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Homeless in Europe

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Health and Homelessness



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Health and Homelessness

By **Dalma Fabian**, *Policy Officer, FEANTSA*

This year several important papers on health inequalities were published by major international organisations, such as the WHO and OECD, and the EU. Together with the recently adopted Council Conclusions under the Finnish Presidency on the Economy of Wellbeing, these reports call for more action to address health inequalities by improving access to health care for all and by addressing the wider social determinants of Health. The starkest manifestations of growing social inequalities with devastating health consequences are seen in the homelessness that is growing in all except one EU member states. It is in this context that we have decided to dedicate this issue of our magazine, "Homeless in Europe", to the realities of health and homelessness.

An important paradigm shift has been taking place over the past decade in the homeless sector. We are moving away from the approach of managing homelessness and toward the approach of ending it. It is very important that health gets a central place in this new understanding of our work because, quite simply, a good healthcare system can contribute to redressing health inequalities and, therefore, play an important role in ending homelessness. Sadly, all of the articles in the Magazine testify that the way health systems are currently organised is not delivering for homeless people. The data speaks for itself: in the UK, homeless women were twelve times more likely to die than other women of the same age in the general population; homeless men were eight times more likely. Zsuzsa Rákossy's article discusses the results of her research which demonstrates extremely poor health outcomes for homeless people and very low health care utilisation. This has been termed a long time ago as the 'inverse care law relationship', which means that those most in need are less likely to receive good quality health care. To address this problem, FEANTSA has been calling for an inclusive and integrated health care system. Pathway is a great example of such an integrated health care model. In his article, Alex Bax presents the key features of such a multidisciplinary approach, which provides care and support from the moment of hospital admission to avoid unsafe discharge to the street and to unhealthy shelters.

Mark Leonard shares his own journey out of homelessness to illustrate how opportunities for meaningful contribution, such as peer work, can be an empowering experience and make a difference in one's life. He gives some very useful examples of how the health system can benefit from learning from and working with people with lived experience of homelessness, to engage with others and

connect them to the health system. Priya Tamby describes the need for women-specific health services which target homeless women and bring, for example, their mobile outreach team to work with women who are hiding and not accessing services. Sari Rantaniemi discusses the factors that influence how women experiencing homelessness understand and experience their sexuality and how important it is that professionals recognise that.

Addressing access barriers and improving access to quality health care is key. But health is more than healthcare. We need to change the way we think about health, as the contributors from Neunerhaus argue. Housing is a key determinant of health and should be regarded as a health intervention. The article by Inês Almas and Teresa Duarte from Portugal makes the case for Housing First policy by sharing testimonies that show the transformative potential of a secure and stable home following the experience of homelessness.

Running through the magazine is evidence for feelings of stigma, shame and humiliation within the experience of homelessness. The negative attitudes and prejudices among health care professionals, that produce these feelings, are powerful access barriers to healthcare for homeless people. It is crucial that they are examined and changed. Education and experience of co-working with peer workers play an important role in changing these attitudes. Likewise, research, including peer research, can be influential and should inform policy and practice. For instance, growing evidence on the impact of adverse childhood experiences (ACEs) and the link to adult homelessness, as outlined in the article from Wales, can inform not only upstream prevention efforts, but also help professionals to understand an individual beyond their behaviour, and adapt their ways of engaging with the person accordingly. As Charlotte Obel from Copenhagen describes in her article, professionals working with homeless people need to be better equipped to recognise cognitive dysfunction and to understand the difficulties that stem from it.

The potential of the major international reports on health inequalities contained in this magazine must not be ignored. They should be a catalyst to action on addressing health inequalities through public policies. We hope this issue of the magazine will contribute to a growing understanding of homelessness as a public health issue and will move this change forward.

LETTERS TO THE EDITOR

We would like to give you the chance to comment on any of the articles which have appeared in this issue. If you would like to share your ideas, thoughts and feedback, please send an email to the editor, laura.rahman@feantsa.org



On the Health of the Hungarian Homeless Population

By **Zsuzsa Rákósy Ph.D.**, Assistant Professor, University of Pécs,
Department of Preventive Medicine

Background

The number of homeless people is rising in Hungary, as in almost all the member states of the European Union, except Finland.¹ According to the current estimation, approximately 700.000 people are homeless in the EU on any given day.² More and more people are appearing in the homeless shelter system in Hungary too, according to the data of the annual 'Third of February Homeless Survey'. In 2019, it is reported that 8568 people used the homeless shelters on the day of the survey.³

Deprivation is strongly linked to poor health. While some health problems, such as psychiatric illnesses, can lead to homelessness, others may result from it. Generally, the health of people who are homeless is poorer, and they have a higher mortality rate than the general population. They are particularly affected by health problems due to their lifestyles and living conditions: accidental injuries, psychiatric illnesses, infectious diseases and chronic non-communicable diseases that appear alongside accelerated aging.⁴⁻⁶ Harsh environmental conditions, overcrowded shelters, poor hygiene and malnutrition, all contribute to the deterioration of their health, compounded by their limited access to health care and the high prevalence of addictions.⁴⁻⁶

Improving the health of people experiencing homelessness is a key issue, primarily for the people themselves, but also for wider society, as an individual's bad health is a burden to both themselves and the health care system. This improvement calls for appropriate public health interventions which can only be performed if the specific health data for homeless people are available. But unfortunately, there is no comparable data on the health of the homeless populations at EU level. The large variability in the quality and availability of data on homeless people's health hampers the development of coherent and effective health promotion programs. In addition, it makes it difficult for decision-makers to accurately communicate the situation of homelessness, which is a barrier for allocating adequate resources to develop the homeless care system.

So far very little information has been available about the health status of the Hungarian homeless population. Only two studies, from 1997 and 2007, provided representative data.⁷⁻⁸ Comparative analysis between the average Hungarian population and the homeless population is available in data for Budapest from 2002.⁹ Therefore, our aim was to provide an overview of the main health problems and health behavior of the Hungarian homeless population in comparison to the general population (reference population).

Methods

453 individuals who used the homeless shelter system took part in our study. The data was collected by a questionnaire survey. The results were compared with the standardized data for age and sex of the European Health Interview Survey 2014 (ELEF2014) of the general Hungarian population. Comparing our survey data to the ELEF2014 survey provides an opportunity to identify differences between the health status of the average population and the homeless population, including perceived health and chronic diseases, as well as health behaviors such as smoking, diet and alcohol consumption.

Results

Socioeconomic status of the homeless people:

The mean age of the homeless population was 52 years and 81% were male. The majority of the people surveyed (52%) had been homeless for more than 5 years. Educational status was the lowest in the homeless population, with 51% having primary school as their highest form education compared to 13% of the average population. The unemployment rate was higher in the homeless population (80%) than in the general population (18%). Furthermore, 42% of the homeless population was divorced, compared to 12% in the average population.

Self-perceived health status, prevalence of chronic diseases and utilization of health care:

While more than half of the average population (56%) considered their health was in a good state, only 5% of the homeless people thought so. Most homeless people reported chronic diseases (79%), but only 38% of them visited a GP within one year before the survey. In contrast, a smaller proportion of the general population had chronic diseases (50%) and most of them visited their GP within 12 months (76%).

Smoking, alcohol consumption, body mass index (BMI):

The majority of the homeless people were current smokers (82%), the prevalence was more than double than in the reference population. Surprisingly 43% of homeless people were reported abstinent, but on the other hand, they also had a high rate of heavy drinkers (29%) compared to the reference population (23%). Of the homeless participants, 33% were classified as overweight and obese, which is half of the prevalence of the general population. It should be noted that while malnutrition was present in a low percentage (4%) of the homeless population, it was still five times higher than the prevalence in the average population (0.8%).

“Improving the health of people experiencing homelessness is a key issue, primarily for the people themselves, but also for wider society.”



Discussion

Our results showed that, besides all the problems they face, homeless people have much poorer health and yet they utilize the health services much less than the general population. The very high smoking rate and heavy drinking among them is a concern, though these determinants are clearly related to the socio-economic status the entire population.

