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Health and homelessness: looking at the full picture

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HOMELESS in Europe

Winter 2006

Editorial

"The Right to Health is a Human Right: Ensuring access to health for people who are homeless" has been **FEANTSA**'s Annual Theme in 2006. During the course of the year **FEANTSA** looked at various issues in relation to health and homelessness; the health profiles of people experiencing homelessness, their healthcare entitlements, access to quality healthcare for people experiencing homelessness, networking and cooperation in the area of health and homelessness and many more. The main findings were drawn together in the **FEANTSA** European Report 2006.[1]

It emerged that health and homelessness have a relationship of both cause and effect. A person's bad health status may be one of the trigger factors leading to homelessness. Once in a position of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development and aggravation of substance-abuse and addiction. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people. The findings clearly demonstrate that a health approach needs to be an integral part of every effective strategy to tackle homelessness in a holistic manner.

The aim of this edition of the **FEANTSA** magazine is to build on the findings of the Annual Theme 2006. The authors look in more detail on several of the key issues raised during the course of the year. What is more, they integrate additional dimensions to the topic by discussing questions such as housing and health, drug addiction, and mental health in relation to housing.

The first article written by Helen Blow et al. is based on the Belgium National Report for the Annual Theme. It provides a comprehensive overview of the health profiles of people who are homeless according to different ETHOS subcategories, including people sleeping rough, people leaving penal institutions and people living in caravans. Blow et al. highlight that despite a well developed welfare system in Belgium there are numerous inequalities in relation to health between people experiencing homelessness and the general population.

Marc Uhry explores the question of the right to health for people who are homeless. He describes the broader historical, political and economic context of the right to health and public authorities' obligation to ensure access to health for vulnerable groups. Uhry states a growing tendency in public policies to individualise responsibilities. He points out international human rights instruments as a tool to evaluate public health policies regarding their impact on the most vulnerable groups.
A current example of health care policies and the risk of a negative impact of healthcare system reforms on socially disadvantaged people is presented by Werena Rosenke. She analyses the impact of recent health care reforms in Germany on people who are homeless. Referring to a recent survey, Rosenke demonstrates how the introduction of generalised obligatory contribution fees to medicaments and a medical consultation fee have become often insurmountable hurdles for people who are homeless to access healthcare.

The following two articles more specifically discuss the relationship between homelessness, health and housing from different perspectives.
"Housing is healthcare" is the title of John Lozier's article in which he presents the "Housing First" approach that has been developed in the United States. This policy is based on the assumption that a practical and comprehensive understanding of health necessarily includes housing as a starting point for further treatment and assistance. Not only does housing promote healing but also prevents the onset of new illnesses.

Benoît Eyraud adopts a very different angle to analysing the relationship between housing and health. The author questions public policies that promote a standardised approach to the right to housing and the reintegration of people who are homeless, resulting in an ideal of "independent housing". He identifies three dynamics in relation to the mental well being of a person who has difficulties in accessing or maintaining housing. Eyraud argues that a mental health approach to people with difficulties in relation to housing is more appropriate than an approach following a idealised linear process towards housing as it allows taking these dynamics into account.

The next articles reemphasise the importance of a health dimension for effectively helping people getting on a pathway out of homelessness. Peter Cockersell presents the work of his organisation St Mungo's in the area of health care for roofless people with severe substance abuse and mental health problems. He argues that chronic homelessness is treatable if health problems are addressed.
Des Ryan shows that healthy food matters in tackling homelessness. Many people who are homeless suffer from malnutrition and have lost the joy of eating good food. A Good Food Programme as developed by the Edinburgh Cyrenians may not only help to increase access to food but also to develop cooking and social skills and to provide work training and social engagement for people who are homeless.

But how can professionals become better prepared to provide health care or health promotion for people experiencing homelessness? In the final article, Angela Jones presents a new set of interdisciplinary training programmes at the University of Oxford for people working in the homelessness sector or people that meet people experiencing homelessness during their work. A first online module covers general topics such as the health needs of people who are homeless. The subsequent modules are delivered face to face and look in more depth on sociological, legal and clinical issues.

As always, **FEANTSA** extends its warm thanks to the contributors of this edition of the magazine and hopes you will enjoy reading it. Your comments are very welcome. You can send them to silke.paasche@feantsa.org.●

[1] FEANTSA Annual Report 2006 : The Right to Health is a Human Right : Ensuring access to health for people who are homeless.

Health Profiles of People who are homeless in Belgium

By **Helen Blow**, **Aafje De Wacker**, **Fred Louckx**, **Liesbeth Van Heusden** and **Gerard Van Menxel**,
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Nobody chooses to live in poverty

We want to clearly state from the outset that we wish to approach the theme of health and homelessness from a model that holds society responsible and does not blame the person who is homeless. We believe *'Nobody chooses to live in poverty*' and therefore, by expansion, nobody chooses to be homeless[1]. This is the first precondition for a policy that offers dignity and improves the health of people experiencing homelessness and includes a rights perspective in healthcare.

When we use the term 'homeless', we use a broad definition which fits with the ETHOS typology[2] that FEANTSA uses. This article will focus on the health profiles of people who are homeless, organised according to the ETHOS categories and sub-categories. For access to health benefits and health care, as well as 'good practises' in health promotion, training for health care workers, networking, health indicators and a rights-based approach, we refer to the full Flemish report, available on the FEANTSA website.[3]

Social inequality regarding health exists, in Flanders as in Europe.

The average life expectancy in Belgium shows strong socio-economic differences. The average life expectancy for a 25 year old man in Belgium without a degree is a further 48,1 years of life, while for a 25 year old man with a university degree this is 53,6 years.[4]

As far as lifestyle is concerned, there are clear differences between social classes. Lower educated people are more likely to smoke, do less sport and have a less healthy diet. They are also less inclined to adjust their diet.[5] These socio-economic health differences were already established in the general health enquiry of 1997.[6]

The Health Survey of 2001 by the Federal Government shows a clear link between individual health and level of education.[7] Lower educated people visit general practitioners more, are admitted to hospital more often and take more prescribed medicine.[8] Finally, the poor have more mental and psychiatric problems. Research shows, for instance, a connection between poverty and depression[9].

The Right to Health

Belgium has a well developed welfare system. In theory the whole Belgian population is covered by an obligatory insurance for medical care. In practice, however, some people prove not to be covered.[10] The main condition for coverage is membership of a health fund. The health fund is the organisation that refunds medical costs. Many persons who are roofless do not have regular careers or have simply never worked and are dependent on the CPAS (*Centre Publique d'Action Sociale*/ "Public Centres for Social Action") for a minimum income or other forms of support. This in itself does not make them ineligible for social security, but not completing the correct paperwork can pose problems. In addition, a fixed address is a precondition. This can be resolved by the CPAS, for they can grant a postal address, but again it requires a concentrated effort to sort out the paperwork. Undocumented migrants and asylum seekers often do not get medical attention, although in theory they should. They are entitled to medical emergency help, but for more general medical care there is an access problem.

Health profiles of people who are homeless

Roofless (ETHOS 1 & 2)

The health related problems of people who are roofless, such as rough sleepers or users of night shelters, are often to do with multiple needs. People who are homeless in these ETHOS categories often have mental and physical health problems and/or suffer disability, personality disorders, learning difficulties, etc. Resolving one problem will not in itself resolve their plight. In Belgium their problems seem most urgent in Brussels and less in the larger cities of Flanders (Antwerp, Ghent, Ostend) or Wallonia (Charleroi, Liège). There is also a lack of safety and the potential for victimization of people who are roofless. The social lack of well being, diet and extreme weather are important factors too, which can add to the single or multiple health problems of people who are roofless. Among people experiencing homelessness, asylum seekers and in particular 'sans papiers' (undocumented migrants) are a special category. Many migrants, especially asylum seekers, are not able to make use of the centres for asylum seekers – an obligatory port of call on entry into the country. But often when an application for asylum is refused these people 'disappear' (ETHOS category 5) and become either roofless or very poorly housed. There is a problem with landlords letting substandard housing at very high rates to this vulnerable group.

The mental health of the roofless

Research by Philippot and others (2003) into the mental health of people who are roofless is unanimous about the fact that the prevalence of mental ill health is greater among this group than among the general population. It also shows that these illnesses occur before the person in question loses his/her tenancy.

As for the organisation of services for the roofless, the high number of depressions and the high risk of suicide for this population points to the need for personal and individual help and treatment. The organisations for welfare, administration and health are separate and autonomous. This implies the roofless person must go to a range of services and interact with a range of social workers. The mental ill health of many people who are roofless makes it difficult for them to adjust to this administrative situation and hinders their reintegration.

Houseless, Residential care and temporary accommodation (ETHOS: 3, 4, 7)

The health situation of people experiencing homelessness in Flanders

Van Menxel et al. (2004) compared the profile of the people who are homeless now with the situation 20 years ago. They approached all homeless people who were in a residential hostel or in supported housing run by a Centre for General Welfare Work on a particular day, and the social workers there, and asked questions about their health[11].

