European Network of Homeless Health Workers (ENHW)

FEANTSA

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Sharing Experiences: News from Health Professionals across the EU

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Events

Building cohesion and Strengthening Health for Growth: ADDRESSING HEALTH INEQUALITIES 2014 AND BEYOND, Brussels, 24 January, 2014
More information at : http://www.health-inequalities.eu/HEALTHEQUITY/EN/projects/equity_action/final_conference/

FEANTSA Policy Conference: Confronting Homelessness in the EU: 14th-15th November 2014, Bergamo, Italy.

Conference on Personalisation in the Homeless Sector, London, 23 January, 2014
More information at: http://homeless.org.uk/events/personalisation#.UrBLfNLuKSp

Editorial

Dear Readers,

We are pleased to share with you the winter edition of the ENHW newsletter, which covers a wide range of topics from all over Europe. We have received four articles for this issue. The first article shares an example of an integrated, psychologically informed environment approach. It demonstrates the benefits of cross-sectoral cooperation, for both clients and services. It aslo shows that the inclusive approach and onsite presence of a clinical psychologist have led to increased levels of engagement and as a consequence, improvements in health. The second article on the behaviour and self-image of homeless people in Denmark summarises a qualitative research among homeless people with problematic alcohol and drug use on the perception of themselves in relation to society as well as to other homeless people. The third article describes a campaign that aimed to raise awareness of the right to health for all including the most vulnerable. It identifies the numerous barriers homeless people face when accessing their right to health. The last article highlights the lack of access to services as the root cause and enabling factor in the extreme exclusion of homeless people with mental health problems, and stigma as playing a crucial role in perpetuating rejection. 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 our 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.

An Integrated, 'Psychologically Informed' Partnership Approach to Homelessness Prevention

By Lindsay Stronge, Hostel Manager, The Waterloo Project, Thames Reach and Dr Emma Williamson, Highly Specialist Clinical Psychologist, Clinical Service Lead of the Psychology in Hostels Project (Lambeth) PIE, South London and Maudsley NHS Foundation Trust, UK

Emma (Clinical Psychologist) and Lindsay (Hostel Manager) discuss how they are working together to revolutionise the Waterloo Project (a 19-bed hostel in central London) and transform outcomes for clients such as Jonathan.

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When we met Jonathan[1] he was in his mid-40s. He had been moving between various hostel placements and rough sleeping on the streets for over a decade, the so called 'revolving door' phenomenon. He was alcohol dependent, had a long history of self-harm, suicide attempts and had served a custodial sentence for assault. Due to his aggressive behaviour he couldn't sustain a hostel placement for more than a few weeks and he was well known at local hospitals in London where, in one month, he had presented 64 times at Accident and Emergency (A&E). This had cost the local health authority £21,400 in the six months prior to his placement with us and Jonathan's circumstances hadn't improved as a result. It was clear that a different approach was needed.

In 2011, with people like Jonathan in mind, and with an awareness of emerging research in working with those who have experienced emotional trauma,[2] London Borough of Lambeth Adult Community Services commissioned a two year pilot to create a *Psychologically Informed Environment'* (PIE)[3] at the Waterloo Project in Lambeth.

Councillor Jim Dickson, Lambeth council's Cabinet Member for Health and Wellbeing, said, "Our Rough Sleepers & Street Population team have conducted in depth work to get to grips with what are challenging issues to tackle. At Lambeth council we are determined to do all we can to help the most vulnerable people in the community and use of the Psychologically Informed Approach is an example of our work with those who are the hardest to reach."

The pilot is a collaboration between homelessness charity Thames Reach, South London and the Maudsley NHS Foundation Trust (SL&M) and London Borough of Lambeth Adult Community Services (LBL). A fundamental difference in our PIE compared to others around the UK is the presence of a full-time, onsite NHS Clinical Psychologist and an Assistant Psychologist. This enables us to take a completely new approach with Jonathan and prevent this placement breaking down, like all the others. There is scope for direct clinical work with clients, staff training opportunities, interventions with the staff team and joint psychology-management approaches in dealing with tenancy issues.

The Psychologists began working with Jonathan by conducting a psychological assessment. He had been exposed to complex trauma from childhood as a result of physical abuse, neglect and frightening caregivers. It became clear how anxious and threatened Jonathan felt in everyday situations, which was resulting in either aggressive behaviour towards others or chest pains and reports that he was having a heart attack and needed an ambulance.

[1] Personal details, including client name, have been disguised to protect individual confidentiality as much as possible, without altering the key facts of this vignette.

[2] There is extensive literature detailing the multiple disadvantages and histories of abuse, neglect and complex trauma common amongst this population (Maguire et al., 2010)

[3] The concept of the PIE was first developed by Robin Johnson and Rex Haigh (2011).

