



# TO LIVE IN HEALTH & DIGNITY

## EUROPEAN REPORT of Study & Action Project in promotion of Mental Health & Social Reinsertion for disadvantaged people

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**Editing note :**

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of all H&D Team and Participants in the European  
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# CONTENTS

## PART 1 : H&D RESEARCH REPORT

H&D Team	page	4
Foreword	page	5
Executive Summary	page	6
<b>1. INTRODUCTION</b>		
1.1 Background	page	8
1.2 Project Aims	page	2
1.3 Barriers to care	page	9
<b>2. METHODS</b>		
2.1 Settings	page	11
2.2 Variables and instruments	page	13
2.3 Application procedure	page	15
2.4 Data analysis	page	15
<b>3. RESULTS</b>		
3.1 The Projects	page	16
3.2 Case Studies	page	29
3.3 Users' Health and Dignity Status	page	34

## PART 2 : H&D FOLLOW-UP

<b>1. H&amp;D PROJECT</b>	page	43
<b>2. STATEMENT OF PROJECT</b>	page	44
<b>3. OUTCOME</b>	page	48
<b>4. H&amp;D EUROPEAN SEMINAR</b>	page	51
<b>5. FINDINGS AND RECOMMENDATIONS</b>	page	52

<b>ANNEX LIST</b>	page	55
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**NB. :** *all other annexes will be located in H&D vol. 2*

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## **FOREWORD**

by Aart J. Vrijlandt, President MHE-SME

This report deals with a problem that is mostly unseen although it is clearly visible for each inhabitant and each visitor of our big cities. Established mental health services not seldom overlook the problem or merely miss the skills or the attitude to meet and care for persons with serious mental health problems who roam our streets. Therefore MHE-SME - as an organisation that strongly promotes mental health and mental health care for all citizens – is very pleased with this practical action research programme and the report that has been produced as a result of it. It compares a variety of programmes and it gives valuable descriptions of projects in 10 different European capital cities aimed at direct practical care for the disadvantaged homeless people with severe psychological suffering not seldom combined with physical suffering. In these projects volunteers and professionals working together give many examples of how the gap between the “outside world” of the streets, stations, shelters etc. and the “inside world” of medical and social institutions can be bridged.

Reading of the report shows clearly that there is no sophisticated “technique” or “trick” to be learned. The answer seems to be in the very difficult skill of really meeting the people on the streets and in understanding their lives and valuing it in their terms that very often differs substantially from the values and beliefs of established medical and social organisation. The report shows how this attitude and this skilfully working with respectful relationships leads to success.

The key word of the process is empowerment, the aim is dignity and to become the actor of ones own life. It has to do with recognition of a person and real participation in the society. When one has a serious mental health problem and no home to go to one can be sure of that there is not much of belonging left anymore. The programmes that have been investigated in this report try to restore a bit of this precious belonging.

In doing this action research enthusiastic workers from different background and different nationalities found each other’s recognition and support. This is probably as valuable as the action research and the report itself. It creates empowerment of workers – volunteers as well as professionals - and helps them to stay creative and helpful in too often very difficult circumstances. I thank every single participant for his or her contribution and I hope that this action research programme will contribute to the visibility of his or her work.

Finally I hope that this report will open the eyes of every European citizen and of all politicians to see what has been visibly unseen for too long.

## EXECUTIVE SUMMARY

At the European Councils in Lisbon and in Feira, the Member States of the European Union took a major initiative by making the fight against poverty and social exclusion one of the central elements in the modernisation of the European social model.

Precariousness affect an increasing number of people in different areas and the “exclusions”, beyond national differences, is a major European problem: anxiety for the future even spreads among those who have not yet been affected by unemployment or poverty. The “phenomenon” of the *homeless & mentally ill people*, abandoned on the streets, living in reception centres and in precarious housing conditions, is only the visible tip of a societal phenomenon which is more serious and widespread than at first appeared.

