

European Network of Homeless Health Workers (ENHW)



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Dalma Fabian, Policy Officer, FEANTSA

Dear Readers,

We are pleased to share with you the latest edition of the ENHW newsletter. The current issue features four articles from four big European cities: London, Brussels, Athens and Milan. The first article gives account through three initiatives of how peers can engage in work on the health issues of homeless people. The second article presents the work of a group of dedicated Street Nurses who provide nursing care for homeless people in the center of Brussels and describes how hygiene can be a key to bring change in homeless people. The third article reports the multiple health needs of homeless people in Athens and examines homeless people's awareness of and access to health services. The fourth article presents a project based on an intervention model that offers flexible care for homeless people with mental health problems who have difficulty accessing public and community based care.

In the resources section, you will find information on guides, reports and research, which are related to health and homelessness and might be of interest to you.

We hope that this newsletter will stimulate further reflection and interaction, which could take the form of articles for the next issue. We would be pleased to receive information on any relevant research or events you might be aware of.

We would like to extend my warmest thanks to everyone who has contributed to the current issue. Please do not hesitate to send your comments, questions and contributions to dalma.fabian@feantsa.org.

Sharing Experiences

Peers Work in Health and Homelessness: Examples of Innovative Practice

Kit McKinley (Peer Advocate, HHPA and Project Assistant, Groundswell) & **Josie Mavromatis** (TB Peer & Care Navigator, London Pathway) on behalf of the Peer Advisory Group¹

The health of people who are homeless is among the poorest in our communities. Homeless people are more likely to suffer from mental and physical ill health, and be unable to access required health services (Groundswell & Homeless Link, 2010). Peer support is essential in giving service users choice and control in meeting their support needs (NCIL,

2008). Peers² have a unique understanding of both the realities of homelessness and barriers faced when accessing care. The Peer Advisory Group was formed by Groundswell in London to guide the Tuberculosis (TB) Peer Education Project (see below) and to *provide advice and guidance and actively participate in campaigning for and promoting the value of peer work in health and homelessness*. The group comprises of professionals from health and social care, as well as peers and user representatives.

Involving peers to address health issues is relatively new. This article describes three peer initiatives, highlighting the excellent work being carried out and the valued contribution peers make.

1. The TB peer education project

In London, TB case numbers have been increasing for 23 years. Disadvantaged communities³ account

¹ The group comprises of allied-professionals from the health and social care sector, and includes: Joe Hall & Alistair Story (Find&Treat), Simone Hellenen, Martin Murphy & Beth Coyne (Groundswell), Helen Mathie & Pip Bevan (Homeless Link), Mary Cate MacLennan (Commissioning Consultant), Josie Mavromatis (peer), James Camp (TB Outreach Worker), April Wareham (User-rep, NTA), Tessa Marshall (TB Alert) and Nigel Hewitt (London Pathway).

² Peers in this article will always refer to someone that has had a history of homelessness and/or drug and alcohol dependence

³ People experiencing homelessness, drug and alcohol dependence and imprisonment



for approximately one in six of all new TB cases, but nearly one-third of all infectious cases in London (Story et al, 2007). By harnessing the experience of former TB patients this project aims to raise awareness of TB and maximise uptake of x-ray screening amongst groups most at risk of tuberculosis. Peers work alongside the Find&Treat team⁴.

Since 2007, 11 former TB patients have worked as peers. Over a 24 month period they helped x-ray over 10,000 clients at more than 300 screening sessions. This resulted in 20 cases of active pulmonary TB. A comparison of sessions supported by a peer compared to sessions without a peer resulted in increased uptake in 60% of venues. A NIHR (National Institute for Health Research) funded randomised control trial (RCT) currently underway will evaluate the cost effectiveness of using peers.

“A lot of people that are on the street are afraid of authoritative figures – they always think there’s something more to it than meets the eye – and they don’t understand the language that’s used either. So that makes them dubious about what the person is saying to them. A peer is somebody who helps out not just with clients, but who communicates between clients and staff on the van – the nurses, drivers. Having a good attitude and being the mediator between clients and staff. Peers break down barriers.” Franklin (TB peer educator)

“A peer is someone who feels it and knows it. I got involved after I saw the dedication of the TB team and I wanted to give something back.” Horace (TB Peer Educator)

2. The Homeless Health Peer Advocacy (HHPA) project - Kit McKinley (Peer Advocate, HHPA and Project Assistant, Groundswell)

⁴ *Find&Treat* are a multidisciplinary pan-London specialist outreach service to strengthen TB control among hard to reach groups. The service screens over 8,000 people annually with mobile chest radiography (Mobile X-ray Unit) and detects a rate of active pulmonary TB of 264 per 100,000. Additionally, the team supports case-management for around 200 active TB cases with very complex social problems and locates and returns around 70 lost to follow up cases to treatment each year.

