FEANTSA

European Network of Homeless Health Workers (ENHW)

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Editorial

Sharing Experiences: News from Health Professionals across the EU

Resources

Upcoming Events

Editorial

Dear Readers,

We are pleased to share with you the summer edition of the ENHW newsletter, which covers a wide range of topics and resources from across Europe. We have received three articles for this issue. The first article is written In French by Mahe Aja and explains how her organisation based in Brussels provides immediate support for frontline workers to help them with mental health problems their clients are facing. In the second article in this issue EUROCARE presents how their two member organisations in Barcelona and in Poland work with homeless people who have a problematic alcohol use. The third article is written by Corma Poelen from the Netherlands and shares their experience working with homeless young people with mental health problems.

I would like to thank each of the authors for their valued contribution to our newsletter in highlighting some interesting practices in the health and homeless sector. I would also like to thank those who have contributed reports, studies, articles and toolkits for resources section.

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.

Please do not hesitate to send your comments, questions and contributions to dalma.fabian@feantsa.org

La Cellule d'Appui du SMES : un appui aux travailleurs, un soutien aux sans-abri

By Mahe Aja

La Cellule d'appui fait partie de l'association SMES, Santé Mentale et Exclusion Sociale. Cette équipe a été mise en place grâce au travail de réflexion et aux initiatives développées par le réseau d'institutions qui constituent le SMES-B et ceci, depuis 1993. Cette association, SMES, est née de la rencontre des professionnels des secteurs de la santé mentale et de ceux du champ de l'exclusion sociale, plus particulièrement ceux travaillant avec des personnes souffrant de grande précarité.

Le point de rencontre entre ces institutions a été la difficulté de répondre de manière adéquate aux problématiques des personnes qui cumulent une situation de précarité extrême et des problèmes médico-psychologiques.

Face à certaines impasses dans l'accompagnement social ou dans la prise en charge médicale, face à l'impossibilité de faire rentrer les personnes sans-abri ou précarisées dans le circuit des services susceptibles de leur offrir un soutien, et face aux difficultés rencontrées par les travailleurs dans la compréhension de personnes souffrant de troubles psychiques, a surgi cette initiative : une équipe pluridisciplinaire : avec la présence d'un médecin-psychiatre, un psychologue, un thérapeute, et un assistant social ; une équipe mobile : pouvant aller à la rencontre des usagers et des intervenants, là où ils se trouvaient ; une équipe d'appui aux travailleurs.

Leurs objectifs ? : Favoriser l'accès aux soins (et sa continuité) des personnes qui sont en rupture avec les liens sociaux, qui sont en difficulté de mener à bien le projet social – éducatif établi par l'institution, qui n'ont pas une demande d'aide, voire refusent les soins, et qui souffrent d'une pathologie psychiatrique.

En s'appuyant sur le réseau existant, la Cellule a comme objectif également, de développer et promouvoir des interventions qui font valoir une pratique d'accompagnement et de prise en charge intersectorielle à la frontière entre social et santé mentale.

Comment la Cellule d'Appui intervient ? Dans quelles circonstances ? Quelles sont ses missions ?

Ce sont les travailleurs de première ligne, j'entends par-là, ceux qui s'occupent directement du suivi social, médical ou éducatif des usagers, qui font appel à notre équipe. Il s'agit des travailleurs des centres ou maisons d'accueil de sans-abri, travailleurs de rue, maisons médicales, services sociaux, logements sociaux…

Leurs demandes partent du constat ou du sentiment qu'ils se trouvent dans une impasse, un blocage, un moment de crise dans le suivi d'une personne et que cette situation est due, au moins en partie, à une problématique de santé mentale.

Un tel travailleur, par exemple, nous demandera de l'aide dans une situation où la personne accueillie devient trop

agressive, ce qui pourrait être un motif d'expulsion. Un autre travailleur se soucie de l'état de santé mentale d'une personne qui vit dans la rue et se heurte à l'impossibilité de faire valoir ses droits fondamentaux, faute de pouvoir lui faire signer les documents nécessaires… Un assistant social nous fait part du risque d'expulsion imminent du logement social d'une personne dont la situation précaire et l'isolement l'amèneraient à se trouver dans la rue… La complexité et l'intrication de leurs difficultés, qui semblent sans issue, sont à la source d'inquiétudes et/ou d'épuisement des intervenants à l'égard de leur public

La Cellule d'Appui intervient donc en deuxième ligne en assumant une fonction de triangulation et de soutien aux travailleurs. L'équipe procède à un véritable travail d'analyse globale de la situation : elle tient compte du récit de vie de la personne bénéficiaire, de son histoire, de sa santé physique et psychique, de sa situation sociale, de ses points d'appui ou réseaux, des difficultés rapportées par le professionnel mais aussi des missions et objectifs de l'institution.

