European Network of Homeless Health Workers (ENHW)

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The articles do not necessarily reflect the views of FEANTSA.

Articles from this publication can be quoted as long as the source is acknowledged.
Editorial

Stefania Del Zotto, Policy Officer, FEANTSA

Dear Readers,

I am pleased to share with you the different articles of the latest edition of the ENHW newsletter, which covers a wide variety of topics. These include: an analysis of, and ethical reflection on, how three Paris hospitals meet the needs of homeless service users and to which extent they respect their autonomy; an article on mental health among rough sleepers in London, including a call for evidence to better explore the relationship between mental ill health and street homelessness (see forum section too); an example of an innovative partnership of three organisations in Ireland that have set up a programme helping people who have completed drug rehabilitation to move on to independent living; the findings of a survey conducted with patients who smoke and are following a alcohol rehabilitation scheme at Rauxa association in Barcelona, which shows that giving up smoking seems to increase abstinence from alcohol; a multidisciplinary overview of evictions and the profiles of households at risk in different countries calling for better data for improved prevention, including on health and social related risk factors.

In the resources section, you will find information on new FEANTSA health related resources concerning alcohol, health inequalities and tuberculosis; details about an Internet based translation tool aimed at health professionals working with non native speaker patients; references to a recent article showing that permanent housing for homeless patients with drinking problems can help reduce medical and social costs; a link to a policy brief devoted to access to health care for people with mental disorders in Europe; as well as a link to resources relating to human rights and health care.

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 happy to receive relevant research you are aware of, which might be suitable either for the next issue of the Newsletter or for our Resource page on homelessness and health.

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 language barriers, and to facilitate exchange, is to give an opportunity to people 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 about 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

What Homeless people expect from hospitals: results of an ethics study about patients’ autonomy

Emma Beetlestonne (1), Patricia Serres (1), Julie D’Haussy (1), Hélène Léger Dechamps (3) Alain Mercuel (2) and Véronique Fournier (1)*,
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Background

As a clinical ethics centre, we are very much concerned with the ethical reasoning that leads to medical decisions, and especially with the place to be given to the principle of the respect of patients’ autonomy in balance with the other important ethical principles of beneficence, non maleficence and justice. Having been consulted on medical
decisions to be taken for homeless and poor people, we wondered if this balance should be the same as than the one used in other cases or not. The issue was the following: do homeless or poor people need some specific protection due to their specific vulnerability or should their autonomy and the expression of their wishes be respected as much as for other patients? Is their autonomy so much reduced because of poverty and difficult living conditions, that we should not consider them as competent of taking a decision on their health and treatment? For example, we had strong debates in our ethics group, on whether we were allowed to send a homeless patient to hospital against his will just in order to be sure he would receive his drugs properly under good observance, or whether we should go and meet people living in the street and “force” them to receive psychiatric care even though they did not ask for it nor want it.

Facing such questions, we decided to go on the spot and ask the concerned people what they thought. This is the perspective of the study presented below:

**Patients and methods**

The study was conducted in Paris in three different medical care settings, all of them being involved in the treatment of homeless patients in one way or another. The first setting (Site 1) was the emergency room of a general urban hospital; the second one (Site 2) was an out-patients hospital setting, open to everyone without any conditions for access and so far welcoming a lot of poor and/or migrant and undocumented people; the third setting (Site 3) was a mental health and social exclusion service (SMES), located in a public urban hospital specialized in mental health care. Patients were considered homeless when declaring themselves without any stable home or daily accommodation, even when saying that they were living for a while with friends or relatives or in a hostel. The study consisted of a qualitative and prospective inquiry through clinical ethics interviews conducted by a physician together with a social scientist researcher. When arriving at one of the three study settings, the homeless patient was met by the ethics team as well as a member of the medical staff receiving him.

The interviews were conducted in order to better understand: (i) from the patients: what do they expect from the hospital; to what extent they were concerned by their autonomy, what the concept meant for them, whether they felt that there was a link between their health status and their autonomy and whether it was important for them to be respected in their wishes by the hospital; (ii) from the health care workers the goal of the interviews was to explore how much they felt they had to respect patients’ wishes and autonomy, was it the same question and how they ethically argued about their medical decisions, facing such patients.

Then, a quantitative analysis of the socio-demographic and medical data as well as a qualitative analysis of the content of the interviews were undertaken.

**Results**

54 patients participated in the study: 19 at Site 1, 18 at Site 2, and 17 at Site 3. Although samples are too small to allow for any statistical analysis, populations seem to be quite different between the three sites regarding patients’ socio-demographic profile and expectations as well as the health care strategy proposed by each setting.

In Site 1, the population is the most marginalized one: 74% of the patients live on the street and have been living there for a long time (54% for more than 5 years), 89% are alcoholic and 60% have mental health symptoms. Even if they come to the same setting repeatedly, each time their requests mainly deal with urgent somatic and highly focused care. They express their autonomy by choosing to stay or not in hospital up until the point of being treated. The health care workers said that they felt disarmed facing such patients, because of the lack of appropriate means and specific knowledge for taking adequate care of them. They thought that it was not their mission to solve the societal issues that such people reveal. They used to let the patients leave the setting even if not being treated. They considered that this might be the best way to still respect them as people, even if their first ethical choice would be to cure and/or care for them properly.