2 in 3 people who are homeless have health problems

Two thirds of people who are homeless have health problems. 50% of them suffer exclusively psychological or psychiatric problems (higher for women); 28% are physically or mentally disabled and 26% suffers from life threatening diseases.

One could assume that the health problems of people who are homeless might increase with age. This is not confirmed by this inquiry. In all age categories, about three quarters of the population suffer from ill health. Only two age categories score lower than aver-

age (31-35 year-olds and 56-60 year-olds), so these variations cannot immediately be explained. We must remember however, that not all health problems are reported to the social workers, who acted as intermediaries in this research.
The nature of the health problems by gender: psychological problems are prominent among both women and men but women have more problems in this area than men. For the female population there is also a significantly higher number that suffer from cancer.

Nature of the health problems

Nearly three in four homeless youngsters have psychological problems. If we look at the nature of the health problems reported there are very clear differences according to age and gender. Cancer also occurs far more frequently among homeless women than among men. Youngsters under 21 years of age clearly have more psychological problems, for these make up 3.1% of their problems. It is also clear that older people suffer more physical ailments. Nevertheless, even in the age category 21-50 year-olds (57.8%) and over 51 year-olds (45.3%) the psychological problems are the most important health problem. From 51 year-olds on, physical problems overtake the psychological.

Homeless women have more psychological problems than men

Psychological problems are prominent among both women and men, but women have more problems in this area than men. This need not surprise us, as women report more psychological problems amongst the general population too. Domestic violence may well be a contributing factor.

Health research among users of hostels & reception centres in Limburg

Comparative research between people who are homeless and the rest of the population in Limburg

Vanheusden (2004) investigated the health, lifestyle and medical consumption among the population of users of Limburg reception centres (ETHOS 3.1), including emergency shelters (ETHOS 3.2), and centres for battered women (ETHOS 4). Limburg is a province in the east of Flanders. All were questioned at length. Because the same indicators were used as in the national health questionnaire of 2001 the data on people who are homeless could be compared with that of the 'average' inhabitant.[12]

140 inhabitants of reception centres filled in a questionnaire, which is a response rate of 92%. The control group consisted of the 555 respondents, older than 18 and living in Limburg, who took part in the national health inquiry of 2001.

It was found that people experiencing homelessness have a significantly worse subjective, physical, and social health than the average Limburg population. People who are homeless have different lifestyle to the average population; and most certainly a less healthy lifestyle. There is more over consumption of alcohol, they smoke more and have more experience with illegal drugs than the average Limburger. In particular, the enormous differences in mental health are worrying. This shows there is a considerable need for more psychosocial support and coaching, in particular as far as use of psychotropic medication is concerned, and the research clearly shows there is a need for close cooperation between General Welfare Work and Mental Health Care. Vanheusden calls for the development of joint European questionnaires so that more internationally comparative research may be done on the health of people who are homeless, including roofless people.[13]

Immigrants (ETHOS cat. 1, 2, 5, 8, 11, 12 & 13)

People without a legal permit to stay are not officially registered and are more or less 'invisible' in society. In order to map this class of 'invisible' people Devillé (2006) did qualitative research based on the 'grounded theory' as developed by Glaser and Strauss. The findings were deduced directly from the experiences and interpretations of this group of migrants themselves. Particularly noteworthy is that undocumented migrants with the largest social capital are also best integrated, regardless of their financial situation. Some undocumented migrants form an 'outsider community' in Belgium. This is a society within society that is strongly focussed on itself. The members very often live together in strong solidarity, whether they reside legally or without papers in the country.[14]

In 2005, 9.925 patients visited the *Medicins Sans Frontières/ Artsen Zonder Grenzen* consultations.[15] The two largest groups of patients are undocumented migrants and asylum seekers. More men than women come to the consultations. The largest group of men is between 30 and 39 years old, the largest group of women is aged 20 to 29. More than 75% of the patients have no normal health insurance and therefore no access to health care as it is provided to the general population. In this category, people are included who are eligible only for 'urgent medical help', i.e. acute and life-threatening emergencies.

Penal Institutions (ETHOS cat. 6.1)

Despite the fact that the majority of prisoners are young men, it is a very vulnerable population[16]: 20 -30 % is drug dependent, which explains the prevalence of infectious diseases: Hepatitis C: 15% versus 1.5 % among the general population, HIV: ten times more than among the general population, TBC: 10 to 20 times more than among the general population. Inmates suffer more chronic ailments (diabetes, high blood pressure, etc). This has to do with various factors such as life style, diet and the use of medication.

Psychiatric problems occur in a ratio of 5 to 20 times as often as among the general population: ca. 5 % of the population is psychotic, ca. 20 % is clinically depressed. Suicide occurs ten times as often as among the general population. A 'new' problem is the growing need for specific care for older prisoners (geriatrics).

A particularly vulnerable group are mentally ill inmates for whom there is too little suitable accommodation and treatment available. Other problems for prisoners are the professional dependence of the health workers on the prison directors, the division between care and expertise tasks which should be introduced in the short run, the limited funding for services and the lack of staff in the central health service.[17]

Polfliet (2005) writes in his report 'Health protection for employees in the social services of the prisons' that there are two illnesses which occur frequently in prisons; tuberculosis and hepatitis. Life circumstances in the prisons, overcrowding, lack of daylight and fresh air in the cells increase the chance of contracting an infection.[18]

In 2003 an investigation into drug use in the prisons was carried out by two NGOs[19]. It shows that the prevalence of illegal drugs in the prisons is around 33%. Cannabis is the most used (28.9 %), followed by heroin (13.3%) and 2.5% of the inmates report having injected drugs.

Mobile home or caravan (ETHOS cat. 11.1)

Research carried out in 1997 among campsite dwellers in Flanders indicates that 34% of the campsite inhabitants and 28% of the total number of their family members suffer a chronic disease which has already lasted for at least a year. With exception of the 65-plus age group, there are more health problems in all age categories of campsite dwellers than for the average Flemish person. 30% of the campsite dwellers take daily medication. Many 'ill' people moved to a campsite for health reasons, hoping they would feel better in healthy and quiet surroundings.[20] Earlier research in the province of Antwerp, where many permanent campsite dwellers live, showed that nearly half the dwellers suffer a chronic illness or disability. This

is reflected in the high daily use of medication (43% of the dwellers), hospital stays in the past year (33%) and daily alcohol use (22%).[21]

Other problems for permanent campsite dwellers are safety (fires, burglary, violence), unhealthy housing (small, damp, unsuitable housing). In certain places there are concentrations of illegal dwellings and dwellings of undocumented migrants.

Homelessness and drug abuse

There have not been any recent studies about drug use amongst people who are roofless in Belgium. There is a broad range of services for people who are roofless, such as night shelters (low threshold, alcohol and drugs are usually not tolerated within the center), day centers, emergency centers. Roofless people are usually poorly educated males.[22]

In the Flemish community the registration system 'Tellus', run by the Centers for General Welfare Work (CAWs), provides a profile of people who are homeless in reception centres. In 2005, 42% of clients in reception centres for men were registered as having an addiction problem upon arrival (75.5% men and 24.5% women). Over half (52.7%) are aged between 26 and 59 years old and about a third (32.2%) is between 18 and 25 years old. 51.3% of them will be offered help in a Center for General Welfare Work and 18.6% request treatment. 34.5% is referred to a specialist center. The majority of these roofless drug users (most of whom are unemployed) are admitted into reception centers. According to the CAWs these figures under represent drug use due to registration problems. In the future there will be a standardised method of registration.[23]

Research in the province of Antwerp indicates that of all the clients requesting treatment for addiction in any one centre nearly 10% are roofless or live in a precarious housing arrangement.[24] A number of reception centres contacted indicate that between one fifth (21.8%) and one third (35.4%) of all roofless people seeking help used illegal drugs and/or alcohol regularly and to an excessive degree.[25] Finally the research also mentions that there was considerable overlap between the drug clinics and the reception centres for people who are homeless: about 25% of the clients with a problem of excessive drug use were registered in a reception centre and a treatment centre at the same time.

Policy Needs

More needs to be done to make treatment available in an accessible, non threatening way. Basic health care should be community based and health clinics in day centers may well be an ideal way to reach people who are homeless. At a more preventive level, public bathing facilities need to be made more widely available in order to ensure that people who are homeless can take better care of themselves. All rough sleepers should be encouraged to make use of reception centers, where basic health education should be an ongoing concern. For asylum seekers and undocumented migrants, basic health care beyond the emergency level needs to be made available.

As regards the development of a mental health policy for people who are roofless, it is an illusion to expect this vulnerable group to come and ask for help regularly and of their own accord. A mental health policy must be developed which is pro active (the mental health doctors must seek out roofless people), personal (they need a fixed anchor person to coordinate their mental health) and designed to reintegrate people who are roofless into society by developing their social network[26]. Colpaert et al. stressed the need for close cooperation between addiction centers and reception centers.