The Peer Advisory Group was central in securing funding for HHPA Service facilitated by Groundswell UK in Westminster and Hammersmith and Fulham with funding from NHS Regional Innovations Fund and Resolving Chaos. The Project was set up in 2010 in order to support people who are homeless to access healthcare, to improve understanding of healthcare staff and their relationship with homeless patients and to reduce costs to the NHS of inappropriate A&E use (visiting the accident and emergency room in hospitals).

There are many reasons why Peer Health Advocates are the best resource available to work with homeless people around their physical health needs. Peers have a unique understanding of the realities of being homeless and the barriers faced when trying to access care, from our own personal experience.

We are independent from all health and social authorities and our only concern is to advocate for our clients to get them the best possible service of healthcare, to which they are entitled but all too often denied.

By accompanying the client to health appointments we act as a bridge between client and health professional and help dispel the misunderstanding and mistrust on both sides. Many of our 70 clients wouldn’t ever have attended health appointments without our help.

The project aims to work on the health issues that the client is most motivated to address. Our spending time with an individual enables them to trust us and very gradually voice what it is they want. There’s no genius in this but all too often people who are very vulnerable easily slip out of the vision of people who work in the homelessness and health care sectors. We hope that our work will empower people to feel more confident to get their health needs met independently.

One gentleman we met Joe, was drinking chaotically, not very mobile and not accessing any health services. In his own words, Joe doesn’t ‘like to make a fuss’. Joe broke his back in a traffic accident, was in constant pain and is diabetic. He rarely left the hostel and was mostly confined to his room, he had lost the will to do anything for himself. Our first appointment was to a podiatrist. On the long, slow walk it became clear that his most

significant problem was not his feet but, Joe, 'not making a fuss' went along with it because he was told to.

Joe is one of our longer term clients. We've spent the last nine months working with him; I enjoy working with these guys and witnessing the change in them. Together we've spent days waiting in A&E and various hospitals, battled with hostel staff to ensure he gets given his medication, overcome an outbreak of scabies which led to a life threatening infection and made numerous visits to the GP to get sliver dressings on the infection. Most recently, Joe has been happy to return to the podiatrist without my assistance.

Working with clients is the larger part of a Peer Advocates role, working with health professionals is of equal significance. Generally health professionals want to help but feel demoralized as the client's conditions worsen due to a lack of continuous care. One of the most vital aspects of our work is enabling clients to address their health issues with consistency. The professionals look at the client differently – previously they wouldn't take them seriously because they knew they weren't going to see them again. Knowing that they will return, they are more willing to take an interest in their case and plan for their future care.

For clients, experiencing someone taking an interest in them encourages them to take an interest in themselves and gives them back a bit of crucial self-respect not to mention better health.

In its first year the HHPA has seen 70 clients to 370+ appointments. Five advocates have moved on into paid employment.

3. London Pathway

The London Pathway aims to provide an integrated healthcare for single homeless people and rough sleepers, both in hospital and post-discharge and is based in a central London hospital. It puts the patient at the centre of their own care pathway and works to transform their health outcomes. The project recruits peers as care navigators.

Becoming a Peer

Josie Mavromatis (TB Peer & Care Navigator, London Pathway)

"I was taken into hospital by ambulance after collapsing on the street, clutching my 4 cans of cider for dear life. I was told I had pneumonia and released with antibiotics. Two days later I collapsed again and underwent a Tharacotomy (piece of lung removed). A nurse said "you might have TB" and I was discharged to the nearest off-license! A TB nurse explained I would be on medication for 6 months. I built up a rapport with [the nurse] and started attending AA (Alcohol Anonymous)."

"At the end of 6 months [treatment], I met Find&Treat. I started to volunteer on the TB van and encourage clients to have an x-ray. I do talks to staff and hostel clients. I re-did my Maths and English, did a creative writing course, courses in counseling and psychology and volunteered for Mind (mental health charity). I am an expert patient on the National Institute for Health and Clinical Excellence (NICE) programme development group for Identifying and Managing Tuberculosis among hard-to-reach groups."

"I am now employed by London Pathway as a Care Navigator, helping homeless patients in a central London hospital. One of the patients, an 84 year old man, had a suspected heart attack and was on life support machine for 3 weeks. I visited him and built up a rapport. He wasn't keen on hospital food so I would bring him up fruit. It was then our job as the homeless team to get him housed. I went shopping and got essentials he needed."

"What I like most about the peer work is the variety of stuff I get to do and the different people I meet and being part of the team. My life has turned from horror to something I'd never have dreamed of and I'm still learning new things all the time."

What do services think about peer advocacy?

One hostel worker said "It was really good, we had a residents meeting the night before (a van session) and someone came to speak who had personal experience. It's good to have someone that can put that view across."