In Site 2, only 11% of the homeless patients who participated in the study lived on the street, even if most of them do not live in satisfying and stable accommodation. 67% of patients were undocumented migrants. Their medical status seemed less serious in comparison with the population in Site 1. It appeared that they were
consulting in the same way that they would have gone to their general practitioner. They expressed needs of general medical care. They come for different somatic iterative minor or less minor purposes. They said they appreciated very much the free, anonymous and easy conditions of access. Besides their medical demands, they were very much concerned by their difficult living conditions, poverty and precariousness. They felt that those were a hindrance to their autonomy. Yet, they did not expect the hospital to help them solve these kind of problems, they said that this was not its mission. The setting firstly answers on medical grounds. But, the health care team is quite concerned by the frequent patients’ vulnerability and isolation, they gave them new appointments, again and again, in order to try to build a sort of social link. The way they respected homeless people’s autonomy relied on a deep consideration of their personal pejorative situations and on maximizing the therapeutic and humanitarian impact of the doctor-patient relationship.

In Site 3, even if they can be classified as poor and “homeless” as the patients in Site 1 or 2, less than 1% of the patients live out on the street. But 83% of them had mental symptoms, actually they are coming or addressed to this specific service because of their mental symptoms. They expected from the service that it would take care of them. Their demand was not very precise and health focused. They felt they needed some help to be restored in their whole autonomy: psychically as well as socially and personally. They were happy with a global and holistic caring strategy. The SMES answer is in great adequacy with this demand. The whole team, composed of social workers, doctors, nurses, psychologists and psychiatrists is committed and convinced that they should act in a very active and coordinated way. Patients are supported in a comprehensive way and backed up for long periods for all their different social as well as medical somatic and psychic needs. Paradoxically, the team, even if acting in a quite over-protective and surrounding manner is very much concerned by patients’ autonomy: they think their mission is to restore it and that the core-point for beginning is the strength and quality of the doctor-patient relationship.

Discussion

The study cannot be conclusive because of its methodological limits, but two points at least deserve to be highlighted:

1. The “structure-effect”: patients’ requests seem to be in strict accordance with the setting, whatever the setting is: is that because patients know where to go to get what they want and choose a setting to address their specific request according to their needs? Or is it that they are led to ask what they are expected to ask, in accordance to the framework of the setting they are requesting from?
2. The “autonomy approach”: the study questions how hospitals take care of homeless patients, starting from what they claim to expect from them. It could help health care workers receiving such patients to rethink their daily clinical practices more from the autonomy perspective than from a strict beneficent medical one. It could be interesting to accept a wider view of what autonomy is than a more restrictive one, reduced to the self determination of ones’ own needs. From such a perspective, the Site 3 approach that pursues to restore the person in her whole autonomy besides giving her medical care is quite remarkable.

Conclusion

Our core question was about homeless patients’ autonomy and to what extent it should be respected. The study leads to two different possible interpretations. It is not possible for us to decide at this point which one is the truest one.

The first one could be called the respective one: the less the patients are excluded, the more they ask for a complete, even quite over-protective and interventionist care to be restored in their autonomy. More excluded and marginalized people ask for less and minimal care, they focused on their strict somatic and urgent medical issues, and leave hospital once they get what they came for or once they understand that they will not obtain it. They will not accept an overprotective and more interventionist care and they jealously defend their remaining autonomy. So, we can conclude that homeless people are quite autonomous and know exactly what they want. As a consequence, hospital should then only propose what patients request from it.

The second one could be called the interventionist one: it leads us to consider that the means of caring for poor and marginalized people should be
attributed in exact proportion with the extent of their precariousness, not to be overprotective at once but to propose different ways of meeting and helping them in their daily life, far from only their health care needs. The objective would be to use the opportunity of their requesting health care to try to actually meet them as persons more than as patients. This point of view encourages the promotion of all the efforts to build a deep and strong doctor-patient relationship as a useful first step towards autonomy enhancement.

Call for evidence on mental health and homelessness: views on best practice

Peter Cockersell*
St Mungo's, London, UK

St Mungo’s has launched a major consultation on mental health and homelessness. No one with a mental illness should be sleeping rough. The UK government has committed to reducing rough sleeping to zero by 2012. While a welcome ambition, we believe there is a clear danger that this target won’t be achieved unless we address the continuing problem of mental ill health, which both causes and prolongs street homelessness.

Despite the efforts of many voluntary and statutory agencies, the proportion of people sleeping on the streets who are reckoned to have a diagnosed mental illness has remained pretty static at about 35 per cent for at least the last 15 years.

Moreover, a survey in one of our hostels by a clinical psychologist found levels of up to 85 per cent of clients met clinical criteria for personality disorders; around 40 per cent for anxiety disorder; and around 25 per cent each with depressive disorder or post-traumatic stress disorder (PTSD). All also had substance use problems, and were characterised by ‘avoidant’ engagement patterns – in other words, they were actively help-shunning, not help-seeking, as part of their mental health condition.

This means that their contact with services is sporadic, not consistent, but they are often discharged by the very services supposed to help them for failing to attend appointments, for example, even though this behaviour can be considered one of their ‘symptoms’. As one clinician put it, they are not so much ‘hard to reach’ – most of them are known to many statutory and voluntary agencies – but ‘easy to ignore’.

But why a Call for Evidence?

Hasn’t everything been said about mental health and homelessness? We don’t think so.

The aim of the Call for Evidence is to gather the most expert range of views possible on the causes of homelessness amongst people with mental ill health, on the links between mental ill health and homelessness, on what helps prevent or resolve homelessness among people with mental health problems, and examples of best practice that work. We think there are new insights into mental health and homelessness, and innovative ways of working that can make a real difference, both in prevention and treatment.