Summary

Homelessness can be both cause and effect of poor health. It is therefore crucial to tackle health as an integrated part of any strategy against homelessness. There is great need for basic preventive health care: access to public baths, facilities to wash and dry clothes, access to basic nursing skills and dental care. Lifestyle issues need to be addressed with educational programs: diet, hygiene, smoking and exercise are areas where simple measures can greatly improve an individual's health for very little cost. There are some small projects going on in day centres which are yielding good examples for the path to follow.

The mental health amongst homeless people is particularly worrying and there is a clear need to change the way services are provided in order to reach those people who are most in need of healthcare. Mental health services and homeless services need to work together to dovetail their services better and to avoid fall out.

For mentally ill prisoners much more needs to be done in terms of care and treatment. •

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[13] For a full discussion, we refer to the Belgian health report on the FEANTSA website.

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The Right to Health: a vital Baseline for Public Policies

By **Marc Uhry**, *Alpil, Lyon, France*

Since antiquity, demographic, economic and social considerations have led all systems of government to put in place public health policies – to contain epidemics, treat the sick and injured, avoid disease arising from bad food, etc. These policies have also always been the focus of contradictory moral arguments, regarding the responsibility of the collective for individuals on the one hand, but also the protection of the individual from the intrusion into the private sphere, that this responsibility justifies, on the other.

Public health policies are so fundamentally present in any form of political organisation that they in fact shape the way that individuals think about public intervention. The medical lexicon absorbs the other fields of public intervention, from the urban hygiene approach of the 19th Century, to present day social work; they are steeped in the terminology of *diagnosis,* of *resilience,* of providing *crutches* for life's *casualties,* etc. Through the triumph of the integration paradigm, all of European social policy has moved towards a reproduction of medical intervention: exclusion is considered in terms of an individual trauma to be treated, with a view to restoring individuals to the ordinary circuit of people in good economic and social health, thus neglecting the underlying structural causes of their difficulties. Given, then, that the paradigms of health policy have an impact beyond their field of application; to determine the basis for their legitimacy, as well as its limits, is an important consideration, also in relation to other aspects of public action.

In Europe, the last century was marked by a profound drift in public health policies, with the eugenic approaches of the totalitarian regimes, but also liberal democracies, which had recourse to forms of sterilisation of people with mental health problems, imprisonment of "deviants" judged to be insane, etc. Health was a pretext to subjugate the individual to the collective, through the definition of the norm and of deviance from it, with the latter seen as illness.[1] In the course of the last fifty years, these policies corrected themselves once more, first with the introduction of a right to care, which is a central element of social security systems all over Europe. Equally, the protection of the place in society of people in bad health (sick, old, disabled…) has become a legitimate axis of public policy. Other facets related to the role of the collective in relation to the health of individuals have emerged in the public sphere and in the law: the right to information has developed a great deal, particularly in Europe - for example, in relation to food products. The right to a clean environment is a notion that is gradually taking stronger and stronger root, as the different laws on pollution or the moratorium on genetically modified organisms show. The right to independence from the care systems has also progressed, with the recognition of the right to refuse treatment, and access for individuals to their medical records etc. In sum, it is clear that the last decades have seen a real right to health take some shape: encompassing a preventative public health protection approach (information, protection), protection in the case of illness (healthcare), and social protection (access to care, protection of liberties in the medical domain, etc.)

Yet, in recent times, this implicit and growing affirmation of a right to health is running up against economic imperatives: social security systems have become too expensive in relation to what society is willing to agree to and the current demographic trends point to a worsening of this tension. In the face of this evolution, European governments are moving towards a more budget-based assessment of the performance of health systems. The reforms that have been undertaken have the common aim of making savings, by increasing the patient contribution to healthcare and medication, promotion of private health insurance schemes, etc. What these measures have in common is the tendency to emphasise individual responsibility in the area of risk management, which obviously serve to penalise the poorest and therefore people who are homeless. Public policies also tend increasingly to focus on individual practices that are damaging to health (cigarettes, alcohol), while undervaluing the structural causes of health problems. For example in the area of road safety, public campaigns are focussed on the wearing of seatbelts and the dangers of speeding, while legislation on the state of the road infrastructure, on the use of transport lorries etc., fails to progress. In the area of cancer prevention, cutting down on smoking has become an almost a continent-wide campaign, while efforts in the area of prevention of work-related cancer have significantly diminished, in France at least, with the direction being taken in occupational medicine.[2]

The two closely-related, driving aims of current health policies are therefore the reduction of costs and the individualising of responsibility, which foreshadow an alternative to solidarity. Every man for himself, alone against the rest, in the competition of responsibilities, until finally, as Boris Vian expressed it in the title of his novel "*on tuera tous les affreux*"[3]. That will be the final stage in the shift of public policies towards intrusion, but also abandonment.

Competition between individuals, whose health problems and coverage in case of risk is increasing being made into their own responsibility, does not add up to positive acts of eugenics, but rather to a system of "abandonment",[4] a kind of "banishing" of individuals responsible for their own situation by healthcare systems.

The forms of this eugenics by abandonment are not very visible, yet formidable nonetheless. An illustrative case is that of people with mental illness, who have less and less access to specialised hospitals, in the name of "the right to the city", which is convenient from a budgetary point of view and which sends them back to the common law of the street. The evolution of psychiatric policies all over Europe produces mass homelessness[5], because the well founded efforts to do away with enclosed psychiatric treatment have not led to a better social system of care for mental illness, but rather to an abandonment of the sick, motivated in particular by budgetary concerns. Thus to some degree health policies are a factor in social exclusion, when the fear of intrusion justifies a policy of abandonment. Intrusion and abandonment are two forms of excess in public policy in the area of health and thus such policies must be founded on invariable and operationally constraining criteria in order to shape and contain them.

International law supplies us with concepts which are not just clearly defined, but which furthermore have legal weight in the States which are signatories of the treaties. It outlines a right to health which protects individuals and commits States.

All UN Human Rights texts include some focus on the right to health: the universal declaration on human rights, the international covenant on economic, social and cultural rights, treaties on the rights of the child, of refugees etc. Obviously, legally speaking, the right to be "in good health" is an aberration: we will all die one day, most of us following illness and bad health. The international legal texts in the area of human rights rather commit States to providing the conditions that offer the highest attainable standard of health for individuals (access to water, information campaigns, social security systems, legal protection against physical harm, etc.)

The Council of Europe is an even more precious resource on the legal level, as its texts offer procedures for redress, and on a political level as it offers definitions of the terms used and evaluations of public policies from the perspective of the enjoyment of rights by individuals. The most important text is the European Convention on Human Rights, certain articles of which relate to the protection of the health of the individual (prohibition of inhuman and degrading treatment, respect for privacy…). This treaty is binding for States and as a last resort offers the possibility of taking a case to the European Court of Human Rights, which rules only on the basis of the convention. But the most complete text on what might be considered a right to health, understood in terms of positive obligations placed on States is the "Revised European Social Charter" of the Council of Europe[6], which sets out, among other things:
Article 11 – The right to protection of health. States undertake to remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health; and to prevent as far as possible epidemic, endemic and other diseases.
Article 12: The right to social security. States undertake to establish or maintain a system of social security and to maintain it at a satisfactory level (defined by the Council of Europe) and to raise it progressively to a higher level.
Article 13: The right to social and medical assistance for any person who is without adequate resources, while ensuring that the person receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

This text is all the more interesting, given that this affirmation of the right to health is both completed by, and clearly set out in, the reports of the social rights committee of the Council of Europe, which furthermore carries out annual evaluations, by country and by theme, allowing for the analysis of public policies from the perspective of the commitments made by States as regards upholding social rights. Finally, a legal procedure, called the "collective complaint" allows certain eligible organisations to put a procedure in train against countries that they believe are not honouring their commitments. For example, France was found not to be offering adequate educational opportunities to autistic children, which led to a change in national legislation. The Council of Europe therefore offers a fairly comprehensive arsenal of definitions, evaluations of public policies and legal redress procedures in order to correct infringements to the right to health. The right to health as it is set out in international law, seems a useful and operational tool to define and evaluate public health policies: a navigational device that will allow us to steer clear of the pitfalls of intrusion and abandonment.

The task of NGOs is both to raise awareness of the definitions produced by the Council of Europe, to make use of the mechanisms of evaluation and even sanction of public policy, and to better bring them into the public sphere. In parallel, it is also necessary to further anchor the proposed definitions through use and engagement at local level and more fundamentally, to thus develop a culture that brings together human rights and social rights as the basic tool to develop and evaluate public policy.

Indeed, at the present time, there is a growing interest among the actors of the social and health sphere in approaching social needs in terms of individual rights. Caritas and ATD Quart Monde are turning their attention to the right to health in Italy and to the right to housing in France; these are significant developments. In parallel, organisations that monitor civil and political rights consider that social rights are part of the full interdependent and indivisible range of human rights. Social rights are not programmatic rights, the implementation of which can be put off indefinitely. The right to vote would not be infringed on the grounds of the cost of an election. Similarly the right to health cannot be reduced on the grounds of the cost of the healthcare system. The enjoyment of rights cannot be tailored to fit a given budget. It is the cost that can be adjusted, with the guarantee of the enjoyment of rights remaining a constant, which is not to say there should not be an effort to optimise quality and value for money. On this basis, Amnesty International in Ireland is having a campaign on mental health and is training organisations in the social sector to adopt a rights-based approach. In France, the same organisation is leading a campaign for a justiciable right to housing.