The research/action “To live in Health and Dignity” initiative is our contribution in promoting mental health, social inclusion and European citizenship especially for this disadvantaged and excluded people.

- ◆ Despite having much higher rates of physical and mental ill health, socially excluded people are far less likely to make use of general medical or psychiatric services. When they do consult, it tends to be with emergency services in a crisis with poor follow-up.
- ◆ Barriers to care arise through poverty, the lack of support and through fragmentation and poor co-ordination of mainstream services. Services exclude users with histories of aggression, those who cannot pay or who do not reside within a particular catchment area.
- ◆ The Health & Dignity study aimed to identify examples of good practice in services for homeless and other socially excluded populations in Europe.
- ◆ Ten capital cities participated: Athens, Berlin, Brussels, Copenhagen, Helsinki, Lisbon, London, Madrid, Paris and Rome. A local expert with a good knowledge of local services was identified from each centre to act as a co-ordinator.
- ◆ Each co-ordinator was asked to identify up to 15 example services and to extract the 6 which best met qualitative ‘good practice’ guidelines for detailed study.
- ◆ Co-ordinators or their deputies visited each service and carried out interviews with the service directors, the staff and a sample of service users.

- ◆ In addition to detailed local reports, each co-ordinator presented the results of the survey at a series of consensus meetings held at regular intervals throughout the project.
- ◆ All capital cities had provision for emergency shelter though few had adequate examples of the sort of long-term supported housing that many of the more severely dependent users require.
- ◆ Despite high rates of unemployment, very few centres provided any occupational rehabilitation or work re-training.
- ◆ Networking, (official and unofficial links with mainstream and other providers) is regarded as essential by all services though the evidence for good practices were harder to come by with many staff on the ground feeling isolated and unaware of available resources. Better networking is needed, even at an informal level. Objectives and tasks must be clearly defined in order to be able to share them within a flexible and adaptive network.
- ◆ Case management is a popular method of organising care. It has the potential for expansion in areas where it is not currently used, especially in people with alcohol and drug problems.
- ◆ While most centres agree that services need to be taken to users who are reluctant to attend fixed clinics, outreach services are still poorly developed and tend to be confined to a few very well resourced teams. There was general agreement that this model of care should be adopted in all centres though local adaptation and evaluation will be necessary.
- ◆ Services need to work conjunction with institutions who provide training of professionals like universities and schools both to improve support and training of staff but also so that the issue of care provision to socially excluded people can be included on academic agendas and curriculum.
- ◆ They need common evaluation tools that allow the continuous study of “Good Practices” using outcomes-based criteria. In this way, decisions can be made and conclusions can be drawn from evidence gathered from all across Europe.
- ◆ The results of the H&D projects show an improvement in their users when compared to other sample of socially disadvantaged people (in Madrid, for example). The average service satisfaction scores also show good results in terms of service impact and outcomes.
- ◆ The Quality of Life results reaffirm the definitions of exclusion based on two axes (social and economic). They also indicate that health seems to be more improved than other variables.

# 1. INTRODUCTION

## 1.1. Background

The organisations and associations working in the field, in collaboration with health public services, for prevention and health formation of the people who live in great social economic and health precariousness (the homeless , precariously housed, jobless youth, isolated elderly, non integrated or “undocumented” migrants) have reached the following conclusions in their MHSE PREMINARY SURVEY:

- The mental and physical health situation of disadvantaged people is deteriorating despite increasing effectiveness and specialisation of public services
- Their life expectancy is falling - For example, in England, homeless people have an average life expectancy of 40 years while the national average for domiciled populations is 75 years, (‘Crisis’, London 97]. Infectious disease and acute pathologies are increasing in these populations. This also affects negatively the national health budget.
- Information about health care and hospital services and in particular access to them remains very difficult, if not impossible. Health promotion, primary and secondary prevention measures often fail to target these most vulnerable populations.
- Specific training is lacking for general practitioners as well as specialist doctors in working with excluded populations.
- Networking remains difficult.