"The homeless services and statutory health interface is notoriously difficult to negotiate. The advocates have provided clients (and staff) access to a range of services informed access into better medical treatment and



improved life chances. The persistent approach has begun to change both the way clients are treated and what they can access." Outreach Manager, St Mungos

Conclusions and next steps

The Peer Advisory Group is now working with the Royal Free Hampstead NHS Trust to secure a grant from the National Institute for Health Research (NIHR) to fund a research project focusing on peer advocacy in homelessness, titled Peer Advocacy Training for Health (PATH)

The three projects highlight the innovative work being carried out and the importance of ensuring homeless people feel heard and supported. To ensure good practice continues, it is imperative that more money be invested in peer-led service delivery.

We would like to share ideas and good practice around peer work in homelessness and health.

For information on how to support people engage in peer activity around health and homelessness you can download the guide *Homelessness and Health: Resources to Support Peer Activity* written by Groundswell on the Homeless Link website: <http://www.homeless.org.uk/sites/default/files/HomelessHealthPeerActivityToolkittoPRINT0.pdf>

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For further information about the TB Peer Education Project, please see the article *An authentic voice – TB peer educators* that featured in FEANTSA Homeless in Europe magazine (Autumn 2009) - <http://www.feantsa.org/code/en/pg.asp?page=35> - accessed 28/11/11

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Can street nurses in Brussels bring change in homeless people?

Céline Riat – nurse, Infirmiers de Rue, Belgium

Even though there are hygiene and health services in Brussels, people living in the streets, and who are in high need of using these services, do not necessarily have access to them. In 2005 the work of "Infirmiers de Rue" (Street Nurses) started to bridge the gap between the streets and services and was

based on the belief that change is possible by connecting, trust and motivation building, and awareness of the importance of taking care of oneself. This article reports the Infirmiers de Rue experiences with homeless people and service in Brussels, and presents hygiene-based interventions toward change.

What is the problem?



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The experiences of Infirmiers de Rue display the dynamics between homeless people and services in three domains.

1) People who live in the street are not always motivated to take care of themselves. They are ashamed to speak about their hygiene and health, and sometimes they are disconnected from their body, so they do not feel the pain, they do not perceive their smell. They do not know where to go for help. If they have contact with medical personnel they do not understand the information or advice given. This explains why some of them are in very bad physical condition.

2) The medical personnel at hospitals or other health settings do not succeed in addressing hygiene issues in homeless people. Staff does not always adapt the treatment to the street environment (e.g. strong and more resistant dressings, simple treatments, etc.). Sometimes staff can be discouraged when they see a homeless person presenting multiple problems, the same problem over and over again, without progress.

Staff in social services and homeless organizations, even if they are more accustomed to the target group than the medical personnel, often do not succeed either in raising hygiene issues.

3) Facilities and their environment are not always adapted, in quantity or quality, to the needs of this group or they are not widely known.

How do we work?

To address these problems, "Infirmiers de rue" has developed the following actions:

1) Street work and follow-up

We use hygiene as a tool for reintegration. We work one step at a time by motivating and helping homeless people to gain self-confidence and trust in the medical services. Unlike administrative papers where one is dependent on administrative structures and decisions, hygiene is something that can be easily appropriated by the person him/herself. Also, hygiene can be divided into small goals accessible and adapted to the rhythm of the person. For one it can immediately mean taking a shower, but another might have to go through different steps of washing their hands with

baby-wipe, then in a bucket, then also wash their face and neck and then the next step could be to move out of their usual place and eventually take a shower... We noticed that while the person is taking care of his body and hygiene, his appearance changes as does self-perception. This allows new projects, perspectives and hopes to develop and makes reintegration possible!

We do intensive follow-up work and regularly meet people living in the streets. The goal is to have a mid-term follow-up until reintegration into housing happens with follow-up by other institutions. Today, we realize that housing and health are closely connected and can not be separated.

Since we are a team of nurses, the person meeting our team, is "forced" to think about his/her health and hygiene. We access the patient's environment during the day, when other medical services are open: when necessary we can also go with the person to a medical consultation or a hygiene centre. We walk in teams of two nurses in the street, and we meet the person where he/she is. By doing this, we gain their trust, and little by little the person will open up to us and then learn to take care of him/herself. Sometimes we give first aid and care in the street, but generally we tend to encourage and support the patients going to the doctor and the dispensary where they can regularly take a shower or receive medical care. Slowly, we create a new dynamic and the person becomes responsible for his/her body again.

Our vision is to be pro-active in our interactions. We believe that even if the person does not have explicit request, there are hidden desires, implicit requests in ambivalent views that we are there to give life to.

As we work we adopt a positive and enthusiastic attitude, believing in the person's resources. We try to learn each person's interests and strengths. Also, we want to be personal in our interactions and try to be as creative as we can to show our concern and care for the person by giving pictures, birthday cards, a favorite drink, an appreciated book. We find it important to give value to the person by recalling who they really are and by this increasing their self-esteem.