Thus we are going through a period where there is a growing and convergent awareness of human rights, and an affirmation that the full enjoyment of social rights – among them, the right to health – is legally and philosophically vital for public policies. We must still give weight and form to this awareness and build up a real alliance for social rights, reaching from local level to European level, in order to put public authorities under pressure to implement fundamental rights, in the name of which they have a mandate to administer the citizens. •

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[1] See Michel Foucault's texts *Discipline and Punish* and *Madness* and *Civilisation*
[2] On the issue of the over-emphasis of individual responsibility and the neglect of structural factors in health policies, see G. Barbier et A Farrachi : *La société cancérigène.*
[3] This novel by French author Boris Vian has not been translated into English, but the title would translate as « We will kill all the baddies »
[4] cf. Georgio Agamben : *Homo Sacer, le pouvoir souverain et la vie nue.* Abandonment is to be put in a situation of vulnerability, of permanent exclusion, by a sovereign power.
[5] In France over the last 30 years, the number of spaces in psychiatric hospitals has gone from 180 000 to 62 000 and the duration of treatment of individuals has gone from 230 to 35 days.
[6] The legal texts, the reports and explanations of the procedures are available on the website of the Council of Europe: www.coe.int

Health Reform in Germany and its impact on Homeless Patients

Germany

By **Werena Rosenke**, *Deputy Director, BAG Wohnungslosenhilfe e.V., Germany*

Since the 1st of January 2004, all persons receiving social benefits in Germany have to pay a patient contribution for medication, hospital treatment and patient care in the home, as well as a 10 euro medical consultation fee per quarter. Patient contributions are limited to 2% of the annual income; for chronically ill people the limit is 1%. For social benefit recipients, including people who are homeless, this means approximately 82 euros/41 euros a year. This ruling means an actual reduction of social benefit payments which in any case have not been adapted to the increase in the cost of living for years. In order to prove that a patient has reached the upper limit of his/her patient contributions, all bills have to be collected and submitted in a specific format. Due to their living situation, many people who are homeless are unable to do this.
Many homeless citizens do not receive mainstream social benefits every month, but a daily rate of approx. 11.50 euros per day. With this daily rate, it is impossible to pay a 10 euro medical consultation fee or patient contribution for medication etc.
In May 2006, the BAG Wohnungslosenhilfe e.V. (which is the German umbrella organisation of organisations working with people who are homeless) conducted a survey on "the impact of the 'law on the modernisation of health' ('Gesundheitsmodernisierungsgesetz – GMG') on people who are homeless and service provision for people who are homeless". The questionnaire was sent to 1195 organisations and agencies of homeless service provision all over Germany, which represents a good coverage of the homeless service sector in Germany. A return rate of 50% (n=587) guarantees representative results for the sector.

The survey focuses on five questions;

1. Did the health situation of service users improve, deteriorate or remain unchanged following the implementation of the GMG?
2. Did the proportion of people with health insurance increase or decrease, or is their status unclear?
3. Do the regulations of the GMG lead to a higher demand for counselling and support in your facility?
4. Does the facility support service users financially in order to enable them to pay the patient contributions for medication or the medical consultation fee?
5. Have referrals of ill people by to the homeless service by police or authorities responsible for maintaining public order ("Ordnungsbehörden") and the emergency medical services become more frequent, less frequent, or remained unchanged?

THE FINDINGS

54% of the organisations surveyed state that the health situation of their service users further deteriorated after the adoption of the GMG. 46 % of the facilities see no change in relation to the health situation of their users, which was bad in any case. However, 34 % of the facilities surveyed were unable to indicate the insurance status of their service users as this status is unclear.

82 % of the respondents note an increased need for counselling and support activities since the adoption of the GMG. 62 % of the facilities support service users with donations and other resources enabling them to pay the patient contributions and the medical consultation fee.
In 75% of the facilities the number of people who were referred from police or authorities responsible for maintaining public order remained unchanged.

The findings seem to confirm the concerns the BAGW had already presented before the law came into force. The BAGW had highlighted that the need to collect bills and make an application for exemption where the limit of patient contributions was reached, would be very difficult or even impossible for many people who are homeless. Their living conditions do not allow them to do so: in precarious housing conditions and shelters or emergency accommodation, the person may not be able to maintain a file with all the bills for medication and from doctors. In such living conditions, many people who are homeless simply do not have the necessary resources to collect the bills and to submit an application for exemption of the obligatory patient contributions.

The results from the BAGW survey on the impact of the health care reform on people who are homeless suggest that the overall situation can only be alleviated where homeless services provide additional financial support; either by paying the patient contributions and the medical consultation

fee or through the provision of loans. However, this cannot and will not be a sustainable solution, because the facilities do not have the necessary financial resources to sustain it. In addition, this short-term "solution" will only reach service users and patients who are in regular contact with mobile ambulances or in-patient facilities for homeless people. For those who were not able to integrate into the mainstream health system before the health reform, the hurdle for a doctor's consultation has become almost insurmountable.

The situation is also very problematic regarding the patient contributions. Again, homeless patients can only afford these payments because homeless organisations advance the money on loan, which the users then have to pay back in small amounts, or by using the money from donations where it is still available. The situation is slightly better, at least on a short-term basis, if a local health care project for people who are homeless exists, which has received medical donations that can be distributed amongst the patients.

The regulation concerning the situation of people with a chronic illness is of no value for most homeless patients. This is because, in order to prove a chronic illness, the person must go through an administrative procedure which is not feasible for people who do not have secure and adequate accommodation. The homeless patients often do not have the necessary documentation of their former illnesses and hospital stays. Some patients have no memory of their former hospital stays or mobile treatment, which makes it impossible to gather the necessary documents. Therefore it is often only possible to prove a chronic illness if the patient is integrated into the mainstream health care system. However, the problem of homeless patients is just precisely that they have been excluded from the mainstream health care system and only through the help of low threshold services can they move towards the reintegration into the mainstream system.

The regulation concerning the situation of people with a chronic illness is of no value for most homeless patients.

LOW THRESHOLD MEDICAL SERVICES FOR PEOPLE WHO ARE HOMELESS

There is no doubt among professionals active in the homelessness sector that there are structural and/or individual barriers for people who are homeless to accessing the mainstream health care system. These barriers include unclear insurance situation, social problems, lack of awareness of health problems, negative experiences with the mainstream health care system and/or social support services, or communication problems during treatment and contact with services.

The proportion of homeless patients with multiple needs is higher than among the general population. Not only is the social situation extremely difficult, but in addition to physical health problems, people who are homeless often also have mental health problems. This is why there have been various attempts over the last years to facilitate the access of people who are homeless to the mainstream health care system and through this, to ensure health provision for this vulnerable group.

People who are homeless depend on low threshold services because of their difficult living circumstances. All projects offering low threshold medical services intervene where the barriers to the mainstream health care system make it impossible for people who are homeless to access the services they need. It often takes a long time to get in contact with this group of patients. The medical treatment usually takes place in their habitual surroundings and often on condition that it should remain the first and only contact. It is not always possible to assume that that there will be follow-up treatment by a doctor. However, the continuity of treatment is crucial. Often it is only through the establishment of a longer-term relationship between doctor/medical staff and patient (which may take several months) and through the development of a relationship of trust, that a continuity of treatment can be ensured. The GMG thwarts these efforts. Through the introduction of the medical consultation fee, the patient contributions and the budget made available for the medical treatment of this group of people, the principle of low threshold health care for these people is effectively cancelled out.

The health care infrastructure for people who are homeless that has been developed over the last years is in danger: doctors within the public system working with people who are homeless, see the medical consultation fee deducted from their income, despite the fact that the patients are not able to pay them. No doctor's surgery working with homeless people can afford this. What is more, low-threshold medical services directly financed by homelessness organisations or through donations, are now facing a growing demand from patients with low incomes who are not necessarily homeless. They cannot afford a normal medical consultation which includes the 10 euro fee and the patient contributions for medication in the pharmacy. This additional burden cannot be taken up by the system of low threshold health care services for people who are homeless. The logical consequence – also in the context of this recent and representative survey - must be the abolition of patient contributions for medication etc. and medical consultation fees for homeless patients. •

Housing is Health Care

By **John Lozier**, *Executive Director, National Health Care for the Homeless Council, USA*

The primary and essential function of housing, to provide a safe and sheltered space, is absolutely fundamental to the people's health and well being.

Dearbhal Murphy[1]

Human rights theory holds that all particular rights are universal, indivisible and interdependent and interrelated. As Americans begin to pay more attention to human rights as the proper conceptual framework for our struggle to end homelessness,[2] we are coming to understand the interdependence of human rights in very practical – not just theoretical – terms. In particular, we are recognizing that housing *is* health care, and that extension of both rights, together, is necessary for ending homelessness.

