

European Network of Homeless Health Workers (ENHW)



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Editorial

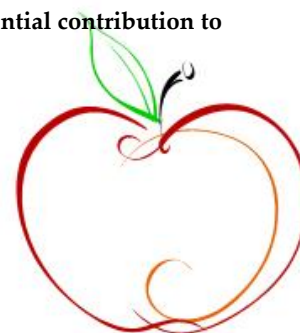
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Editorial

Editorial

Dearbhal Murphy, Policy Officer, FEANTSA

Dear Readers,

The first ENHW newsletter for 2008 is a very rich one, with a range of articles from all over Europe. This edition offers a particular focus on the issue of health care coverage for people who are homeless and some of the specific insurance/ care payment provisions that have been developed to meet the needs of this vulnerable group. Contributions from Spain (by Antonio Rodriguez), Ireland (by Austin O'Carroll) and the Netherlands (by Peter Rensen) offer an interesting and complementary focus on this area. They highlight how some efforts to improve access to care for homeless people still continue to fail them and how even packages especially put together for vulnerable groups may still prove difficult to access for people who are homeless. The example from the Netherlands by Peter Rensen also highlights the surprising finding that a shift towards market-oriented and competition-based principles in the provision of health care insurance does not necessarily have a negative impact on vulnerable groups, where adequate safeguards and some flexibility in terms of solutions are built in from the outset.

There are a range of other great contributions bringing together the experience of health professionals working with homeless people in an outreach capacity. Of particular interest for mental health care workers may be the article "Wellness Recovery Action Planning" and its possible applicability for empowerment of people who are homeless and suffering from mental health problems. The next Health and Homelessness Conference in Oxford is also announced in this edition of the newsletter, so that will be a useful date to note in your diaries!

As always, I would like to extend my warmest thanks to all contributors who help to make this newsletter such an interesting and varied resource.

Finally, I must also inform you that sadly this will be the last edition of the ENHW newsletter that I edit. I will shortly be leaving FEANTSA and my colleague Stefania Del Zotto will assume responsibility for FEANTSA's work on health, including coordination of the ENHW. I am sure that the network will continue to go from strength to strength and I wish all of you the very best in your future efforts to exchange and learn from one another and to work towards comprehensive social and medical care for people who are homeless in Europe.

Should you have comments, questions or contributions for the ENHW newsletter, please take contact with Stefania Del Zotto (stefania.delzotto@feantsa.org).



The European Union and crossing borders for a Social Medical Union

Dr Igor Van Laere

Doctor for homeless people in Amsterdam

The leaders in countries that are part of the European Union have decided to make Europe a Monetary Union, with the aim of facilitating money crossing borders. It is about banking and business, marketing and economics, for financial protection. Since 2002, the EU partners have been sharing the same currency, the Euro, but do they share the same history? History, with traditions and local leaders and heroes, reflected in the images printed on former currencies, how are they united? What do EU countries have in common?

Is it possible, with the unification of money, that diversity and uniqueness of the traditions of EU countries, are fading away and being levelled out at interest rates and stock markets? Is it possible that the captains of politics and industry are occupational, with marketing- and economizing activities, for the sake of policy-palaces and courts? What does united money do to unite people and traditions? Does united money come with health, welfare and peace?

The Dutch Humanist Scholar Desiderus Erasmus (1469-1536) lived at a period of profound change, when every European country managed to go to war with another European country. In response to conflicts, in 1521, Erasmus wrote his *Querela Pacis*, the complaint of peace. In the introduction he states:

"...Though I certainly deserve no ill treatment from mortals, yet if the insults and repulses I receive were attended with any advantage to them, I would content myself with lamenting in silence my own unmerited indignities and man's injustice. But since, in driving me away from them, they remove the source of all human blessings, and let in a deluge of calamities on themselves, I am more inclined to bewail their misfortune, than complain of ill usage to myself; and I am reduced to the necessity of weeping over and commiserating those whom I wished to view rather as objects of indignation than of pity. For though rudely to reject one who loves them as I do, may appear to be savage cruelty; to feel an aversion for one who has deserved so well of them, base ingratitude; to trample on one who has nursed and fostered them with all a parent's care, an unnatural want

of filial affection; yet voluntarily to renounce so many and so great advantages as I always bring in my train, to go in quest of evils infinite in number and shocking in nature, how can I account for such perverse conduct, but by attributing it to downright madness? We may be angry with the wicked, but we can only pity the insane. What can I do but weep over them? And I weep over them the more bitterly, because they weep not for themselves. No part of their misfortune is more deplorable than their insensibility to it. It is one great step to convalescence to know the extent and inveteracy of a disease..."

What disease does Erasmus mean? Is it *social disease*; for which Erasmus proclaims he does not deserve ill treatment from mortals of marketing and economics? Is it *medical disease*; for which insanity Erasmus weeps, and salutes those nursing and fostering the dependent? Does Erasmus pity captains of politics and industry, those responsible to turn laws and rules of insensibility into sensibility, to make one great step to convalescence?

If we step through Paris, in times of aristocratic decline and democratic increase, we find a man who believes in the preservation of traditions that are the hallmarks of a civilised society. After his visit to England to observe and explore dependency, public welfare and the results of Poor Laws, Alexis de Tocqueville (1805-1859), in 1835, reflects on his step to convalescence in his *Memoir on Pauperism*. In the introduction he states:

"...When one crosses the various countries of Europe, one is struck by a very extraordinary and apparently inexplicable sight. The countries appearing to be most impoverished are those which in reality account for the fewest indigents, and among the peoples most admired for their opulence, one part of the population is obliged to rely on the gifts of the other in order to live. Cross the English countryside and you will think yourself transported into the Eden of modern civilisation—magnificently maintained roads, clean new houses, well-fed cattle roaming rich meadows, strong and healthy farmers, more dazzling wealth than in any country of the world, the most refined and gracious standard of the basic amenities of life to be found anywhere. There is a pervasive concern for well-being and leisure, an impression of universal prosperity which seems part of the very air you breathe. At every step in England there is something to make the tourist's heart leap. Now look



more closely at the villages; examine the parish registers, and you will discover with indescribable astonishment that one-sixth of the inhabitants of this flourishing kingdom live at the expense of public charity. Now, if you turn to Spain or even more to Portugal, you will be struck by a very different sight. You will see at every step an ignorant and coarse population; ill-fed, ill-clothed, living in the midst of a half-uncultivated countryside and in miserable dwellings. In Portugal, however, the number of indigents is insignificant..."

