European Network of Homeless Health Workers (ENHW)

Issue N°2: Summer 2007

Editorial

Welcome to the summer issue of the ENHW Newsletter!

In future there will be four issues of the newsletter per year. There was a strong response from readers after the first issue and a lot of rich and interesting articles were sent for this second newsletter. As editor, I would like to extend my sincere thanks to the contributors, who have shared a variety of experience, ideas and approaches coming from their work in the area of health with homeless people across the EU.

Unfortunately, the **ENHW's online discussion forum** got off to a rather rocky start after being hacked twice in its first few weeks of existence. Following that, it was taken offline, redesigned and made secure. There have been no further problems, so we hope that you will sign up and make contact with other health professionals working with people who are homeless all over Europe. You can read instructions on how to join online on FEANTSA's website, or access the forum directly here.

Also included is a detailed outline of the health and homelessness conference in Oxford in September, which will host **an ENHW reception**. We hope that some of you will be able to make very time for this very interesting event. You will find full details in the article on the conference in the News from ENHW below.

Please do circulate the newsletter to any colleagues that you think may be interested in reading it. To sign up to receive future issues, you can email me at the address below. If you think you would like to contribute an article to the next edition, please do not hesitate to get in touch! Your comments and feedback are also welcome. You can contact me by emailing: dearbhal.murphy@feantsa.org.

News from the ENHW

Housing, Health and Hippocrates

By Dr Igor van Laere

Doctor for homeless people in Amsterdam

One hundred years ago the medico-social housing message was clear. "The relation of the dwelling to health constitutes a problem, the seriousness of which the medical profession has not yet fully appreciated….The regulation of building and the provision of sanitary dwellings is empathically a medico-social function, in the performance of which the physician must take a leading part by virtue of his special knowledge….By acting with a wise foresight, we shall be fulfilling our highest duty as guardians of the public health." [1]

Oscar Wilde said: "we are all in the gutter, but some of us are looking at the stars". For those dwelling under the stars, during outreach practice for homeless people, social and medical workers are confronted with the extreme results of the lack of housing, education, redundancy, displacement, grinding poverty and extremely ill health. On the bottom, it is strenuous to fulfil the Hippocratic duty, in growingly dehumanised societies, in which financial control determines and rules human activity.

Today, listen to Dr. James O'Connell, reaching out for homeless people around Harvard Medical School in Boston, saying: "Physicians willing to care for populations on the fringes of society need not be marginalized by their own profession. Academic medical centres, long a refuge for the urban poor, should embrace the care of homeless and other vulnerable populations as vital to their missions and as a critical component of the teaching curriculum. Caring for homeless people poses an uneasy ethical dilemma. As we work to prevent illness, alleviate symptoms and minimize suffering, our helplessness in influencing the fundamental determinants of health — which include housing — inevitably haunts and outrages us. The ultimate solution to homelessness will require change in many sectors. This public health crisis will not be ameliorated until housing and health become a fundamental right for every human being". [2]

Health matters and generalist public health physicians should always be embraced and included in the political agenda: making rules and policy on infrastructure, transportation, housing, education, employment, leisure and subsistence services. If not, we can only wait for more people in ill health, to be neglected and excluded. Growing

penury drives a massive attack on our emergency-, intensive care-, chronic nursing- and penitentiary rooms. The cost for repair of medical damage by social exclusion can only rise: doctors will always be too late.

In our modern societies, the preoccupation with cost shifting and cost reduction, as an impetus for mental poverty, undermines public assistance and citizens. To restore social health by medical guidance, Porter and Teisberg strongly promote health care reform by physician leadership, following three principles: (1) the goal is value for patients, (2) medical practice should be organized around medical conditions and care cycles, and (3) results—risk-adjusted outcomes and costs—must be measured.[3] We fully agree with the approach, except for the focus on organisation around *medical conditions*.

Public health urgently demands investment in *people* and their *social conditions*, by access to land,[4] affordable housing and a variety of options for guided living,[5,6] skills tapered education and employment in a safe environment. A healthy mission includes *social medical leadership*, guarding the principle of integrating housing-, social- and medical professionals, and aim for *best community practice*.[7]

One hundred year ago the message was clear: "We should not allow the opportunity to pass for the establishment of laws and regulations which will prevent the development of a situation so favourable to disease and immorality."[1] For our future, as stated by the *Lancet* today: "we need more engagement, more consultation, more leadership, more thinking, and more advocacy from the professions to secure the public interest". [8] It is our highest Hippocratic duty to stand up together, for housing and health, and against neglect and exclusion of human rights.