The centrality of housing to issues of homelessness is no news. The earliest stirrings of the movement to end homelessness in the United States was the "Housing Now" march in Washington DC in 1989. The movement's mantra was "Housing! Housing! Housing!". The US faced an emergent crisis that was firmly rooted in huge reductions to the budget of the federal Department of Housing and Urban Development under President Ronald Reagan; between 1980 and 1987, $45 billion for subsidized or publicly-owned housing was lost.[3] Advocates sought restoration of major public investment in housing for the poor, but won only the shallow victory of the McKinney Homeless Assistance Act, intended to provide emergency shelter and services to the masses who were now living on the streets.

In the decades since, most activists' energy has focused on responding to the emergency needs of people who are homeless, and a gargantuan homeless services industry has emerged – now well over $2 billion in federal expenditures, and growing; the writer admits to being part of that industry as Executive Director of the National Health Care for the Homeless Council.

Housing has not been altogether forgotten in those intervening decades. The National Low Income Housing Coalition has stood stalwartly for the creation of new affordable housing on a necessarily massive scale. The real action, however, has been in the federal tax system, which provides housing subsidies through tax write-off for mortgage interest deductions for homeowners – an entitlement for the wealthy that was worth $122 billion in 2006.[4] Meanwhile, rental housing has become steadily less affordable and scarcer for poor people, and the crisis of homelessness has deepened. In 2005, for the first time, there was no jurisdiction in America where a full-time, minimum-wage worker could afford a one-room apartment.[5]

Meanwhile, homelessness and ill health have been locked in an ongoing cycle of cause and effect, spiraling constantly downward.

- Poor health puts one at risk for homelessness. Half of all personal bankruptcies in the US are caused by health problems,[6] too often and too quickly leading to eviction and homelessness. Dispossessed people often land with friends or family at first, but their living arrangements are tenuous, and break down particularly quickly for those with mental health or substance abuse problems.
- Homelessness puts one at risk for poor health. Exposure to infection, to the elements, and to the violence of the streets is common. Lack of control over nutrition or personal hygiene or sleep demeans and debilitates homeless people. Risky survival behaviors are the currency of the streets. The psychological toll is as dire as the physical.[7]
- Furthermore, homelessness complicates efforts to treat illnesses and injuries. Neither health care financing nor the structure of the health care delivery system is attuned to the particular needs of homeless people.[8]
- The outcomes are disastrous: people who are homeless suffer all illnesses at three to six times the rates experienced by others, have higher death rates, and have dramatically lower life expectancy.[9]

The McKinney Act provided the same sort of partial response to the health needs of homeless people as it did to their need for shelter and housing. It provided funding for a system of safety-net clinics that has steadily grown to 185 projects throughout the nation, worth $170 million and serving 600,000 homeless persons per year. The system is vital to their wellbeing, but it reaches only a fraction of the 3.5 million persons thought to experience homelessness each year, and it does not provide specialty care or hospitalization. Major deficiencies remain in mental health and substance abuse care for homeless persons and others.

Although the majority of Americans support a system of universal health insurance that would pay for comprehensive health care for everyone, 15.9% of the population, 46.6 million Americans, are uninsured: a million more are added each year. 71% of Health Care for the Homeless clients are uninsured. The growing rights-based movement for universal health care faces strong resistance from insurance, pharmaceutical and other industries that profit obscenely from the current inhumane system.

A new and widely-accepted approach to these problems has emerged. "Housing First" declares that first, and above all, a person who is homeless needs housing.[10] This new emphasis differs from "Housing! Housing! Housing!" in its focus on resolving individuals' homelessness, rather than on the broad systemic deficits and political decisions that drive mass homelessness.

The US government promotes Housing First approaches in its "chronic homeless" initiative, which targets single individuals who have been homeless for a long time and who have a disabling condition (that is, a *health* condition, and likely *several* health conditions). Housing First moves people who are homeless directly from the streets into Permanent Supportive Housing where treatment services are readily available, but participation in such services is not mandatory.

The premise of Housing First is that housing will improve the new tenants' health and social status, will improve their use of primary care and outpatient services, and will reduce their utilization of hospitals, jails and emergency services (thereby reducing costs). At its heart, Housing First claims that housing *IS* health care.

The HIV/AIDS community in the US has long promoted the notion of housing as health care, and research from that constituency is beginning to validate this common-sense idea. The 2005 National Housing and HIV/AIDS Research Summit concluded that "recent studies […] show strong correlations between improved housing status and reduced HIV risk, improved access to medical care and better health outcomes."[11] Preliminary findings of a major study by the Centers for Disease Control and Prevention, reported at the same Research Summit in 2006, suggest that, controlling for all other variables, housing itself may improve the health of persons living with HIV or AIDS.

Housing improves health for the same reasons that homelessness is deleterious. A clean, dry, secure environment is fundamental to personal hygiene (including wound care and dressing changes), medication storage (refrigeration of insulin, safe storage of needles), and protection from assault and the elements. Private space allows for the establishment of stable personal relationships; housing has been shown to reduce risky sexual behaviors.[12] A stable residence facilitates effective interaction with others, including treatment providers and social support systems, and increases adherence to treatment plans including regular meals and keeping appointments. Housing may reduce anxiety and consequently reduce stress-related illnesses.[13] In these ways, housing both promotes healing and prevents the onset of new illnesses.

Housing must be considered a first-line response to the *personal* health problems of homeless individuals. Moreover, the creation of additional affordable housing must be understood as a critical *public health* responsibility, for the control of communicable disease and for efficient and effective health care planning and spending. Public health has long understood the role of housing as a determinant of health, and has played an historic role in developing and enforcing housing standards.[14] The known health effects of modern mass homelessness demand that public health renew and broaden its advocacy role to insist that affordable housing is a necessary prerequisite to eliminate homelessness.

A practical and comprehensive understanding of health necessarily includes housing and other social factors. Ultimately, these factors must be considered together in the political and funding arenas. Divided funding streams and uncoordinated policy-making must yield to unified budgets and synchronized policies which will promote – in the language of the World Health Organization – "a state of complete physical, mental and social well being".[15] A growing human rights movement offers new hope that this can be accomplished. •

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[2] See, for example, *Without Housing*. San Francisco, Western Regional Advocacy Project: 2006. or Foscarinis, M. Advocvating for the human right to housing: notes from the United States. *New York University Review of Law amd Social Change*, 30:, 2006.

[3] Western Regional Advocacy Project, 2006.

[4] Western Regional Advocacy Project, 2006.

[5] National Low Income Housing Coalition. *Out of Reach 2005*.

[6] Himmelstein, D, et al. Illness and injury as contributors to bankruptcy, *Health Affairs*. February 2, 2005.

[7] See Murphy, op. cit., for a thorough exploration of these topics.

[8] Institute of Medicine. *Homelessness, Health and Human Needs*. National Academy Press: Washington, DC, 1988.

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[11] National AIDS Housing Coalition. Housing is the foundation of HIV prevention and treatment: results of the national housing and HIV/AIDS research summit. Washington DC, 2005.

[12] National AIDS Housing Coalition, p. 4.

[13] Rajesh Parekh, MD. Prescription for homelessness: housing. Presentation at Health Care for the Homeless Policy Symposium, National Health Care for the Homeless Council, Washington DC, June 9, 2006.

[14] Krieger J, Higgins DL. Housing and health: time again for public health action. *Am J Public Health*. 2002;92:758-68.

[15] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946.

Housing Difficulties and Mental Health Policies

France

By **Benoît Eyraud**, *PHD student at the Centre d'études des mouvements sociaux, Ecole des Hautes Etudes en Sciences Sociales*[1], *France*

If a homeless person does not want to get in to the SAMU Social van, it is not madness on his part.

Every year, when the temperatures drop with the arrival of winter, the attention of the general public is drawn to the unacceptable conditions borne by people who are homeless. And each year the same amazement greets the information from people working in homelessness organisations that there are homeless people who refuse to use the shelters and services available to them. This refusal is an expression of the suffering and resistance of individuals, and also highlights weaknesses in the system and social blindness. It is unreasonable because it is life-threatening, but it is ultimate way of questioning a social world in a state of collapse:

> "If a homeless person does not want to get in to the SAMU Social[2] van, (…) it is not madness on his part, even if it is unreasonable. It is because he fears that for those taking action around him, the emergency is not to offer him adequate housing but rather to get him off the street so that he is no longer visible and the city is clean. So he resists and dies as a result. Through his degradation, his negligence and his refusal to be taken care of, he defies anyone to help him." [3]

This experience of a rough sleeper does not correspond to that of all people who are homeless[4], nor to that of all those experiencing housing exclusion and even less so to that of an ordinarily housed person. Yet it does highlight the universal ontological functions of housing (protection, ownership, maintaining of identity) both by their presence and by their absence:

- the refusal by a rough sleeper to leave such a hostile place dramatically illustrates the function of the dwelling place to "maintain identity". This maintaining is the ultimate capacity relating directly to the dignity of the individual.
- The almost certainly tragic outcome of this refusal also highlights the other functions of housing through their absence: the absence of protection; the absence of possibilities for ownership.