Last year St Mungo’s published a Health Strategy. Within it, we highlighted the need to work with all the psychological disorders – severe depression/anxiety, post-traumatic stress disorder, and personality disorder – and to find ways of ensuring access to treatment for these as well as for the ‘classical’ psychiatric illnesses. We also have to work with people who have mental ill health and substance dependency, if we are to tackle homelessness.

Some of the key practical approaches we think would make a real difference to people with mental health problems, and which we identified in our Health Strategy, are:

- Assessment of mental wellbeing as part of the person’s Health Check – every homeless person...
should have a thorough health check within a short period of arrival in a hostel

- Accompaniment – peer support to go places, from appointments with clinicians to shopping trips

- Advocacy – to ensure that people who are so unheard have their voice heard

- Access to Psychological Therapies – there is very strong evidence that attachment disorders and long histories of trauma underlie most mental ill health and most chronic homelessness. There is also evidence that psychotherapy is an effective treatment, and psychotherapists need to work with people with substance dependencies as well as mental ill health.

- Access to specialist workers in hostels – people with histories of chronic exclusion need periods of intensive support by someone who understands what’s going on for them

- Increased housing options – different housing solutions work for different people: not everyone wants a self-contained apartment. Many long-term rough sleepers prefer a more interdependent form of living, such as small shared houses.

- Opportunities for occupation, including training and employment – having something purposeful to do gives status and meaning to life, and both have significant impacts on mental wellbeing

- Increased user involvement and participation – if people are given responsibility and more say in how their own lives are directed, they grow stronger and their mental resilience increases

- Improved staff/management training and support through reflective practice groups – we recognise the difficulties that arise for staff groups working with people with significant psychological damage, and the need for a safe, facilitated space in which to process these feelings

- Provision of training on working with rough sleepers and homeless people, and people with complex needs, to health professionals – we have an expertise often not shared by statutory services many of whom do not work with, or do not work intensively with, the multiple needs client group.

There are, no doubt, more innovative or just plain effective ways of working that we or other providers of services to homeless people don’t know about, and this is one of the key reasons for the Call for Evidence. We want to know about your best practice.

We also believe that there is room for a greater understanding of the aetiology of homelessness, especially the chronic homelessness apparent in long-term rough sleeping. We think a greater understanding of mental health and its relationship to homelessness will play a crucial part in this.

We hope that one of the outcomes of our Lifeworks psychotherapy service, which works with homeless people from St Mungo’s projects, as well as with chronically excluded adults in the psychiatric system, will be a greater understanding of the psychological factors causing homelessness. Early results show that our Lifeworks clients are characterised by very high levels of childhood abuse combined with early and repeated traumatic events: we would argue that much of the behaviours of so-called ‘chaotic’ and ‘difficult’ clients are explicable in terms of severe attachment disorders and responses to chronic trauma. This in turn indicates effective ways of working with them.

When the causes of mental ill health and homelessness are better understood, we hope that better treatment systems will be put in place, and that scarce resources can be more effectively targeted. In this way, the target of ending rough sleeping by 2012 – or certainly of nobody with mental health problems rough sleeping by 2012 – can really be met.

The Call for Evidence findings will feed into a major report that will be published in autumn 2009. We look forward to hearing from you, and sharing with you, the results of this consultation.

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If you would like to contribute, please read the “Forum” section of this Newsletter.

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Rationale

Taking a step in the right direction: drug rehabilitation and independent living

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The relationship between homelessness and drug use is complex. Whether homelessness or drug use comes first, it is clear that they are interrelated in terms of risk behaviour, which further exacerbates personal difficulties.

Research in Ireland has indicated that drug treatment for people experiencing homelessness can have positive outcomes, particularly when provided in conjunction with support to address the person’s housing needs (1). Lifestyle factors, such as appropriate and secure housing, can be a determining factor in ensuring that people who have successfully completed drug rehabilitation continue on their pathway to a stable, secure and healthy life experience.

It is clear from this that the co-ordination of drug and homeless services must be strategic and based on a partnership approach, in order to meet the multiple needs of persons that have experienced drug use and are at risk of homelessness. Partnership between service providers is key to ensuring that this vulnerable group can access effective integrated support, and are protected from falling between the gaps of various service responses.

Three organisations in Ireland – Keltoi, the Rehabilitation Integration Service (RIS) and Focus Ireland - have joined together to form an interrelated approach to rehabilitation called the ‘Step-Down’ programme. The success of this programme illustrates the need for intensive partnership work to support those most vulnerable to remain drug free, move on from homelessness and live independent lives.

RIS was established by the Health Service Executive (HSE) in 2000 to develop a co-ordinated and integrated response to individuals seeking to progress out of problem drug use. The service assists individuals by recognizing that rehabilitation is a process not an event. RIS assess, plan, broker and provide linkage for the client in line with their own aspirations, and meet and work with clients at all stages in their drug use. The service assists in accessing rehabilitation programmes, training, education, employment, housing, counselling and support services. RIS works with clients for a two year period, which can involve a drug detoxification programme and attendance at a residential drug rehabilitation unit (such as Keltoi).

Keltoi is a HSE residential therapeutic rehabilitation facility designed to meet the needs of former drug-users. The Keltoi model uses an innovative systematic approach whereby an environment is created in which clients can enhance their living skills. An outcome evaluation study completed in 2007 on the Keltoi programme found that 51% of respondents were alcohol and drug-free between one to three years post-completion of the residential component of the programme.