2) Training

We have set up two kinds of training: “Hygiene and Precariousness” and “Pharmacy”. The main one is Hygiene and precariousness. It reaches three different groups: health personnel, social workers, and security personnel (railway and underground stations, parks). The aim is to train people to adapt their way of working with the homeless people, to allow these professionals to have better reactions and to be more efficient in their work. For example, health professionals are told to put more energy into the relationship with the patient, and to simplify the treatment. Social workers are sensitized to the importance of hygiene, how to use it as a tool in their daily work and how to speak about it. Security personnel are told about how to approach homeless people and maintain good relations with them, how important hygiene is and how to adapt the environment for better hygiene and cleanliness.

- 3) We change the environment or the way people can make use of it

We issued tools, like a map, which features all drinking water fountains available in Brussels, or a poster with what to do when the weather is very hot (drink more water, stay in a cool place etc.). The map of the fountains was given out in the street to homeless persons, but also to homeless organizations, and it was also posted in the railway and in the underground stations. The poster was distributed to all interested organizations and its aim was to improve the use of the existing infrastructure, but also to stimulate the authorities to improve and enlarge it. We find it interesting that these services are also used by everybody, not only homeless people: e.g. fountains or public toilets are also used by tourists and passers-by.

Change is possible

So far, we can really see an improvement in the self-esteem of the persons we have been following. They speak more easily about their health and hygiene, they ask about risks and they act in a more responsible way towards their health. For example some of them bought and continued to use the cream that we used with them, while others went back to the doctor. During the last six years we have witnessed a decline in the number of homeless people living with very serious conditions. In 2010, 16 persons were integrated into housing. They lived for 10 to 15 years in the street. For many, those around them did not believe a change was possible.

Further development

“Infirmiers de rue” hopes to further develop a number of activities in the near future, including:

- scaling up Infirmiers de Rues presence in Brussels and other cities across Belgium, to respond to the demand and reach more homeless persons living in the streets;
- developing training tools and capacity building sessions for more professionals and organizations, in order to create a different service approach and consideration in dealing with homeless people helping them to make a change.

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Awareness, access and use of health care services in the homeless population of Athens, Greece

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The aim of this article is to study the phenomenon of homelessness in Greece, and more specifically the health of the homeless population in Athens. The main aim is to investigate the living conditions of homeless people and how this affects their health,



focusing on their awareness, access and use of health services.

The theoretical and methodological framework of the study is based mainly on literature reviews from other countries as research data on this topic in Greece is outstandingly limited. In addition, data were collected based on records used by organizations offering their services to the homeless population of Athens. The research used qualitative methods and 15 semi-structured interviews were conducted with homeless people in central areas of Athens, from August to September 2009.

In the sample there were mainly men interviewed (13/15 interviewees) with an average age of 46 years. Regarding their marital status, the majority of the sample was single or divorced with children. As far as the education level is concerned, most of the interviewees were high school graduates. As regards to the place of origin, the majority of the people interviewed were Greek (13/15), three from Athens, one from Piraeus and the other nine were from other provinces. They all declared they had been homeless for an average time of four to four and a half years.

Regarding their awareness on the existence and availability of health services, most interviewees claim to be adequately informed. They also state that they know where to go in case a health problem occurs. In many cases, when they do not feel well, they choose to visit a health service on their own. Often, homeless people use emergencies when either they or a third person call an ambulance to take them to the nearest hospital. However, there were cases mentioned, when while they knew where to go for the health problem they were facing, they chose to remain inactive, either because of an unpleasant previous experience with the health system, or because of other personal or practical reasons (such as negligence, feeling of embarrassment over their physical appearance, difficulties in transportation).

Access to health services is a complicated part of homeless people's relations with health. More specifically, a number of obstacles and restrictions are reported that are on one hand related to this group's specific characteristics and on the other, to the structure and functioning of the Greek health system.

People who are experiencing homelessness for a long time need access to extended services that correspond to their multiple health care needs. Insurance is an important requirement for all citizens to have free access to all health care services. The majority of the sample mentioned the fact that they had to issue a health booklet from the Welfare Authorities which covers the non-insured and poor people. However, there are also homeless people who are deprived of any insurance due to unwillingness, poor mobilization, a former insurance's recent expiry, health booklet being stolen, ignorance of both social and welfare provisions or simply because they are unable to obtain insurance because they are undocumented migrants.¹

According to this study, the difficulties in accessing health care do not only appear in cases of emergencies but also in preventive health care, like regular medical check ups and even medicine prescription and administration.² Frequently, the lack of insurance, makes the percentage of homeless people who can not have access to health care services even greater. In addition, lack of financial resources, mobility problems, physical and mental weariness, which derive from their living conditions, feelings of embarrassment and fear of rejection, former negative experiences of the health system, frequent delays in scheduling and conducting medical tests, or even lack of registrations (in case of undocumented migrants) are factors that are reported by the interviewees as obstacles to access to and therefore to the use of health services.³

Most homeless people claim that even when they do not have a health booklet, they can still go to health services in cases of emergency. This belief in combination with the tendency of neglecting the not so urgent health matters - a common situation among homeless people⁴ - has, on the one hand, a negative impact on both the health status of homeless people and on the other hand, on the health services which have to deal with the significant rise of health needs and also with the treatments' estimated time and economic costs.