De ce fait, les interventions de la Cellule d'appui, visent à débloquer la situation sans se substituer au réseau d'aide et de soins existant, en s'appuyant sur ce qui fait crise pour l'intervenant et pour le bénéficiaire, identifiant avec l'intervenant le besoin éventuel d'un suivi médical, psychologique ou social supplémentaire, en stimulant les échanges entre le réseau existant ou la construction d'un réseau adapté.

La Cellule reste également disponible pour reprendre le fil de la prise en charge psycho-médico-sociale de l'usager lors de ses ruptures avec les institutions de première ligne ou le manque de professionnels adéquats à la situation. Il s'agit d'une « danse entre les lignes », dans une optique de relais pour la durée nécessaire à la (re)construction d'un réseau et de soutien au travailleur qui a épuisé les moyens d'aider l'usager.

Et les résultats, les effets de notre travail ? Quelques réflexions…

Nous constatons que les interventions de la Cellule permettent d'aller d'une situation de «crise», de blocage, de mise en danger ou de risque d'exclusion, vers une situation de remise en route du travail porté dès lors par le travailleur ou l'institution avec l'usager et la Cellule, si nécessaire.

D'autre part, l'aide apportée par la Cellule permet aux professionnels de prendre un peu de distance par rapport à l'analyse institutionnelle qui peut être la leur à un moment donné et de ne plus être seul face à des situations fort complexes. La prise de recul vis-à-vis des situations présentées, introduit d'emblée une autre parole dans l'institution et par conséquent une souplesse dans l'accompagnement des usagers.

L'appui de la Cellule, spécifiquement avec la présence du médecin-psychiatre, peut permettre de donner une impulsion forte à certaines démarches nécessaires pour la continuité des soins et l'acquis des droits fondamentaux des personnes sans-abri. En effet, vis-à-vis des institutions demandeuses et du système de soins traditionnels, la Cellule d'Appui joue un rôle de chaînon manquant pour pallier au manque du suivi de l'usager.

Dès lors, l'analyse globale de la situation, décrite précédemment, pour laquelle le travailleur demande notre appui, s'avère incontournable et primordiale. Pour autant, il ne s'agit pas de faire de la prise en charge psychiatrique,

ambulatoire ou hospitalière, la première et seule intervention qui permettrait au travailleur de sortir de l'impasse ou de la situation de crise.

Il s'agit, au cas par cas, de mesurer tant le danger et les risques qu'encourent ceux pour qui nous nous sommes engagés dans ce travail, les personnes précarisées, sans-abri, que les conséquences de nos actes. Ce travail de deuxième ligne, d'appui aux travailleurs, comporte toujours un positionnement et un questionnement éthique.

Eurocare members working to end homelessness -

By Paulo Nunes de Moura

Eurocare is an alliance of 60 non-governmental and public-health organisations, across 25 European countries, advocating for prevention and reduction of alcohol related harm in Europe. Member organisations are involved in advocacy, research, provision of information and training on alcohol issues, as well as in services for people whose lives are affected by alcohol problems.

Some member organisations have been working hard to help homeless people at national and local levels. Since we are dealing with a population who are likely to face barriers and obstacles to accessing healthcare, problematic alcohol use among people in this context can have aggravated physical and mental health consequences.

Here, we discuss briefly the work of Associació Rauxa, in Barcelona, and of Markot, a Polish organisation, part of the Monar Association. Both organisations see that achieving reduction of alcohol harm through brief intervention would avoid the development of dependency. This is because if problematic drinking is identified early, then multiple and grave life-long consequences can be avoided. Rauxa has also been specifically campaigning for information on the risks associated with alcohol consumption to be incorporated in the training of medical professions as well as in the daily practice of primary care.

Helping to address the high levels of problematic drinking among homeless people in Barcelona, Rauxa does not see as necessarily true that people start using alcohol in order to cope with homelessness, but rather that people can end up becoming homeless due to a combination of alcohol addiction with other adverse structural circumstances, such as, for example, unemployment.