In 2004, Keltoi and RIS identified a number of people who had completed drug rehabilitation at Keltoi that did not have a secure and safe living environment to return to, and as a result were more likely to relapse within a short period of time. In addition, some people required accommodation and support before returning to independent living.

The HSE approached one of Ireland’s leading voluntary organisations working to prevent people becoming, remaining or returning to homelessness - Focus Ireland – to discuss the development of a partnership programme with Keltoi and RIS. A housing needs assessment was undertaken with a small sample of Keltoi residents, which confirmed that residents experienced accommodation difficulties, and all identified the need for a programme to assist them to “step down”.

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The Step-Down programme was launched in September 2005. Agreed policies and procedures, roles and responsibilities of each partner, criteria for acceptance onto the programme, and content for the programme were adopted by all partners. It was agreed that accommodation for the programme would be provided at one of Focus Ireland’s Dublin locations and that a maximum of seven units of accommodation would be available at any one time.

**A Seamless Service**

The aim of Step-Down is to provide a short term housing programme (lasting six months) to enable men and women who have completed drug rehabilitation to move into appropriate housing and live independently in a supported environment. Focus Ireland, Keltoi and RIS work in partnership to provide a seamless service to the client.

The objectives of the programme are:
- To provide clients with a programme of support that will assist them to develop their skills and capacity in making a home for themselves;
- To provide clients with accommodation as part of a programme so that they can experience managing a home;
- To address issues that may have contributed to their being out-of-home in the past or put them at risk of being homeless again in the future; and
- To support individuals in accessing move-on accommodation.

RIS refers people to Keltoi, where staff identify and nominate residents who may be suitable for the Step-Down programme, due to their accommodation needs.

**Supports**

Upon entry into the programme, each customer is allocated a Focus Ireland project worker, who they meet with individually on a weekly basis and who provides support with any personal and social needs. The customer also continues to meet with their RIS case worker on a regular basis, and is encouraged to attend weekly aftercare sessions at Keltoi and to meet with their Keltoi key worker.

The customer must also attend a monthly review meeting with their Focus Ireland project work and RIS officer.

**Activities**

Each customer attends an appropriate day-time programme on a full time basis during weekdays. The customer also attends two facilitated group sessions per week, which assist them in educational and personal development, as well as home management skills for independent living.

**Move-On Accommodation**

Step-Down participants are responsible for the payment of rent and other household services while staying at the programme. This responsibility assists customers in building their household management skills and confidence in living independently.

Towards the end of the six month programme, Step-Down customers are assisted by Focus Ireland project workers in sourcing independent living arrangements. This is usually private rented accommodation or in some situations (where Focus Ireland staff have assessed the customer as not being fully ready to live independently) supported accommodation.

A Tenancy Support worker is provided to each customer by Focus Ireland for up to six months after they leave the programme and RIS also continue to work with customers for another year after they have finished the Step-Down programme.

The partnership approach to the delivery of this programme is key to providing a ‘seamless’ service to Step-Down customers. Staff from the three agencies work closely with each other on a day to day basis to deliver the programme successfully.

**Success**

Focus Ireland commissioned an external evaluation of this pilot programme in 2007 (2), which found that the programme is essential in ensuring that persons who have completed drug rehabilitation programmes are supported in moving on from homelessness in Ireland. The programme has a high success rate, with the majority of customers remaining drug-free and moving on to independent living.

Staff described the relationship between the three programme agencies as “open and transparent” and “flexible”. Customers stated that the programme gave them the opportunity to “start afresh” and get back to independent living.
The Step-Down programme has successfully brought together the expertise of the homeless, housing and drug rehabilitation sectors in Ireland.

Challenges

It is clear that the Step-Down programme is a successful new initiative for the three partner agencies. However, access to suitable permanent accommodation for people who have completed the programme has been, and continues to be, a major issue for the programme staff. “The fundamental problem of insufficient supply of affordable, good quality and secure long-term accommodation remains” (3) in Ireland.

The intention of the programme is that customers are able to live independently at the end of the six-month period and move-on to accommodation, such as a privately rented apartment or social housing. However, in reality the last few months of the programme can be a challenging and stressful time for both customers and staff in accessing accommodation.

Focus Ireland is continuing to lobby and advocate the Irish Government for better housing options, particularly for single persons. It is clear that the challenge for accessing move-on accommodation is the lack of affordable and good quality housing in Ireland, and this issue is not just specific to the Step-Down programme.

Continuing to Take Steps in the Right Direction

The Step-Down programme has supported people who have overcome drug addiction to remain drug-free and move-on from homelessness. At the end of the programme’s pilot period, the customers who had completed the programme were in good emotional, mental and physical health; had good interaction and socialisation skills; had the ability to manage a home; and were involved in training, education and / or employment.

The three partner agencies have made considerable efforts to discuss and address any issues that were identified during the two-year period of the pilot programme. Coolmine Therapeutic Community has recently become a referral partner for the programme along with Keltoi, and Step-Down is being expanding to 12 units at another Focus Ireland Dublin location in 2009. This partnership approach to the provision of multiple services to customers with a variety of needs is clearly working.

Ireland is currently facing difficult economic times and now, more than ever, it is vital to protect and invest in those who are most vulnerable in society. Supporting people who have successfully overcome addiction is essential. One of Step-Down’s previous customers, who has successfully moved on from homelessness, concludes that “Step-Down gives you a place to go at a crucial time. It’s a life and death thing, this programme saves lives”.