## 1.2. Project Aims

The « LIVING IN HEALTH AND DIGNITY » project set out to identify good practice in the delivery of health and social care to some of the most vulnerable and deprived populations in Europe.

Private welfare and charity associations are central to this. They contribute in an irreplaceable way to health promotion, information and education of the socially disadvantaged and socially excluded. For this reason they are well placed to provide information about the needs of excluded populations, and suggestions about the most appropriate methods and strategies for primary and secondary health prevention.

These practices could be multiplied and efficiently supported by health policy makers in the implementation of “proximity” methods and approaches for health promotion and a dignified way of life for socially disadvantaged persons.

A first step towards improving services involves a mapping exercise to describe what exists, identify promising models of good practice and raise questions about standards of care. It must address the concerns and needs of front-line workers; and be bottom-up rather than top down. Not enough is yet known about services in the European context to adapt a more prescriptive approach or to evaluate performance against existing criteria - rather it is to identify and agree these criteria that can be the basis for later studies.

The Health and Dignity project is such a mapping exercise. In it we set out to identify and describe services that have tried to improve the delivery of health and social services to deprived and disadvantaged people. Our aim was to be attentive to diversity; to seek out services which were innovative, that might be capable of wider replication and which might form the basis of later work.

### **1.3. Barriers to care**

Despite having much higher rates of mental ill health, socially excluded people are far less likely to make use of general medical or psychiatric services and when they do consult, it tends to be with emergency services in a crisis with poor follow-up and less chance of being offered psychological treatment.

Socially excluded people face many obstacles in the way of receiving the care they need:

- *Poverty* - in most countries, although disabled people are entitled to some welfare support, the level is seldom enough to raise the person out of poverty and almost never enough to permit access to anything above the absolute necessities of daily life.
- *Lack of kinship & other support* - the lack of supportive family also means that there is seldom anyone who has a personal interest in the welfare of the homeless person. Many come from poor families that even if willing to help, do not have the financial resources to offer.
- *Disadvantaged starts in life* - many socially excluded people report long histories of abuse; neglect and disadvantage: Poor educational attainment; a criminal history and traumatic experiences all add up to push the individual to the margins of society.
- *Active rejection and discrimination* - prejudice is not confined to the general public: professionals also are prejudiced against these populations; Health care systems exclude those who they fear will be aggressive; who cannot pay or who are ungrateful; the emphasis on treatment is unattractive to the homeless person whose immediate needs are for food, shelter and security.

- *Illness* - the disabilities associated with illness; particularly mental illness; create severe barriers to help seeking: The mentally ill person may lack insight into his illness and the need for treatment; he may wish help but be afraid of the consequences of attending a psychiatric clinic.
- *Fragmentation of care systems* - services are fragmented and poorly co-ordinated: physical health care is typically provided separately from mental health care, substance abuse services provided separately from either and basic housing and welfare support delivered from yet more organisations and agencies. Housing departments, medical services and psychiatric services often serve different geographical sectors of the city. When people move , which homeless people do often, they may have to change both their doctor and social worker. In such circumstances, it is hardly surprising that they drop out of care.

**Improving services for socially excluded people requires strategies to reduce and eliminate these barriers of poverty, isolation, service fragmentation and hostility.**

**As social and health care professionals we have a duty to root out prejudice; to ensure that our services are non-discriminatory and facilitate access to care.**

**We must ensure that we assist people to help themselves and in our efforts to help we do not end up increasing disempowerment and dependency.**

## 2. METHODS

### 2.1. Settings

The project was prepared by the leader of MHSE and elaborated with several academic experts. The development of the project involved regular meeting in order to devise the methods, develop the project, supervise data collection, analyse the data from local reports, and preparing the final report and its publication.

The H&D Team comprised:

- Executive of project
- Director of research
- Academic experts
- Local co-ordinators
- Local working team.