The impossibility of bringing together these three functions is what makes the way of living of people who are homeless unbearable. To put it differently, if we consider living somewhere as "*staying in a certain place and occupying it as a home*", the figure of the rough sleeper embodies a situation where it is impossible to bring together a space of protection and maintaining of identity, over which ownership can be extended. Worse still, the only small act through which a rough sleeper can express his dignity and his way of living - the refusal to leave the street - places his life and health at risk. The self-endangering refusal is the final action in order to make the maintaining of identity possible.

Thus, starting from the figure of the rough sleeper, one is confronted with the full range of difficulties in accessing and sustaining housing: how to promote the joining up of the three functions of housing (protection, ownership and the maintaining of identity) and prevent them from entering in to opposition with each other? The usual institutional responses do not take account of the way in which these three functions relate to one another. Health actors respond to the somatic and mental pathologies; reintegration and housing actors defend access and the right to housing. To approach questions of access to housing and sustaining of tenancies from a mental health perspective allows one to take account of the conditions that allow the three functions of housing to be brought together.

This kind of approach is based on work in the area of the psycho-dynamics of the dwelling place[5], as well as in the area of sociology and social support[6]. It takes account of the of the interdependence of different forms of social structures of support (housing, social networks, rights…) and the psychological dynamics of ownership necessary for a dignified living situation, compatible with social and political life. In maintaining or in fleeing them, rough sleepers express the rupture of the relationship between the private and the social. The psychologist explains this rupture in terms of an individual pathology. The sociologist explains it as the result of the inadequacies of the social structures of support available to the individual. An approach in terms of mental health, one that seeks to both include and go beyond the framework of psychiatry,[7] aims to promote a better joining up of the social and the psychological in housing policies.

Three dynamics of « mental health » in relation to the dwelling place allow one to take account of the relationship between the configuration of identity, social structures of support and psychological investment. These dynamics

relate to different phases that people experiencing difficulties accessing or maintaining housing go through.

A DYNAMIC OF DISTANCING: TOWARDS THE LOSS OF HOUSING

A first dynamic weakens the relationship between the individual and his housing, leading to its possible loss. The suspension of a lease, an eviction and leaving home are sudden events. The process leading up to this rupture, the weakening of the relationship between the private and the social, takes place over time. The psychological investment in the dwelling place diminishes progressively, in a way that is interdependent with the deterioration of the social structures of support: exerting control over one's housing situation becomes difficult, as this no longer offers the protection that it should. Several symptoms point to the deterioration of the capacity to maintain one's living situation: indebtedness, difficulties with the other occupants, problems in the neighbourhood, the deterioration of the state of the housing itself. These symptoms lead to the stigmatisation of the person falling outside of the norms, by the landlord, the neighbourhood, by friends and family.

The balance between inside and outside is blurred and points of reference are lost and replaced by an absence or an overwhelming presence: the housing is invaded; the housing is emptied. Solitude or the presence of others becomes impossible to live with. Suddenly this distancing is unbearable: rupture combines forms of rejection and of escape. The loss of the housing is enacted. Yet there were indications, but public policies have difficulties identifying such signs.

Policies to prevent evictions are a vital element for the prevention of housing loss.[8] Yet they are inadequately developed. The identification of the signs of the weakening of the relationship between the private and the social structures supporting the person should be part of a policy to prevent the loss of housing. Which actors might be able to identify such signs? Family, friends, neighbours, social services, social landlords…Why identify them? Not to prevent the process of distancing from the housing, which is the temporary expression of the fragile state of its inhabitant, but rather to open this process of distancing towards new forms of social support, so that the individual can find new footholds to retain the housing. Without this, the distancing, the difficulties in living in one's home according to the accepted social norms, represent failure. The role of public policy then is to transform this failure into an experience which individuals can draw upon in order to manage new social support structures that they encounter.

THE ABSENCE OF A DYNAMIC: THE NEED FOR STRONGER FORMS OF ACTION

The diminution of psychological investment and the deterioration of social structures of support can lead to a rupture between "inside" and "outside"; between the "psychological investment and social structures of support". Two types of paradigmatic situation illustrate this rupture: the refusal of help or shelter by certain homeless people; and the refusal to go outside their house by people who shut themselves in to their homes. Furtos calls this psychological reaction, the "syndrome of self-exclusion". Socially speaking, what these situations reveal is an overlong absence of social supporting structures.

Becoming socially invisible explains the state of extreme withdrawal that they are living in and the absence of a link between "inside" and "outside". These situations are generally revealed when strange or even worrying signs are noticed by the neighbours or by professionals. When the alert is given, the "institutional support services", embodied by professionals in the area of social work or health, are confronted by a paradoxical situation: the help being offered is refused. The institutional action then becomes difficult to plan. To take no action places the life of the person in danger, but a badly planned action may destroy any possibility of building up a new relationship between the individual and his environment.

Vigilance towards the need for stronger forms of action is therefore necessary. At worst this intervention takes place against the will of the person, if the threat they are under is too great. Forced hospitalisations are thus a form of action that may make sense on the condition that they are accompanied by other forms of action and support. In relation to these interventions without the consent of the individual, experience shows that professionals may sometimes go beyond the institutional framework in order to be sure of reaching individuals in an extreme state of withdrawal. This transgression of the formal rules may be the opening through which a new relationship can be formed and a way out can be found. The role of the professional has moved from its normal setting in response to the suffering of the user, not within the framework of care in the medical sense of the term, but rather in a form of "care-giving" which constitutes a "psycho-social clinic", that is to say an extension of the clinic beyond its usual walls.

A DYNAMIC OF BRINGING TOGETHER: INTEGRATION THROUGH HOUSING

After the rupture, after the experience of the street and/or that of the psychiatric hospital, the return to ordinary housing is made possible by a

new relationship between the psychological investment in the housing and the social structures of support which condition it. New 'institutional" forms of social support are appearing: professionals in the field of social work, reintegration and psychiatry… These professionals support the search for housing, but also work to orientate the individual towards a normal way of living in it: they try to lead the individual through an idealised reintegration process. In France, these tools were conceived starting from an ideal model of an integration process going from the street to independent housing by passing through a range of forms of temporary and supported housing. But access to this process is dependent on a range of guarantees to be provided in order for the institution to allow access or the possibility of staying on in housing. Marginal ways of living, which express the singularity of a chaotic housing situation, are suspect.

Yet, for the individual, the return to housing is founded on the development of a new balance, often strange or conspicuously different, between "the inside and the outside", sometimes in reaction to, and as way of resisting, forms of monitoring and control of their way of living by professionals. Specific ways of living in housing are then developed, of which the most common is the "in-between" form: in-between housing and the street; in-between housing and hospital; in-between housing and public space (for people who until then had been shut inside their homes). This "in-between" has a specific social temporal framework: the return to the street or to the hospital is for a defined period of time.

This new relationship between the private and the social is favourable and necessary for access to housing and the sustaining of the tenancy. But the dynamic is still fragile due to the temptation to normalise on the part of the institutional forms of social support and the temptation to withdraw into marginalisation on the part of individuals. These dynamics of bringing together depend therefore on the capacity of institutions and professionals to support a process of integration without making access to housing for individuals overly conditional on a normalised conception of the way of living in it.

CONCLUSION

The public policies promoting the right to housing have led to the development of a conception of integration through housing as a process allowing one to move progressively towards "independent housing"; and thus all housing products, services and ways of living in housing are defined in terms of their lack in relation to this ideal. An approach in terms of mental health shares the aim of allowing enjoyment of the right to housing, but does not start from the idealisation of the way of living that is independent housing; rather it starts from the recognition of the capacities and ways of living that are adopted at different stages in a chaotic progress, where phases of distancing from, and moving closer to, the housing, succeed one another.

All too often, progress in this « housing » process is linked to an evaluation of the way of living of individuals by the institutions, serving to attach conditions to their enjoyment of the right to housing. The presentation of the three dynamics has shown that the individual does not cease "living in" the housing, whatever the relation that may develop with the dwelling place; a mental health approach towards people in difficulty in their relationship to their housing allows for the recognition of different. •

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[1] "Research Centre for Social Movements, Research School of Social Sciences".

[2] This is an emergency outreach service, which goes out to homeless people in the street to offer them material help and a space in an emergency shelter.

[3] Maisondieu (J.), Rhizome n°7, December 2001.

[4] Cf. Colin (V.), « Psychodynamique de l'errance », Doctoral thesis in Psychology at the University of Lyon, January 2002; For an epidemiology of the psychiatric problems of rough sleepers, cf. Kovess (V.), Manzin-Lazarus (C.) Toxicomanie et Addictologie, 2000, vol.22.