References

(2) (2008) Focus Ireland Step-Down Programme, George’s Hill, Evaluation Report, Focus Ireland, Dublin
(3) Focus Ireland Strategy 2,010 by 2010: a home a day for thousands who are homeless

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Tobacco treatment for homeless people undergoing alcohol rehabilitation at Rauxa association

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Associació Rauxa, Barcelona, Spain

Summary

Tobacco consumption is the first avoidable cause of death and sickness in developed countries. Also, it has been demonstrated that tobacco abuse and dependency are the most frequent reasons for death amongst former alcohol dependent patients; in the same vein, the relationship between nicotine dependency and a higher risk of damage due to alcohol is evident.

On the other hand, tobacco consumption amongst alcohol addicted people is very high and research shows that there is an interest in quitting smoking amongst users suffering from alcohol addiction; the same happens with people who are homeless.
Homeless people start smoking cigarettes earlier and have more difficulties quitting. As a result, this population faces higher risks in terms of tobacco related illness.

The high rates of morbidity and mortality amongst smoking alcohol addicted patients are a factor in favour of tobacco treatment, the advantage being that quitting smoking seems to increase abstinence from alcohol beverages.

The survey was conducted with a group of patients suffering from alcohol dependence who were following a rehabilitation scheme at Rauxa.

Health and medical care of single homeless people in Germany

Gerhard Trabert *
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Abstract
In Germany the homeless population is increasing steadily. Featuring prominently among those on the increase are women, young persons and homeless people from Eastern Germany. Studies concerning the health of homeless individuals in recent years show that incidence of illness is far higher for many disorders than for comparable groups who are housed. The results from many studies in Germany show that more than 90% of homeless people urgently need medical treatment. According to research, the main health problems of the homeless are: coronary artery disease and hypertension (40-60%), skin-disease (scabies, lice, leg ulcers, abscesses, pyoderma) and acute infections (50-70%), lower respiratory tract diseases (COAD) (45-65%) and trauma victims (50%), followed by liver diseases (30-50%), kidney diseases (25-30%) and gastrointestinal disease (GU) (20-40%). Problems of alcoholism and mental disorders of various sorts need to be added to this picture. Violence against homeless people is increasing. Many homeless people are faced with multi-morbidity.

The relationship between the duration of homelessness and the state of illness did not appear to be linear. It was found that at the beginning of homelessness most homeless people were in a poor physical condition. The poor physical condition of homeless people does not stem from only one cause, but results from a combination of different factors: individual social conditions (social class; social relations; sedentary lifestyle), personal or family life crises (life events and coping behaviour), the individual risk behaviour (for instance the unusual sleeping conditions, alcohol and tobacco consumption), unemployment in a depressed economy, structure of the society (cutbacks in government welfare and the social service programme).

As a result of negative experiences with existing medical institutions, homeless persons do not consult a doctor or do so too late. Many are afraid of large institutions; most are not members of a health insurance scheme (are uninsured); and many are perceived in some sense to be “undesirable” as patients.

Medical care offered to homeless people must be re-examined and changed in accordance with the requirements of the patients and the acceptability of the measures. Health care for the homeless is urgently needed. It is an urgent necessity to create special low threshold medical care institutions. These health care services should be made available to homeless persons at the places where they gather (for example, through setting up a mobile medical service, medical street work, medical care ambulances). The interdisciplinary team approach, which integrates the skills of physicians, nurses and social workers, is an invaluable strategy for establishing thorough and continuous care.

A related article is available in German.
The magnitude of evictions and the households at risk: lessons for prevention

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Introduction

Evictions can be viewed from many perspectives. For this article, the knowledge and experience in housing sciences, social sciences and public health were integrated. Although evictions are an important contributor to homelessness, systematic data on evictions is few and far between. Available statistics do, however, point at rent arrears as the main factor triggering evictions. With the deepening recession leading to rapidly rising unemployment, many tenants will find themselves hit by suddenly reduced incomes bringing a greatly increased risk of falling into rent arrears. As a consequence, eviction numbers are likely to rise and this will have an impact on people’s health.

Magnitude of evictions

What do we mean exactly by ‘eviction’? This is something more specific than simply the end of a tenancy contract determined by a landlord. The term implies a situation where a tenancy is brought to an end ‘prematurely’ by landlord action. A similar scenario is re-possession of a mortgaged home by the lending agency. Lender re-possessions are certain to rise as the recession bites. In the UK, for example, lender re-possessions have already risen sharply since the beginning of 2008, just as they did in the last major economic downturn in the early 1990s (Wilcox, 2008). As on that occasion, mortgage-defaulting households are likely to swell the homelessness numbers over coming months. In the remainder of this article, however, we will focus on tenant evictions.

Private tenant evictions are a bigger issue in countries where – as is typical in Northern Europe – tenancies tend to carry substantial legal security of tenure. In countries like the US and the UK, by contrast, most private tenancies are of short duration and landlords enjoy substantial freedom to bring tenancies to an end without resort to any legal action. In the UK, for example, most tenancies provide security of tenure for only six months, with landlords subsequently free to terminate at will. This would not be termed ‘eviction’. In Britain, therefore, recent policy debates on tenant eviction have tended to focus on re-possessions in the social rented sector where most tenants enjoy open-ended security of tenure which can be ended only where the landlord convinces a court that the tenant has breached their tenancy agreement. In the Netherlands and Sweden all landlords need to pass courts to evict their tenants.