Previous research found that limited access to health services contributes to the remarkable rise in the cost of health.⁵ So just because homeless people are often not insured and have no access to preventative low cost care, they remain without

care until the minor health problems become emergencies that need immediate treatment. Eventually, the majority of the homeless people are treated, but this is the most expensive kind of treatment which is offered in the E.R. and in intensive care units in hospitals. Non-governmental bodies and volunteering organisations offer alternative solution to the lack of health insurance coverage. They also provide homeless people with preventive care and medical treatment in cooperation with public hospitals and other health services in Athens.

Furthermore, there is a lack of access to services that incorporate the understanding of double diagnosis. A homeless person who has double or multiple diagnosis demands thorough care which does not only focus on one illness, but also functions in combination to others. An additional problem that appears in health services is the lack of knowledge and awareness that has to do with the needs of homeless people who suffer from mental or other disorders. There are limited data available on how frequent these disorders are in the homeless population, and also there is not enough information on the specific health needs of homeless people.

The nature of specific illnesses prevents some people from having access to the health services.⁶ What is known as “cure - treatment avoidance” is a common symptom of addictions and psychiatric disorders and becomes worse to many homeless people due to previous negative experiences with the care system. Moreover, the homeless and mentally ill people are faced with curiosity, suspicion and with stereotyped concepts by the rest of the population, the press or the media. The social “stigma” often obstructs the ensured availability and access to health services or leads to discrimination and unfair practices.

Considering the fact that the economic crisis will certainly affect homelessness in Greece to an even greater extent, a national homelessness strategy through appropriate legislation, the required institutional framework and welfare benefits should be among the priorities of the government.

The need for better coordination between organizations and services, a systematic and formal recording of data and preventive actions constitute the three main components of an integrated approach to combat homelessness. Finally, allocation of additional funds is required to support the development and the reinforcement of health services.⁷

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Progetto Diogene: Integrated approach to homelessness and mental illness in Milan

Vita Casavola, Project Coordinator, Fondazione Casa della Carità

Emanuela Iacono, Support worker, Fondazione Casa della Carità

The research-intervention Progetto Diogene was set up in Milan in 2005 by a network of private/non-profit social service, in partnership with public mental health services. Due to this multidisciplinary approach to homelessness it was included in the list of the World Health Organisation pilot projects. This intervention model is designed to offer flexible care to homeless people with a mental health condition who are unable to access public and community-based services. It aims to prevent or reduce emergency treatments, help irregular migrants who experienced migration-related psychiatric symptoms and improve the costs and effectiveness of public mental health systems.

Milan is the main city of the Lombardy region, in the north of Italy. Despite the fact that it is known as a wealthy city and as the Italian capital of fashion and business, homelessness in Milan is a large phenomenon: around 4500 homeless people live in the area (Caritas Ambrosiana, 2008).

Although the city seems to address effectively all the basic needs of homeless people like food and shelter, (Ministero del lavoro e delle politiche sociali 2011) health services for homeless people are less numerous and no specific mental health service has been offered to them since 2005. Before that, some pilot programs have been promoted by Caritas Ambrosiana to address mental health issues in the homeless population.

The experience gained by these projects and recent research show that often mental illness co-exists with

homelessness and many homeless people admit having mental health problems and do not refuse to be supported when contacted on streets. Yet, access to mental health care for this very vulnerable group of people is significantly more difficult than for the rest of the population.

PROGETTO DIOGENE: Facts and figures

Progetto Diogene is specifically targeted at those who have mental health problems and/or a specific psychiatric disorder and live on the streets. Both Italian citizen and foreign nationals can be enrolled even if they are irregular migrants.

The program was launched in 2005 and funded by Regione Lombardia. A second trial period was funded from 2009 to 2011 and recently entered into its final phase. It is designed to engage at least 50 clients in three years.

Main tasks and goals

The main aim of the program is to reduce mental health suffering on the streets and increase the number of people accessing public mental health care by optimizing public and non profit services in the area and by promoting an effective cooperation among professionals from both sectors. Public institutions involved are expected to gain flexibility and improve access procedures to community centres and hospitals units.

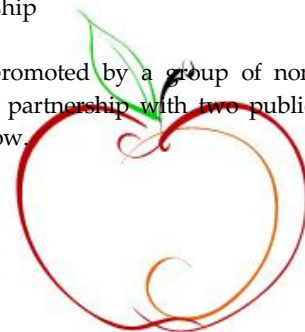
Specific trainings and courses are offered to professionals and volunteers to increase their knowledge about homelessness and mental health. Social awareness campaigns are organized to educate citizens on mental health and prevent social marginalization of those suffering from a mental health problem.

A research was carried out in collaboration with Milano Bicocca University to describe mental illness on the streets and outline the profile of homeless people with psychiatric problems.