The study was conducted in ten capital cities of the European Union: Athens, Berlin, Brussels, Copenhagen, Helsinki, Lisbon, London, Madrid, Paris and Rome. Of all the possible programs or projects fighting against social exclusion and social disadvantages in a particular city, six centres in each capital were chosen according to the following procedure:

- Target services:** The study was targeted on services that provide care and assistance to people who were at the more severe end of the social exclusion continuum – for example, homeless people, refugees and the long-term unemployed.
- Innovative & efficient practices criteria:** In order to define broad criteria to determine more “adapted practices” within such services, local co-ordinators were asked to collaborate in creating a list of innovative practice criteria useful in their particular centres, taking into account the specific characteristics of his/her city and with the input of project experts. These lists were circulated and discussed during the course of an early workshop to produce a sufficiently exhaustive but absolutely not discriminatory list of criteria covering the most important aspects of “good practices” (see figure 2.1), where the word “good” can be taken to include notions of innovation, efficiency and adaptation to local circumstances

Figure 2.1.: "Good practices" criteria

• The user is the central focus of the project
• The project should have a global integration approach
• The “proximity” methods and approaches, “decent” & non-humiliating are prioritised
• Attention to the ‘whole’ person, with complex needs
• Assistance is tailored to the specific needs of individual clients
• Focussed on empowering the disadvantaged persons
• Capacity for flexible responses to different needs
• Have the possibility of urgent & crises intervention to program
• Collaboration between project staff and professionals of other institutions
• Multidisciplinary team structures
• Participation of non professional volunteers
• Partnership and inter-disciplinarity, inside as well as outside the project
• Integration and collaboration in a local network
• Supervision and continuing training
• Involvement of the civil society

- C) **Disseminate information of research:** The local co-ordinators were required to gather sufficient information of existing social and health projects and to establish contact with those responsible for individual projects in order to present an accurate summary of each project to other participants in the H&D initiative. Collaborating projects were invited to participate and, encouraged to organise a meeting  
Inform the appropriate institutions and local administrations (by means of the official letter from Mental Health Europe) to implicate and also to present a request of co-financing.
- D) **Centre selection:** Each local co-ordinator was asked to identify 10-15 projects that broadly met these criteria in his/her own city. Next, in a joint meeting, all local co-ordinators met together with the project experts to discuss each project in detail and to identify a maximum of 6 projects for which there was a consensus agreement that they (a) best met the good practice criteria and (b) represented a good spread of available resource within the city. Of the resulting centres studied in this investigation, some receive public financing and others private monies and cover a broad spectrum of health and social care.

## **2.2. Variables and instruments**

A review of similar previous studies was carried out. This included consultations with international “fight against social exclusion” service evaluation specialists. The main conclusion of this process was the importance of using distinct evaluation methodologies:

- project evaluation through the opinions of the professionals who work in them
- evaluation of the main characteristics of their users
- evaluation via case studies that provide a qualitative and holistic vision of the users and project’s impact

In order to achieve these evaluation objectives, a new instrument needed to be designed and the Health & Dignity Modules were born – a measuring tool with the potential to gather information on every aspect previously indicated: the practices within each project via reports from professionals, user health status and quality of life via self-report questionnaires, and a qualitative perspective of the project’s functioning via case histories of its users.

### **2.2.1. Module 1: Health & Dignity – Professionals (H&D-P)**

The first objective of the study was to identify both quantitatively and qualitatively the main strategies used by each project. Because no instrument was found to meet this goal, a new instrument was developed and adjusted to the particular needs of these types of services and projects (Module 1 of the H&D Modules). The main objective of this measure centred on identifying the different strategies utilised by each project to tackle the health and social difficulties of its users.

The construction of Module 1 followed a typical scale construction procedure:

#### ***Variable selection:***

Local co-ordinators and project experts together identified a list of variables that reflected the good practice criteria defined earlier (section 2.1).