Available data

Some studies, often only available in local languages, give a preliminary estimate of the magnitude of the problem. In Australia, there are an estimated 100,000 “bailiff assisted” evictions each year (Beer et al. 2006). Over the last decade the scale of evictions and homelessness in Canada is described by some as having evolved into a national crisis, although national figures are not available (Lapointe 2004), and in the US evictions are believed to number many millions, annually (Hartman & Robinson 2003). In the 1990s FEANTSA observers in 15 European countries estimated that 1.6 million people were subjected to re-possession procedures each year, with 400,000 actually being evicted. Victims of eviction form an important element within what was, at that time, estimated as 2.7 million homeless people rotating between family, short term accommodations and services for homeless people (Avramov, 1996).

What data are available to indicate the extent and trend of evictions in Europe? Time series data collected after the 1990s are largely incomplete. Most of the national and local data available suggest that evictions have increased over the past decade or so. In the Netherlands, for example, evictions in the large social housing sector (2.4 million dwellings) rose from 6,020 (0.25 percent of dwellings) in 1995 to 8,550 (0.34 percent) in 2007.
(Aedes 2009). In Amsterdam (310,000 rented homes) over the five years to 2006 evictions increased by 23% to 1,429 (van Laere et al., 2008). During the same period tenant evictions in Antwerp, Belgium, rose by over 50% to 512 (Kristof 2007), while in Denmark, evictions rose by 73% to 2,589 in the four years to 2006 (Christensen & Nielsen 2008). In Finland, enforcement services received 3,000 eviction cases in the 1980s, and just short of 7,700 in 2003, of which 1,300 were factually evicted (Solovaara-Karstu & Mutililanen 2004).

Swedish data are more comprehensive and it is possible to continuously follow the number of evictions since 1982 (Stenberg 1991). Having fluctuated around 5,000 per year during the 1980s evictions increased to 7,500 in 1993-1995. This reflected a severe economic crisis causing historically high levels of unemployment combined with an overhaul of the financing system of the housing making it more market-oriented and leading to substantial rent increases. Since peaking in 1994, however, evictions have constantly decreased and by 2008 were running at only 3,000 - the lowest level in 25 years. These figures represent 0.9 and 0.4 percent of dwellings in public housing. As this decrease has been parallel to stricter demands on new tenants (permanent employment, no outstanding credits etc) it is not necessary a good sign. It might also indicate that fewer low income households acquire leases.

In the UK, the late 1990s saw a sharp increase in social landlord evictions, with re-possession actions entered in court by social landlords in England rising by 130 per cent in the seven years to 2001 (Pawson et al, 2004). Recent data suggests that evictions by English housing associations peaked in 2004/05 and that the past few years have seen significant reductions in evictions by both housing associations and local authorities. Research evidence suggests that this reflects more structured and professional rent arrears management techniques – in part, a response to central government’s post-2002 emphasis on homelessness prevention (Pawson, 2007). All the same, with annual re-possession rates remaining at 0.4-0.5% of dwellings, this means almost 20,000 households continue to be ejected from social housing each year – a figure which might well begin to rise again with the onset of recession.

Profile of households at risk of eviction

Although characteristics of households at risk of eviction have been described in the literature, utilisable service information is lacking about how to target those most at risk (Crane & Warnes 2006). The vast majority of evictions follow from the build-up of rent arrears and a much smaller number results from housing related nuisances and misbehaviour. Social landlord evictions for anti-social behaviour account for some 4-5% of the total in the Netherlands and Sweden, and some 5-10% in the UK (Aedes 2009, Flyghed & Stenberg, 1993; Nilsson & Flyghed, 2004, Pawson et al, 2004.) Either way, early signs of such problems should be recognized as signals to formulate active responses to unmet support needs.

A study among households in Amsterdam with rent arrears (n=275) and causing nuisance (n=190), showed that those most at risk of eviction were living alone, (65 percent in the rent arrears group and 74 percent in the nuisance group), were 25-44 years of age, and of Dutch origin (41 percent). Financial mismanagement and drug problems were independent risk factors for eviction (van Laere et al., 2008). In Toronto among 277 tenants facing an eviction, 31% were living single, most were in the 25-44 age group and 55% were Canadian (Lapointe, 2004). In Australia, the percentage living alone among 145 evictees was 33% (Beer et al., 2006).

In Sweden, Germany (Mannheim) and the US (Michigan) similar demographic profiles were observed among households at risk of eviction. Social and medical problems differed slightly, possibly also as a result of the methodology. In Sweden, households with a criminal record, a dysfunctional family background, serious financial difficulties and poor health were overrepresented among those evicted (Stenberg 1990; Flyghed & Stenberg 1993). In Mannheim, the sample was restricted to the mentally ill, and unemployment and alcoholism were found to be risk factors for becoming homeless after eviction (Salize et al., 2006). In Michigan, the sample was restricted to female welfare recipients, and a low level of education and use of hard drugs were risk factors for eviction (Phinney et al., 2007).

These data show that those at risk of eviction are often single, between 25 and 44 years old, and struggling with underlying social and medical problems that might lead into a pathway of eviction, and, as a consequence, towards homelessness (Crane & Warnes 2000; van Laere et al., 2009). In

The articles do not necessarily reflect the views of FEANTSA.

Articles from this publication can be quoted as long as the source is acknowledged.
Britain, however, recent survey evidence shows that around 140,000 families with children (2% of all families) are at substantially greater than average risk of homelessness and other social problems (Social Exclusion Taskforce, 2008).