Developing effective health promotion programs among homeless people is a difficult challenge. The combination of severe social exclusion and poor health calls for integrated approaches between social and health services. Homeless people can be motivated to live a healthier life only if their basic needs are met and they can see their health as a value in their life.

The provision of the necessary funds for interventions is a prerequisite, but currently the services are severely underfunded. The intersectoral collaboration and coordination between the social, health and labour sectors should also be improved at the level of the central and local governments. The integrated policies and actions must be based on scientific evidence to ensure interventions are efficient and cost-effective.

Research itself should be improved, including the use of standard taxonomy, appropriate research methods, and broadened scope. Less studied, but policy relevant areas, like the health and special problems of homeless women should be more highly prioritised in the research agenda. Similarly, the diet of homeless people, which is a permanent challenge for them and affects their health profoundly, should be subject to more focused research.

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Improving Care for Homeless Patients in Hospital

By **Alex Bax**¹, *Chief Executive, Pathway*

In 2009 an eminent UK doctor became interested in the way homeless patients were treated in hospital. Professor Aidan Halligan had just become Director of Education at University College London Hospitals NHS Trust (UCLH), one of London's foremost teaching hospitals. UCLH is also a major centre for clinical research, hosts a variety of world-class specialist health services and is acknowledged as one of the top performing hospitals in the UK. It is one of London's busiest hospitals, serving a socially mixed inner-city urban community.

Each day before work, as Aidan came out of the tube station by the hospital he met a homeless man selling The Big Issue. Aidan began to ask him what happened when people on the street ended up in hospital. The Big Issue vendor spoke of busy medical staff at times being unkind and judgemental and of cycling in and out of hospital with nothing really changing. This connected with Aidan's social conscience and career-long interest in how cultures of care are created. Here were stories of desperate patients, getting little from an apparently world class healthcare institution, itself part of the NHS, the UK's much celebrated free-at-the-point-of-need universal health service. Aidan decided he had to do something.

A decade later Pathway is a national UK charity with affiliated Pathway teams working in eleven acute hospitals across the country. Colleagues in Australia have borrowed the model. We've created a national professional network (The Faculty for Homeless and Inclusion Health), with around 2,000 clinicians on our mailing list. We have built a growing body of evidence on the benefits of the Pathway team approach and the costs for homeless patients and the system of failure. We have led major research projects on homelessness and end-of-life care, the role of nursing in homelessness, dentistry and homelessness, and on health data sharing. We have convened eight international homeless and inclusion health conferences. We have begun to use the evidence we have generated to push for change within health systems, and within UK politics.²

Pathway teams saw nearly 4,000 homeless patients in hospitals in England last year.

Homelessness and health

2017 saw the publication of a seminal paper in the international medical journal The Lancet.³ Pooling data from hundreds of separate studies, the paper calculated standardised mortality ratios for people experiencing homelessness, people with substance use disorders, prisoners, and people involved in selling sex. This internationally valid study found that mortality ratios in this group were elevated by a factor of 10 compared to the general population. It showed that homelessness and severe exclusion is associated with extreme health harms and risks, startlingly

elevated rates of disease and premature death. People who die while they are homeless often die of treatable medical conditions, and they often die several decades early.

This extreme morbidity and mortality necessarily brings sick homeless people into hospital.

People experiencing homelessness in the UK:

- attend A&E six times as often as people with a home,
- are admitted to hospital four times as often,
- stay three times as long.⁴

Without a Pathway team in place homeless patients are regularly not identified until the day the medical team declare them 'fit for discharge'. Fearing the stigma of disclosing homelessness some patients will give a past address to conceal their situation. Others will give the address of a friend, a made up address or a hostel or night shelter address.

At the same time hospital staff may be confused over complex entitlements or rights of access to services provided by different state and charitable organisations, to housing, social care and other services. Staff attempts to help routinely lead to patients staying in hospital longer than needed. But with a system under pressure, and with no-one paying much attention, homeless patients also report hospitals quietly discharging them back to the street. This runs contrary to a variety of legal duties of care to safeguard patient's interests, but after a decade of austerity in the UK services outside of hospital are under huge pressure, and patients without friends, family or advocacy are vulnerable.⁵

Of course, the health of anyone discharged to the street is highly likely to deteriorate, and lead to their readmittance. The individual will be caught in a downward cycle of deteriorating health, in the most expensive part of the health system.

A Pathway team is a simple intervention designed to break these cycles of failure and exclusion. A Pathway team is a specialist medically led multidisciplinary homeless team based in the hospital. It works with and alongside a patient's medical team to enhance the quality of care offered during their time in hospital. Teams include housing specialists working alongside clinicians so that before the patient leaves hospital a plan has been developed for their onward care. Teams are led by specialist GP's who bring their knowledge and skills of caring for homeless people in the community, as well as their expertise in prescription of methadone, personality disorder, and chronic disease management. Nurses manage team caseloads and bring vital clinical experience in homelessness, addictions and mental health, as well as practical knowledge of how to get things done in

“Good healthcare can play a significant part in ending homelessness, especially for people who have experienced chronic exclusion and multi-disciplinary practice is essential to get better outcomes for patients with more complex needs.”

1 Email to: Alex.bax@pathway.org.uk

2 Bax, A., Middleton, J., 'Healthcare for people experiencing homelessness: a public health crisis caused by political choices'. *BMJ* 2019; 364 doi: <https://doi.org/10.1136/bmj.11022> (Published 08 March 2019)

3 'Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis'. Aldridge, R. W. et al. *Lancet*, 391(10117), pp. 241-250. (doi:10.1016/S0140-6736(17)31869-X)

4 Department of Health (2010). *Inclusion health: improving primary care for socially excluded people*.

5 <http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted>



a hospital. Housing specialists bring their expertise to the bedside and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators, paid staff who have personal experience of homelessness who focus on relationship building. Larger teams also include occupational therapists, social workers and mental health practitioners.

Based in the hospital, Pathway teams co-ordinate input from housing departments, mental health and addictions services, social services, community and charity sector partners. The teams aim is to provide empathetic, patient-centred, recovery-focused care.

Funded and employed by the NHS, Pathway teams:

- Provide expert advice and clinical advocacy on homeless and inclusion health issues (such as substance misuse and substitute prescribing), improving care and treatment outcomes
- Ensure patients with complex needs are able to engage with health and other services through holistic inpatient support and care, reducing rates of early self-discharge
- Help homeless patients find somewhere safe and appropriate to stay on discharge, taking into account their health, care and general support needs
- Support patients with financial issues, welfare entitlements and accessing specialist legal help where possible
- Help to replace lost ID documents
- Ensure patients are registered with a GP for ongoing care
- Refer and signpost patients to specialist community services to help with a variety of social, mental and physical health, and addiction issues
- Reconnect patients to family and social support networks on discharge

The teams coordinate and host regular multidisciplinary team meetings, which are attended by key professionals within the hospital and by community services. They carry out ward rounds to review the care of all homeless patients within the hospital.

Pathway's research shows that multidisciplinary teams are most effective in addressing the multiple health issues homeless people face. National evaluations have shown that integrating housing and clinical staff leads to 'better outcomes and more positive working practice'⁶.

In the UK health system the drive for financial savings seems to compete for priority with improving patient care. Pathway promotes medically evidenced models of care with compassion and better health at their heart. However, a randomised controlled trial has shown that a Pathway team is also cost effective, and improves people's health and housing status.⁷

Pathway's wider evidence base shows that the teams:

- **Improve outcomes for homeless patients:** Better health 90 days after discharge,⁷ less rough sleeping⁷ and improved housing outcomes on discharge.^{6 8 9}
- **Improve capacity in a busy hospital** by reducing the average duration of admissions for homeless patients^{10 11 12 13} and by reducing subsequent A&E attendance,^{7 11 12} and the number and duration of subsequent unplanned admissions expressed as total bed days.^{7 10 11 12 13}
- **Are cost effective.** This has been calculated using Quality Adjusted Life Years,⁷ and also by comparing the costs of the team to the reduction in secondary care activity for involved patients.^{13 14}
- **Help hospitals meet the legal 'duty to refer' requirements** of the Homelessness Reduction Act 2018. Emergency departments, urgent treatment centres, and hospitals providing urgent care are now subject to this duty, in order to prevent homelessness.¹⁵

Pathway has now launched a 'social franchise' partnership offer, to streamline the replication and spread of the Pathway team model across the UK health system.