References
1. The housing problem. JAMA 1907; 48:1188. (JAMA 2007;297(13):1498.)
2. O'Connell JJ. Dying in the shadows: the challenge of providing health care for homeless people. CMAJ 2004;170(8): 1251-2.
3. Porter ME, Teisberg EO. How Physicians Can Change the Future of Health Care. JAMA 2007; 297:1103-1111.
4. Geisler C. A new kind of trouble: evictions in Eden. International Social Science Journal 2003; 55(1):69-78.
5. Nettleton S, Burrows R. Mortgage debt, insecure home ownership and health: an Exploratory Analysis. Sociology of Health & Illness 1998;20(5):731–753.
6. Crane M, Warnes AM. Evictions and Prolonged Homelessness. Journal of Housing Studies 2000; 15 (5): 757-773.
7. Allen T. Improving housing, improving health: the need for collaborative working. Br J Community Nurs 2006;11(4):157-161.
8. Horton R, Gilmore I, Dickson N, Dewer S, Shepherd S. Do doctors have a future? Lancet 2007;369(9571):1405-6.

Second Oxford Health and Homelessness Conference 25th September 2007 – ENHW Evening Reception on Monday 24th!

By Dr Angela Jones

As was mentioned in the first edition of the ENHW newsletter, we are pleased to confirm that there will be a small ENHW reception this coming September, within the framework of the Oxford conference described below. There are still places available and we hope that some of you might be able to come along.

Following last year's successful conference, the Continuing Professional Development section of Oxford University's Department for Continuing Education are at the final stages of planning this year's exciting event. It will be held in the comfortable surroundings of Rewley House, in the centre of historic Oxford, UK and is entitled: **"Planning together, working together: delivering health and well-being for homeless and insecurely housed people".**

During the first session, a top UK government official will present the current policy on joint commissioning of health and social care and explain how this can relate to services for homeless people, after which there will be an opportunity for questions and discussion. A busy mid-morning session follows coffee, with brief presentations on various public health issues relating to the homeless and insecurely housed population including TB, problems of extreme heatwaves and pandemic influenza. All these presentations will stress the role

of forward planning and joint working in tackling these issues.

After this, one of the most experienced psychiatrists in the field of homelessness will speak about the service he heads in South London and we also hope to offer, as an alternative, a session on suboxone prescribing for those with a particular interest in substance misuse. Then it will be time for a well-deserved lunch break during which we hope to be displaying research posters form a range of researchers in the field.

After lunch, there will be a choice of four workshops covering topics such as the role of medical street outreach versus office / buildings based services, healthcare provision for homeless young people or the latest developments in the field of social enterprise. Alternatively, if you are are using psychological or counselling therapies you may wish to join a group of colleagues to share experiences and knowledge about what works and doesn't work in the field of homelessness.

Our final plenary session will be chaired by the star of last year's conference, Dr Justin Varney who will facilitate a discussion about how to gain key support from public health departments and professionals in the planning of healthcare services for people who are homeless, including contributions form our own UK Department of Health and from a major UK voluntary sector provider.

We hope very much that you will join us for what promises to be an informative and challenging day. Apart from the presentations, there will be ample time to network with colleagues. Furthermore, we will be hosting a reception and dinner on the previous evening at which Dr Igor van Laere from Amsterdam and Dearbhal Murphy from FEANTSA will speak briefly about the newly formed European Network for Health Workers working with homeless people. We look forward to welcoming you in September and encourage you to book soon as places are limited.
For further details and registration see our website:
http://www.conted.ox.ac.uk/cpd/events/homeless/

Sharing Experiences

Reaching Out and Encouraging In - The Development of Primary Health Care for Homeless People in Dublin.

Dr Austin O'Carroll
Doctor for homeless people in Dublin

Ireland, during 1990's period witnessed an economical phenomenon known as the Celtic Tiger where the nation's coffers swelled with huge tax returns. Despite this the number of people using homeless services never reduced (1290 in 1999[1], 1470 in 2002[2] and 1317 in 2005[3]). Not only had the population not decreased but also the health profile of homeless people remained poor.[4-7] This profile mirrored the international experience where the inextricable link between homelessness and ill-health, both physical and mental, has been repeatedly demonstrated.[8-10] Also reflecting international experience, the risk behaviour pattern of the homeless population shifted from alcohol abuse to drug addiction over the same period. With this changing risk behaviour profile came an upsurge in associated health problems in particular blood borne infectious diseases. Despite this worsening health profile and increased national wealth homeless people still had poor access to health care. Studies have shown between 24% and 45% of homeless people not having access to free primary health care and medications.[4-7]