Regarding causes of homelessness, most cases involve personal problems and incapacies, policy gaps and service delivery defects. Moreover, vulnerable people are being excluded because health and welfare services do not have the responsibility or resources to search for people with unmet treatment or support needs (Crane et al., 2006). In a recession, however, with more people subject to eviction simply due to unexpected loss of employment, it is likely that a larger proportion of all evictions will involve people without a previous history of health or social problems.

Linked with a greater awareness of ‘risk factors’ (Bowen et al, 2008), there is a growing recognition in Europe that it makes sense both socially and economically for the state to actively identify vulnerable households and to target them for ‘early intervention’. (Thorpe 2008) In relation to the much larger numbers of families at risk of eviction for rent arrears, recent years have also seen social landlords placing much greater emphasis on early identification of emerging problems and on making personal contact with the families concerned – rather than relying on essentially ‘reactive’, impersonal correspondence.

Lessons for prevention

Comprehensive statistics based on clearly defined measures are a basic pre-requisite for efficient eviction prevention. Statistics about households at the margin of the housing market are often surprisingly rudimentary. National statistics usually cover numbers of dwellings, forms of tenure and ownership etc but tend to lack information about how households occupy these dwellings and about the incidence of social problems which place some households at much greater risk of losing their homes. We very seldom have figures about sub-lettings, lodgers, people locked in dysfunctional families due to lack of alternative dwellings, and homelessness statistics are, of course, mainly based on approximations.

The causes and consequences of eviction remain shrouded in a degree of mystery, partly because of the formidable practical and ethical problems posed in attempting to research such issues. In particular, while it would be highly desirable to track and interview a cohort of households subject to re-possession there are major obstacles to identifying, tracing and contacting such households following eviction.

Ideally, internationally comparable data should include statistics on 1) the process and timing of evictions (landlords’ notification to quit, applications to courts, courts’ decision, applications to bailiffs, abandoned dwellings and finally executed evictions) separately for each tenure, 2) the characteristics of the households concerned, and 3) the process, timing and effect of the assistance introduced. As regards more in-depth research, we see a strong case for re-running the FEANTSA 1990s observation on evictions in Europe (Avromov 1996).

In daily practice landlords, service providers and others should have a responsibility for monitoring and acting upon early indicators of households at risk of eviction (whether for rent arrears or nuisance) - e.g. by making referrals to local care networks. These local care networks should have the responsibility, resources and quality to cater for vulnerable people in the community.(Ng & McQuistion 2004). Case workers in the care networks should be trained to reach out and formulate an integral response to unmet care needs, among those at risk to fall into a status of social and medical exclusion (Holmdahl 2006; van Laere et al., 2008). Together we should keep more people at home!

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* The authors of the article are Igor van Laere, MD, doctor for homeless people, GGD Municipal Public Health Service, Dr.Valkenier outreach practice for homeless people in Amsterdam, the Netherlands; Steen & Stenberg, Professor, Swedish Institute for Social Research at Stockholm University, Sweden; Hal Pawson, Professor, School of the Built Environment, Heriot-Watt University, Edinburgh, UK. Contact Igor van Laere at laere@tiscali.nl.
New FEANTSA health related resources available online (in different languages)

FEANTSA has recently published a number of papers relating to health and homelessness, which can be downloaded from our web site:

1 Briefing paper on alcohol and homelessness: as part of its commitment in the framework of the European Alcohol and Health Forum, FEANTSA has started gathering relevant information relating to alcohol addiction and homelessness on a specific resource page and has issued a “toolkit”, aimed at raising awareness on the issue. The briefing paper is available in English and French.

We would very much like to hear your feedback: do you think the information contained in the briefing paper is useful? Is the format appropriate? Would you like to add relevant links to our resource page? Please do not hesitate to contact us about this.

2 Contribution on the Consultation on EU action to reduce health inequalities: this document has been submitted in view of a forthcoming communication to be published by the European Commission on this topic after the summer. The contribution is available in English.

3 Translation of the article on Tuberculosis control among homeless persons in the EU, which had been published in the last year’s summer issue of the ENHW Newsletter: the article is now available in English, French, Dutch and Romanian. We would like to thank the translators and ask anyone interested in translating it into his/her language to contact us.

Please do not hesitate to circulate the information to interested colleagues and to contact us, should you have any question.

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**Resources**

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**Traducmed: Internet based translation tool aimed at health professionals**

Charles Vanbelle*

Chambéry, France

I am a General Practitioner working in Chambéry, France, and part of my activities involve working with people in poverty, notably asylum seekers, homeless people and undocumented migrants. I am sensitive to the problems that migrants come across when they seek care, particularly those to do with language problems/barriers.

In patient care, some tools already exist to make communication easier – written tools, such as dictionaries and vocabulary lists, are sometimes difficult to use and are not very practical – and interpretation tools (such as interpretation via telephone or onsite interpreters) are very costly and more complex to put in place.

I felt that what was missing was an intermediary tool that could be used at any time of the day, and by all practitioners/carers.

I therefore developed a new tool, in collaboration with doctors from different structures who were in contact with foreign populations, to limit language problems. I created a website which gives standard, pre-recorded audio phrases from a medical consultation: http://www.traducmed.fr.

The website does not intend to replace the services of an interpreter, but it does allow practitioners to get by in an emergency medical situation, for free, 24 hours a day. They can draw quick medical, social and administrative conclusions immediately and can formulate an adequate response accordingly. It also allows the practitioner to evaluate the degree of medical urgency.