In a Reflective Practice session,[4] the team discussed typical interactions with Jonathan and, combined with Psychologist's insights from the assessment, we developed behavioural guidelines to inform how we responded to him. Once the staff realised that Jonathan's aggression was a result of anxiety and fear it became easier to understand and support him. We started to be more explicit about telling him we cared about him and wanted him to stay at the hostel. To help him with his panic attacks we practiced breathing exercises and guided him through these, averting the need to call an ambulance. We have significantly decreased his use of emergency services to a few presentations per month but are doing ongoing work with both the hospital and his General Practitioner to encourage him to use mainstream services, rather than attend A&E in a crisis.

Jonathan's story is not unique. Fifty-nine people have lived at the Waterloo Project in the first 20 months of the PIE with an average duration of 36 weeks. Ninety-seven percent were found to have drug and/or alcohol difficulties, 97% had mental health and some form of substance abuse problem and 59% a personality disorder diagnosis or notable features of a personality disorder. There were also high levels of offending, antisocial behaviour, forensic histories and an over-representation of individuals raised in social care and those with children currently in care.

As onsite clinicians, the Psychologists become a familiar face to the clients and this is crucial in the development of trust before clients engage in psychological therapy. Many of our clients have long avoided contact and may even have been suspicious of mental health services. The psychologists work creatively to engage clients through informal activities if they are not ready for more formal individual therapy (e.g. walking the dog, gardening, having a cup of tea, going shopping).

Once engaged clients have access to a range of individual and group psychological assessment and treatment options, with the main psychological approach being Mentalization-Based Treatment (MBT).[5] These interventions are demonstrating clinically significant improvements in mental health on standard clinical assessment tools, as well as a reduction in substance misuse and challenging behaviour.[6] The Arts activities run in the hostel by hostel staff and psychology have proved invaluable in helping the most entrenched service users access help for the first time. Assistant Psychologist, Theresa Schwaiger, began a weekly MBT therapeutic art group which has demonstrated improvements in reducing depression, anxiety, aggression and substance misuse. It has also enhanced the self-esteem, interpersonal skills and social inclusion of some residents who have entered art exhibitions, competitions and had their work published. One client, Lee Scales, articulated how the Art group had been instrumental in him accessing mental health services after a decade of homelessness and fearing help;

"I was scared at first to talk about things. I don't think I wanted help, but then coming along to the art group and slowly talking in that was the best thing for me. It then helped me get use to [the Psychologist] and think that it might be helpful to talk more in a one-to-one. I remember thinking that I would not want to talk to psychiatry and they would come in white coats and lock me up. But [the Psychologist] helped me see that it was ok and that [the Psychiatrist] was nice. That has really helped me - seeing him and trying some medication. It wouldn't have happened if [the Psychologist] hadn't been here."

One of Lee's pieces of art created in the therapeutic art group is on the front cover of this magazine. Other arts-based interventions run by the hostel have included photography, creative writing, a film club with discussion group and gallery visits.

[4] Reflective Practice case based discussion meetings, facilitated by Psychology, aim to increase hostel staff's capacity to reflect on their practice and develop psychological understandings of client's.

[5] Mentalization-Based Treatment is an evidence-based treatment for working with personality disorders and supports the development of emotional regulation, leading to a reduction in impulsive, risk taking and aggressive behaviours, self-harm and substance misuse (Bateman & Fonagy, 2010).

[6] Direct psychology interventions have demonstrated highly significant (large effect size) improvements in mental health based on service user and clinician rated outcome measures of global distress (Clinical Outcomes in Routine Evaluation, CORE-10; and Health of the Nation Outcome Scales, HoNOS respectively).

Eighty-one percent of hostel residents have had direct contact with psychology in the hostel (1:1 or group therapy) with a consistently high attendance rate at planned appointments (73%). The usual barriers to accessing therapy have been removed; clients who are still using alcohol or other substances can access psychological therapy if they are not too intoxicated at the time of the session. We believe it is the inclusive approach and onsite aspect of this PIE model which has led to increased levels of engagement and as a consequence, improvements in health. We have also seen an increase in the numbers of clients offered treatment by external physical and mental health services. Many of these clients had previously been unsuccessful in accessing or maintaining a link with these services.

The Waterloo Project PIE is a partnership in every sense of the word and this has been fundamental to its success in maintaining placements for the most excluded clients and preventing further homelessness. Being onsite together means that Psychologists and hostel management are able to work closely to incorporate a psychological understanding of service users' needs into all aspects of the project.

Psychologists and hostel staff assess new referrals together, visiting clients offsite in hospital or other accommodation if necessary. We discuss when residents are ready to move on and what accommodation option is likely to work for them to maximise chances of a successful move back to the community. We also formulate strategies together after incidents to ensure we manage similar behaviours in the most effective way in future. Joint meetings are commonly conducted between clients, management and psychology to combine the need for care and support alongside clear boundaries and tenancy management issues. This provides a containing frame for the clients and ensures that psychology and hostel staff have a joined up and consistent approach.