Internationally, the need for 'safety net' type of service has been recognised.[13-14] Riley et al (2003) noted that 'it is the heterogeneity and specialist requirements of homeless people that make catering for their health needs problematic, particularly by overstretched GP services. As a consequence separate services or the work of innovative practitioners, have been initiated to facilitate homeless people's access to health care.'[15] Timms et al noted that 'Conventional clinic times will not do for homeless patients. It is more realistic to arrange meetings at times that fit in with their often irregular timetables. Even better is a drop-in service at a hostel or day centre where people can be seen quickly without an appointment.'[16]

During the 1990's, there was one voluntary service (Trust) which offered a nursing service and intermittently a doctor run clinic and a small number of GP practices who were known to take on

homeless patients. Homeless people did report that there were difficulties getting GP's.[4-6]

In 1995 a review of homeless services by Dublin Corporation and the Eastern Health Board recommended that general practice services should be provided in the city centre, catering for hostel residents, rough sleepers and families in Bed and Breakfast accommodation.[17] This was endorsed in subsequent reports and studies.[5, 7] Feeney et al (2000) found 85% of a sample of 100 hostel dwelling men said they wanted GP, Nursing, Dental and Chiropody care provided within their hostels.[4]

In 2001, the Health Authority set up a nurse run primary care service, open 7 days a week from nine to five, in a Salvation Army Hostel in the city centre. Medical cover was obtained from a local single-handed GP family practice that was provided by running three clinics and providing seven-day cover by telephone for the nurse and access to appointments in their own surgery when required. Over the next 4 years, similar clinics opened in 5 other hostels, a drop in centre and a food hall with cover again provided by two GP practices. By 2005 over 300 homeless people were being seen in the nurse run clinics while doctors were attending to approximately 130 patients a week.

While there was a lot of communication amongst the medical staff running these services, they still essentially, operated as independent units, with different medical record systems, different protocols and differing procedures. It became apparent that many service users wandered from clinic to clinic and that often there was double scripting for medications and having repeat tests / referrals and interventions.

A proposal was sent to the social inclusion unit from the Mountjoy St Family Practice in 2005 to coalesce all the clinics into a network of safety net services. The idea was to unite all clinics to a single Internet accessed medical record database. This would allow the different clinics to share information and identify when patients had been seen in other clinics and what medication / interventions they had received. It also would allow users to communicate with instant messaging across the Internet.

It was argued this service would offer a variety of benefits including:

- Improved follow up care for patients who move from clinic to clinic.
- The avoidance of multiple or interacting prescriptions and of repeating work, investigations already done in another clinic.
- The sharing of important medical information between doctors and dentists working within the network.
- The opportunity to have virtual case conferences about patients with intractable health and social problems.
- The fact that patients could be tracked now allowed the introduction of preventative measures such as BP, cervical, sexual/ blood-borne infectious-disease screening and flu/hepatits vaccination etc.
- The development and implementation of common procedures, protocols and disease specific guidelines that would lead to improved clinical standards and care.
- The development of primary care based strategies to tackle drug and alcohol abuse and other risk behaviours amongst homeless people.
- Lastly, systems theorists tell us the introduction of a new variable can cause change within the overall system. This new service hopefully will influence and stimulate other primary and secondary care services to improve the service they offer to homeless people.

The process of obtaining support from the Health Authority was significantly aided by the argument that such a service would reduce significantly the burden placed on secondary care services. It seemed to us, unfortunately, that this approach had more persuasive political power than that of improving the health of homeless people. It was estimated in 2005 that two fifths of homeless people attended A/E, one third hospital outpatients and one fifth had been an inpatient in the previous six months.[11]

The Health Authority agreed to fund the new service. Once their consent was obtained it became imperative to obtain buy-in from the voluntary agencies who hosted the various services and the private GP's who provided medical care. Hasenfield & Brocks Political Economy Model (1991) suggests that if the implementing agency presents other agencies that it needs to achieve its aims with the technological certainty (i.e. that the service to be developed would fit the actual needs to the target population along with adequate resources that the power to implement would become a non requirement and implementation would follow

automatically.[19] This proved to be the case with all parties supporting the proposal at the first meeting.

SafetyNet was launched on the 4th May 2007. Already the service has been instrumental in obtaining out of hours cover for homeless people irrespective of whether they have a medical card or not. Contacts have been made with the National Drug Treatment Centre to address the development of proposals to specifically address drug use problems within the homeless population. An outreach service for linking rough sleepers to services has decided to specifically link its clients in with SafetyNet while also providing a needle exchange programme that will have medical supervisioin from SafetyNet. It has become apparent that what appeared to be a lack of services was in many instances a lack of service co-ordination and SafetyNet is effectively fulfilling this interlinking function.