As a step to convalescence, De Tocqueville holds individual charity above public charity, for its bonding between helper and the dependent. Regarding public charity, he comments on the knowledge and experience needed among public servants that are sent to Eden, to separate the deserving from the undeserving poor.

Through the Eden of the Monetary Union, without borders, many poor from the east cross various countries in Europe in the west, often ill prepared and not appreciating the high cost of living on one hand, opposed to scant support possibilities of the local public charity services on the other. Ever changing public services, being pressured and squeezed by economics and marketing, affect the circumstances of those who fail to access and/or sustain housing and income, whether poor resident or immigrant, and conspire to both social and medical decay. As a result, European countries are

in growing need of social and medical workers without borders (FEANTSA - ENHW), to unite knowledge and experience to protect and nurse unique local traditions and provide the basic needs.

The leaders in countries that are part of the European Union should decide to make Europe a Social Medical Union, with the aim to facilitate people crossing borders with access to the basic needs, wherever people try to find their health. Unity and traditions are about people and possibilities, and social medical care, for human protection.

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Sharing Experiences

Health care insurance the Dutch way: Market principles, Pragmatic Provisions

By Peter Rensen

Trimbos-instituut Utrecht, The Netherlands

In the Netherlands two years ago, some fundamental changes occurred in the health care system. From January 2006, the Law on Health Care Insurance (*Zorgverzekeringswet*) adopted as a basic principle that all citizens of The Netherlands are individually responsible for taking out health care insurance. In addition, everybody is obliged to be insured. Those who are not, run the risk of a fine. Prior to the introduction of this new law, a large group of people had health insurance that was paid more or less automatically. The payment was done through the deduction of an amount of money from

their salary or social security benefits. In practice those who earned or received an amount of money beneath a certain fixed level were insured this way. This system was called: *Ziekenfonds*. The new Law was intended as a general measure to introduce greater competition between health insurance companies and, as a result of that, to ensure premiums that conform to market prices.

Although convinced of the general benefit of the Law, policy makers were afraid that the new Law would result in a growing number of uninsured people, especially vulnerable people, because they are not 'willing' or able to provide themselves with an insurance (Ministry of Health, Welfare and Sport, 2005). That's why the government asked the Trimbos-institute in Utrecht to research whether the new Law increased the number of uninsured homeless people in the four largest cities. The

resulting research report was published last year and some remarkable findings were collected in it (Rensen, 2007). First of all, we did some desk-research on existing material on the topic collected in the past. It became quite clear that the percentage of uninsured homeless people depends on the specific group of homeless people that under investigation. Among rough sleeping homeless people, the percentage who were uninsured used to be quite alarming (50%). Among those (residential) homeless people (ie: those living in 24 hours residential homeless services, the percentages were much more lower (15-25%). So prior to the introduction of the new law in 2006, the problem of not being insured against health care problems already existed, especially among those living in the street. This coincided with not having any income, which includes no social security benefits. No income meant no 'automatic' insurance. In principle all Dutch citizens were (and are) entitled to social security if they are not able to work or cannot find any work. Nonetheless, for a variety of personal and administrative reasons, a substantial part of the estimated 25.000 homeless people did not have any regular income and part of this group had no health insurance.

In spite of the fundamental changes, our research shows that the new Law did not have a major impact on the numbers of uninsured homeless people. The new Law obliges insurance companies to maintain as clients all people insured before January 2006. Together with Central Statistics Bureau in the Netherlands (*Centraal Bureau voor de Statistiek*), we did research via the (postal) addresses of people who are homeless in the four largest cities in the Netherlands. The percentage who are uninsured amongst this group amounts to 6% (of 6090 persons), which is relatively low and not very much higher than the 1,5% of the general Dutch public (Central Statistics Bureau Netherlands, 2007). This figure doesn't tell the whole story of course. The homeless people in greatest danger of becoming uninsured are those who have no address, not even a postal address. But this group seems to be diminishing because of an ambitious new Dutch programme against homelessness in the four largest cities, which aims to put all homeless people on an individual route for housing and rehabilitation. The new Law on Health Care Insurance takes as a starting point the individual responsibility for all people to make sure that they have health insurance. However, this starting point might be overruled where people are unable to insure themselves due to mental or social problems. More

than 400 cities and small cities, together with insurance companies, use this exception to offer a collective insurance to people on social security. All (ex-) homeless people in those cities are encouraged to take part in this 'collective contract' and their premium is 'automatically' paid to the insurance company. This means that quite a lot of socially vulnerable people get insured the moment they get social security, which in practice is very much similar to the situation before the introduction of the new Law. So, people already insured stay insured and an unknown number of people on social security will *become* insured against health care problems.

It seems strange that a new policy of encouraging individual responsibility and supporting market working leads to a diminishing number of vulnerable people who are uninsured. Still it is the Dutch reality at the moment. However, the question arises: will this continue to hold true? Our report warns about so-called 'hidden lack of insurance' of people who are homeless. Part of the Law is that it is forbidden for insurance companies to suspend or expel clients. In theory, it is therefore possible that a relatively large group of homeless people are subscribed as clients of various insurance companies, but are no longer paying premiums since January 2006. This means that the client is still entitled to basic medical aid and at the same time it means that he or she is building up a substantial debt through arrears, which might cause later problems. How many 'insured' homeless people are in default of payment is not known, because the insurance companies do not register homelessness.