[5] The dwelling place is characterised in this framework as a space of « psychological ownership », which allows « the symbolic expression of the imagined », which needs to be delimited (by walls, neighbours) and which is an expression of the dynamic of identity. Cf. Fischer (1991), Moles (1972), Anzieu (D.), 1987, Bonetti, 1994.

[6] This approach identifies the protections that are necessary for individuals in order to be independent. Cf. Castel (R.), 2002 ; Joubert (M.), 2004.

[7] "Mental health concerns the individual in his capacity to live and to suffer in a given environment, without destructiveness, but not without revolt, that is to say his capacity to stay in touch with himself and with others, and his capacity to invest and to create in this given environment, including productions that are atypical and not normative", Furtos (J.), Introduction to the International Conference in Lyon entitled "La santé mentale face aux mutations socials", Lyon, 12-14 October 2004, ONSMP-ORSPERE.

[8] In France, this policy is bearing its first fruit, as the number of evictions has dropped for the first time since the law to promote the fight against exclusion.

Drugs, Disease, Madness and Death

By **Peter Cockersell**, *St Mungo's, UK*

I hope the title caught your attention!

But it is not just to catch your attention that I have used this title – they are the daily realities that most chronic and street homeless people live with, and that our frontline staff has to try to work with. This is not just about people who have not got anywhere to live, it is about people with severe addictions, severe physical health problems, severe psycho-emotional problems, and who then die at an early age.

Chronic homelessness is treatable, if we reconfigure it as a health problem.

However, I do not think that this is a reason for despair. On the contrary, it offers the opportunity to look afresh at what we are doing with the long-term homeless people. Substance dependency is treatable, physical health problems are treatable, mental health problems are treatable. *Chronic homelessness is treatable*, if we reconfigure it as a health problem.

St Mungo's is London's main hostel provider, with around 1500 bed spaces. We work with rough sleepers, single homeless people, and other vulnerable adults. We also provide street population services, offender services both in prisons and the community, and specialised mental health, substance use, and employment and training services.

I have said that the daily reality of chronic homeless people is drugs, disease, madness and death – so let's have a quick look at those four areas among our clients (statistics are from internal surveys conducted by external researchers).

Drugs –

- 86% of our intake into frontline hostels have substance dependencies
- Most of them are intravenous poly-substance users
- Most have substance-use related physical health problems: abscesses, respiratory problems, kidney and liver disease, DVT's (deep vein thrombosis), BBV's (blood borne virus), etc.

Disease –

- 2 out of 3 have physical health problems and half of those are not getting treatment
- Clients have up to 13 untreated treatable conditions on arrival at our hostels (average being 6)
- They include the 'diseases of rough-sleeping': pneumonia, trench foot, bronchitis, infections, TB (tuberculosis), broken bones

Madness –

- Around 30% have a mental health diagnosis
- But a recent survey by a consultant psychologist found
  - Up to 85% with personality disorders
  - 49% anxiety disorders
  - 25% depressive disorders
  - 23% Post-Traumatic Stress Disorders
- The majority have avoidant engagement patterns – they avoid support rather than seek it out

Death –

- Bed spaces have increased by 50% in the last two years – the death rate has increased by 150%
- The average age of those who die in our frontline hostels is 37 – half the average life expectancy of a man in Britain

St Mungo's offers some treatment – around substance use particularly, but also in the area of mental health, relationships etc. Mostly we do it in partnership with the NHS (National Health Service). But it is not enough. And it is not seen as the priority – indeed our main funding stream, "Supporting People", expressly forbids the funding of 'care', and treatment falls into the care category.

I argue that what chronically homeless people need is treatment. Yes, they need accommodating – it is very, very difficult to provide high quality treatment if the person is living in the street – but to make long-lasting change happen, and to enable people to end the cycle of repeat homelessness we need treatment.

What sort of treatment? Well, we need treatment for substance dependency, mental health, and physical health. Of course, many of these are available in Britain through the NHS, but what we find is low take-up or follow-through by many of our clients. Or that one aspect gets some treatment, but that is then undermined by a lack of treatment of the other aspects of the person's ill-health.

So what we need are treatment services that are accessible to the clients, that are holistic and deal with all aspects of ill-health, and which are appropriate and effective for people with this range of conditions. In practice this probably means hostel-based services.

St Mungo's developed the first hostel-based substitute prescribing services in Britain and we have had higher take-up and retention rates than mainstream services, even though working with so-called 'chaotic' street-based users. Similarly, we have worked with the NHS to ensure GP's (General Practitioners) and nurses do surgeries in our frontline hostels, so we can at least assess people's physical health needs.

But there are still big gaps in the treatment we can offer. These surgeries cannot deal with many of the conditions our clients have. The clients end up hospitalised - but they cannot cope with hospital, or the hospital cannot cope with their behaviours, so they self-discharge - or they are discharged when the medical crisis has passed but before treatment is completed. And there is nowhere for them to go that can offer medical support in a hostel setting: we need hostel-based 'sick bays' urgently. People are dying because we do not have them.

And there is little treatment for mental health apart from drugs, and our clients take their own for that. In London, there is almost no provision of psychological therapies to people who are homeless or hostel residents. One team, Westminster PCT's (Patient Care Technicians) Homeless Health Team, provides psychodynamic counselling at day centres in Westminster and achieves 80%-plus attendance from 'chaotic' chronically homeless people: they want the service. It achieves results: people move on; to accommodation, to treatment, to relationships. When St Mungo's surveyed its clients and asked what they wanted in treatment terms, the second most requested (after dentistry) was counselling. Psychological therapies are the stated best practice treatment (according to the Department of Health and NICE (National Institute for Health and Clinical Excellence) guidelines for personality disorders, depressive disorders, anxiety disorders etc. Our clients have all of these psycho-emotional disorders, but they get no treatment at all.

The simple truth is that most people with chaotic and street-based lives will not and cannot move on from substance use and chronic homelessness without treatment. If we want to resolve the current situation, we need to provide appropriate and accessible treatments. That requires adequate resources. And for this to happen, we need politicians and public health officials to accept that *chronic homelessness is a health issue.*

It is very straightforward:

If you are
- poly-substance dependent,
- with untreated wounds and illnesses,
- and with a personality disorder, an anxiety disorder, and avoidant behaviour patterns,

you are likely to become homeless and remain homeless

If you get *accessible and appropriate*
- treatment for your mental health,
- treatment for your physical health,
- treatment for your substance use,

you are likely to be able to get a job and to keep a place to live

Peter Cockersell is Director of Programmes for St Mungo's, with responsibility for substance use, street population, offender, and mental health services. He is also an Adult Psychotherapist working with homeless people on a sessional basis for Westminster PCT (Primary Care Trust).

Good Food in tackling Homelessness

By **Des Ryan**, *Edinburgh Cyrenians, UK*

Food matters! We are what we eat. We feel as well or as badly as we have eaten. We can all relate to the warm, beneficial feelings of health and well-being associated with enjoying a good meal that is well presented in pleasant surroundings and in good company. Most of us will also know the low energy, stress and feelings of depression that come during those periods when we do not stop and eat regularly or sufficiently. A period of poor diet also exacerbates any ills we have and weakens our immune system, making us more vulnerable to ill health.

Seventy per cent of people who are homeless in the UK were found by research to suffer from malnutrition. Three out of five go without any daily fruit and vegetables whatsoever. Their immune systems are depleted, putting them at risk of serious illness. Loneliness, isolation and low self-esteem take their toll as well. In addition to physical damage, the common experience was that food in homeless shelters was of poor quality and served in a way and in an environment that brought people down rather than up-lifting them.

People who are homeless are the very people who are most in need of the therapeutic effects of good food and are most at risk from its absence. We who seek to help should look at the transaction around food as a great opportunity to engage with homeless people at the point of need and to use it as a means to promote physical, emotional and mental health.

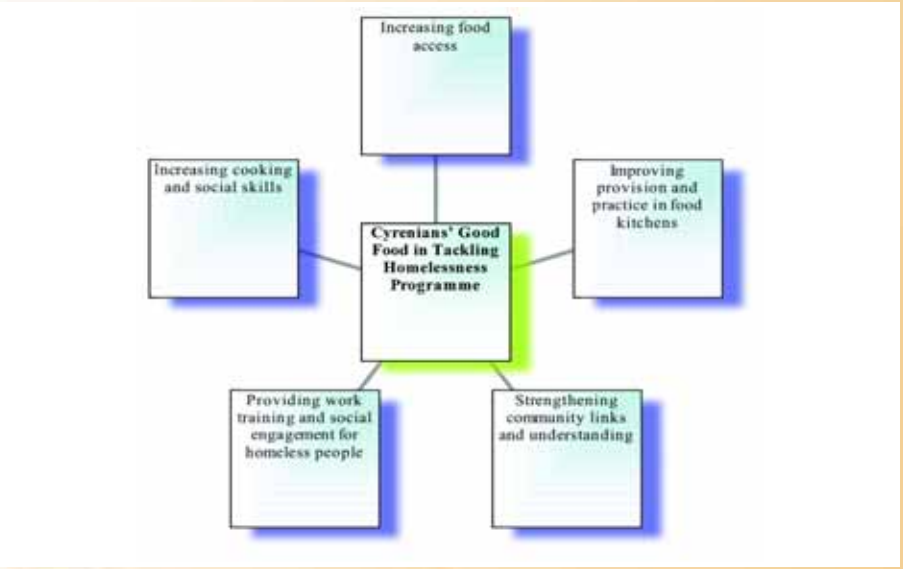
Since 1968, The Edinburgh Cyrenians have worked at every level in the community to address the problems associated with homelessness. Cyrenians has a holistic strategy for tackling homelessness. We encourage individuals to develop and maintain lifestyles that in time can build a bridge between the streets and a home of their own. And we educate the community to be more inclusive of people who want to settle in and belong.