Conclusion

Sadly Professor Halligan died prematurely in 2015, but building on his legacy we have shown: that good healthcare can play a significant part in ending homelessness, especially for people who have experienced chronic exclusion; that multi-disciplinary practice is essential to get better outcomes for patients with more complex needs; and that changing anything in a large complex system takes time and perseverance. Additionally, by stimulating new research and a wide range of collaborations, Pathway has helped to shine a light on the devastating consequences that chronic exclusion and homelessness had on human health and on the links between poor public policy choices, homelessness and ill health. One of Aidan's favourite aphorisms was 'you get your authority from how much you care.' We have tried to create teams that care a lot and to build the authority of Pathway as a charity to speak out on health and homelessness based on the practice of that care.

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Homeless Healthcare in England - How the Experience of Homelessness Makes a Difference

By **Mark Leonard**, *Homeless Health Case Worker, Groundswell*

Poor health and the experience of homelessness go hand in hand. In 2018 two people experiencing homelessness died every single day in England and Wales,¹ and nearly one third of these deaths were caused by treatable conditions.² In my job as Homeless Health Case Worker at Groundswell, I see the people behind these numbers and the social factors that are a barrier to accessing and benefitting from healthcare. We support people to get their health problems addressed and under control, to help people on their journey out of homelessness, but it's not easy. For example, if you're rough sleeping, finding a safe spot to sleep is usually a higher priority than going to see a doctor. Using drugs and alcohol is frowned upon by society but often used to relieve the anxiety and difficulties of rough sleeping; however, this is another barrier to accessing healthcare. It is still complicated for those sofa surfing or living in hostels – with delays in benefit payments causing stress or an untreated leg ulcer physically stopping someone from being able to walk. These are all reasons why someone might not be addressing their health issues.

One of the biggest problems in England when you are homeless is registering with a doctor.³ Groundswell's peer research 'More than a Statistic'⁴ found that often people are turned away because they don't have a proof of address or identification, although this is against NHS guidelines.⁵ In response, Groundswell produced small 'My Right to Healthcare' cards⁶ that people show the receptionist when registering with a doctor. The cards state:

- You do not need a fixed address.
- You do not need identification.
- Your immigration status does not matter.

Over the past three years Groundswell have distributed over 80,000 cards in London to make sure people are aware of their rights and have access to the healthcare they need. As a result of this research and the solution, that was led by people who have been homeless, NHS England are planning to roll these cards out across the country. This is a huge opportunity to overcome a big barrier in homeless people addressing their health problems.

Groundswell is a homelessness charity specialising in healthcare – both physical and mental. The charity's vision is of an equal and inclusive society, where the solutions to homelessness come from the experience of people who are, or have been, homeless. My

journey with Groundswell started nearly two years ago, when I was slowly getting my life back on track and staying off the alcohol, but it was tough as I was living in a wet hostel, I knew it could lead me back to drinking. My keyworker suggested I started volunteering, so I went for the interview with Groundswell to join the Homeless Health Peer Advocacy (HHPA) training programme.

I started the six-week programme in early 2018, which covered everything from advocacy to boundaries to managing challenging behaviour. I have only good memories of the HHPA training. One of the best parts of the training was about empowerment, I think this is the most important part of what we do. The training kept me focused and driven towards what I wanted to achieve; ultimately being a paid worker in the homelessness sector, which I have been since August this year. Once we had finished the training, we shadowed experienced volunteers or workers, giving us a chance to see the challenges we, and our clients, may face. Once we graduated – a celebration with colleagues, family, friends and partner organisations – we began our role as volunteer Peer Advocates.

Groundswell is unique – we focus solely on healthcare, physical and mental. But also, because all volunteers and two thirds of all staff have lived experience of homelessness, from rough sleeping to living in a hostel setting. I feel that my shared experience of homelessness makes a difference, I can empathise with my clients which puts them at ease, making it easier to support them.

HHPA has two main parts:

1. One to one peer advocacy – engagements with individuals experiencing homelessness; building relationships to support them to attend health appointments and engage with health services; providing practical support such as travel fares, telephone reminders and accompaniment to appointments. In addition, we focus on building the skills and confidence to enable clients to access health services independently in the future.
2. Health Promotion In-Reach – we facilitate regular events at homelessness services to engage their service users. Activities include building relationships with potential new clients, raising awareness of specific health issues and bringing in health professionals.

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2 <https://www.thebureauinvestigates.com/stories/2019-03-11/homelessness-kills>

3 <https://www.theguardian.com/society/2019/jul/02/homeless-people-60-times-more-likely-visit-ae-study>

4 <https://www.healthylondon.org/wp-content/uploads/2017/10/More-than-a-statistic.pdf>

5 <https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/>

6 <https://groundswell.org.uk/what-we-do/healthandhomelessness/my-right-to-healthcare-cards/>



“One of the biggest problems in England when you’re homeless is registering with a doctor. Groundswell’s peer research ‘More than a Statistic’ found that often people are turned away because they don’t have a proof of address or identification, although this is against NHS guidelines.”

After I graduated, I volunteered a few times a week as a Peer Advocate for around eighteen months. Groundswell really values the lived experience of homelessness, but this often means volunteers and staff can have difficult backgrounds or situations. We have a fantastic Progression Manager who is always there to support people from the minute they start on the HHPA training. This support ranges from helping with benefit enquiries, housing issues, CV writing or applying for training or education courses. During my time volunteering I was fortunate to be supported by the Progression Manager, gaining experience and building my confidence which prepared me to apply for paid jobs. I was over the moon to be offered a job working for Groundswell. I now work across several of Groundswell’s homeless health projects in London.

On Mondays I work with the Pathways team at Kings College Hospital⁷ with patients who are homeless. I introduce myself to patients and explain how we can offer support to them as they leave hospital so they continue to manage their health. This may be supporting them to register with a Doctor, attend a hospital outpatient appointment or follow up for wound dressings. It can be upsetting for anyone in hospital, I try to brighten up their day – a piece of cake and a coffee sometimes just makes them a little better and it helps our relationship.

On Tuesdays and Thursdays, I work with the Find and Treat team at University College London Hospital on our joint Hepatitis C project. People who are, or have

been homeless, have a much higher chance of being impacted by Hepatitis C. Risk factors for Hepatitis C are often associated with homelessness in relation to a history of injecting drugs combined with a chaotic and unstable lifestyle.⁸ I work closely with healthcare providers and homelessness services finding and testing people for the virus. A lot of this involves building close relationships with professionals and clients. I have been trained to do mouth swabs and dry blood spot testing. Recently our team has been focusing on those with multiple complex needs, who may have been diagnosed with Hepatitis C but failed to engage with and complete the treatment. A lot of my job involves locating these people and offering support, emotional and practical, to begin treatment again.

As HHPA grows across London, as well as in other UK cities through our national #HealthNow partnership,⁹ I also support volunteer recruitment. I ring around local homelessness services to talk with staff focusing on employment, training, and education to promote the HHPA training and volunteering opportunity for their clients. I feel like it is important that more people know about volunteering at Groundswell, so they can receive the same opportunity that I have. From the day I joined Groundswell as a trainee Peer Advocate I knew I could go to anyone – staff or volunteers. Everyone has time to listen and time for a chat. I’m proud to work for Groundswell and be part of a team that really does change lives.