The insurance companies acknowledge the problem of non-payment and they reached an agreement with the Ministry of Health, Welfare and Sport (*Ministerie van Volksgezondheid, Welzijn en Sport*) on this issue. In general: the insurance company is indeed obliged to retain clients, even where they fail to pay their insurance premiums. For the first six months the insurance company tries to force the defaulter to pay; after six months the Ministry takes over the financial risk of the insurance company. A new Law is in preparation to give the possibility to the ministry to put a claim on the income of the defaulter. During a congress organized by the Trimbos-institute in 2007 (<http://www.trimbos.nl/default22384.html>) representatives of the Ministry presented a proposal to make a distinction in the way they treat defaulters who are not *willing* to pay and those who

are not *able* to pay, like people with psychiatric problems.

During the same congress, representatives of cities, of medical care organisations and homeless service organisations were moderately positive regarding this outcome. For them, what is of greatest importance of course is that socially vulnerable people will not be excluded from medical care and of course that the necessary medical help will be available without exhausting paperwork for the social workers and first-line medical aid. In addition, the possibility of putting a claim on the income of non-payers would mean that the problem of huge debts is also tackled in advance.

Here we stand with a quite clear example of what I as a sociologist would call the unintentional outcome of intentional policy. A moderate right wing government introduced a Law to stimulate more market-oriented health care insurance system, in which personal responsibility is a leading principle. For better or worse, socially vulnerable defaulters end up with a deduction from their income, which in a way is the opposite of leaving it to themselves.

All in all, as far as people who are homeless are concerned, the general principle of the market at work, with the detailed conditions and provisions

relating to non-payment, has resulted in a policy in the Netherlands which, it would now seem, is broadly socially based.

Peter Rensen is a sociologist and scientific researcher at the Trimbos-institute in Utrecht (www.trimbos.nl), The Netherlands.

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An Overview of the "Document for Medical Care" in Madrid:

A system created to improve access to care for people who are undocumented and socially excluded

Antonio Rodriguez

President of Spanish Homeless NGO FACIAM

In the Community of Madrid there are many cases of people, both nationals and non-nationals, in a situation of social exclusion and in need of ongoing medical treatment. Often, these people have problems accessing medical care, as they are unable to procure an "Individual Sanitary Card" (Tarjeta Sanitaria Individual -TSI) through the standard procedures, as they do not have the documentation or meet the necessary requirements, according to the current rules, in order to be eligible for it. The TSI is the identification document that grants any Spanish person or resident in Spain access to the mainstream health care system. This system is universal and free for all citizens.

With a view to ensuring that people who find themselves in this situation can still access the care that they need, the Consumer and Health Council can issue them a document called the Document for Medical Care (Documento de atención sanitaria - DAS). It is issued on an exceptional basis, and following an examination of the individual circumstances, to see whether the person meets the requirements. It is intended to facilitate access to emergency health care services and primary care and is specifically aimed at people in a situation of social exclusion and in need of ongoing health care, living long-term in the Community of Madrid, but lacking any identity papers and apparently not registered in any municipality of the region of Madrid.

This measure is one of the actions undertaken by the Consumer and Health Council within the framework of the Plan against Social Exclusion in

the Community of Madrid 2002-2006 and was approved on the 18th of July 2006. The document allows them to accede to the same healthcare and in identical conditions to the rest of the citizens of the Community of Madrid. In addition to the individual benefits that it offers to the people concerned, the normalisation of access to care also allows public system the opportunity to come in contact with, and be aware of, health situations that may require additional sanitary control.

The requires in order to be eligible for the DAS are as follows:

- to suffer from a disease that requires treatment or follow-up of an ongoing nature;
- a recent diagnosis by a doctor registered in the public healthcare system;
- to be in situation of social exclusion, in contact with a social worker, but unable to access the general healthcare care through the standardised procedure;
- habitually resident in the Community of Madrid.

The situations of social exclusion that are detected through the treatment in emergency services and other welfare services, receive a special treatment on

the part of social workers in charge to offer social and health support to those concerned. After an initial evaluation of the case, there is an information-gathering procedure to gather the minimum data available concerning the situation that had been detected so that the patient will receive the necessary treatment in all the welfare levels. This includes establishing the need for ongoing medical treatment, exceeding just once-off, emergency treatment.

The validity of the document is provisional, based on whether the health circumstances that necessitated it are ongoing and also on whether the individual becomes eligible for the general Individual Sanitary Card (TSI) if they acquire the necessary documents. The validity of the DAS is six months, although it can be renewed or extended.

Up to now, 109 documents have been issued to facilitate medical assistance to people in situations of exclusion and unable to access care.

In any case, the philosophy behind this measure is to facilitate access to mainstream health care to excluded groups. In no way does it seek to create a parallel system of care for "poor people".

Ensuring Health Care Coverage for People who are Homeless in Ireland:

Recent and Necessary Reforms of the Medical Cards System.

Dr Austin Carroll,

Doctor for homeless people in Dublin

In Ireland entitlement to free primary health and dental care is dependant on income. When a person's income is below the means threshold they are issued with a medical-card. Entitlement to this is reviewed at one, three or five year intervals. This involves sending the patient a review-form by post which they must complete and return to the Health Authority. If the patient does not return the form, or their income has risen over the means barrier or they have died their entitlement is removed. Homeless people by definition (as all are on social welfare payments that are less than the means limit) are universally entitled to a medical-card.