The Psychologists provide fortnightly staff reflective practice sessions, and attend team meetings and 'handover' between shifts. This allows the team to utilise psychological models and theory to help better understand the client's behaviour, current difficulties and what might help to bring about change in their individual work with clients.

"[the Psychologist] gave us guidelines on how to deal with him [client], he really is very challenging …before it used to make me get annoyed with him and we'd both be clashing …but by me [using the guidelines] he doesn't feel embarrassed or insulted…I do see those de-escalation techniques have been working with him". [TR hostel staff member]

"Reflective practice enables me to critically analyse what I could have done better or differently and ensure that I invest in my professional development." [TR hostel staff member]

We believe that we have developed an approach which works with the clients who need it most; those that have been multiply excluded from other services and for whom standard services and approaches are not working. The clients we have worked with over the past 20 months are desperate to improve things in their lives and make use of the support available when provided in an accessible, flexible and creative way. We therefore passionately agree with one client who, in a recent focus group review of the service said *"I think everyone can benefit from this [PIE approach] and it would be good if all hostels were like this*".

As for Jonathan: he began attending 1:1 psychology sessions and the therapeutic art group which has helped him become more aware of his emotions rather than acting impulsively. He has been living at the Waterloo Project for 15 months, the longest he has ever sustained a placement in his adult life. He is engaged with alcohol services and working towards a goal of detox and rehabilitation with his key worker.

Jonathan says *"I feel I have done well since being here. Things were really bad before…But being here and knowing help is available makes me feel calmer. I want to go to rehab, but I will miss it here".*

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The behaviour and self-image of homeless people in a societal perspective

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In Denmark homeless people are often described in the media, by the general public and professionals as the 'most marginalized', a 'heavy group of citizens, who are socially deprived and vulnerable' and as such a group of wretches with few resources and chances in life. They are symbolised by images of the drug addict lying in a staircase with a needle in his arm, the alcoholic sitting on the bench or the beggar in the street. Scenes that leave little room for hope and a possibility of seeing the homeless as a person with values and a life content based in the homeless community, and even as a group of people with an ability to survive that exceeds what most of us is capable of.

In the last 8 years I have been working as part of a street based health team with 1 doctor and 4 nurses. I have met a lot of homeless people who do not see themselves as 'having hard luck' or being 'wretches', but instead as people who are part of a subculture where the community formed by living in the streets is an important factor. This community involves several aspects; the use of alcohol is one of them.

One of the aims of my master thesis in addiction studies was to let the homeless people be heard, to let them tell their life story with a focus on their perception of themselves in relation to the society as well as to the group of homeless. The thesis was based on qualitative interviews with six homeless people. My focus was on homeless people with alcohol and/or cannabis use.

My results revealed that throughout the experience of homelessness a learning process takes place based on how to behave, how to appear in public and how to communicate. The process is twofold: on the one hand it is to handle the stigmatization of society; on the other it is to become part of the homeless community. Some of the homeless interviewed are sellers of the homeless newspaper 'Hus Forbi' (Big Issue). Being a seller plays a major role in their everyday life, it allows them to feel part of society, to be seen and to talk about little everyday things with 'normal' people that pass by or stop to buy the paper, as one of the interviewees stated:

' – those 20-30 seconds where you talk with people about small normal things, that feels cool. I think they respect you more when you sell newspapers; you strive to earn your money instead of just begging'

The importance of feeling oneself as part of 'normal' society can be seen as a way to handle the stigmatization of being homeless, an attempt to adapt to an expected behavior and by that be worthy of acceptance and respect from society.

Most of the homeless people I meet use alcohol on a daily basis, and most of them in a way that is damaging for their health. A lot of them have been attending treatment programs, primarily in outpatient clinics, where the aim is total abstinence from alcohol.

The interviews with the homeless people in my master thesis showed that the use of alcohol is only part of a complex picture. Beside the physical need of alcohol to prevent withdrawal, alcohol is used by the individual for a 'time-out' from the everyday struggle and to give a 'buzzy' feeling of being on the top of the world. Furthermore, the use of alcohol plays a big role in homeless community – to meet with peers for a beer and talk about all and nothing. However, drinking in public as a homeless person creates stigmatization – in one the interviewee's words:

' – yes, I know I am an alcoholic, but I am so damn tired of people seeing me like that instead of the person I really am. I like to drink once in a while, and act silly. If I am

not drunk, it feels degrading and humiliating to sit on the bench among the others and enjoy a beer. But if you (the society) cannot see me as a normal person, when you have labeled me anyway, I might as well get wasted, you see me as an idiot anyway'