Concurrent to the development of SafetyNet, the Mountjoy St Family Practice approached the HSE about the possibility of developing an intermediate care centre. This was in response to experiences where homeless people were discharged from hospital into very unsuitable accomodation and also to the amount of homeless people with serious illnesses who needed treatment in a bed but who were not sick enough for hospital. This centre would accept referrals from both hospitals and the homeless services which would be screened by the medical team to ensure they were suitable. The HSE agreed to fund the Mountjoy St Research team to investigate the necessity for such a facility. This research was published in 2005 and concluded that an intermediate care centre would be an essential component in a comprehensive health care system for homeless people but due to a lack of varied accomodation options for homeless people with complex medical and social needs there was a significant risk it would become blocked up if there were not further developments in the provision of health care within homeless facilities. Simultaneously, the Health Authority was considering another proposal from a psychiatric service for homeless people for a unit to offer tempoary care to homeless people who were vulnerable due to their mental ill health but who were not considered eligible for admission into a conventional pscyhiatric unit.[20] The Social Inclusion unit accepted the arguments for both an intermediate care centre and a mental health facility and has committed to developing such a service.

In conclusion, the last 6 years has seen a shift of service delivery for homeless people form "encouraging in" to "reaching out". New specific services for homeless people both at primary care and within the interface between primary and secondary care are being developed. This new approach to service delivery is yet to be formally evaluated though this is planned to take place in the next two years and will hopefully give an indication of whether safety net type services do impact on the health of and/or the access to services for homeless people.

1. Williams J , O Connor Counted In 1999 Homeless Agency 1999 Dublin
2. Williams J, Gorby S. Counted In 2002. The Report of the Assessment of Homelessness 2002. Homeless Agency 2002 Dublin
3. Counted In 2005. Homeless Agency 2005 Dublin
4. Feeney, A. McGee H, Holohan T. Shannon, W. 'The Health of Hostel dwelling Men in Dublin', Perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels. 2001.RCSI & EHB 2000
5. Condon M, Holohan T, Hyland C, Birkbeck G, O Neill C, Mrozek S, Murray N, O Brien L, Neary G The Health and Dental Needs of Homeless
6. People in Dublin. Northern Area Health Board. 2001
7. Smith M, McGee H, Shannon W. Holohan T One Hundred Homeless Women. Health Status and health service use of homeless women and their children in Dublin. RCSI/ERHA 2001
8. Holohan T Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin. Dublin RCPI 1997
9. Burt M, Aron LY, Douglas T, Valente J, Lee E, Iwen B. Homelessness: Programs and the People They Serve: Findings of the l National Survey of Homeless Assistance Providers and Clients. Prepared for Interagency Council on the Homeless. Dec 1999
10. Lewis JH, Andersen RM, Gelberg L. Health care for homeless women. J Gen Intern Med. 2003 Nov;18(11):921-8.
11. Martens WH. A review of physical and mental health in homeless persons .Public Health Rev. 2001;29(1):13-33.
12. O' Carroll A, O Reilly F, Homelessness and health in Dublin- has anything changed? Unpublished.
13. Lawless M, Corr C. Drug Use Among the Homeless Population in Ireland. NCAD 2005 Dublin
14. Mainstreaming Health Care for Homeless People (2005) Nat Health Care for the Homeless Council. U.S.
15. Gorton S Guide to Models of Delivering Health Services to Homeless People. 2003 Crisis UK

16. Riley AJ, Harding G, Underwood MR, Carter YH. Homelessness: a problem for primary care. BRJGP. 2003 Jun;53(491):473-9.
17. Timms P, Balzs J. ABC of Mental Health : Mental Health on the Margins. *BMJ* 1997;315:536-539
18. Review of Service Provision for the Homeless in the Dublin Region. Report to the Department of the Environment and the Department of Health. August 1995.
19. Holohan T Health Status, Health Service Utilisation and Barriers to Health Service Utilisation among the Adult Homeless Population of Dublin. Dublin RCPI 1997
20. Nakashima J, McGuire J, Berman S, Daniels W. Developing Programs for Homeless Veterans. Understanding Driving Forces in Implementation. Soc Work in Health Care. Vol 40(2) 2004 1 – 12.
21. Carroll A, O Reilly F, Corbett M, Quinn L. Homelessness, Health and the case for an intermediate care centre. Mountjoy St Family Practice/HSE Social Inclusion 2006. www.feantsa.org/ code/EN/pg.asp?Page=5

Street Hospital for Drug Addicts in Oslo, Norway

Dr Ole B. Hovind
Doctor working with people who are homeless in Oslo

Introduction
Gatehospitalet (The Street Hospital) in Oslo, Norway has now been in operation for 2 ½ years. It is owned by the Salvations Army, Norway. It is a so called low threshold medical institution, staffed with medical doctors (3 part time) and RN nurses.