7 <https://www.guysandstthomas.nhs.uk/our-services/homeless-team/overview.aspx>

8 <https://groundswell.org.uk/what-we-do/healthandhomelessness/hepatitis-c/>

9 <https://groundswell.org.uk/healthnow/>



Rimbaud and Colette Medical and Social Care Outreach Services (PASS)

By Dr Priya Tamby, *Locum Hospital Practitioner, La Timone University Hospital, Marseilles*

Colette, The Healthcare Access Outreach Service (PASS) in Marseilles

In France, homelessness is a huge public health issue. And yet, the most recent attempt to count the number of homeless people dates from 2013 and covers the year 2012. In this study, INSEE (the National Institute of Statistics and Economic Studies) counted 141,500 homeless people in France, double the number counted in 2001.¹ It is very difficult to give an exact measure of the homeless population today, but it is estimated that it amounts to 200,000 people. The number of homeless people is increasing all the time, for women and men. In the words of French psychiatrist Dr Jean Furtos, placing people in an exclusionary system creates such mental suffering that they begin to exclude themselves as a means of protection.² Homeless women are exposed to different risks from those that homeless men face. Homeless women are subjected to different types of violence and face different realities. Because they are subjected to physical, psychological and sexual violence, they stay out of sight. Women involved in prostitution rings, for example. They can be seen at night when they are working but they disappear during the day. Some of them don't want to lose their source of income and others are threatened if they don't work.³ For all these vulnerable women, their health takes a back seat. Their day-to-day priorities remain where they are going to stay, what they are going to eat and how they are going to maintain their hygiene, which means that access to physical and mental healthcare treatment is of secondary importance. Overcome by feelings of shame and worthlessness, they stay in isolation and do not prioritise their healthcare.⁴

In order to provide a response to these various and interconnected issues, Colette, The Healthcare Access Outreach Service (PASS in French) was set up in 2016, in Marseilles city centre. Funded by the Regional Health Authority (ARS), this is an outreach service that aims to “go to” women experiencing hardship and offer them health- and social-care support, using a van that travels around the city. The van offers a space where they can access care that is beyond the hospital walls. We want to make it easier for all these women, who because of their isolation and hardship forget about themselves and their health, to access care. We aim to meet them and to help them regain their lost trust in themselves and in institutions. Thanks to the

converted van, a medical and social care team – made up of a nurse, a social worker, a GP and a gynaecologist – can provide care in the different spaces where our network has found homeless women staying. One common factor can be found in all these women's life stories: They have all experienced some form of breakdown. This could be losing their job, experiencing a breakdown in a romantic or family relationship, addiction, physical, or psychological trauma. Through these consultations, that are social first and medical later, we try to understand these breakdowns and allow the women to put them into words and regain their self respect.

To do that, we have set three main objectives for the Colette Outreach Service:

The first objective of Colette is to “go to”.⁵ As described in the 2013 policy bulletin, “a PASS must intervene inside and **outside** the institution, to make it easier to identify and offer care to these patients and to construct a wider partnership between services.” We must be able to go to these women for whom health is not a priority. We must be where they are. By going to them, going to meet them in the spaces that accommodate them, we provide a service to the women who are furthest away from services and from care provision. These women, whose health does not come into their daily preoccupations, can meet healthcare professionals without having to ask why and how to come into contact with them. Thanks to our van, we can meet these women in a confidential space. This way they can feel able to confide in us and this creates trust. Positive initial contact is key to rebuilding, or in some cases, building, this lost trust in themselves and in care providers. In this first conversation we identify these women's needs. In another, lockable, adjoining room, there is an examination table which is used for gynaecological exams. This is where medical examinations are carried out. After a medical assessment, we can dispense medication free of charge, depending on the pathology identified.

We can illustrate the benefits of this approach through the case of a Nigerian woman who was 8 months pregnant when we met her. She had been in France for several weeks but had never seen a doctor. Her priority was to find accommodation and to register with the authorities so that she could start her asylum claim, before she could think about any arrangements for the birth. Meeting her at the emergency shelter sped up the process of getting her to the maternity ward as she would not have to worry about how her

“For all these vulnerable women, the day-to-day priorities remain where they are going to stay, what they are going to eat and how they are going to maintain their hygiene, which means that access to physical and mental healthcare treatment is of secondary importance.”

1 <https://www.insee.fr/fr/metadonnees/source/serie/s1002>

2 Jean Furtos, *De la précarité à l'auto-exclusion (From Hardship to Self-Exclusion)*, Éditions Rue d'Ulm/Presses de l'École normale supérieure, 2009

3 Report no. 2017-05-29-SAN-027 published 29 May 2017, Danielle Bousquet, President of the High Council for Equality Between Women and Men, Geneviève Courard and Gilles Lazimi, rapporteurs, Margaux Collet, co-rapporteur

4 Improving Health Care Management in Primary Care for Homeless People: A Literature Review by Jego, Maeve; Abcaya, Julien; Ștefan, Diana-Elena; Plus... International Journal of Environmental Research and Public Health, 02/2018, Volume 15, No. 2

5 Bulletin No. DGOS/R4/2013/246, 18 June 2013



care was going to be organised. This allowed her to receive essential antenatal care in a timely manner.

The second objective of Colette is prevention. According to the WHO (World Health Organization), there are three levels of prevention.⁶ Primary prevention means acting before disease occurs so its incidence is reduced. Secondary prevention means stopping a disease from getting worse. Finally, tertiary prevention means reducing the complications of a disease. Acting on these three levels is essential from a medical care point of view and from a public health point of view. By limiting the onset, progression, or complications of disease, we improve the global health status of this very marginalised population. We also reduce the risk of visits to hospital emergency departments. This way we can reduce the number of bills that are likely to remain unpaid, which have a significant economic impact.

In August 2019, we met a woman who had been raped eight days earlier. When she presented to the emergency department, she was given some medication to avoid the risk of sexually transmitted diseases but she was not given a long enough course of treatment. We managed to give her the rest of the medication she needed. In this way, we prevented the risk of infection, in particular HIV.

Colette's third main objective is to reduce the number of people foregoing care. One of the definitions of foregoing care was made by the anthropologist Caroline Desprès, and it articulates the fact "*that individuals [...] only seek out care services and health-care professionals when they experience a problem or notice a physical or psychological disorder, or do not receive the entirety of their prescribed treatment.*"⁷ We can identify two types of foregoing care.⁸ The first is "*barrier foregoing*", which means not accessing treatment for financial⁹ or, simply, geographical reasons. One of the emergency shelters in which we work is in a northern district of Marseille. The journey to the hospital in the city centre is long and complicated; you have to understand the timetables and pay for bus tickets. The second type of foregoing care is "*refusal foregoing*". This is a personal choice by which people reject health services and express a lack of trust in institutions. The result is that the individual distances themselves from, or even shuns, these services and institutions.

For two years now, we have been visiting chosen partner organisations once or twice a week, including:

- Two emergency shelters: *Claire Joie*, a women-only service, hosting 18-25-year-old women in Marseille city centre, and *Saint-Louis*, in the northern part of the city.
- Two charities that work with women involved in prostitution in Marseille city centre: *l'Amicale du Nid* and *Autres Regards*.
- We have periodically visited the refugee platform (PADA) where all asylum seekers lodge their asylum claim.

Our work with women is being redefined in today's context. The current government wants to restrict asylum seekers' access to care, but needs will only increase in the coming years. This means we have to adapt the way we work: we will now take our van to the PADA once a week and treat men as well as women, without losing sight of our three main objectives. Colette's target group will therefore change from January 2020.

To ensure we are as effective as possible in our work, we have to adapt our approach to political decisions and to people's needs, which change over time. With what little financial, material, and human resources we have, we want to help as many homeless people as we can, to see these people in the best possible conditions. In Europe, only Finland is seeing a reduction in its homeless population, in part thanks to the "*Housing First*" program.¹⁰ In France, public policy on health and homelessness is not in line with existing needs. Homeless people experience extreme vulnerability and it is our duty to do our utmost to make sure they are included in our exclusionary society.

6 Health Promotion Glossary, WHO, 1999

7 Desprès et al., 2011, « Le renoncement aux soins : une approche socio-anthropologique » (Foregoing Care: A Socioanthropological Approach), In Questions d'économie de la santé (Economic and Health Topics), n°169, p.3

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9 <https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/recueils-ouvrages-et-rapports/ouvrages-thematiques/article/renoncement-aux-soins>

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The Right to Sexuality

By **Sari Rantaniemi**, *Project worker, sexual counsellor, NEA - securing housing for women – project the Deaconess Foundation, Finland*

Sexuality is a basic human trait that can sometimes be difficult to define. At its best, sexuality is positive energy, power, and freedom, but it can also include anxiety and fear. Sexuality and sex are two different things. One might think that sexuality is simply what we are, and sex is what we do. The World Health Organization (WHO) defines sexuality as a central aspect of being human throughout life which encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.¹ Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. In a nutshell, sexuality is somehow present in most aspects of our lives.