Rauxa has also carried out a study to look at the prevalence of suicide within a sample of 495 homeless individuals who had received treatment at their centre. It showed that 36% had attempted suicide, and that when researchers

considered specifically the subgroup of people addicted to alcohol, tobacco and cocaine the percentage increased to 57%.

Of the total sample, two of the homeless people in question ended up committing suicide, and Rauxa staff argue that other deaths have probably been avoided because service users receive round-the-clock professional help and are also warmly encouraged to communicate their feelings. In this context, Rauxa staff have observed that psychiatric symptoms tend to disappear between 6-12 months after admission to abstinence treatment.

In Poland, following national policies, and cooperating with social services, Markot - part of the Monar Association, offers help to homeless people in its 50 projects across the country. Their work is based on the principle of active participation, i.e. clients take part in the activities centres where they stay, and they accept the approach of co-responsibility and cooperation. From the beginning clients are encouraged to undertake different social roles and tasks (e.g. work in the kitchen, housekeeping, gardening), which, the staff argue, naturally prepares them to rebuild their professional and social lives.

Different Markot centres across Poland have been helping diverse groups and, specifically in Warsaw, there is a centre for homeless people, where clinical and psychological alcohol-recovery treatment is provided, combined with legal and vocational assistance. In 2015, 4,775 people, including 91 children, benefited from Markot's services.
While members have been working at national level to alleviate the problem of homelessness, at European level, Eurocare, in collaboration with the colleagues from FEANTSA, has also been supporting the European Parliament written declaration calling for a renewed focus on reducing homelessness across the EU through a specific EU action plan.

Ending homelessness and improving the quality of life for people who are homeless is a realistic and achievable policy goal which will require action and a commitment from EU policy makers. Join the European Economic and Social Committee, the Committee of the Regions and the Employment, Social Policy, Health and Consumer Affairs Council in expressing the need for EU support in addressing homelessness
Eurocare believes that any strategy to end homelessness must also incorporate an adequate alcohol policy approach to address consumption, which is both associated with the causes and the consequences of homelessness.

Youth F-ACT – an effective model of care for homeless youth with mental health problems

By Corma Poelen

Background

Homeless youth suffer from severe mental health problems and social economic problems more often than other young people. Depressed mood, anxiety problems, aggressive behavior, paranoid thoughts and a mental disability are frequently seen in this population (Krabbenborg, Boersma & Wolf, 2013; Planije, Land & Wolf, 2003; Barendregt, Schrijvers, Baars & Mheen, 2011). Both hard and soft drugs are more often used as well. The high percentage of suicide attempts in this population is also concerning (Beijersbergen, Jansen & Wolf, 2008; Wolf, Altena, Christians & Beijersbergen, 2010).

Research shows that severe mental illness impedes sustaining stable housing, income and a supportive network (Altena, Boersma & Wolf, 2014). Mental health problems withhold many homeless young people from achieving their goals and make reintegration into the community more difficult. Albeda (2010) and homeless young people themselves point out the positive effects of stabilization of mental health on achieving a stable living situation. This means that giving young homeless people with mental health issues the best chances of functional recovery, it is very important to make sure they receive effective support. It is important to note that homelessness, however, is a housing problem in the first place, so affordable housing is needed as well.

There is little research on what mental health problems young homeless people experience and what kind of care is effective and evidence based. For interventions to be effective and cost-efficient, the specific characteristics and needs of this subgroup have to be known. Only then it is possible to deliver care that gives fair chances to functional recovery.

Homeless young people themselves name mental health as an urgent problem which comes with reduced quality of life. Many homeless young people do not get the help they need (Altena, Boersma & Wolf, 2014). Although part of the population receives mental health care or social work assistance, nearly one quarter does not receive the mental health support they wish for (Wolf, Altena, Christians & Beijersbergen, 2010) and there are still few mental health teams responding to the specific needs of this population.

Where are the outreach teams working in a multidisciplinary way who are able to be involved for a longer period of time, to build a trusting working relationship and to assist young people on diverse areas of their lives? National

and international literature indicates that an outreach and multidisciplinary approach is key to prevent homeless youth from continuous rejection and to make sure these young people get the support they need (Planije et al., 2003; Ensign & Panke, 2002). To achieve functional recovery an integrated approach is needed that covers diverse life areas (school, family, work, psychological, finances, social network etc.) especially in this specific stage of life (Ploeger, 2010). Also, treatment of psychological problems needs to be accompanied with practical support.