It is a hospital for drug addicts who need

- medical inpatient treatment, but not needing a regular hospital's full services;
- medical treatment for malnutrition, physical and mental exhaustion, health neglect;
- medical treatment before, during and after operations, dental treatment etc.;
- medical care and treatment after severe infections etc., after in- or outpatient care in hospitals;
- a combination of all above.

The hospital has 8 single rooms, of which 4 makes it possible, if needed, to isolate patients with severe infections. We do use the diagnostic services of the hospitals in Oslo extensively (X-ray. Clinical laboratories and specialized services like neurology, orthopedic, internal medicine etc.

The patients are referred to the Gatehospitalet from hospitals, low threshold health clinics (LTHC), physicians, psychiatric services, social services etc. Gatehospitalet does not admit patients directly from the street. Many patients knowing about our services will, however, call us directly. They will be asked to see LTCHs, street nurses, ED's etc. who then will refer them if they find it appropriate. The physicians at Gatehospitalet have out-patient clinics in the LTHCs and can admit patients directly.

Background
The Norwegian branch of the Salvation Army had, through their work with addicted people, seen many drug addicts struggling with health problems. Experience has shown that drug addicts and alcoholics suffer from a large number of diseases and they have poor health. At the same time they are, for many reasons, not able to or willing to use the regular health services. This seems to be a common problem in many societies and makes it necessary to develop health and social services more tailored to these patients needs and their understanding of what are acceptable services.

Their poor health, physical or mental, is further undermined by their underutilization of health services in general; their lack of ability to follow up on recommended treatment (life-style changes etc.). They are frequently dismissed from hospitals without appropriate follow up, to sheltered housing, hospices or to the streets. This led to contact with the Norwegian Department of Health and Welfare who funded a report entitled: "The worst is to discharge them to the streets". Accordingly, as a result, the project Gatehospitalet was founded, initially for 3 years.

Experience:
The number of treated patients in 2005 was 96, with 138 admissions; in 2006 it was 97, with 128 admissions. Men were 66,6 % in 2005 and 77,3% in 2006. The occupancy rate was around 80 % (table 1).

1. Treated patients

	% Female	% Men	Totalt	Antall pasienter
2005	33,3	66,6	138	96
2006	22,7	77,3	128	97

The ALOS was 18,3 in 2005, and 22 in 2006 as shown in table 2. There is a wide variation. We do not limit on the length of stays. We treat their medical condition as long as deemed necessary.

2. Average length of stay (ALOS)

	Female	Men	Totalt	% Belegg
2005	13,5	20,6	18,3	76,29
2006	13	26	21,48	83,71

The main reasons for admittance are abscesses, infections like pneumonia, endocarditis, erysipelas, sequels from DVTs, fractures, psychiatric disorders, exhaustion and malnutrition including anemia, extreme weight loss and liver diseases.

In 2005, 35% of patients were referred from hospitals; 50% from sheltered housing and the social services, including low threshold health clinics; 15% misc. In 2006 hospitals referred 35%, sheltered houses 50%, but during the year, the referral from the psychiatric services increased from almost nothing to 10%. The rise in referral from psychiatric services continues in 2007. The cooperation the hospitals and the psychiatric acute services is getting closer and is a two-way cooperation. There are surprisingly few referrals from MD's, which probably reflects the fact that these patients are having difficulties in using their services for other things than getting prescriptions.

The demand for beds varies a lot and there is still unmet needs. 16 beds would probably be sufficient. As the drug addicts are getting older, there should be a nursing home with a competent staff for these patients.

Gatehospitalet operates without waiting lists or bureaucratic procedures. If a bed is free and there is a patient in our target group, the patient is admitted. Approximately 30 % of the patients are referred to long-term rehabilitation centers. Being at Gatehospitalet gives the patients and the social services better opportunities to find suitable alternatives for rehabilitation and plan accordingly for the time after discharge from Gatehospitalet.

Unplanned discharges (breach of treatment) usually take place after the medical treatment has been finished and the gradual reduction of substitution therapy has started. Women leave the hospital more often than men and have shorter stays. They also tell us that they have to go in order to earn money for their dependents. We do see that women have other needs than men, and we are planning an expansion to try to meet their special requirements (more protected, longer stays and more focus on well-being and special housing projects).