To be able to enjoy your sexuality, you need your sexual health to be in good condition, you need to be able to express your gender identity safely, and you need your sexual orientation to be accepted in your social environment. Sexual health is closely linked to reproductive health, but its concerns are wide-ranging, encompassing sexual and gender identity, sexual expression, relationships and pleasure. It is not only about negative conditions such as sexually transmitted diseases, unwanted pregnancies or sexual violence. Especially when people are in challenging life situations, when dealing with the topic, it is often only to deal with the problems they are encountering.

But sexual rights are human rights. Good sexual health is built on the fulfilment of sexual rights. They are universal and fundamental. Sexual rights secure the right to decide about your own sexuality, body, and reproduction and for these decisions to be without fear of discrimination, violence or mistreatment. Decision-making also requires proper knowledge of sexuality issues. People have the right to information throughout their lives. The World Association for Sexual Health (WAS) revised [The Declaration of Sexual Rights in 2014](https://worldsexualhealth.net/resources/declaration-of-sexual-rights/).²

Women's sexuality when experiencing homelessness

Homeless women are one of the most marginalized groups in societies. They face discrimination because of their gender and life situation. In addition, there is a special stigma for homeless mothers. The lives of homeless women are not safe and women who belong to minorities are particularly vulnerable. Homeless women face a wide range of violence. It can be mental, physical, social and sexual, and in most cases a combination of these. Homeless women face more sexual harassment and abuse than other women. Typically, in return for a place to stay overnight, women have to have sex. Sex is not always voluntary and women get raped. Prostitution is also a way to earn some money.

When it comes to the sexual health of women experiencing homelessness, the aspect of enjoyment is often ignored. And that's no wonder, because sexual pleasure was not proclaimed as a sexual right until October 2019. Sexual pleasure is the physical and / or psychological satisfaction and enjoyment derived from shared or solitary erotic experiences, including thoughts, fantasies, dreams, emotions, and feelings. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are the key enabling factors contributing to sexual health and well-being³. The lack of a private space like home creates challenges for these women to be able to enjoy their sexuality. Temporary housing solutions and shelters rarely provide the privacy that is needed to enjoy sex by themselves or with someone. The need for pleasure and intimacy should never be underestimated or ignored. They are basic human needs.

1 https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

2 <https://worldsexualhealth.net/resources/declaration-of-sexual-rights/>

3 <https://worldsexualhealth.net/resources/declaration-of-sexual-rights/>



LGBTIQ women

When talking about women experiencing homelessness, it is important to think about who people are LGBTIQ. Womanhood is not only built on personal factors but also in relation to culture, religion and society. Understanding gender diversity is also particularly important when you are providing gender-specific work or services. Gender corresponds to various genetic, developmental, hormonal, physiological, psychological, social and cultural characteristics. Therefore gender is not just male and female. A person can be both at the same time, something in between or something else. In some cases, people have no gender at all.

Heteronormativity seems to dominate when it comes to homelessness. However, we have data that shows homelessness, especially among young people, is linked to gender and sexual minorities. The special needs of these people should be recognized in the homelessness sector and special attention should be paid to the fulfilment of their sexual rights. The gender of another person cannot be determined by appearance, name or any other factor. This is often an area where the training needs are not yet clear and some work on collecting this information would allow appropriate training.

“Sexual rights are human rights. Good sexual health is built on the fulfilment of sexual rights. They are universal and fundamental.”

Needs after having experienced homelessness

Women also need support after having experienced homelessness. At home, a woman begins to recover and rebuild a feeling of security. Safety is important as traumatic experiences can only be addressed once basic safety has been established. It is common for survivors to relive their sexual trauma even years later. This may be confusing for the survivor and her case worker. If a woman had previously been a substance user and had stopped using after getting a home of her own, she has to reclaim her sexuality and has to learn to express her sexual needs without substances. Being a sexually active and available woman can be difficult for women who have experienced homelessness. Finding new identities is also important for recovery. Likewise, couples' needs should be recognized, because getting a home of one's own after having experienced homelessness as a couple modifies the dynamics of a relationship.

Many professionals find it difficult to talk about sexuality. These issues may be seen as not belonging to the work of the homelessness sector. However, it is the duty of the professional to face the person holistically. It is the duty of the professional to talk about difficult issues, because women want to be directly asked, for example, about violence. As there are various taboos associated with sexuality, it is good, as a professional, to be aware of the impact of their own life history and values. No woman should be condemned, no matter what she says. A woman's privacy must also be respected if she does not want to share her private issues. Building trust takes time. It is also typical that a professional is frightened of not having enough knowledge about how to handle these matters. The most important thing, however, is the goodwill and the courage to listen and be present.



For an Inclusive Healthcare System: the Neunerhaus Health Centre, Vienna

By **Anja Christanell**, *Stephan Gremmel* and *Elisabeth Hammer*, *neunerhaus*

Introduction

The Viennese social organisation *neunerhaus* has been offering medical services for homeless and uninsured people since 2006. The *neunerhaus* Health Centre opened in 2017 to offer low-threshold, interdisciplinary primary care. A medical clinic, a dental clinic and mobile doctors form the backbone of this centre.

The *neunerhaus* Health Centre is reliant upon close cooperation with social workers: cross-disciplinary discussions are held on a regular basis and these practitioners then develop perspectives based on patients' realities and needs. In addition, the outreach services provided by *neunerhaus'* mobile doctors are now available in 27 institutions managed by the Viennese Advisory Service for Homeless Assistance. Since many patients also suffer greatly with their mental health, *neunerhaus* is currently working on social innovations and low-threshold offers in the area of mental health, both by involving patients and incorporating their needs.

Social problems and exclusions are made visible at the *neunerhaus* Health Centre. The number of patients has tripled since 2010. The number of female patients is on the rise: in 2010, 26% of those treated were female while by 2018, the proportion had increased to 36%. In 2018, 4,892 people were seen by *neunerhaus* doctors and social workers, including 266 children and young people. Half of all patients are not covered by health insurance. Our patients come from a total of 69 countries. For the past four years, we have therefore been using a translation tool (online video interpreting in 45 languages) to support patients, doctors and social workers in building trust and establishing patients' medical history, as well as for clarification and diagnosis.

Fighting shame and humiliation – for an inclusive health system

The *neunerhaus* Health Centre provides barrier-free access to medical care for people affected by homelessness and those who are not entitled to insurance. It also shows what a healthcare system could look like when one of the main aims is inclusion.

Austria's current healthcare system confronts people in precarious situations with a number of formal and informal barriers. The lack of entitlement to health insurance is the greatest formal barrier and thus the most common reason for someone not being treated within the healthcare system.

There are many informal barriers preventing people from seeking medical help. According to our doctors and social workers, the most frequent barriers their patients experience are:

- Language barriers
- Shame and humiliation
- Mental and psychiatric disorders (e.g. anxiety disorders, schizophrenia)
- Precarious living conditions

Language barriers prevent effective communication and, by extension, good treatment. In contrast with language barriers, which are quickly recognised by all those involved, the barriers relating to shame and humiliation are more complex, and only become apparent through a trusting relationship and in discussions with patients. The fact that people have had bad experiences with the health system is often not because they have not received medical treatment but because they have not received good human treatment. Being humiliated leads to shame. Moreover, the feeling of being excluded and one's own shame in turn lead to people no longer taking advantage of medical help or only seeking it in an emergency. In addition to homelessness, many people also suffer from poor mental health and psychiatric disorders and are thus stigmatised twice.