In 1997 Holohan conducted a census of homeless people in Dublin and found that 45% did not have a medical-card.¹ The Health Authority reacted by developing a fast-track mechanism whereby homeless people would be issued with a medical-card within a week (the normal being 4-6 weeks). In 2005, we (O' Carroll and O' Reilly) repeated that census and found that 44% of homeless people did not have a card.² The Homeless Agency were surprised at this figure and repeated their own survey which confirmed the findings. So the question arose why did the fast track mechanism did not work.

Simultaneously, we (O' Carroll & O' Reilly) were conducting a research piece into deletions from our GP practice. In this practice over the period January 2004 – August 2006, 1489 patients had their medical card removed. The practice list varied between 1700 and 1850 over this period so this represented approximately a third of the practice being deleted

annually. Ninety-one (6%, 95%.CI 5-7%) of these were homeless and 69 (5%, 95%.CI 4-6%) were asylum-seekers, both groups of people who should automatically be entitled to a medical card. When we examined the reason for removal, 89% of the total group and 95% of those who were homeless were removed due to non return of their review form.

We took a 25% random sample of those seen between January and August 2006 (i.e. 70 patients including 5 homeless people) and conducted a telephone survey. Of these 42 responded (a 60% response rate) and none of the homeless people were contactable or locatable. Of this group, 60% (95%.CI 45-75%) said they did not receive a review form and the same amount said they had not been informed of the removal of their medical card. Ninety-one per-cent said they felt they were still entitled to a medical card and 67% (95%.CI.53-81%) had already re- applied and obtained their card within a 4 – 6 month time period. During the period without cover 11% had not obtained medical-card (5% did not attend their GP) due to cost. Over 30% had needed to pay for health care with costs ranging between 30 and 510 euro with a mean of 174 euro.³

So the answer to why the proportion of homeless people not being in possession of a medical-card was likely due to there being a hole in the bucket, those being added to the medical-card list being equalled by those who were being deleted. We since

discovered that when people were removed from the medical-card list when they re applied they were automatically issued only a one-year card. Thus, they were likely to face the same scenario after a further twelve months.

The results of this were brought to the attention of the Homeless Agency as soon as they were produced. As a result a new system has been developed whereby review forms are returned to a community welfare officer who will locate the homeless person and ensure the form is completed and returned. In addition since the publication of the resultant article the Health Authority is to meet ourselves and we are to explore other options such as issuing longer term medical-cards to homeless people and asylum-seekers. Hopefully the hole can be plugged.

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Specialised Health Care for People who are Homeless:

An Evaluation of the Rotterdam Street GP System

Agnes van der Poel and Luuk Krol



Homeless people generally suffer from problems with their physical and mental health. In order to improve the accessibility of health care for the homeless, this care is best offered 'on location'. In Rotterdam, with 600,000 inhabitants the second largest city of the Netherlands,

doctors and nurses hold GP hours at

10 day or night shelters. Seven doctors have united in a cooperative GP practice for the homeless, called 'the Street GP' (in Dutch: 'de Straatdokter'). With a weekly minimum of 16 GP hours, the Street GP practice has registered 1,196 unique patients over a period of three years (2004, 2005 and 2006). Of every patient an electronic file is made and all doctors have access to these files at all locations on the computer. The local Municipal Health Authority (MHA) wanted insight into the functioning of the Street GP. The Addiction Research Institute Rotterdam (IVO) conducted a study that answered the following main question: *How does the Street GP function?* In this article the results are summarized.

Street GP

For decades, GP care for the homeless was offered by a few doctors on their own account, encouraged by some Rotterdam shelters. In 2003 the Street GP

practice became official. The MHA is responsible for organizing the access to health care, including the Street GP. It does so by cooperating with several other local organizations, which are the Municipal Social Affairs and Employment department, the local cooperation of health care insurance companies, Basisberaad Rijnmond (a client participation platform of consumers of mental health care), and the four organizations that manage the local shelters (CVD, Salvation Army, Stichting Ontmoeting and NAS). From the start, the cooperation between representatives of these organizations in a so-called management group has been largely successful. The Street GP aims to reach 'actual homeless people' who – occasionally – sleep in night shelters, and 'residential homeless people' who visit day shelters (and who may or may not have a permanent abode). Additionally, homeless persons admitted to official shelter based nursing beds are Street GP's patients.

Patients and visits

First a few numbers that come from the study. In each of the three research periods (see boxed text) about 250 unique patients were seen by the Street GP doctors. The majority of the patients is male and aged over 40 years. About 75% has health insurance, leaving 25% with no insurance (including illegal immigrants). Two thirds of the patients visited a Street GP once or twice (over a period of three months). The mean number of contacts per patient has increased over the years from 2.4 to 2.7. An average consult takes about 25 minutes. In comparison: the Dutchman who visits a GP does that on average 5.0 times *per year*, with the mean duration of a consult being ten minutes.

Nurses: referring patients to GP

Besides the doctors, nurses also offer health care during nursing hours at the ten shelters. For four frequently occurring problems among the homeless, protocols were developed and implemented in the nursing care (in 2005): wound care/burns, lung diseases, feet problems, and skin abnormalities. Nurses – and doctors – evaluate the protocols as usable, practical and adequate. The fifth protocol, care for pregnant women and childbirth, is not used often because pregnancies do not occur frequently. It is mentioned that training in working with the protocols, especially for new nurses, is a point of attention. During nursing hours, if a nurse sees a patient who should be seen by a doctor, she puts the patient on the list for the next GP hour. In addition, some shelter visitors go to the Street GP on their own initiative. Patients claim that *"if something's*

wrong or you have something, you go see a nurse or a doctor". Furthermore, nurses are always present during the Street GP hours, assisting the doctor. *"Because the nurse is present, we can achieve more immersion, effectiveness and result"*, according to one doctor. It is clear that the referring of patients to the Street GP hours works better when a nurse is present for many hours at the shelter, preferably daily.