Good food and the dinner table has always been central part of our work. Cyrenians Farm, for example, has grown organic food for and with the residents living there since 1972, as key part of being a therapeutic community.

The breakthrough that led to the Good Food Programme starting in 2000 was that **FareShare UK** had developed a way of safely getting large scale donations of surplus stock from the food industry and Cyrenians took this operation to Scotland as a social franchise. *Each week* we collect, inspect and redistribute about 7000 kg of surplus food to over 40 kitchens providing meals for homeless people. The operation has to meet a high standard of food safety standards throughout the whole process of collection, storage and delivery. All kitchens are regularly inspected. We can only operate with the trust of food businesses. Every day homeless projects receive a regular if unpredictable supply of good quality food that supports their food budgets and helps them to provide quality, nutrition and variety – and even some treats!

But we were determined from the outset that the food should not be a 'hand out' but should be a 'hand up' to a better life. There are, therefore, 5 elements to the Good Food Programme and food is a means to an end.

- **Increasing food access**: Although we use the FareShare scheme, we encourage all homelessness projects to think about other means, such as growing some of their own food, especially with the help of service users
- **Increasing cooking and social skills**: We have developed a teaching model called Cooking at Home that works with homeless people to help them learn cooking skills and to appreciate the social value and pleasure of cooking and eating with others



- **Improving provision and practice in food kitchens**: As we don't charge homelessness projects for the food, we ask that they use any money saved from food budgets to (e.g.) improve their eating areas or train staff in food safety or nutrition. We provide a Good Food Handbook (download from website) and good practice support service for homelessness project workers and managers.

- **Providing work training and social engagement for homeless people**: Around 100 homeless people a year are able to help in the running of the Good Food Programme, both in FareShare, Cooking at Home and in training and consultancy work. Some use the opportunity to get paid work.

- **Strengthening community links and understanding**: The Good Food Programme brings together people from all walks of life; businesses, community volunteers, professionals and homeless people, all sharing as equals in the delivery of the Programme. This has a huge impact in challenging stereotypes, creating new links between people and groups and enriching the local community as a whole. People with experience of homelessness are trained to disseminate learning from the Programme.

Healthy food builds healthy people – and healthy people are better prepared to build lives for themselves away from the streets. Through the Good Food In Tackling Homelessness programme, Edinburgh Cyrenians have discovered food to be a powerful means of transforming experiences of loneliness, isolation and low self-esteem into experiences of confidence and enjoyment, as well as being a key to better physical health. •

The Good Food film is available on DVD from the contact below, (English only).

*Through **SIREN** Training & Consultancy we are now able to provide Study Tours for anyone who wants to know more about the Good Food Programme.*

Contact:
Programme Manager, Carol-Anne Alcorn
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How to provide Healthcare for People who are homeless? Interdisciplinary Training Courses at the University of Oxford

By **Dr Angela Jones**, *Course Director, Department for Continuing Education, University of Oxford*

The image of the English city of Oxford with its beautiful architecture of 'dreaming spires' and students cycling around in academic dress does not immediately accord with the statistic that it has had historically one of the highest counts of rough sleeping in the UK. Yet anyone who understands the 'economics' of homelessness will understand that Oxford's status both as tourist hotspot and as an intersection point of numerous major transport routes from north to south as well as from London to the west, will also understand why Oxford attracts homeless and displaced persons from all over the UK (and beyond).

An inspirational and innovative doctor, Hilary Allinson, set up a primary care service dedicated to the care of homeless people in the 1980s along with her friend and colleague, Dave Collett. Under their guidance, the service moved from a temporary 'Portakabin' to a beautiful purpose built surgery next to the night shelter and is staffed by primary care physicians (GPs), nurses and support staff paid for out of the National Health Service budget. When I came to work there as a locum GP in the late 1990s, I had never worked with people who are homeless before. I was immediately 'hooked' by the complexity of the task and by the power of the multidisciplinary team when working together to maximum effect – so I stayed on.

HOW DID THE IDEA FOR THE COURSE ARISE

Gradually, I became involved in the teaching work of the service, where medical and nursing students as well as GPs in training came to experience and observe the work of the team. Team members also gave regular teaching to the local hospital accident and emergency trainees as well as to anyone else who wanted to hear. This teaching had the potential to have a great effect locally on the health staff who, hopefully, would approach people who are homeless with a greater understanding of the issues involved with being homelessness and unwell.

I also had the opportunity to witness and run a number of interdisciplinary teaching sessions within the service, and also including members of other local homeless services on health issues. There were challenges to running this kind of training but every time we did so, we noticed an improvement in working relationships which was unrelated to the topic of the training but seemed to be a function of getting together and learning together. Out of this experience, together with an increasing exposure to some of the literature on interprofessional education, came the idea of an interdisciplinary training course for people involved in providing healthcare to people who are homeless.

WHAT DOES THE COURSE COVER

Designing and planning the course was made a far easier task by having the support of a University Department with a special interest in continuing professional development and of a portfolio director, Dr Janet Harris, with a background of participatory practice and research with hard-to-reach groups. We started by interviewing people who had experienced homelessness and various professional groups about the kind of education that they felt would be helpful and worthwhile. This information was collated and combined into a curriculum delivered via six modules.

The first module covers the key concepts of healthcare provision for people experiencing homelessness. It is delivered online, requiring about ten hours work per week over ten weeks, including reading and fieldwork for the assignment. Topics covered include:

- Definition of homelessness
- Causes and consequences of homelessness
- Stigmatisation
- Health needs of people who are homeless
- Health promotion for people who are homeless
- Keys to engagement
- Significant event analysis
- Confidentiality and consent
- Complex and multiple needs
- Clinical risk management
- Case management and coordination
- Self care as a professional
- Harm minimisation
- Enablement
- Values-based practice

We feel that this module functions well as a stand-alone short course, suitable for people staring out in the homelessness field to orientate them to the issues, and also for people who meet homeless people occasionally in their work such as ambulance staff, casualty staff, pharmacists and so on. There is a strong emphasis on reflective practice, as an important discipline and tool in ongoing learning and professional practice and development.

The subsequent modules are delivered face to face in three two-day sessions in Oxford from January to September and are designed to go over the issues covered briefly in module one in more depth (this revisiting of topics is known as a spiral curriculum) plus other more

complex subject matter, particularly in the sociological and legal areas as well as more in depth work on the clinical issues affecting different homeless groups. Reflective study is encouraged and the online journal started in module one remains available to be added to online throughout the course and printed off at the end. The final module is a seminar where students present their own work and reflections for their final assignment to each other and to the tutors followed by attendance at an international health and homelessness conference, which is to be held in Oxford annually in mid-September.

Having obtained university accreditation for the course, it is now ready to run and we are hoping to have the first group of online students in the spring of 2007, and the first full run of the certificate starting in September 2007. As the course is nominally at postgraduate level, any person with an appropriate degree is eligible. However, we are also able to take students who have not obtained a university degree but who have at least five years experience in working with people who are homeless, subject to them being able to satisfy us of their ability to study on the course. All disciplines are welcome from psychiatry to podiatry, from support and outreach workers to family practitioners and probation workers. The wider the range of disciplines, the better the opportunities to share our knowledge, our attitudes and our own unique perspectives on the task of providing appropriate healthcare to people experiencing homelessness.

POTENTIAL FOR DEVELOPMENTS

At the moment, the course is largely oriented toward the United Kingdom, with Government documents drawn largely form English or UK legislation. There is potential, however, to develop the course to have a more international application or flavour, by providing European or US references alongside the British ones. Indeed, by introducing this international aspect, it could enhance the interest and the sharing of knowledge and viewpoints within the learning. There might also be an opportunity to deliver all the modules online, if there were a demand. However, although marvellous things can happen in an online community, it is also wonderful to meet up with like-minded colleagues and to have some protected time away from home and the workplace for personal development so I would be sad not to have at least one face to face session during the certificate.

CONCLUSION

I hope this has given a flavour and an overview of this unique educational intervention and that you may be interested in finding out more and even in participating. Further information is available by email to: courses@conted.ox.ac.uk •

Dr Angela Jones is a family physician who has worked with homeless people in Oxford and is now Course Director for the Certificate in Provision of Healthcare to People Experiencing Homelessness at the University of Oxford's Department for Continuing Education. She can be contacted on angelajones@doctors.org.uk