Within the *neunerhaus* Health Centre, various occupational groups are working together to break down the barriers preventing access to medical care. Here, we can offer people low-threshold access to high-quality medical care in a variety of ways (e.g. video interpreting, low-threshold interactions without fear of being stigmatised in the adjoining *neunerhaus* café). Where complex health and social problems merge, prospects are discussed together with the patients in an interdisciplinary setting.

Although the healthcare system is not yet inclusive, we try to act as a bridge to that system. We can only achieve this by cooperating with various hospitals and specialists in private practice, who provide the required treatments beyond primary care, regardless of the current insurance status. Operations as well as long-term and costly treatments (oncology, neurology, orthopaedics) are only possible through this cooperation.

“The fact that people have had bad experiences with the health system is often not because they have not received medical treatment but because they have not received good human treatment.”



Health problems faced by homeless people

The health problems faced by homeless people range from coughing, sniffing and hoarseness to advanced malignant diseases such as cancer. In that way, they do not usually differ from the health problems that doctors otherwise encounter in general medicine or in hospitals' acute outpatient departments.

However, our patients suffer more than average from:

- chronic wounds;
- dental problems (particularly the loss of teeth requiring prosthetic treatment);
- poor mental health and untreated psychiatric disorders;
- multimorbidity (several diseases concurrently).

Precarious living conditions cause stress, which can manifest itself psychologically or physically to different extents. For example, cardiovascular diseases, high blood pressure and metabolic diseases such as diabetes mellitus worsen under stress.

New challenges I: housing as a health intervention

At a FEANTSA conference in Lyon in 2018, a colleague described homelessness as a life-threatening disease as long as it is not treated with housing. This statement aims to understand residential care as a health intervention and thus goes far beyond previous approaches in which medical care is seen as supplementing residential care and in which reciprocal actions are ignored.

The respective housing situation has a direct influence on physical and psychological well-being. From a medical point of view, it makes little sense to offer people good treatment if they end up back on the streets. This reciprocal action is briefly described in the following case.

A young woman suffered from a rheumatic disease for years. As a result of many years without treatment, both of her hips were severely affected and movement caused her a great deal of pain. The woman slept on the streets of Vienna and initially denied any support because of several traumatic experiences in her home country. Thanks to work undertaken by social workers at the neunerhaus Health Centre, she was offered accommodation at an institution managed by the Viennese Advisory Service for Homeless Assistance. This institution is also open to those without further entitlements over and above the minimum benefits system or homelessness assistance. Only the residential care she received made it possible to offer preoperative clarification and subsequent physiotherapy treatment over the course of several weeks. She had an operation and now has the prospect of recovering and determining her own life for the first time.

Correctly storing and taking medication, attending doctor's appointments and incorporating recommendations on nutrition and physical activity into everyday life – all these aspects are necessary prerequisites to aid recovery. They also require stable living arrangements yet fulfilling these prerequisites ranges from difficult to utterly impossible if you do not know what you will eat or where you will sleep. Experts strongly advocate for housing in Vienna that would be suitable for the above-mentioned target groups. Only by combining medical services with an offer of housing can people have the opportunity to determine their own lives, with gainful employment where appropriate.

New challenges II: perspectives for new flexible offers with increasing deinstitutionalisation

Housing First and similarly designed mobile services are changing the homeless assistance services on offer. The City of Vienna built on the momentum and experience gained from pilot projects run by social organisations and has now set its sights on further deinstitutionalising its homeless assistance services. This objective gives us an opportunity to ask new questions:

What does the deinstitutionalisation of housing mean for medical care? What health strategies do we need in future?

More decentralised and mobile housing services require flexible medical services so that we can continue to reach the people who have been given housing and who need our health services.

A first step is to understand health interventions more broadly. We need more space where we can take a deep breath and where we can simply be, without time or consumer pressures. These could be, for example, "extended living rooms" in different locations across the city that encourage social participation and where a doctor is not far away. We have already gained initial experience here with our own café, which is adjacent to the neunerhaus Health Centre and where we can offer a first point of contact without fear of being stigmatised. This form of interaction is particularly important for people with untreated psychiatric disorders, but also for promoting the structuring of everyday life in a healthy way and encouraging social participation.

Our long-term aim is to work together with cooperation partners and decision makers in new ways to shape an inclusive healthcare system in which every person has access to high-quality medical care, regardless of the prescribed prerequisites. New ways require courage and flexibility. With its stable health and social system, Vienna offers the ideal foundation to make improvements in these areas.



Casas Primeiro – Housing First Program in Lisbon for Homeless People with Mental Illness

By **Inês Almas** (Coordination of Housing First Program Team) and **Teresa Duarte** (President of the Board of AEIPS)

Casas Primeiro - Housing First was the first Housing First Program implemented in Lisboa, Portugal, created by a non-profit organization, AEIPS – Associação para o Estudo e Integração Psicossocial. The program was established in 2009, in the city of Lisbon, by AEIPS - founded in 1987 - to develop community-based support recovery and to fully support community integration of people who experience mental illness (Ornelas, Duarte and Monteiro, 2014). AEIPS and the ISPA University Institute are partners in a joint collaboration on evaluation and research of the Housing First Lisbon Model, in particular when it comes to intervention and results (Ornelas, Duarte e Costa, 2018).

This program aims to support people with dual diagnosis (mental illness and substance misuse), and who are experiencing long-term homelessness, in accessing and maintaining permanent individual apartments scattered across the city of Lisbon. The program provides immediate access to permanent housing, separating housing from treatment, considering individual choice and not demanding that users engage in psychiatric treatment or maintaining sobriety (Ornelas, Martins e Silva, 2016).

Apartments are rented from the private housing market and scattered across mainstream neighbourhoods, with access to diverse local resources such as public transportation, health care centres, coffee shops, grocery stores, recreation and leisure centres and other local resources. Support services are flexible, individualized, recovery-oriented and provided according to tenants' needs and goals in different stages of the community integration process. Services are available on working days, though the daily home visits and community resources in local communities are on call 24/7 in case of emergency situations (Ornelas, Martins e Silva, 2016).

The program organizes a monthly group meeting at AEIPS's head office, where participants have the opportunity to discuss issues they find relevant or even share experiences with their peers and the program staff, thus contributing to the development and improvement of the program. Using an ecological and collaborative approach, the staff plan the intervention with tenants in order to address their needs and preferences regarding housing management, citizen documents and legal issues, access to health services, income and social benefits, employment and education projects, community activities in the neighbourhood, and personal relationships.

Over the years, the program has demonstrated a high housing retention rate ranging from 85% to 90%, a significant decrease in participants' use of emergency services and psychiatric hospitals, and significant improvements in their quality of life and their integration to community (Ornelas, Martins, Zilhão e Duarte, 2014; AEIPS, 2016; AEIPS, 2017).

Many participants reported that when they were on the streets they were hospitalized on multiple occasions due to physical or mental health issues. They

described how the stressful and difficult conditions they experience on the streets strongly contributed to the deterioration of their health. Since moving into secure housing, the number of psychiatric hospitalizations has decreased by 90% and none of the tenants has spent the night in the emergency room or police station (Ornelas, 2013). Most of them mentioned the importance of living in a stable and secure environment, and how this contributes towards considerable improvements in their physical and mental health (Duarte, Costa e Ornelas, 2018).

I remember that when I was homeless I heard voices all the time... I don't know how many times I was hospitalized. On the other hand, it was a positive thing for me; at least I could sleep in washed sheets and have food [...]. Four years ago, when I entered the Casas Primeiro project, everything changed for me. I've been hearing less voices and I haven't been hospitalised again since I have had this house ...

The housing impact is perceived by tenants as very meaningful regarding their quality of life, their privacy and personal safety (98%), the quality of their food/meals and their sleeping habits (82%), their physical and mental health (80%) and their social life and relationships (52%). The separation of housing and treatment, using local health centres and the mental health care system as an available resource for participants, has been an important asset in providing quality health services in several medical specialties. It has also helped promote the right to access to health care and contributed to community integration. Finally, it has had a positive impact on the way tenants perceive their home - i.e. as a place to live instead of a place of treatment.