4. Breaches of treatment

	Female	Men	Totalt
2005	29	34	63
2006	16	48	64

The larger hospitals in Oslo have developed a set of recommendations in order to get a more uniform practice for substitution therapy during hospitalization. Gatehospitalet uses those guidelines with some modifications. We have a very limited list of drugs that we use for substitution therapy and have especially limited the number of anxiolytics, hypnotics and sedatives. The addicts are well aware of our guidelines and only a few patients do not accept our policy.

At Gatehospitalet there are rules of behaviour. The patients are not allowed to use other medications than those prescribed. By offences they are asked to leave the institutions. In 2006 there were 5 who left Gatehospitalet due to breach of the regulations. So far there has been only one minor incident with threats; demanding drugs. The project has had ongoing evaluation. Report 2 will be finished at the end of July 2007.The Minister of Health has however been impressed with the results and promised funding for the years to come.

Young Single Homeless People: Their Perceptions of Health and Use of Health Promotion Activities

Gary Wilson
Programme Manager for young People at NHS Health Scotland
http://www.healthscotland.com/about/index.aspx

Introduction

In January 2005, NHS Health Scotland and the Scottish Executive appointed Blake Stevenson Ltd to research young, single homeless people's perceptions of health and use of health promotion activities. The research took a participatory approach, which enabled participants to shape the report's recommendations. This Summary sets out some of the key findings and recommendations from the research.

Background to the research

Whilst there is already a large body of literature concerning health and homeless ness, much less has been written about *young* homeless people or the broader issues around perceptions of health and use of health promotion activities. This research was designed to address these gaps.

Methods

The methods used ion the research were: a literature review; a national statistical profile of young single homeless people; 62 semi-structured interviews with young single homeless people; six focus groups with frontline staff working with this client group; one consultation focus group and three consultation interviews with frontline staff; and two consultation focus groups with young, single homeless people. It should be noted given the relatively small sample size this is a snapshot and not necessarily absolute evidence. However it did point out some issues for further research.

Findings

The three main sectors involved in health promotion activity amongst young, single homeless people are the NHS, local authorities and the voluntary sector. There was a clear need for greater recognition amongst these sectors of the health promotion needs of young, single homeless people and a more structured approach to be taken to addressing them. In order to do this the research recommended the following:

Each NHS Board develops a Health Promotion Plan for young, single homeless people. This could be an annexe to the main Health and Homelessness Action Plan.

The Plan should be a practical document written collaboratively with key individuals in local authorities and the voluntary sector. The authors recommended that a short timeframe of no longer than six months should be imposed on producing the Plan. Key individuals should be assigned responsibilities and be accountable for the delivery of the plan at a local level.

Local authorities should use the Plan to supplement their Homeless Strategies, which should (a) acknowledge the needs of young, single homeless population and (b) set out their responsibilities towards this vulnerable group of homeless people.

Provision

The study revealed that the health promotion needs of young single homeless people were influenced by a number of different factors including age, gender, sexual orientation, length of homelessness and area of residence and therefore the research recommended provision as needing to be targeted in line with this.

The researchers found key workers in hostels were best placed to provide health promotion activities, drawing on what they already do as a matter of course but also being more proactive in tapping into services, activities and health events which are currently being delivered locally and any outreach work delivered by other specialist voluntary sector services.

Self-esteem and confidence building

Low self-confidence and low self-esteem were consistently highlighted as characteristic of the young, single homeless population. Group activities and skills-based activities it was argued can be used to do build up confidence and self-esteem and the authors recognised that this is being carried out to a varying degree in hostels and other voluntary sector agencies but is not necessarily recognised as health promotion.

Health topics

Addressing a range of health topics is what many consider to constitute health promotion. Young participants as well as professionals expressed their views as to how this can best be done and these have been highlighted in this report in particular the following priorities were identified:

Sexual health

Participants considered this to be of high importance to their health and many had access to free contraceptives. Despite this, many do not appear to practice a safer sex on a regular basis and this is particularly the case for older participants. This research also found that professionals are more likely to take a reactive approach to addressing this issue.

Low level mental ill health

Whilst severe and enduring mental ill health requires specialist provision, low level mental ill health can be addressed in part by those working closely with young homeless people. Whilst many participants had access to someone to talk to when feeling stressed out or depressed, a considerable number do not do so on regular basis. Professionals were found to take a reactive approach to addressing stress and/or depression.

Sleep

A large number of participants report being unable to get a good night's sleep although they consider this as of high importance to their health. This was particularly the case for females.

Health damaging behaviours: smoking, alcohol misuse and drug misuse

Older participants, males and those with longer histories of homelessness are more frequently engaged in health damaging behaviours. Living in close contact with a number of other young people in the hostel environment raises the potential for peer pressure to influence residents' behaviour. Smoking is an interesting topic as young participants identified it as a priority whilst professionals did not.