F-ACT - Flexible Assertive Community Treatment team for youth

A Flexible Assertive Community Treatment team for youth might be an effective model of care for homeless youth. F-ACT is a rehabilitation-oriented case management model, which is based on the ACT (Assertive community treatment) model but is more flexible and therefore able to serve a broader range of clients with mental illness. Youth F-ACT teams have been set up for the purpose of providing the care needed by young people suspected of having complex psychiatric problems and malfunctioning at several other areas. Youth F-ACT intervenes on individual mental health problems but also on risk factors identified for youth homelessness inside families. Risk factors concerning the network and living environment are integrated as well allowing functional recovery and reintegration into the community.

The methods of youth F-ACT teams are in line with the key principles described above. They deliver outreach and long lasting care for homeless young people listening to their wishes and goals. The multidisciplinary team consists of a psychiatrist, child- and youth psychologist, family therapist, social psychiatric nurse, social worker, job coach and a peer worker. There is no gap in healthcare between 18 minus and 18 because the population of youth F-ACT ranges from 0-23 years. There is also collaboration between child- and youth psychiatry, childcare, addiction and adult psychiatry, to avoid losing trust because of having to cope with too many different agencies.

Several publications show sufficient evidence for implementing F-ACT for youth (Kwaak & Kramer, 2009; Hendriksen-Favier, 2011). However, controlled studies on their effectiveness are scares. We do have solid research showing effects of ACT care with adolescents with a first psychosis (Hendriksen-Favier, 2011). There is a great need for solid studies on the effectiveness of youth F-ACT for homeless young people.

In the Netherlands there are about 15 active youth F-ACT teams (www.ccaf.nl). We need to know more about how these teams are working together with the homelessness sector and how this cooperation can be reinforced by municipalities.

Resources

Stop the scandal: investigating into mental health and rough sleeping

Homeless charity, St Mungo, has called on the British government to increase its mental health support for homeless people. The charity stated that about 4 in 10 rough sleepers have mental health problems, which is much higher than previously estimated figures. Moreover, it was found that many have lost their tenancies and ended up homeless due to their lack of access to community health services. Therefore, St Mungo has called on the government to publish a new national rough-sleeping strategy, to invest in specialised mental health care for homeless people, and to introduce laws guaranteeing accommodation for discharged patients from mental health hospitals. The report can be downloaded here: **http://www.mungos.org/documents/7021/7021.pdf**

Homeless Health conference report by Queen's Nursing Institute

This event organized by the Queen's Nursing Institute gave professionals and students from across health, housing, and the voluntary sector a chance to network and hear from expert speakers in the field of homeless and inclusion health. 'Inclusion health' refers to the health needs of those at most risk of marginalisation, including homeless people, refugees and other vulnerable migrants, prisoners, Gypsies, Boaters, Roma and Travellers, and sex workers. The event showcased innovative examples of healthcare practice and present current policy to tackle health inequalities. Presentations can be downloaded here: **http://www.qni.org.uk/events/214**

Housing First Guide Europe

The Housing First Guide Europe is now available online. The contents of the guide have been designed to inform housing and homelessness workers on the ways in which Housing First can be practically implemented in Europe. In addition to the Guide itself, the website includes links to the Housing First community as well as other relevant resources, including videos to complement the written text. You can see the guide here: http://housingfirstguide.eu/website/

How naloxone can save lives?

This guidance is designed to give managers in accommodation-based homelessness services a framework to implement good practice around using naloxone as part of a wider harm reduction approach. This guide can help reduce the number of lives unnecessarily lost to heroin and other opioid overdose. This is especially relevant given that homelessness is understood to increase the risk of opioid use. Provision of naloxone is an evidence-based intervention that can save lives. Incorporating naloxone into homelessness services encourages drug users to

engage with treatment services and helps to keep them alive until they are in recovery. It is important to remember that the intervention is not just about providing naloxone: training people to recognise the signs of overdose and how to respond appropriately are key steps in reducing drug-related deaths. The guide can be downloaded here: http://www.homeless.org.uk/our-work/resources/naloxone-in-homelessness-services/how-naloxone-can-save-lives