Research methods

- quantitative analysis of registration data (patient medical files) in three periods: September, October and November of the years 2004, 2005 and 2006
- qualitative interviews with and questionnaires among all doctors and nurses
- qualitative interviews with 20 patients

Complaints

Complaints about joints, lungs, skin and stomach were each expressed by 10-20% of the patients. The number of patients expressing psychic or psychological complaints has halved in 2006 (to 9%). Also, the number of patients with tramp's feet has decreased (to 10%). Keep in mind that the measured number of complaints does not show severity or complexity of the complaints. All doctors indicate that complaints are generally real and that the patients they see should indeed be seen by a doctor. In the course of time, there seems to have been a shift from acute complaints to chronic complaints with acute elements. Doctors attribute this to more stable (self) care and the better physical condition of the homeless. The improved housing for a large number of homeless persons in the past years seems to have contributed to this (the local administration made supported housing programmes a major priority). For example, tramp's feet and scabies are reported less frequently. Also, the group is aging and this results in specific (chronic) complaints of old age, like diabetes. Furthermore, the chronicity of complaints, related to protracted alcohol and drug use e.g. chronic stomach and lung complaints, is likely to increase rather than decrease. Compliance, especially regarding medication intake, will become more important than it already is. In fact, nurses play a key role in this.

Medication

In 2004, 44% of the patients were prescribed medication; in 2006, this percentage has decreased to 28%. The majority of them took one prescription; mostly antibiotics, pain killers and medication for lung, stomach and skin complaints. Medication for



diabetes and high blood pressure is more often prescribed in 2005 and 2006 (than in 2004). Throughout recent years, prescribing medication for the uninsured, including illegal immigrants, remained problematic. For illegal patients the 'Koppelingsfonds' ('Connection' fund) exists which pays for the costs of medication (the doctor sends the prescription to the fund, and the fund pays the pharmacy for the illegal patients' medication). For legal patients who have no health insurance there is no such solution, except that social workers, in collaboration with the homeless patient, can organize health insurance by arranging an identification card and unemployment benefit. "Medication for the uninsured is a major problem; how can we treat a patient if medication is not accessible?", is the question raised by one nurse.

Substance abuse and psychiatry

Many homeless people struggle with substance abuse and/or psychiatric problems; over half of the Street GP patients do (54%). The majority of them (66%) has a registered problem exclusively with substance abuse (alcohol, cannabis, heroin, methadone and/or crack), 10% exclusively with psychiatric problems and 23% has a dual diagnosis. However, doctors and nurses indicate that these numbers underestimate: they do not match their experience from their practice hours. Apparently, they (sometimes) fail to question and register accurately. A more complete and accurate notion can be reached if doctors and/or nurses systematically question and register the patients substance abuse and psychiatric condition, e.g. at the first consult. The screener "Addiction and Psychiatry among Homeless People" (developed by IVO and O3) can be helpful.

Success of Street GP

The doctors and nurses are generally satisfied about the functioning of the Street GP practice. Three main factors are held accountable for this success. The first is that the Street GP offers GP care within the shelters, making GP care accessible for the homeless, not in the least because the nurses effectively refer patients to the GP hours. The second is the continuity in care and in time. Medical files are built in a virtual private network, which are accessible for doctors and nurses at all participating shelters, so that the patients medical history is known. With regard to time, every weekday there is at least one Street GP hour in Rotterdam, and most shelters have GP hours every week (some every other week). The third success factor is the cooperation at both management and operational

level. At management level it is about the successful cooperation between the municipality, the local health care insurance companies and the shelters in organizing the Street GP. At operational level it is about the successful cooperation between doctor and nurse. Nurses know the patients and refer them to the Street GP. During the GP hours doctors and nurses work together, and after the GP hours the nurse has follow-up responsibilities in e.g. replacing bandages, cleansing wounds and the intake of medication. Of course, there are several points which could still be improved: more hours of nursing care, more and better screening and registration, more and more targeted collaboration with other organizations (psychiatry, addiction care, hospitals) and higher accessibility of medication for the uninsured.

Future of Street GP

All participating organizations are content with the standard of health care for the homeless in Rotterdam. Many of the homeless people have confidence in the nurses and doctors, and through the health care they have a personal connection. "Doctors and nurses have a friendly approach towards the patients, everything can be discussed and we always take the person seriously", says one of the nurses. And this creates an atmosphere that fosters more than just health improvement.

The full study is published in Dutch and can be downloaded from www.IVO.nl (search for 'Straatdokter'). Agnes van der Poel and Luuk Krol (2007). Huisartsen-praktijk 'de Straatdokter', Sociaal Medische Zorg in Rotterdam: bereikbaarheid, continuïteit en samenwerking. Rotterdam: IVO.

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Efforts to care for the homeless in Ottawa, Canada.

By Jeffrey Turnbull, MD and Wendy Muckle, RN*
Ottawa Inner City Health Inc

Welcome to our colleagues in Europe and it is a great honour to outline our efforts to care for the homeless in Ottawa, Canada. Like you, we have an alarmingly large and growing number of homeless

living on the streets of this affluent city within eyesight of our country's parliament. Each night we have approximately 1,000 adults, adolescents and families who seek shelter, services and food in one of our many homeless shelters. Like many large urban cities, people who are homeless are the addicted, the psychiatrically unwell, the disabled and always the vulnerable who find themselves isolated and living in a street culture that perpetuates their suffering. Politically, it has been difficult to create appropriate housing and support services for people who are homeless. The lack of "quick fix" solutions discourages politicians and policy makers from investing in the needed infrastructure.