A consistent theme in the interviews was the feeling of loneliness when not being part of the homeless group in the streets. All six interviewees had at some point in their life as homeless been referred to an apartment, and all of them had either terminated the rent or kept the apartment and continued spending most of their time in the homeless community. To be alone in an apartment generated an overwhelming feeling of loneliness. Having a place to stay created expectations of being able to create a normal life with job, family and abstinence from alcohol, but instead it became a stress-generating factor - a curse rather than a blessing. Quoting an interviewee:

' – being homeless and living in the streets creates s social interaction that disappear when you move into an apartment. When you're sitting alone behind the four white walls, listening to the life that goes on around you and feeling sad and sorry for yourself, it always helps to seek the homeless mates and have a beer or two. You get into a better mood and are enjoying yourself'

The last issue I want to focus on in this article is the aspect of freedom. All interviewees mentioned the feeling of being free and being able to live from day to day as a valuable aspect of homelessness. For the homeless, freedom equalizes a more giving and eventful life than most of us live. One of the interviewees recently moved into an apartment, and expresses the feeling of freedom like this

' – when you are homeless you take one day at a time, no big plans…, you learn to see life in a different way than if you have a nine to five job, pick up the kids, cook dinner bla bla bla…, by being homeless you experience life, if you get a sudden impulse, you go – since I moved into this apartment I haven't seen the forest, before I just went off if I felt like'

' most people feel sorry for the homeless, they think they live a miserable life, but in a way it is a free life to be homeless..'

These statements give an impression of the homeless as the free bird that live a life without responsibility and trivialities. However this is not the case for all homeless, some of them live in what can be called 'theoretical freedom', a consequence of the feeling of failure to meet the demands from the society. They may have unfulfilled expectations to themselves and their ability to live as 'normal', and freedom can in that context be seen as theoretical as it is chosen due to a fear of not being able to 'succeed in life'. Freedom can in this case be associated with uncertainty and insecurity – to live from day to day and not knowing which problems the day will bring, and not knowing where to sleep the next night.

The aim of my master thesis was to let homeless people with their 'expert-knowledge' contribute to research and give us all an opportunity to get a broader view on the homeless population, a view that emphasizes the resources contained in the group, and a view that makes us as professionals in the field, aware of the importance of involving the homeless community in our work.

Most vulnerable need fundamental shift in attitudes and service provision

By Silvana Enculescu and Olga Kozhaeva, Mental health Europe

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When dealing with the massive problem of the ever increasing poverty sweeping through Europe, it has become obvious that the so called austerity measures have perpetuated, rather than solved the economic and social crisis. The increase of homelessness is a dramatic proof that more and more people are finding themselves in extreme precariousness and exclusion, conditions which are incompatible with the core values of the European Union - human rights, solidarity and cohesion. It is widely documented that the cuts to public spending national governments employed in trying to speed

up recovery have failed, and that a growing number of people are falling under the poverty line and through the increasing cracks of already overburdened health and social care systems. Unless effective access to quality services is guaranteed for all, we can only expect a further tragic deterioration of the homelessness phenomenon and the mental health issues that inevitably go with it.

When prejudice undermines support

More than 120 million Europeans are currently living in, or at risk of, poverty. Among these, a newly-published Mental Health Europe (MHE) position paper estimates that more than 500,000 people are homeless. MHE reports that 30% of homeless people experience mental health problems in their serious, chronic form. Thus, more than 150,000 people with severe mental health issues are homeless on the EU territory, undoubtedly experiencing the most extreme form of exclusion. Their position on the brink of society engenders a loss of trust in social care on behalf of the general public, along with high emergency services costs. For the homeless people themselves, living on the streets with no support is associated with developing mental health problems, which may even result in death. Indeed, in Denmark, homeless men were found to be 7.3 times more likely to take their own lives than the general population, and homeless women were an astonishing 14.8 times more likely to do so.

The MHE position paper identifies the lack of access to services as the root cause and enabling factor in the extreme exclusion of homeless people with mental health problems, and stigma as playing a crucial role in perpetuating rejection.

The prejudice still surrounding mental health problems underlies all problems, a type of attitude unfortunately fuelled by the complicity of certain mass media and widespread misinformation, as well as a striking lack of adequate training at all levels, from the professionals working on the ground to policy makers. Prejudice among the general public often leads to a Not in My Back Yard kind of attitude, which makes it even more difficult to gain support and set up services for homeless people with mental health problems.