Dental health

The low number of participants, particularly males, who have visited a dentist in the last six months coupled with the difficulties experienced in registering with an NHS dentist, indicates that many participants will not be receiving the advice and treatment they require in relation to their dental health.

Conclusion

The research has provided rich material on which to base actions to improve health promotion activity for young, single homeless people in Scotland. The approach taken allowed young, single homeless people, and practitioners working with them, to be directly involved in the development of recommendations to improve services. It is hoped that the research will help lead to improvements in delivering health promotion activity to this vulnerable group of people.

For a full copy of the report visit www.healthscotland.com/documents/481.aspx or contact Gary Wilson on 0131 536 5500 (email: gary.wilson@health.scot.nhs.uk).

Forum

Daily Practice: An online exchange between health professionals working with people who are homeless

Reproduced below (with the prior permission of those concerned) is an interesting exchange from two UK based health professionals who use the online health and homelessness forum hosted by Oxford University. The Oxford Forum has gathered enthusiastic users in the UK and we hope that in the future the ENHW's own discussion forum will have a similar function for health professionals across the EU! So do sign up and get the discussion going!

Invented client stories: what confrontation is needed?

In my work I come across clients who at times invent and/or embellish their life event histories with stories of personal tragedy and loss that seem to serve for them the purpose of explaining their present predicament of homelessness.

An example case: male, mid-twenties-early thirties. There were no significant interpersonal relationships. Transient history - up and down the country (UK). Life event story that partner and

children/child were killed in a car accident (obviously this could be true but in this and other cases the story does not seem accurate). No significant learning difficulties. Treatment seeking (frequent requests for help) but attendance following initial appointments (and divulging of traumatic story) poor.

I tend to interpret the way in which life event stories are conveyed by clients, details that are added in, bits missed out, the degree of trauma involved and so on as one element in an incremental process of building a working relationship. Basically a part of the 'getting to know each other' process in therapy. There does however, appear to be something in particular about a homelessness lifestyle (the transience, instability in relationships, lack of a stable basis from which to develop the narrative skills to be able to think in terms of ones own story) that can be a breeding ground for invention/embellishment.

Do you have any ideas/experiences around invention/embellishment of stories by clients in a homeless setting? I am not thinking of something that can be explained away easily by reference to pathology, Munchausen's for example. Can anyone point me in the right direction in terms of research or do you think I need to go back to the drawing board with this? Am I coming up with a Friday afternoon muse that is not really going to help clients?

Doneil Macleod
Practice Mental Health Nurse
Edinburgh Homeless Practice, Scotland

Munchausen's syndrome: do not confront with falsity of invented stories

I would call this psychiatric Munchausen's (or whatever the ICD10 equivalent is). We have had several over the years - but none in the last 5 years, I think - with feigned bereavement being the most common story.

We usually offer quite intensive support, often without challenging the story at all. Sometimes I have made it clear that I know the story is not true but that there is obviously a problem and that we are interested in offering them help and support. We have usually managed to support them for a reasonable length of time before they again go missing. Attempts at simple psychological work have not generally taken off - clients have tended to prefer to stick to the here and now and to deny specific psychological issues, as you might expect if you construe this as an extreme form of denial or somatisation.

The fact that there is a continuum - from the slight embellishment of our symptoms or histories that many people do to ensure that the doctor is properly attentive to them, to the complete fabrication of symptoms or histories - does not mean that it is unhelpful to give it a diagnostic label. I have seen at least one case like this where, because it was not recognised as psychiatric Munchausen's, the worker involved took it into their head to confront the person about the falsity of their story - unsurprisingly he disappeared and we have heard nothing of him since.

It's important to remember that "Munchausen's syndrome" is a descriptive term only - it implies no particular model of pathology or of intervention, biological, psychological or of any other modality.

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What is health?

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If we define health, we can say that: health is a unity and harmony within the mind, body and spirit which is unique to each person, and is as defined by that person. The level of wellness or health is, in part, determined by the ability to deal with and defend against stress. Health is on a continuum with movements between a state of optimum well-being and illness which is defined as degrees of disharmony. It is determined by physiological, psychological, socio-cultural, spiritual, and developmental stage variables.

If health is all that, can homeless people be healthy? If we consider homeless in this perspective we notice how big a problem homelessness is. To have a home is one of those basic things that includes you in everyday life. Regardless of that we have, there are 7400 homeless people in Finland. This is less than year a go, but still is too much.