For many years we had been trying to address the health care needs of people who are homeless but in an inefficient and ineffective manner. In 2001, many of the key partners dealing with our homeless people got together to rethink approaches to the health care targeted to them and Ottawa's Inner City Health Program (OICH) was born. The tenets of this program are that it is a partnership of all involved organizations, it is based upon a harm reduction framework and it focuses on chronically homeless people with multiple medical problems. Over the years, we have grown from a funded research /developmental program that demonstrated improved health and health care indices of people who are homeless yet realising significant cost savings to the system at all levels.

In view of this, we are now fully funded by our Ministry of Health and the program now comprises: a hospice program where up to 15 people who are homeless and dying receive full palliative care by ICH in a building funded and fully equipped by a shelter, an intermediate care program of 30 beds where sub acute medical conditions such as diabetes, infections and addictions are managed

outside of a hospital environment; a managed alcohol program where refractory alcoholics, up to 30 in number, are given alcohol on an hourly basis to stabilize their addiction thereby allowing us to provide meaningful health care and social services; and finally we have a community program with a daily nursing and dental clinic, as well as, outreach services to those in rooming houses and under bridges. In addition to providing services to people who are homeless, we are involved in advocacy, teaching, and an ongoing research program.

Like you, as we look ahead, we are all too aware of the challenges of an increasingly diverse population of homeless people with unique needs and an exploding drug and alcohol problem with its consequences including Hep. B/C, HIV, TB and MRSA.

Finally, we would like to invite you to visit our website or review some of our publications. Also we would like to extend an invitation to any of our colleagues from overseas to visit, as this is always of benefit to us.

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Thinking about WRAP (Wellness Recovery Action Planning) and its potential contribution to working with people without homes

Piers Allot, WRAP Facilitator

WRAP (see www.mentalhealthrecovery.com) was developed in the US by Mary Ellen Copeland. In the

mid 1980's she asked her psychiatrist how she could help herself and when he said he did not know she began a research project and collected information from people across the US who had similar experiences to hers about how they managed on a day to day basis. WRAP is the self-monitoring and response system that resulted from that research in the early 1990's and it has gone on developing each year as more and more recovery narratives have been told and new learning and knowledge accessed. It is now used in many countries around the world and to self-manage many different issues. WRAP identifies five key recovery concepts that provide the foundation for effective recovery work.

They are:

Hope. There is much to hope for as many recovery narratives attest to. With good self-management of distressing experiences or difficult behaviours, people experience long periods of wellness and life satisfaction.

Personal/Self Responsibility. It's up to each person, with the assistance of others, to take action and do what needs to be done to effectively manage their distressing experiences and difficult behaviours.

Self-advocacy/Self-agency. Becoming an effective advocate for ourselves enables us to get the services and treatment we need, and to make our life the way we want it to be and become effective self-agents.

Education. Learning all we can about our personal experiences, distress and diagnosis or formulation of our issues allows us to make good decisions about all aspects of our treatment and life.

Support. While working toward wellness is up to each of us, receiving support from others - and giving support to others - is essential to maintaining our stability and enhancing the quality of our life.

WRAP is a self-monitoring and Response System; we identify what 'wellness' means to us and begin to identify those wellness tools we use or can use to

keep us well; the things we need to do every day to keep ourselves well; external events that may trigger an increase in our distressing experiences and behaviours; early warning signs of an impending distressing experience; and distressing experiences that indicate we are in trouble. With this knowledge, and by using the tools listed in WRAP, and others we have discovered for ourselves, we are able to develop a distress monitoring and response system (Wellness Recovery Action Plan) that will help us manage our experiences.

That includes:

Daily Maintenance Plan: those things we need to do every day to keep ourselves well, such as eating three healthy meals and getting a half-hour of exercise.

Triggers: external events that could trigger distressing experiences or behaviours, such as an argument with a friend or being excluded from a shelter, and identifying responses that might keep this event from causing or worsening distressing experiences or behaviours.

Early warning signs: such as irritability or anxiety - that indicate our distressing experiences may be worsening, and a response plan.

When Things are Breaking Down: distressing experiences or behaviours that indicate the situation is getting much worse, such as reckless behaviour or isolation, and an action plan to stabilise the situation.

Crisis Plan: through developing a crisis plan when we are well to let others know what our wishes are and how to care for us when we become unwell, we can remain in control even when we are out of control.

Post Crisis Plan: The Post Crisis Plan is different from other parts of our WRAP plan in that it is constantly changing as we heal. It is hoped that two weeks or so after the crisis we will be feeling much better than we did after one week, and therefore, our daily activities will be different. After we feel we are no longer in the post crisis time, we can go back to using our Daily Maintenance Plan and other parts of our WRAP.

WRAP is a self-exploration and self-management framework and approach that can be used by anyone for any issue and therefore is very versatile. It can be used to manage the whole of your life or



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just one small issue that particularly needs attention.

It is a values based approach to managing our lives and to supporting others to manage theirs. It values the lived experience of people and recognises each person as the expert on themselves whilst at the same time not excluding professional knowledge and skills but rather seeking to integrate all approaches through recognising that each person is the expert on her or himself and having unconditional acceptance of each person as they are; unique, special individuals.

No one tells someone to complete a WRAP plan and the plan a person completes belongs to them and them alone – though they can ask for support in developing it and share it with anyone they wish. It may be completed in a day, a month or a year; the person decides the pace.

So how might WRAP be enabling for people without homes and those that support them?

WRAP is underpinned by a value system that is behaviour based. To deliver recovery and WRAP it is essential that staff and peers recognise that recovery is about the practice of values; it is about valuing each person for the unique people we are. That includes recognising the difficulties and traumas each of us has faced and recovered from together with a recognition that some of us have not yet found the ability to overcome some or all of our lives adversities and given up or been stripped of hope, becoming helpless and hopeless.