Tenants noted that taking part in a traditional addiction treatment is not a pre-condition in the Casas Primeiro Program, and despite this, they have reduced their drug and alcohol use. According to them, they reduced their alcohol and substance intake after the program. Some tenants pointed out that the housing and support services help them to open "a new chapter of their lives", and some of them stated that they had established new relationships since they moved and as such, do not want to be labelled "drug addicts" anymore. Some tenants have decided, with the support of the staff and other significant parties, to engage in an alcohol or drug treatment years after entering the Casas Primeiro. They state that knowing they have a safe place to return to and that they will have all the support they need before, during, and after the treatment helped them to take that decision (Duarte, Costa e Ornelas, 2018).

AEIPS is one of the partners of the HOME_EU research project which was developed in Portugal, France, Ireland, Italy, The Netherlands, Poland, Sweden and Spain. The project compiled data from such diverse



“Some tenants pointed out that the housing and support services help them to open “a new chapter in their lives”, and some of them stated that they had established new relationships since they moved and as such, do not want to be labelled “drug addicts” anymore.”

sources as citizens, service users, providers and policy actors, to understand how this phenomenon is viewed and to highlight effective solutions, such as the Housing First approach. The global aim of HOME_EU is to contribute towards advancing homeless policies and practices aimed at ending homelessness in Europe. Hence the research and comparative analyses results will have a transnational effect on national homelessness policies.

The HOME_EU research demonstrated that the permanent, scattered and independent Housing First Model is the most suitable to attain community integration and mental health well-being or recovery for people who have experienced homelessness.

Consistent evidence across a range of outcomes shows that the Housing First model is more effective at decreasing time spent in staircase-like accommodation for homeless people, increasing time spent in independent accommodation, decreasing psychiatric

symptoms, increasing community integration, and promoting equality defined as enhancing people's capabilities (Greenwood R.M., Manning, R. M., O'Shaughnessy, B., 2019).

Most of the local policy makers (62,6%) consider homelessness in their region a moderate or a major problem, and 42,4% of local policy makers consider that in their country there is no policy that could reverse homelessness. 16,2% say that the Housing First Model is already included in local policies and 15,7% indicate that the Housing First Model is implemented in their municipality (HOME_EU brochure).

In conclusion, the investment in Housing First programs and policies according to the core principles can be the answer to addressing the complex task of ending homelessness through the incorporation of an ecological approach and the promotion of community integration.

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Homelessness and Childhood Adversity

By **Charlotte Grey** and **Louise Woodfine**, *Public Health Wales*

In a survey from Wales (United Kingdom), we found that around 1 in 14 (7%) of the Welsh adult general population reported lived experience of homelessness (1). We know that having a home is an important stabilising factor, and inadequate housing is a serious societal issue that directly and indirectly affects social, physical, and mental health (2). Homelessness is an indicator of fundamental breakdown in a person's life, and is an extreme form of social exclusion and inequality (3,4).

Finding effective solutions to the problem of homelessness is complicated, as it involves not only identifying and implementing effective interventions to support people currently experiencing homelessness, but also addressing the multiple complex causes (5). We know that homelessness is caused and maintained by a wide range of structural and individual factors interacting (5–7). These structural factors include a lack of affordable housing, unemployment, and changes in social support; and individual factors include life histories (e.g. childhood adversity), disadvantage (e.g. poverty), and life events (e.g. family breakdown) (2,8,9).

There is growing evidence to suggest that adversity experienced in childhood can lead to vulnerability in adulthood by impacting on health and life chances and contributing to adverse housing outcomes (10–16). Many of these adversities in childhood are recognised collectively as Adverse Childhood Experiences (ACEs), and are defined as stressful experiences that children can be directly or indirectly exposed to while growing up (10). ACEs include: childhood abuse (physical, sexual or emotional); family breakdown; exposure to domestic violence; or living in a household affected by substance misuse, mental illness, or where someone is incarcerated (10); and emotional and physical neglect (17). ACEs are interrelated; if one ACE is reported this increases the chance of reporting at least one more (10,18,19). So, grouping these adversities as 'ACEs' has been found to provide a better assessment of the breadth of childhood adversity and the relationship with health and social issues, irrespective of the potential for relative effects of individual ACEs and different combinations (13).

There has been growing evidence in the past two decades that exposure to ACEs early in life can have long-term impacts on health, wellbeing, and behavioural issues (10–12,18,20). A recent systematic review found that ACEs are risk factors for many health conditions in adults, but the associations were seen to be particularly strong for violence, substance misuse, problematic alcohol use, and mental illness (13), which are also all factors associated with homelessness (21). The systematic review also highlighted a consistency between studies in the links between exposure to multiple ACEs and poor health, despite variations in type and extent of exposure (13).

Homelessness in youths and adults is one of the negative effects that has been associated with adversity in childhood (16,22,23), where homelessness in adults is more likely amongst those who have a history of childhood adversity and poverty (7,9,24–28). Exposure to social disadvantage in childhood leads to being less likely to adapt successfully and more

likely to adopt unhealthy coping behaviours (29). This suggests that homelessness is a symptom of a life-pathway that is influenced by a range of known variables (30). In particular, homelessness in adulthood has been associated with individual risk factors experienced in childhood such as parental addiction, domestic violence (DV), and living in social housing or local authority care as a child (9). Family relationship problems and lack of support networks are common amongst teenagers and young adults who find themselves homeless (21).

In a national survey in Wales, we wanted to understand how the prevalence of ACEs in those with lived experience of homelessness compared to that of the general population (1). We found that compared to those with no ACEs, individuals with a high number (four or more) ACEs were 16 times more likely to report lived experience of homelessness. ACE-prevalence was found to be high in the homeless population; we found 87% of those reporting lived experience of homelessness had experienced at least one ACE, and 50% reported four or more ACEs. This compares to 46% and 11% in the general population, respectively. A significant association between ACEs and experiencing homelessness was evident for each specific type of ACE. This would suggest that reducing or preventing adversity experienced by the child, may help reduce future vulnerability by mitigating negative health and social outcomes in the adult, including homelessness.

The findings of the cross-sectional survey were supported by qualitative interviews with a group of people with lived experiences of homelessness, as well as with service providers, to better understand how ACEs contribute to homelessness across the life-course and what would have helped mitigate this impact (1). From the interviews, participants with lived experience of homelessness discussed developing maladaptive coping behaviours in their teenage years, or earlier, in response to the ACEs they were experiencing in often chaotic home lives. These destabilising behaviours present in children and young people, included being overly-independent at a young age, repeating unhealthy relationship patterns and finding it difficult to form and maintain relationships, self-medicating, self-harm and suicidal ideation, violence and criminal behaviour, staying out or running away, and finding it challenging to cope with rules. This behaviour, attributable to ACEs, combined with a lack of trust from the vulnerable child and a feeling of not having a voice and being heard, and services throughout the life-course not being able to see the 'person behind the behaviour', contributed to poor school attendance and the participants not coping academically. These negative coping behaviours continued into adulthood and participants often felt these had contributed to their homelessness.

The research helped us to identify recommendations and next steps (1). A better understanding of the impact of ACEs and the impact on the life-course could help improve our understanding of some of the underlying individual factors contributing to homelessness, as well as enabling better-informed early intervention and prevention options to reduce the effects of ACEs in vulnerable children and adults.



“There is growing evidence to suggest that adversity experienced in childhood can lead to vulnerability in adulthood by impacting on health and life chances and contributing to adverse housing outcomes.”

Achieving sustainable change can only be done through a multi-agency, collaborative approach to reducing the risk of homelessness, of which ACEs is part of the multiple, complex causes; as well as the impact of ACEs being a barrier to services supporting those who find themselves homeless.