The pre-recorded questions are either ones that the patient can simply nod ‘yes’ or ‘no’ to, or they require some sort of action from the patient, such as pointing (for example, the question may be ‘show me where you are hurting.’) There are therefore no problems with translating the answers given.

The second objective of the website is to put patients at ease. In the course of doing a training with migrants, they explained to me their doubts and fears when confronted with a medical situation: they often did not know who the people present in the room were, they did not understand what was being done to them, nor how long they had to stay...
in hospital, etc. It therefore seemed to me to be pretty necessary to integrate phrases in the website that would explain things for the patient.

This site has been created with the help of volunteers. It is free and not is a money-making venture. Since it’s creation in 2006, the website has been visited 11,000 times and has about 1,000 regular, return visitors. Currently, the most used languages are Chinese, Russian, German and Arabic.

I have had some very positive feedback from doctors and other health care practitioners. This website is used by certain emergency services, health centres in deprived areas, in prisons, in detention centres…it is even consulted by practitioners in other francophone countries such as Belgium, Canada and Switzerland.

While doing research for the site, I discovered that Dr Laurent Goût had written about a database of questions in his thesis based on the same principles as mine, but more targeted towards the emergency services. I have added some of his phrases on Traducmed.

I envisage some developments for this project in the future. I also want to complete and improve the existing translations, and would like to increase the number of languages available by finding new volunteer translators. Finally, I would like to have the interface in Spanish and German so that the website can be used by foreign doctors. The web site contains an English section.

See the [web site](#). A [French version](#) of this article is available.

* Dr Charles Vanbelle’s contact: traducmed@free.fr

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The study, which has been published recently by the Journal of the American Medical Association (JAMA), shows that permanent housing for homeless patients with ongoing drinking problems can help reduce medical and social costs and contribute to lower alcohol consumption.

An abstract of the article is available on the [JAMA website](#).

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**Policy brief on Access to health care for people with mental disorders in Europe**, by Kristian Wahlbeck and Manfred Huber*

**Abstract**

Poverty and social exclusion continue to be serious challenges across the European Union. People with mental disorders are at high risk of poverty, stigmatisation and social exclusion. They are also more likely to face physical health problems and to die prematurely. There is evidence that they do not receive the general health care that best responds to their needs. Improved access to general health care is therefore essential to minimising disadvantage for people with mental disorders. This Policy Brief outlines hurdles of access to health care for people with mental disorders and discusses policy implications.

The results presented are part of a research project on “Quality in and Equality of Access to Healthcare Services” (HealthQUEST) that was financed by the European Commission. This study analysed barriers of access to mainstream healthcare services for people at risk of social exclusion as well as policies in Member States to mitigate these barriers. The study had a focus on three groups at risk: people with mental disorders, migrants and older people with functional limitations. Eight countries were studied in depth: Finland, Germany, Greece, the Netherlands, Poland, Romania, Spain and the United Kingdom.

Read the [policy brief](#).

*Kristian Wahlbeck is Research Professor at the JHL National Institute for Health and Welfare, Finland. Contact: kristian.wahlbeck@jhl.fi. Manfred Huber is Director Health and Care at the European Centre for Social Welfare Policy and Research, Vienna, Austria. Contact: huber@eurocentre.org.*
Human rights in health care: introduction and framework for local action

The UK Department of Health has made available online two interesting publications devoted to human rights and health care. The first one is a general introduction to the topic, while the second is a guidance document for local action.

Both documents are available on the Department of Health website.

Forum

Call 4 Evidence on mental health and homelessness

Deadline: 10 June 2009

As mentioned in the “Sharing experiences” section, St Mungo’s, London’s largest charity for homeless people, has launched a major consultation, a Call for Evidence, on mental health and homelessness.

The Call for Evidence findings will feed into a major report that will be published in autumn 2009. St Mungo’s looks forward to hearing from you, and sharing with you, the results of this consultation. Contribute to the Call for Evidence before 10 June at www.mungos.org/call4evidence or email: call4evidence@mungos.org.

Events

Information session on Influenza A (H1N1) aimed at the Homeless sector
Dublin, Ireland
Date: 28 May 2009

This event is organised by the Health Service Executive in relation to Influenza A (H1N1) and the precautions that can be taken to stop the flu spreading. For more information, please contact Liz Piggot Glynn at liz.piggotglynn@hse.ie.

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Rauxa Associació celebrates its 20th anniversary
Barcelona, Spain
Date: 21 June 2009

For more details, see relevant leaflet.

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European Action on Drugs, Launch event
Brussels, Belgium,
Date: 26 June 2009

The European Action on Drugs (EAD) is an action foreseen by the EU Action Plan on Drugs 2009-2012, designed to be a platform for all European public and private organisations, stakeholders, NGOs, citizens and anyone who already acts in this field or who wants to do so. It will complement the different drugs policies and actions in Member States, and will serve as a new tool for EU citizens and organisations, whatever their organisation, approach, national policy or attitude towards drugs. The EAD will be launched in Brussels on 26 June 2009.

For more details, including information about commitments, see web site or contact: info@action-drugs.eu (these will be activated before the event).

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Health Impact Assessment conference
Rotterdam, The Netherlands
Date: 14 - 16 October 2009

The relevant information is available here.

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Conference on Health Care and EU law
Nijmegen, The Netherlands
Date: 1 and 2 October 2009

The relevant information is available online.
The FEANTSA ENHW Newsletter is supported by

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](http://ec.europa.eu/employment_social/progress/index_en.html)