Recovery and WRAP are about believing that there is no such thing as a completely hopeless situation and that we all need help at some point or other in our lives. Where people are unable to be hopeful for themselves then it is the task of others; family, friends or other supporters (if they exist) or staff to be 'holders of hope' whilst those that feel hopeless are unable to be hopeful for themselves.

Where there are difficult experiences or behaviours that may affect a persons' situation including accommodation, however small, then WRAP can be used to explore those experiences and behaviours and design an action plan to deal with them. That could address drunkenness, cleanliness, abusiveness and find ways in which those issues can be better managed, taking small steps, always based on a sense of what 'wellness' means for that particular person.

Many people may not be 'ready' to address difficult issues and have a negative view of wellness or be unable to conceive of being well as a result of childhood learning and experiences. The task of peers and staff is then to create a climate within which a person may want to explore issues and identify what it might be like to be well in different circumstances.

The key is enabling people to be respected and valued whilst at the same time supporting them to find their own path to personal growth and life fulfillment.

Looking for the person behind the problems

By Connie Rijlaarsdam, Nurse Practitioner
GGD Hart voor Brabant, Tilburg, the Netherlands

"Everything is a coincidence or nothing is a coincidence. Believing the first I couldn't live, but of the last I am not yet convinced".
Etty Hillesum

Working for the GGD (Municipal Health Service) as a social nurse for homeless people in Tilburg, it is my pleasure to write about my job for the ENHW. Tilburg is the sixth largest city of the Netherlands with a little over 200,000 citizens, harbouring about 200 homeless people (persons using night shelters).

In 1999 in Groningen, I started to work with homeless people. I had the good fortune to work with very inspiring colleagues, investigators and initiators of theories and guidelines in this field. From them I learned many important principles, such as how to get in touch with this group of people and how to build trust. If we talk about homelessness we often talk about client characteristics, but then we tend to disregard the interaction between the development of a problem and the functioning of institutions and how services are provided in response. The question is not only how clients fit in the existing possibilities but also which offer is adequate for the clients. This concerns

multiple problems demanding an integrated approach, involving multiple institutions.

Since 2003, I have been working in Tilburg and my specific task is to detect physical problems and to initiate medical care necessary. I started with weekly outreach consulting-hours in the shelters for homeless people, where I see most of the clients. Because I go and visit shelters, we get to know each other and build a relationship. During my outreach activities, when noticing a physical problem it might occur that the person concerned has no insurance and no general practitioner to attend. Sometimes the clients are reluctant to find a solution. To me, it is always a challenge to look for possibilities in order to solve problems and to motivate both client and physicians to see each other. It is important that doctors are accessible to treat these 'different' patients. After all, everyone has the right to professional health care. If necessary, I take my clients by bike. I have learned that there is another and a different world behind all the problems and their lifelong impact. A world that exceeds consulting hours.

In Tilburg, I also participate in a specific project for street prostitutes called Dot.spot.

In this project several institutions work together to assist 35 women. Each organisation brings in their own specialisation in order to learn and listen to the problems of clients and helpers, and to improve the circumstances these vulnerable 35 women live in. The aim of this project is to get and stay in touch with these women and to support them together with their specific and personal problems. In 2008 Tilburg will open a house for five women. A home where they can live and learn together with personal attention in order to achieve a more stable life.

Last year I started a study in advanced nursing practice and I will specialise in Public Mental Health Care (OGGZ). My aim is to improve the holistic care and cure in Tilburg for these colourful people. To look at the person behind the problems.

Forum

Have your say: the ENHW online Forum!

Why not join now and [have your say!](#)

Message of Support

Dear International Homeless Health Workers,
Thank you for all you are all doing for the world. By caring for the world's poorest and most disadvantaged people, you are lifting us all up. Nothing is more important than the health and

wellbeing of the most vulnerable among us.
With warm wishes,

Lawrence O. Gostin*

Faculty Director, O'Neill Institute for National and Global Health Law, Georgetown University Law Center, Washington, DC, USA

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The American dream - why is homelessness untreated?

By Susan Partovi, MD

Homeless Health Care Los Angeles, USA

I'm flying home to Los Angeles after participating at the Third International Street Medicine Conference in Houston, www.streetmedicine.org. I'm somewhat reflective, thus I feel it's time to write. "Street Medicine?" you may ask. "What is this?" Well, it's when a clinician practices medicine...

well... in the streets. It's when the clinician attends to the medical and mental needs of the unsheltered homeless. Didn't think there was a specialty called Street Medicine, did you? I'm not sure when the term was first coined, but the practice began in the 1980's when the homeless population began to explode. Primary Care Physicians began to realize that this demographic was extremely ill, not getting appropriate care, using Emergency Rooms frequently, often hospitalized, and dying at an alarming rate.

But why develop an entire field called Street



Medicine? This is a miniscule group of people, most of whom either choose to be homeless or not to work at all, right? Shouldn't they get their acts together or pull themselves up by their boot-straps? After all, this is America, where anyone can succeed, go from "rags to riches", become a millionaire, even a billionaire. Look at Trump, Gates, Oprah, the NBA roster list! This is what our society is all about! Isn't that the American dream? Anyone and everyone can get there, right?

Right? I gave a presentation on "Street Medicine, Los Angeles." Equipped with the most recent statistics, provided last month by the Los Angeles Housing Service Association www.lahsa.org, I received abundant "ooohs" and "ahhhs" as the conference attendees were impressed with our statistics. On any given night in Los Angeles County, 73,000 people are homeless. 142,000 are homeless each year, one-third of whom are chronically homeless. Fewer than 13,000 shelter beds exist in L.A. County, meaning more than 60,000 people live in the streets. This is the largest number of homeless in any American city. Skid Row has the highest concentration of homeless, 5100 people, in all of Los Angeles County. Twenty-five percent of the homeless in Los Angeles are families and fifteen percent are under the age of 18. Families and children?! Hmmm, they might have difficulty reaching their bootstraps. Are they even eating well? Getting vaccines? Going to school?