Methods, policies and procedures are constantly tested, verified and updated to design a replicable model of intervention.

Institutions in partnership

Progetto Diogene is promoted by a group of non profit organisations in partnership with two public hospitals as shown below.



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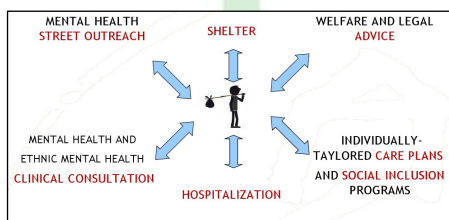
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NON PROFIT SECTOR	PUBLIC INSTITUTIONS
Casa della Carità : - OUTREACH TEAM - NIGHT SHELTER - CARE AND HEALTH CARE SERVICES - HELP CENTRE AND LEGAL ADVICE	Azienda Ospedaliera Niguarda Ca' Granda, Milano: - 2 ETHNIC MENTAL HEALTH TEAMS - 2 COMMUNITY MENTAL HEALTH CENTRES - PSYCHIATRIC UNIT
Caritas Ambrosiana: - DROP-IN HELP centre (CITY CENTRE) - COMMUNITY ADVICE CENTRES	Azienda Ospedaliera San Gerardo, Monza: - 1 COMMUNITY MENTAL HEALTH CENTRE - PSYCHIATRIC UNIT
Novo Millennio: - DAY CENTRE	- UNIVERSITY HOSPITAL - Research

Each institution offer one or more specific services but can also offer its clients preferential access to other services provided by the network. Each homeless person enrolled has the opportunity to choose an individual pattern of care in accordance to their expectations, personal history, social and mental health conditions.

Whichever service the homeless person first accesses, it is always possible to refer them to one of the other services and to address a wide range of personal issues.



Program highlights

Experience demonstrates that the Street Outreach Service, the Ethnic Mental Health Clinic and the multiservice centre (Casa della Carità), are the preferred ways to access the program for our clients.

THE OUTREACH TEAM

The Outreach Team professionals work in mobile units. Each unit is composed of a psychiatrist and a specialized support worker. They visit the main train stations and city centre area on a weekly basis. They also meet people in specific places on call. After a preliminary psychosocial assessment, the client is registered as engaged and a medical and social record is created and updated step by step. An individual care plan is developed and specific resources are activated.

Specific attention is given to fostering and maintaining a relationship of trust, a so-called

therapeutic alliance that is essential for successful treatment.

Each mobile unit plans meetings and contacts before the outreach session and writes a report. Regular team meetings and a clinical supervision give the workers a chance to discuss cases and share strategies.

Accessing public mental health institutions

Care plan goals usually include being enrolled for treatment at a community mental health centre. Very scrupulous case-management and strong relational support are necessary in this delicate phase of the project. The case manager evaluates the response to the treatment and offers job trainings and socialization opportunities when appropriate.

ETHNIC MENTAL HEALTH CLINIC

Foreign nationals including irregular migrants can ask for help at the Ethnic Mental Health clinic. A cultural mediation service is provided and an ethnically sensitive approach to care adds value to the psychiatric treatment.

CASA DELLA CARITÀ

Casa della Carità offers services and help to marginalized people in Milan and also leads research projects about social deprivation and good policies and practice. It provides Progetto Diogene with 10 dedicated bedsits and access to all the internal facilities including health and mental health clinics, a soup kitchen, showers, a laundry and clothing service and an advice centre.

Outcomes 2005-2008

A sample of clients was chosen to compile the profile of homeless people with mental health disorders in Milan. There is a prevalence of males (65%) and a marginal prevalence of Italian nationals to foreign nationals. 67% of clients were between 30 and 60 years old.

Clinical data about diagnosis show that the most common diseases were psychotic disorders (52%) and personality disorders (18%). Frequently foreign nationals suffer from post-traumatic stress disorder as a consequence of unsuccessful migration experiences or of failure of integrating in society.

A constant element seems to mark the difference between Italians and non-European foreign nationals who live on streets. Italians follow an *exit path* that leads them away from “normal” life and their social network (Marconi, 2008). Foreign nationals, particularly when non European, take and fail an *entrance path*. Social exclusion, lack of resources and loneliness associated with a mental disorder may drive them from the dream of a new life to being homeless.

Key findings

A statistical study has been carried out to identify useful indicators to build a “working alliance” with these clients and verify the effectiveness of the results through the evaluation of psychosocial treatment outcomes. The results, previously published in Italian (Camarda et al., 2010), highlights that those with a longer period of homelessness have a lower drop-out rate (52%) than other group, but they achieved a more modest improvement after the intervention. Clients with a short to medium period of homelessness show a more severe mental disorder at first, but a more significant improvement after the intervention.

Open issues

Progetto Diogene is in the final stage of its second trial period but several ongoing issues have to be addressed to improve future programs:

- Access to care for irregular migrants: complicated procedures and long waiting times make even the passport renewal a substantial barrier to care development.