Individuals who are incapable of maintaining employment and managing their lives effectively due to prolonged and severe drug and/or alcohol abuse make up a substantial percentage of the Finland's homeless population. Many times homeless people edge out of society in so many ways. But can people make a mistake? And if the people make mistakes should they have to let go of their healthy and good life also?

When we define health and good life, those become our goals. We define that to be a good person you have to have a job, home and interesting life. Then you are useful to society. If those are our goals, then it follows that we also aim for goals in our work . But can we give that kind of good life to people? Are those goals realistic? If we can't offer those goals to people, should we change our goals? Because if we keep those goals we also keep thinking that homeless people are not good and useful people.

It is wrong that people who are without homes and have to deal with this situation have also to deal with our prejudice. We have to change our attitudes. We also have to work for goals that offer health to all people also those who are homeless.

Resources

FEANTSA's Research Observatory has recently published the report entitled: "The Changing Role of Service Provision: Barriers of Access to Health Services for Homeless People"

This report is available to download for free from FEANTSA's website (see link below) and a paper copy can be requested by email. (mary.fay@feantsa.org).

"This paper examines the approaches adopted to meet the health needs of homeless people in Europe. The paper does not discuss the specific health needs of the homeless since these issues are extensively discussed in related literature and are understood to involve increased morbidity, poor life expectancy, substance misuse, mental ill health, multiple needs and increased health risks to children of homeless families. Rather the focus is on barriers of access to health care and the nature of health interventions. The paper draws upon evidence from seven countries - Austria, Denmark, Estonia, Greece, Netherlands, Portugal and the UK - and aims to describe the different approaches in their national context as well as to draw comparative lessons from the evidence.

In the context of strategies to combat social exclusion the health inequalities faced by homeless people represent a policy issue of some importance which, arguably, should be a priority for health policies and homelessness interventions. This is a cross-cutting issue which, given the differences in governance involved across Europe, involve national as well as local policies and co-ordination across departmental boundaries and between health services and providers of homeless services."
http://www.feantsa.org/files/transnational_reports/2006reports/06W3en.pdf

Paris, France : University Diploma Course on « Mental Health and Homelessness – Medico-Psycho-Social care approaches
(*Santé mentale et précarité : Interventions médico-psycho-sociales*)

This recently launched course is run by Pr. R. Dardennes and Docteur A. Mercuel. It is offered by the Faculty of Medicine in the University René Descartes –Paris 5 and the Hospital Sainte-Anne.

The aims of the course are to:

- improve the psychological-medical care offered by those working in this area;
- improve the knowledge of how medical and social infrastructure is organised and operates: joining up actions, coordination, networking;
- give professionals the theoretical, methodological and practical tools necessary to understand and engage with different groups (clinical, therapeutic issues etc.)
- exchange experience and knowledge from working on the ground to develop a multidisciplinary approach to working with excluded and marginalise groups, improving practice on the ground and challenging a siloed way of working.

The course is aimed at:
Health workers: general practitioners, psychiatrists, psychologists, students in these disciplines, nurses, all other parmedical and professional workers who work with people who are homeless: social workers or professionals in social–medical services catering for vulnerable and excluded people.

This one year, three module course, is delivered in French in Paris. To find out more about it, you can consult the course flyer online.

Events

UK Event: "Home, Homelessness and Community"

Our aim is to explore the meaning of home and community through in-depth consideration of the experience and the meaning of homelessness and 'unhoused' states of mind

Saturday 29th September 2007: 10.00 – 5.00 pm
(9.30 for tea, coffee and registration)
Turvey Abbey, Nr. Bedford
Cost £40 including lunch
(some bursaries are available for the unwaged)

This, the first in a series of workshops, will comprise a combination of talks and small and large groups for further in-depth discussion and exploration. We will begin by considering the difficulties of working with hard-to-reach homeless persons whose membership of society is defined by their placing of themselves in *liminal* spaces that are neither in nor out. This will be followed by discussion and exploration of the meaning, and our experience, of 'community' and its potential contribution to personal, social and spiritual health as well as a consideration of the pain caused when communities become corrupted, divided, damaged or fail.

You can consult the full programme, booking form , contact details and directions online.

Nordic Event: "Health and Homelessness Nordic Conference"

This conference will take place on the 15-16 of November 2007 in Stockholm. It is open to all health professionals working with people who are homeless and aims particularly to build up a Nordic network of health professionals working with people who are homeless. Guest speakers from abroad include Dr Jim Withers from the Street Medicine Network in the US and Tiina Podomow from Monteral.

The work and exchanges will take place through four simultaneous workshops on each of the days of the conference. These will cover themes including networking and lobbying, harm reduction approaches, mental health and religious and ethical questions.
You can consult the full programme online.

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