Okay, what about the others? Surely they can pull themselves up by their boot-straps or get a job. Let's see...seventy-four percent are disabled. One-third suffer from severe mental health problems; more than fifty percent are depressed; thirty-five percent have physical disabilities; and forty-two percent are plagued with addiction. The Institute of Study of Homelessness and Poverty (2004) showed that seventy-six percent of the homeless were employed for at least two years before becoming homeless and as many as forty percent of the homeless were employed. And here's a statistic I learned at the conference: the average age of death for a homeless person? Forty-five! Other attendees voiced similar figures—forty-one in the U.K., forty-seven in Pittsburgh. "Well it's cold in those places," I suggested, "that's why, right?"

"No," Dr. Peri, from the Boston Health Care for the Homeless Program www.bhchp.org, reminded me. The study done by Dr. J. O'Connell showed that the incidence of death in Boston was higher in the summer and fall months than the winter and spring

months. What do they die of? Heart attacks, strokes, cancer, just like the rest of the U.S. population. But thirty years earlier!

I started seeing patients in the streets of Santa Monica in January of this year through the Venice Family Clinic. In the first weeks, I met Joseph. He balanced all his belongings quite skilfully on his bike. The first time I saw him he seemed shy, but pleasant. He smiled and said "No, thank you" to my offer of medical help and avoided looking at me. The next time I saw him, one of the medical students actually engaged him and he asked for something for a rash. Ticked that my once spurned efforts were now welcome, I took out the rash cream and gave it to Joseph as if he had just agreed to proceed with a life-saving cancer treatment. When I saw him the next week, Joseph said that the cream didn't work, so I arranged for the supervision of his bike and life long belongings and took him to the clinic for a proper exam and thus proper treatment. He was seen, treated and even referred to a specialist.

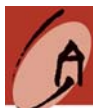
The next week Joseph was "still not better!" So I took things into my own hands, brought a male outreach worker with me as a chaperone, and examined his rash in a men's bathroom. In only seconds, I diagnosed him with a type of infection only seen in people with diabetes. Soon, I measured his blood sugar at 289 and his blood pressure at 210/105. After a few more park visits, he finally agreed to see me at the clinic to receive treatment for his diabetes and hypertension. I'd declare proudly to anyone who would listen that I had diagnosed diabetes in the field and now the patient visits me in the clinic and is doing great!

But then I didn't see him for a while. Months. Not even in the park. Until just a few weeks ago I found him hanging out at another park. "The cops ran me out," he explained.

"Where've you been? I've been looking for you? Why haven't you come to the clinic? Are you still on all your medications?"

"No," he said, a little embarrassed and half-smiling. "Do you want to die?" "Well..." he says and shrugs his shoulders.

Crap, wrong question. "Ok, you're not actually going to die any time soon, you're just going to get really sick, have a stroke and then not be able to walk or talk, need an amputation. Maybe even dialysis. Life will only become more miserable!"



He shrugs again. His hopelessness seeps into me until I feel it, too. The figures ran through my head. The cost of taking care of a stroke victim is approximately \$75,000. An amputation, perhaps \$50,000. Dialysis, up to \$100,000 annually. Permanent housing for a year, maybe \$10,000.

If a disease that emerged that struck hundreds of thousands of people and had a 30% five-year mortality rate, the CDC would jump on it. The NIH would grant millions of dollars for developing treatments. The scientist who found the cure would surely be a favourite for the Nobel Prize in medicine.

This disease does exist and its cure is widely available, immediate and ultimately even cost-saving. Why is this cure not implemented? Why

is homelessness untreated? I keep returning to our cultural values. Perhaps we need to redefine the American Dream. I don't mean to suggest that you are bad if you want to succeed, improve the opportunities available to your family, or even to be rich. But what if we didn't have this as the only focus in our lives? What if we tried to make a difference in other people's lives, too? What if we gave something to those who need it most, even if they were strangers?

What if that was the American Dream?

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Events

For your Diary: Third Oxford Health and Homelessness Conference

Date: 16th September 2008, Oxford, UK

After two successful conferences in 2006 and 2007, we are changing the format slightly and have chosen a research theme for the 2008 Oxford Conference.

It has long been recognised that people experiencing homelessness often bear a heavy burden of ill health and find access to mainstream health services difficult. Health services tailored to the needs of homeless people have been set up at venues in many countries but good evidence on their effectiveness is hard to come by. Nonetheless, services have to compete in the harsh world of finite funds and conflicting priorities and need to show that they offer value for money. Furthermore, we all need to be aware of the evidence for good practice, in order to offer our patients and clients the very best standards of care.

You are invited to come and hear the latest research in health and homelessness from the people who are doing it. Researchers from all disciplines, working in the field of health and homelessness, are invited to submit papers or posters for this unique event at which we will share the knowledge that we have and discuss potential lines of enquiry in order to improve quality of services and to encourage and inform smart commissioning.

Please submit your abstract, indicating whether you would prefer to make an oral or poster presentation, together with your CV, by 30th March 2008. We will inform successful applicants by 31st May 2008. All successful applicants will be expected to register as a delegate of the conference.

You are also most welcome to attend the conference, without presenting, in order to participate in this unique event. Email now to reserve a place. kiera.sullivan@conted.ox.ac.uk

Conference fee: £150

Pre-conference dinner: £25 for a 3 course meal with wine at Rewley House on the evening of 15th September 2008.

Your comments and questions about the ENHW are welcome!
Send them to: stefania.delzotto@feantsa.org