Moreover, several characteristics of services that stem either from policy decisions, or from staff capacities, attitudes and behaviors, can create exclusion. For example, some mainstream services, such as community mental health services, do not perceive people who are homeless, including those with psychosocial disabilities, as their responsibility. Consequently, services with various specializations fail to collaborate well, although that is required to support people with complex needs. Services also lack the ability or willingness to accommodate 'non-standard' behaviors - for instance, for some people with psychosocial disabilities, keeping appointments constitutes a major challenge. Lack of follow-up strategies also put homeless people with mental health problems at risk of being overlooked. What is more, access to services is often conditional on fulfilling certain requirements – for example, income support may require having a bank account, which can be difficult for homeless persons due to a lack of address. Such 'ordinary' requirements, that would cause no problems for the majority of citizens, could lead to temporary or permanent exclusion for people who are homeless.

A focus on true solidarity

To address the issue of homelessness, Mental Health Europe therefore believes that all Member States, guided by European institutions, should invest in integrated, personalized, relationship-based services underpinned by a legal environment promoting human rights and equal access.

The adequate resourcing of services and welfare support for the most marginalized members of society at the European Union, national and local levels should constitute a clear priority for Member States. There is a need for social investment that will promote the well-being of all, understood in a broad and humanistic way, and not limited to economic concepts. Authorities should not hesitate to prioritize resources to respond to extreme forms of exclusion and injustice, even if the return on such investment is slow and therefore cannot bring instant political visibility. While the efficiency of

any investment in services is always important, it should not impact the ability to provide quality care in line with the principle of equality. Services that come under too much pressure to perform and meet certain success indicators are likely to be discouraged from working with clients with the most complex needs. Placing too much emphasis on short-term economic gains also fails to recognize the much broader nature of well-being in society. As an alternative approach, authorities that are responsible for service design, funding and provision should focus on effectiveness by ensuring that services are integrated and personalized.

A secure home and adequate income are the bases for all interventions necessary to build trust and achieve true social participation in line with the individual's needs. Therefore, providing stable housing with support and sufficient income to pay rent must be the primary solution, as it constitutes a basis for any further work. However, providing only a home is insufficient, and must be complemented by further service provision. In this regard, Mental Health Europe supports the Housing First approach and emphasizes the importance of integrated social and health services.

Overall, user empowerment and a genuine sense of social solidarity should be underlying all measures.

At EU level specifically, MHE calls for an EU Strategy on Homelessness with a comprehensive mental health perspective to strengthen the Union's initiatives on this issue. The European Union should also complete the negotiations, adopt and implement the Anti-discrimination Directive. Moreover, Mental Health Europe recommends that socio-economic status be recognized as a ground for discrimination.

While engaging with the worst cases of poverty and exclusion can be daunting, systemic changes in service provision and in dealing with the most vulnerable are bound to offer valuable lessons that would help the population at large. It is high time that governments stopped looking for quick fixes and started searching for viable long-term solutions for recovery. Starting with the most vulnerable might just be the way to go!

"NOBODY WITHOUT HEALTH. ENDING HOMELESSNESS "

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The Spanish Homeless People Campaign this year was celebrated on **November 24, 2013**, with the motto "**NOBODY WITHOUT HEALTH. ENDING HOMELESSNESS** ". Its main aim was to visualize the difficulty for people experiencing homelessness in our country to access the **right to health.**

The campaign has been underway for 21 years in dozens of towns and cities with the help of organizations like FACIAM, the fePsh (Spanish Federation to support homeless), the Xarxa d'atenció a Persones sense llar from Barcelona and BesbeBi from Bizkaia.

Homeless people experience barriers in accessing their right to health:

- Because of lack of information or because of the information provided to homeless people is unclear.
- Because of stigmatisation and discrimination by health-care professionals.
- Because of the complex bureaucracy involved in processing and assigning health-care professionals.
- Because services are not adapted to the needs of homeless people. As a result homeless people often access health services through emergency departments and only when their health conditions become critical.
- Because of lack of coordination between social and health services (prevention, treatment and discharge).
- Because of long waiting lists (especially for treatment of mental illness and drug addiction).

- Because no monitoring is arranged (residential registration).
- Because of lack of official documents.
- Because the mistrust of homeless people.

La Campaña Nadie sin salud. Nadie sin hogar 2013 se enmarca en el período 2010-2015 de la Campaña Europea "Ending Homelessness" con dos claras referencias de incidencia:

- **Todos estamos incluidos.** Todos formamos parte de la sociedad: no puede haber dos categorías de ciudadanos. TODOS SOMOS PARTE de la misma historia… del mismo camino… La sociedad no puede mirar hacia delante "borrando" las vidas, los cotidianos de las personas "que no quiere ver".. "que molestan".. "que estorban".

- **Derechos sociales + acceso real a esos Derechos :** como la realidad ha ido mostrando, no es suficiente con hacer declaraciones de derechos (universales, regionales, estatales – Constitución Española 1978- etc)… si no se propicia, generan herramientas etc, de acceso a esos derechos… los derechos promulgados y enunciados pierden todo el sentido… no se dan.. no son… no existen si no es real su ejercicio por las personas. De ahí que sigamos incidiendo en cada Campaña en este tema.