- Versatile resources: co-existence of homelessness, mental disease and being a foreign national challenges both the non profit and the public care system, which are too sectorial in their methods and strategies.

- Stigma over stigma: stigma is still a common experience for people who have mental health conditions. Being homeless and/or immigrant add even more negative labels.

Conclusion

This model of intervention has received a positive feedback from the target clients chosen. In addition to food and shelter, psychological and emotional needs are very important to homeless people. A consistent therapeutic alliance, a focused case-management and availability of versatile resources are basic components of the care plan. Furthermore this approach seems to be crucial to strengthen the motivation to care in all phases of the treatment.

We feel that Progetto Diogene represents a successful model of integrated welfare and mental care. It is replicable and relatively low-cost as it is based on resources optimization.

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Guide on Violence against Women with Substance Abuse Problems

Maria Boustedt Hedvall *

Swedish National Board of Health and Welfare

The Swedish National Board of Health and Welfare recently published an educational report focusing on violence against women with substance abuse problems. The aim of the guide is to raise awareness and improve the competence of different groups of personnel, e.g. from social services, health care and non-profit organisations, in order to offer these women adequate support and assistance. The guide includes themes for discussions and plans for how to arrange educational sessions on a local level.

The report points out that women with substance abuse are exposed to violence often experience blaming attitudes from society. The violence they experience is considered to be a consequence of their substance abuse, and therefore the women's vulnerability is neglected, and their need for help and support is often disregarded. The guide highlights the need for personnel working with these women to reflect on their attitudes. A good, respectful and professional attitude is important, but also a holistic approach and cooperation between different professions.

For women with these problems it is essential to be accepted at sheltered housing, which is still rather unusual in Sweden. It is necessary that personnel from social and health care services acknowledge that these women have been subjected to violence,

instead of merely focusing on their substance abuse. It is also important to discuss the possibility for these women to participate in women-only drug treatment programmes – for safety reasons, in order to minimize the risk for them to come across former perpetrators.

To better acknowledge violence against women with substance abuse, health workers as well as other personnel need to ask questions about violence – without questioning, moralizing, blaming or criticizing the woman. Personnel also need to have knowledge about different signs of violence (both physical and psychological indications) as well as possible consequences. Furthermore, it is important to understand that it could be particularly difficult for women with substance abuse to seek help and to talk about the violence they have been subjected to.

The report is available in Swedish on the website of the Swedish National Board of Health and Welfare and could be downloaded from the following page: <http://www.socialstyrelsen.se/publikationer2011/2011-10-1> (An English version will soon be available.)

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New European Portal for Action on Health Inequalities

Yoline Knipers *

EuroHealthNet

A new European Portal for Action on Health Inequalities – www.health-inequalities.eu – has been launched. The new website is an exhaustive source of information on health inequalities, the social determinants of health and Health in All Policies. It aims to provide visitors with practical

and useful information and to give them opportunities to promote their own work.

Health inequities are preventable and unjust differences in health status between different population groups. They are shaped by the conditions in which people are born, grow, live, work and age – the so called social determinants of health. Health inequalities are present in all European countries and evidence shows that health inequalities are currently widening.

The Portal includes over 300 examples of policies and good practices implemented at EU, national and regional level. Visitors can search for information by country, area of work (e.g. disease prevention, mental health or smoking), target group (e.g homeless people, migrants or people in difficult social situations) setting or key word. Visitors of the website are encouraged to share expertise or to submit examples of initiatives they are involved in or aware of, and that they wish to promote via the site.

The European Portal for Action on Health Inequalities was developed by EuroHealthNet on behalf of the Equity Action Programme. This is the EU funded Joint Action on Health Inequalities, which aims to develop knowledge for action on

health inequalities, to support the engagement of Member States, regions and other stakeholders and to share learning and action at a European policy level.

For more information on the European Portal For Action on Health inequalities, please visit www.health-inequalities.eu

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Mental Health and Addiction amongst the homeless population in the Paris region - conference report

The *Observatoire du SamuSocial de Paris* and ISERM (*Institut national de la santé et de la recherche médicale*) have organised a conference to present the findings of a recent report on mental health and addiction problems faced by homeless people in the Paris Region (original title « *SAMENTA, Rapport sur la santé mentale et les addictions chez les personnes sans logement personnel d'île-de-France* »).

The presentations of the conference can be downloaded from the following page: <http://observatoire.samusocial-75.fr/index.php/fr/colloque-samenta>

The [report](#), which is the result of a survey and has been written under the supervision of Anne Laporte and Pierre Chauvin, is available in French and can be downloaded from the web site of the Samusocial de Paris: <http://www.samusocial-75.fr/enquete-samenta.html>

Homelessness, Mental Health and Well-being

Homelessness services play a large part in stabilising and preventing more serious mental health problems by offering emotional and psychological support to vulnerable people. They work with individuals at an extremely fraught and complex time and can offer essential support to

those in need. They also play a key role in guiding people through statutory and voluntary support services. The purpose of this guide published by *Homeless Link (UK)* is to support homelessness services work with people who present with various mental health and well-being needs.