In order to achieve early intervention and prevention, the key messages from our recent work (1) are that:

- **Capacity** needs to be built into services across all sectors in order to take a multi-agency, trauma-informed approach to better support the vulnerable child or adult, where a trauma-informed approach would include understanding of ACEs, create an environment of physical and emotional safety, and taking a strengths-based approach (31).
- **Awareness** of the impact of ACEs on later vulnerability in adults, including homelessness, would need to be improved so that all services that come into contact with children and young people are better informed to identify those at-risk from adversity in their household.
- The **support needs** of both child and adult vulnerable populations that have been impacted by ACEs need to be better addressed. Support and provision of services should be culturally and environmentally supportive of individuals with ACEs, and barriers to accessing health and social support minimised.
- **Early years’ settings** and youth services should be supported to work in a trauma-informed way and to recognise vulnerability in the child; and to ensure that **early intervention is multi-agency** and centred around supporting the child and their family.
- The value that teachers, support workers, youth and community support systems play in early intervention must be recognised and a **holistic system of support** for the child provided, with the focus on taking a trauma-informed approach to vulnerability and building a **trusted and constant relationship** with the child.
- **Empowering children and building resilience** is seen as protective by mitigating against developing health and social outcomes from exposure to ACEs (17,32–34), and public bodies should take a **Children’s Rights Approach** to supporting children at-risk from adversity to ensure that children’s voices can be heard.

Report: www.publichealthwales.org/preventinghomelessness

Infographic: www.publichealthwales.org/preventinghomelessness-infographic

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Cognitive Dysfunction - Do We Acknowledge the Difficulties?

By **Charlotte Obel**, *General Practitioner and supervisor, HealthTeam for Homeless, Copenhagen City*

“Rather than analysing the patient’s individual attributes and addressing them, the system fits the patient into its present institutional organization with its current theoretical approach and treatment paradigm.”

Having worked for 25 years in the health system, I have noticed that the system in its structure and capacity sometimes neglects to properly observe and understand the patient. Rather than analyzing the patient’s individual attributes and addressing them, the system fits the patient into its present institutional organization with its current theoretical approach and treatment paradigm. In order to see our patients clearly, we have to be aware of the way our institutions ignore inconvenient information. If we hold to a specific theoretical approach, we risk overlooking the information that is inconsistent with the theory. If, for instance, we don’t have the necessary housing facility for a person with specific important needs, there is a risk that the needs are not addressed. When our actions do not work out as planned, we have to consider if there are aspects that we overlooked.

One of the difficulties that is easily overlooked or confused with other difficulties is cognitive dysfunction. In Denmark, scientific evaluation will often describe the problems of a person who is homeless in terms of drug or alcohol abuse, psychiatric and physical illness, poverty, social strain and exposure to violence. Looking at the trajectory of homelessness you can observe three different categories: transient, chaotic and long-lasting homelessness¹. However, the profiles of the people (in terms of their problems) in these three trajectories do not greatly differ. This suggests that there are some aspects related to the problems of the homeless person, that are not being considered. One factor which may impact trajectories in homelessness is cognitive dysfunction. Cognitive dysfunction can appear as a lack of motivation, aggression, dishonesty or a personality disorder. Furthermore, the health and social systems caring for homeless people are not sufficiently informed, or even equipped, to recognize cognitive dysfunction. If we mistake cognitive dysfunction for something else, the help we supply may not be relevant or efficient, it may even be harmful and worsen the cognitive dysfunction. If we interpret cognitive dysfunction as

lack of motivation, we might even cease to offer help. Likewise, if we recognize the cognitive dysfunction but do not understand or feel comfortable in dealing with it, we may, as professionals, feel powerless.

Scientific evidence shows that homeless people are more likely to experience cognitive dysfunction. There are signs of cognitive dysfunction both among older and younger homeless people. The extent is however debated. There are plenty of obvious reasons to assume that cognitive dysfunction is widespread. Among homeless people there are higher rates of alcohol and drug abuse, mental illness, violence and adverse social experiences. Each of these conditions are associated with brain damage to a varying extent. Overdoses, toxic effects of drugs, head injuries, depression, schizophrenia and dementia, are just some of the possible mechanisms.

One central subset of cognitive function is the executive function. The executive function comprises different aspects such as working memory, planning and problem-solving ability, selective attention and inhibition, impulsivity and risky decision making, verbal fluency. All functions are important for adapting to changes in daily living, learning, working, and cooperating with others. Executive dysfunction is shown to be associated with both early life family trauma or maltreatment and poverty, both of which have commonly been experienced by homeless people.

Executive function is primarily located in different areas of prefrontal cortex and in the neural pathways that are connected to the prefrontal areas. Prefrontal damage is of great importance because deterioration in prefrontal function and thereby executive function can cause both subtle and severe changes in what we understand as personality. There can be changes in mentalizing, self-awareness and the ability to adjust behavior. When you consider the implications of dysfunction on these personality traits it becomes

1 Benjaminsen L., Enemark, MH, Veje ind og ud af hjemløshed. En undersøgelse af hjemløshedens forløb og dynamik. VIVE 2017



obvious that dysfunction can cause difficulties in relating to other people, including professionals. Thus it is easy for conflicts to arise from the inability of the patient to understand the motives of the professional. They might also arise from difficulties understanding one's own part in communication, or a lack of confidence. Therefore difficulties in holding on to agreements are possible and not uncommon ways of losing access to professional help.

Research shows attachment styles and executive functioning are linked. Among people experiencing homelessness, there appears to be a connection between insecure attachment style and lower level of executive functioning.

Memory deficits can also be related to damage to the hippocampus. A recent study has correlated the size of certain areas of the hippocampus with difficulties in immediate and delayed verbal recall. These difficulties were found in up to 75% of the examined population of 227 people experiencing homelessness.

Executive dysfunction may be more subtle and difficult to detect than more global difficulties but will become apparent in, for instance, a housing process. It has been shown, among young homeless people, that working memory is of particular significance in attaining more independent housing in a short-term housing process². Apart from the long-term impairment of brain damage, working memory can also be temporarily impaired by adverse life events and psychosocial stress via the negative effect of stress

hormones in the hippocampus and prefrontal cortex. Homeless people are more likely to have experienced adverse life events. Living in the street, even very temporarily, will increase psychosocial stress.

When testing for cognitive dysfunction we should remain conscious that testing facilities are not equivalent to real-life function. Testing can only give us an indication of difficulties, it can't give the complete picture of a person. Test results should always be considered together with other observations. We tend perhaps to think of cognitive dysfunction as something stable. This is however not always so. The cessation of drug and alcohol misuse, reduction of stress, treatment of mental or physical suffering or training of executive functions will often to some extent improve daily function.

There is a risk that both minor and severe cognitive difficulties will increase the risk of chronicity or long-term homelessness. The housing process emphasizes the need to adjust the process of helping and accommodating homeless people to adapt to these difficulties. When we consider the association between psychosocial stress, adverse life events, attachment style and cognitive dysfunction, the need for calm and safe hostels with professional knowledge of coping with executive function becomes clear. It can be facilitating for professionals to view these difficulties as signs of minimal brain-damage instead of personality traits and on that account try to fight the unproductive distinction between worthy and needy in the assistance of homeless people.

2 Fry, Charlotte E, Langley, Kate, Shelton, Katherine H. (2019). Executive function in homeless young people: Working memory impacts on short-term housing outcomes. *Child Neuropsychol.* 2019 Jun 24:1-27

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Cover Art: Richard Turipa, Auckland.

Richard is a pupil of the Auckland City Mission art programme. This particular piece is the result of an international art exchange entitled “This is where I live”, initiated by Café art London.

About the artist:

Richard Turipa has been coming to the Auckland City Mission art class for nearly four years. Although housed now, he has experienced many times the health problems, trauma and life uncertainty being homeless brings. Art for Richard is a mode of expression he has never experienced before. In his words, “Doing art makes me feel happy and proud. I never knew I could be an artist. Art keeps me off the streets and out of trouble.”

About the Auckland City Mission art programme:

“My art programme aims to work with both the therapeutic healing and transformative qualities of engagement with creativity and to enable, nurture and guide any emerging talent into the fine arts arena. For many participants, coming to the art class every week gives them respite for a few hours from all the challenges and dangers of their street life, and it’s a place where they can feel heard and feel safe. For others, it is a platform to discover a new and emerging talent - usually one they never knew they had or had opportunity to explore. My role as facilitator is to hold both activities and participants with respect, with love, and without judgement.” Clare Caldwell (Art tutor. Auckland City Mission. New Zealand)

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