Las ideas clave para la sensibilización han sido:

- Entendemos que SALUD, según el preámbulo de constitución de la Organización Mundial de la Salud (OMS), es "**un estado completo de bienestar físico, mental y social y no solamente la ausencia de dolencia o enfermedad**". La protección de la salud abarca al individuo y a sus circunstancias de manera global.

- **La equidad obliga al Estado a garantizar la universalidad, gratuidad y el acceso de este derecho, a todos los ciudadanos y ciudadanas, especialmente, a los más desfavorecidos.**

- Los problemas de salud pueden provocar la exclusión (causa), o aparecer después (efecto), en ambos casos, las personas en situación de sin hogar ven reducida su esperanza media de vida en 20 años respecto el resto de la población.

- **Especial relevancia de la enfermedad mental en las personas en situación de sin hogar (30%).**

- El estigma y la discriminación que sufren las personas sin hogar en razón de sus enfermedades, los convierten frente a la sociedad en "personas indignas". **La discriminación que sufren les limita el acceso al derecho de salud.**

- **Ante la situación actual en el Estado Español (Reforma Sanitaria de 2012)[7]:** *"Esta reforma supone un cambio de modelo que afecta fundamentalmente a las personas más desprotegidas, tanto a ciudadanos españoles como a ciudadanos comunitarios (modificando los requisitos para obtener autorización de residencia), aumentando la estigmatización de los colectivos más vulnerables y con mayor riesgo de exclusión social (como jóvenes desempleados, personas afectadas por enfermedades infecto-contagiosas, personas con discapacidad, enfermos de entornos rurales), así como de los ciudadanos extracomunitarios en situación irregular.[8]" Y este extracto solamente cabria añadir que, a la postre y en cuanto cambio de modelo en el sistema, es un asunto que nos afecta todos y a todas, en la medida de que hemos pasado de ser ciudadanos ejerciendo un derecho a ser asegurados recibiendo una contraprestación".*

Una herramienta clave para la Campaña ha sido el Informe de Cáritas **"La salud de las personas en situación de sin hogar acompañadas por Cáritas"** llevado a cabo por 35 Cáritas Diocesanas y donde, fundamentalmente, se hace constar que:

[7] CIRCULAR Nº 2 Cáritas Española **CRITERIOS PARA LA ACCIÓN SOCIAL ANTE LA REFORMA DEL SISTEMA SANITARIO** ***Octubre 2012***

[8] Nota de prensa. 21/05/2012.

- Casi un 65% de las personas en situación de sin hogar que acompaña Cáritas tienen enfermedades físicas/orgánicas crónicas; un 72% como enfermedad más habitual tienen transtornos mentales.
- Existen largas listas de espera para la atención especializada. No hay plazas suficientes. Cada vez menos medios profesionales y de infraestructura. El pago de los medicamentos. Todo esto conlleva que la situación ya de por sí inestable de las Pssh se cronifique e intensifique.
- En la atención primaria hay muchas dificultades por la burocracia documental (petición de tarjeta sanitaria) y la estigmatización de las personas que intervienen.
- Muchas personas en situación de sin hogar con transtorno mental no tienen diagnosticada su enfermedad o su diagnóstico no ha sido actualizado.
- No hay coordinación con las altas hospitalarias y el seguimiento de las enfermedades y situaciones personales.

Como cada año, hemos lanzado peticiones y propuestas:

A LAS ADMINISTRACIONES PÚBLICAS:

- Garantizar el **acceso, como derecho subjetivo**, de todas las personas que viven en el territorio del Estado al conjunto del sistema de Servicios de Salud en situación de igualdad.

- **Planificación e implementación de estrategias adecuadas en Salud Mental:** El tratamiento de enfermedades mentales, necesita modos de intervención más flexibles y ligados a la calle (Equipos de calle, red de acompañantes para enfermos mentales).

- **Incorporar de forma real y decidida, a través de procesos de participación, a destinatarios y a organizaciones sociales**, en cuanto sujetos de la intervención social unos y miembros de la sociedad civil organizada otros, como actores de pleno derecho del sistema de Salud.

- **Formación del personal sanitario**: En áreas como psiquiatría, psicología clínica, drogodependencias, y alcoholismo, para prevenir el trato discriminatorio a las personas en situación de sin hogar.

- **Coordinación socio-sanitaria:** Entre salud, asuntos sociales y vivienda; para abordar los problemas de salud de manera integral.

A LA SOCIEDAD EN GENERAL:

- Que sigamos **trabajando y movilizándonos** para que todas las personas puedan vivir con la dignidad plena que ostentan.

- Solidaridad y esperanza.