The guide is available on Homeless Link website and can be downloaded from the following page: <http://www.homeless.org.uk/mental-health-guide>

Battered, broken and bereft – a new rough sleeping report

The report published by homelessness charity *St Mungos (UK)* highlights relationship breakdowns, domestic violence and mental health conditions as three of the main traumas leading people to sleep rough on the streets today:

- Relationship breakdown is the largest single trigger of rough sleeping cited by outreach workers, leading to 42% of male rough sleeping.
- Among women, 35% slept rough after leaving home to escape domestic violence.
- Perhaps the most shocking finding is that 57% of outreach workers believe that the number of rough sleepers in their area



with mental health problems has increased over the last five years.

The report is available on St Mungos website and can be downloaded from the following page:
http://www.mungos.org/press_office/1002_battered-broken-bereft-new-rough-sleeping-report

Voices of Experience - how people who drink on the streets can make positive changes in their lives – a report

This research focused on persistent street drinkers – people who drink heavily in public spaces for “many hours on many days” and are poorly motivated to stop drinking. Little research has been conducted on the experiences and on the needs of street drinkers. This study by Broadway, a London based homelessness charity focused on street drinkers who made positive changes in their lives and aims to help practitioners and policy-makers to hear and learn from the “voices of experience” by former and current street drinkers.

The report published is available on Broadway London together with an academic report and can be downloaded from the following page:
<http://www.broadwaylondon.org/ResearchInformation/Research/VoicesofExperience.html>

Moving Forward Health and Homelessness in Scotland – conference report

The Moving Forward conference was jointly organised and supported by NHS Health Scotland, the Scottish Council for Single Homeless and the Scottish Government. Its aim was to re-invigorate the health and homelessness agenda and the national Health and Homelessness Standards in the run up to the full implementation of the Scottish Government’s legislative commitment that by the end of 2012 all unintentionally homeless households will have a right to settled accommodation.

The report of the conference including the recommendations of the four workshops on the national health and homelessness standards, on the challenges of making provision for homeless households in mainstream health provision, on examples of best practice and on the role of health

in the prevention of homelessness can be downloaded from this link:

<http://www.feantsa.org/code/en/theme.asp?ID=2>

Homelessness: a silent killer – research briefing on mortality amongst homeless people

This briefing draws on and sets out the interim findings of a study commissioned by Crisis investigating homeless mortality in England between 2001 and 2009.

Key findings of the research:

- Despite improvements in the health of the general population over the last 15 years, the average age of death for homeless people still remains shockingly low at just 47 years old, and with the average age for homeless women being even lower at 43. This compares to an age of 77 for the general population.
- Drug and alcohol abuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths.
- Homeless people are over 9 times more likely to commit suicide than the general population

The initial findings of the research are available on Crisis website and can be downloaded from this link:

<http://www.crisis.org.uk/data/files/publications/Homelessness%20-%20a%20silent%20killer.pdf>

The next phase of the research will investigate cause of death by age and analyse more detailed causes of death. It is hoped that mortality by different accommodation type and area can also be investigated. The full research report will be published in summer 2012.



Environmental burden of diseases associated with inadequate housing – WHO report

This guide describes how to estimate the disease burden caused by inadequate housing conditions. The guide outlines, using European data, the evidence linking housing conditions to health, and the methods for assessing housing impacts on population health. It also summarizes the recent evidence on the health implications of housing renewal, and provides a national example on assessing the economic implications of inadequate housing. The findings confirm that housing is a significant public health issue. However, to realize the large health potential associated with adequate, safe and healthy homes, joint action of health and nonhealth sectors is required.

The guide is available on the WHO Europe website and can be downloaded from this link:

http://www.euro.who.int/data/assets/pdf_file/0003/142077/e95004.pdf

Call for proposals

The European Commission published its call for proposals for EU co-financing for projects, conferences and grants in the field of health. The deadline is 9 March 2012. For more information, please visit the following link:

http://ec.europa.eu/health/programme/how_does_it_work/call_for_proposals/index_en.htm

Under the specific DAPHNE III programme, call of proposals for transnational projects have been published. The aim of such projects should be to prevent and combat violence against children, young people and women and to protect victims and groups at high risks. The deadline is 29 March 2012. For more information, please visit the following link:

http://ec.europa.eu/justice/newsroom/grants/daphne_call_for_proposals_action_grants_2011_2012_en.htm

Events

From individual to collective responsibility – The social determinants of mental health

Split, Croatia
14 – 16 July 2012

Conference organised by Mental Health Europe. For more information, please contact Mental Health Europe at secretariat@mhe-sme.org or Sto Koluri at direktorica@stokoluri.org



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

To that effect, PROGRESS purports at:

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

For more information see: <http://ec.europa.eu/social/main.jsp?catId=327&langId=en>.