Piecing together a solution: Homelessness among people with autism in Wales

There is compelling evidence that homelessness is considerably more common among people with autism than the general population. A survey conducted in Wales by the National Autistic Society Cymru (2011)1 reported that 12 per cent of their adult participants disclosed being homeless at some point in their lives. Beyond Wales, Pritchard (2010)2 conducted a small study into 14 rough sleepers in Devon and found that 65 per cent of entrenched sleepers had been diagnosed with Autistic Spectrum Disorder (ASD). Nevertheless, at present, there is very little evidence that provides an accurate assessment of the risk factors for a housing crisis and the lived experience of homelessness for people with ASD in Wales. The aim of this research was to use a qualitative approach to explore the homelessness experiences of people with ASD. The research is published here: http://sheltercymru.org.uk/wp-content/uploads/2015/02/Piecing-together-a-solution-Homelessness-amongst-people-with-autism-in-Wales.pdf

Accompagnement santé des personnes sans domicile : les pratiques innovantes recensées

In partnership with the Directorate General of Social Cohesion (DGCS) and the Ministry of Social Affairs and Health, the new Agency for Active Solidarity (ANSA) published its new report called "How to manage better the health of homeless people? Identifying innovative practices. "

The aim of the study was to present the health problems homeless people and face and to identify innovative practices accompanying health problems of homeless people that promote cooperation between the homelessness sector and the health sector. The report is available here: http://www.solidarites-actives.com/pdf/Ansa_Contribution18_SanteHebergement_juin2016.pdf

Structured review of the evidence on intersection of housing and health policy in the WHO European Region

A central challenge in promoting good health is to ensure access to adequate housing for all. The United Nations Committee on Economic, Social and Cultural Rights defines adequate housing as not only simple shelter, but a secure, affordable, accessible and fully equipped home. While there is potential for the housing sector to promote, or to harm, people's health, housing policies are often made with little regard to their potential health impact. To better promote joined-up intersectoral action across health and housing policy, this paper reports a structured and thematic review of literature relevant to the WHO European Region. Eighty documents met the study inclusion

criteria. The paper summarizes the impacts on health of physical housing quality, affordability and stability, and location, as well as the role of health in achieving desirable housing outcomes. Individuals who are especially vulnerable to housing impacts on health are those who spend greater quantities of time in their household, including self-employed persons who work at home, older persons, carers, children and persons with disabilities. The paper concludes with directions for future research and policy, with a view towards joined-up intersectoral action, such as policies that establish minimum housing standards and ensure housing affordability. The paper can be downloaded here:
http://www.euro.who.int/__data/assets/pdf_file/0005/314087/Volume-2-Issue-2-June2016.pdf?ua=1&utm_source=WHO%2FEurope+mailing+list&utm_campaign=f53e2bc5b1-News_highlights_July_2016&utm_medium=email&utm_term=0_60241f4736-f53e2bc5b1-93291045

Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway')

Homeless people have complex problems. GP enhanced care (Pathway) has shown benefits. We performed a randomised, -parallel arm trial at two large inner city hospitals. Inpatient homeless adults were randomly allocated to either standard care (all management by the hospital-based clinical team) or enhanced care with input from a homeless care team. The hospital data system provided healthcare usage information, and we used questionnaires to assess quality of life. 206 patients were allocated to enhanced care and 204 to usual care. Length of stay (up to 90 days after admission) did not differ between groups (standard care 14.0 days, enhanced care 13.3 days). Average reattendance at the emergency department within a year was 5.8 visits in the standard care group and 4.8 visits with enhanced care, but this decrease was not significant. -Quality of life scores after discharge (in 108 patients) improved with enhanced care (EQ-5D-5L score increased by 0.12 [95% CI 0.032 to 0.22] compared wtih 0.03 [-0.1 to 0.15; p=0.076] with standard care). The proportion of people sleeping on the streets after discharge was 14.6% in the standard care arm and 3.8% in the enhanced care arm (p=0.034). The quality-of-life cost per quality-adjusted life-year was £26,000. The Pathway approach doesn't alter length of stay but improves quality of life and reduces street -homelessness.
Find out more here: http://www.ncbi.nlm.nih.gov/pubmed/27251910

Upcoming Events

ELEVENTH EUROPEAN RESEARCH CONFERENCE ON HOMELESSNESS

"Homelessness and Social Work in Europe"

23th September 2016 Copenhagen, Denmark

Registration is now open: https://www.xing-events.com/BQYXFCP.html

1st EU Mental Health Forum at Hotel Le Royal in Luxembourg on 6-7 October 2016. Programme and registration will be available soon http://ec.europa.eu/health/mental_health/events/ev_20161006_en.htm#d