A LOS MEDIOS DE COMUNICACIÓN Y LAS REDES SOCIALES:

- Que sigan colaborando, como vienen haciendo los últimos años, en **visibilizar la realidad de las Personas en situación de sin hogar**. Desde su humanidad y dignidad plena.

- Que esta **colaboración sea durante todo el año**, no sólo durante el mes de Campaña Nadie sin hogar.

- Que muestren también las "buenas noticias": los proyectos, las propuestas, las acciones...

A TODOS NOSOTROS:

- Nos volvemos a pedir aprehender que no hay derechos para nosotros y "sobras" para las personas que están en situación de calle, de pobreza, de sin hogar. **Somos todos seres humanos y, por tanto, titulares de derechos.**

Exploring the impact of sport participation in the Homeless World Cup on individuals with substance abuse or mental health disorders

This article explores role of social capital in mental health and substance abuse outcomes and the role of the relationship between sport and social capital in negotiating improved social outcomes for homeless individuals with mental illness and/or substance abuse issues. The research method included a qualitative analysis of semi-structured interviews with 27 participants of the Melbourne 2008 Homeless World Cup (eight from Scotland and 19 from Australia). Interview questions focussed on the participants' interest of and participation in sport; factors influencing participation; any changes perceived by the individuals as a result of program participation; and in order to identify changes pre and post event, any current experiences of social exclusion.

Its findings suggest that sport initially provided social bonding within a limited social network, yet over time other types of social capital (bridging and linking) were exhibited by participants, and enabled access to ancillary services provided by the program that led to reductions or cessation of both substance abuse and symptoms of mental illness. The research reaffirms that sport can provide an effective vehicle for the accrual of social capital, which may positively impact the mental health and substance abuse patterns of participants from marginalised and at-risk communities.

The full article can be accessed here :
http://jsfd.org/article/exploring-the-impact-of-sport-participation-in-the-homeless-world-cup-on-individuals-with-substance-abuse-or-mental-health-disorders

Review of the Social Determinants and Health Divide in the WHO European Region

The WHO Regional Office for Europe commissioned this review of social determinants of health and the health divide to identify actions needed to address health inequities within and between countries across the 53 Member States of the European Region. The conclusions and recommendations of the review informed the development of Health 2020, the new European policy framework for health and well-being – along with a companion study on governance for health in the 21st century. The review analysis the extent and social causes of these inequities and proposes action on the social determinants of health across the life-course and in wider social and economic spheres in order to achieve greater health equity and protect future generations. The European review builds on the global evidence and recommends policies to ensure progress can be made in reducing health inequities and the health divide across all countries, including those with low incomes. It provides numerous case studies - examples and experiences of addressing social determinants of health and health inequities in the Region. One of the key goals of the review was to identify what can be implemented with sufficient scale and intensity to make a difference across the diverse contexts of the European Region.

You can access the review here:

https://www.instituteofhealthequity.org/projects/who-european-review

Report on health inequalities in the European Union

In 2009, the Commission adopted a communication on 'Solidarity in health: reducing health inequalities in the EU' which aims to help to reduce health inequalities by supporting action by Member States and stakeholders, and through EU policies. As a follow up to the this communication, a progress report was published. The report begins with an overview of the size of, and trends in, health inequalities in the EU since 2000 with a focus on recent years. It goes on to describe the main actions that the Commission has taken to implement the communication on health inequalities since 2009.

You can access the full report here :

http://ec.europa.eu/health/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf

Health and homelessness : Understanding the costs and role of primary care services for homeless people

It is widely known that homelessness, especially rough sleeping, has significant and negative health consequences for an individual's health. Many studies have found strong correlations between homlessness and a multiplicity, and increased severity, of both physical and mental health conditions. However, depsite this increased morbidity, homeless people consistently miss out on the healthcare they need. As a result, health problems are left untreated and health deteriorates. When homeless people do access health services, they are likely to do so in an unplanned way (for example through accident and emergency) and to be in a state of chronic ill health. This results in longer stays in hospital and multiple resadmissions, and has clear cost implciations for the public health system. The report, published by St Mungo's, brings evidence base regarding homeless people's use of primary health services. It is based on consultation with six services providing health care to homeless people, 17 case studies showing the renge of presenting health issues and use of health servcies by homeless people, and analysis of five case studies illustrating the financial impact of this pattern of service use.

The full report is available here : http://www.mungos.org/documents/4153/4153.pdf

Trauma among street-involved youth

Research shows that street-involved youth experience rates of trauma and posttraumatic stress disorder (PTSD) that are significantly higher than their housed counterparts. Trauma and PTSD are of particular concern for homeless youth as they can negatively affect their ability to adapt and transition off the streets. This study investigates the intricacies of trauma experienced by homeless youth across three US cities and discusses the implications for services wishing to prevent and treat trauma among homeless youth

To access the full article please, click here : http://www.homelesshub.ca/Library/Trauma-Among-Street-Involved-Youth-56362.aspx

Getting home : Outcomes from Housing High Cost Homeless Hospital Patients

This study evaluates outcomes from April 2011 to May 2013 for 163 hospital patients screened by the 10th Decile Project in Los Angeles, which works with hospitals to identify the 10 percent of homeless patients with the highest public and hospital costs – the 10th decile – and provide immediate services for placing these individuals into permanent supportive housing. This is affordable housing that provides access to health and social services, such as mental health and addiction therapy, medical care, and case management.

