 guests who slept in bunk beds in the living room. They had no place to stay, so during the cold nights they were welcomed in.

Being young and without any experience with homeless people, this first period was very shocking to me. My personal worries that month had to do with which clothes to wear at Christmas dinner and what to cook for my own family. The image I had of homeless people appeared to be much more shocking in reality. I remember feeling guilty about my insignificant problems, while listening to the stories of the lives of my clients. I was especially touched by those my own age that were homeless. I was surprised that their lives had developed in such a different, and much worse way than my own. The memory of my first December at the shelter gave me the ability to put things into perspective. I have learned to love working with these people and have developed a great deal of respect for their survival skills.

In December 2008, thirteen years later, I am now responsible for three residence hostels. Each hostel provides shelter and supported living for twenty men and women who have a long history of hard drug addiction and homelessness. In terms of service provision, teams consist of social workers and a nurse, who coach and support our clients in creating new perspectives on life. Every day we try to find the balance between working professionally and working with our heart. I think these aspects can be perfectly combined. The name for the shelters is 'Domus', which means 'home' in Latin, and this is exactly what we try to create for formerly homeless people. Most of the people who joined from the start are still with us and we consider this a small miracle.

As an important part of creating a feeling of 'home' for people who have never had a safe and warm home, is celebrating Christmas. December is the time of the year when families and friends come together. Over the last twelve years I have learned that December, and especially Christmas, can be a very difficult time for people who have dropped out from their own family and social networks. I try to



FEANTSA

The articles do not necessarily reflect the views of FEANTSA.

teach my teams that this should not be underestimated.

If you have been addicted to drugs for years, and have had no contacts with your family and friends for a long time, December will be the time of the year when you will feel most lonely. Moreover, due to the fact that our clients usually express their conscious and unconscious feelings of sadness with anger and aggression, this time of year makes them argue even more with each other and the staff than during the rest of the year. Knowing this, members

of my staff know that they have to be more patient and set boundaries in the most respectful way.

I wish that our clients may be able to feel and enjoy the special warmth and care we try to provide at Christmas. For our workers, I wish they are able to express all the patience and understanding in the most loving way, so everyone feels at home. That it is what Christmas should be about.

*Katia Maas is manager of Domus residence hostels for the homeless, Salvation Army Amsterdam. Contact: k.maas@legerdesheils.nl.

Events

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: jmoneill@btinternet.com

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

Date: 12 May 2009

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

Hudson Year Urban Health Conference, Amsterdam, Netherlands

Date: 6 April 2009

Information is available [here](#).

**FEANTSA is supported financially by the European Commission
The views expressed herein are those of the author(s) and the Commission is not
responsible for any use that may be made of the information contained herein.**



The FEANTSA ENHW Newsletter is supported by
the European Community Programme for Employment and Social Solidarity (2007-2013).

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.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries.

To that effect, PROGRESS purports at:

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

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