The triage tools that are used for screening employ accurate, simple to use statistical models that analyze information about individuals that is available in hospitals, jails and homeless service agencies affiliated with medical clinics to identify the one-tenth of homeless persons with the highest public costs and the acute ongoing crises that create those high costs. Because there are multiple paths into this highest-cost group, ranging from young persons with psychoses who are publicly disruptive to older persons are simply very sick, each tool uses a cluster of statistical models specifically designed to assess risk factors for different age and gender groups. An analysis of cost outcomes shows that housing 10th decile patients resulted in avoidance of significant public and hospital costs.

See more at: http://www.economicrt.org/summaries/Getting_Home.html#sthash.xwQfa7aO.dpuf

Les enjeux santé et logement en région bruxelloise : l'exemple Forest

This new publication is a result of a qualitative research on the link between housing and health in Forest (one of the 19 municipalities of the Brussels region).

The full report in French is available here :
http://www.pourlasolidarite.eu/T%C3%A9lex_Mailing/ColloqueLogement%20sante/Sant%C3%A9_Logement_en_R%C3%A9gion_bruxelloise.pdf

Inequality in Access to Care - Des inégalités d'accès aux soins aggravées

The Doctors of the World France report shows that the effects of the crisis on health and access to care were significant in 2012. Health inequalities were worsening for the poorest people. This was in addition to government responses to migrants, sex workers and drug users that seem more security-focused than socially-minded. Access to healthcare is becoming more and more difficult for these people, and their health is deteriorating as a result.

En 2012, en France, les conséquences de la crise économique sur la santé et l'accès aux soins sont prégnantes, selon un rapport de Médecins du Monde France. Les inégalités sociales de santé s'accentuent chez les plus démunis. À cela s'ajoutent des réponses publiques souvent plus sécuritaires que sociales, notamment envers les migrants, les personnes se prostituant et les usagers de drogues. Ces personnes accèdent de plus en plus difficilement au système de soins, avec pour conséquence une détérioration de leur état de santé.

Accédez le rapport complet :http://www.medecinsdumonde.org/Publications/Les-Rapports/En-France/Synthese-du-Rapport-de-l-Observatoire-de-l-acces-aux-soins-2013

PROJET DENOMBRER ET DECRIRE
Améliorer l'exhaustivité et la description des personnes en situation de rue décédées en 2012
- Rapport final -
The Association Morts de la Rue published its first report in the framework of the project « Counting and Describing ». This study on the deaths of homeless people in 2012 in France aims to improve the knowledge about the mortality among homeless people. You can read the full report in French here :

http://www.mortsdelarue.org/IMG/pdf/Rapport_ColMortsdelaRue_2012_final_octobre13.pdf

The full paper is available here : http://www.mhe-sme.org/assets/files/publications/MHE_Task_Force_Position_Paper_Homelessness.pdf

Skating on thin ice – Difficulties faced by people with mental illness accessing and maintaining social housing

Through its work with the Homeless Persons Legal Service (HPLS), the Australian Public Interest Advocacy Center gained significant experience with people who experience mental illness who are homeless or in housing crisis, and who are seeking to access social housing, or have had difficulties sustaining their social housing tenancy. In this briefing paper, PIAC collected the problems identified in their casework.

The full paper is available here :

http://www.piac.asn.au/sites/default/files/news/attachments/briefing_paper_mentalillness_socialhousing_final-1.pdf

Events

Building cohesion and Strengthening Health for Growth: ADDRESSING HEALTH INEQUALITIES 2014 AND BEYOND, Brussels, 23 January, 2014
More information at : http://www.health-inequalities.eu/HEALTHEQUITY/EN/projects/equity_action/final_conference/

FEANTSA Policy Conference: Confronting Homelessness in the EU: 14th-15th November 2014, Bergamo, Italy.

Conference on Personalisation in the Homeless Sector, London, 23 January, 2014

This conference is designed to support homelessness services and commissioners who are considering adopting a personalised approach in response to rough sleeping or entrenched homelessness or for those who want to build upon their current practice. Personalisation is about giving clients choice and control over the support they need. It is a move away from a 'one-size fits all' approach to a more flexible and responsive model.
More information at: http://homeless.org.uk/events/personalisation#.UrBLfNLuKSp

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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.