The final list included the following blocks of variables:

- Descriptive variables of the project
- Variables associated with the project’s strategies and practices
- Dignity
- General and mental health
- Variables associated with the project’s evaluation

#### ***Item pool:***

Within each of these broad blocks, a large pool of possible items was created to cover all related aspects. The pool was designed taking into consideration the following:

- Previous instruments with similar characteristics (e.g. “Preliminary Survey”)
- The opinions of the local co-ordinators, who were advised by the project experts, in each city
- The opinions of the project experts, who were advised in a similar fashion by local and international specialists

Using this process, the first rough draft was completed.

***The drafts:***

The drafts of the Module were subjected to the following process:

- The draft was studied at a group meeting of local co-ordinators and project experts who condensed the information and created the second rough draft.
- The second rough draft was used in a pilot project study of one centre in each city.
- After an analysis of the instrument's functioning during the pilot study, the second draft was edited once again producing the third and final copy of the instrument.

***Procedures:***

The instrument was administered through a process that included:

- Visits to the centre or project being evaluated
- An interview with the person responsible for the program or project
- A group interview session with the professionals who provide direct attention to the project's users
- An evaluation by the evaluator(s) via an evaluation grid

A complete version of this module can be found in Annex.

In addition to the information collected by this assessment, local co-ordinators also prepared a detailed report of each centre, summarising factual information and comments that could not be wholly captured by Module 1.

**2.2.2. Module 2: Health & Dignity – Users (H&D-U)**

The objectives associated with the selected project's users included a determination of their quality of life, general and mental health status, and satisfaction with the services/attention they'd received. In this case, instruments that sufficiently measure quality of life for the selected variables *do* exist. Therefore, the decision that had to be made was which tools to use.

***Instrument selection process:***

The instrument selection was carried out in two phases.

First the project experts proposed various instruments for each of the variables to be examined. Second, the final instrument were selected in a joint session with the local co-ordinators. This selection was based on their technical quality, ease of application, interpretation, brevity and wide previous use in other studies. The selected instruments were grouped and subjected to a pilot study involving a low number of users (n = 15) in different cities.

The following scales were included in the module:

1. Quality of Life Questionnaire (Baker & Intagliatta, 1982)
2. Two items from the Self-esteem Scale (Rosemberg, 1967)
3. General Health Questionnaire, 28 item version (GHQ-28) (Goldberg, 1981)
4. Treatment Satisfaction Questionnaire (Larse, Attkinson, Hargreaves & Nguyen 79)

***Procedures:***

The selected questionnaires were administered to the users as part of a structured interview in order to avoid a less than adequate performance by some users on these types of tests, and as much as possible, to control the biases typical of these kinds of instruments. The complete version of this module can be found in Annex.

### **2.2.3. Case histories**

Finally, one case history was included in the evaluation of each of the six projects in each city. Local co-ordinators and project experts created an outline to structure the information gathering process. This gives a picture of typical user of the project and what the project has meant in his/her life. The objective of the case history was to show the principle advantages and disadvantages of the project's day-to-day, real-life functioning and the later integration of the collected data. This outline can also be found in Annex.

## **2.3. Application procedure**

The application procedure was identical in every city. First, consent was obtained from the project managers and interviews scheduled with the project director and group sessions arranged with staff. The user questionnaire was also administered by the local co-ordinators to a random selection of 10 users from each centre. Once selected, the user was asked for his/her anonymous collaboration in the study and an informed consent was obtained from each participant. The H&D-U was administered in the form of a structured interview to help guarantee that even the people with the most difficulties would be able to understand every question. Finally, the local co-ordinator, in collaboration with the staff of the selected centres, selected one case history that would best show how the project functions for a particular user.

## **2.4. Data analysis**

### **2.4.1. H&D-P**

Qualitative and quantitative methods were used to examine the global situation across the 10 collaborating European centres, extracting common themes, practices and service trends in their approach to outreach, health promotion, shelter and quality of life. First, the detailed descriptions of each project were scrutinised and common themes extracted against a coding framework that tapped each area of 'good practice' as described earlier. Second, the responses from the Module 1 interviews were examined using a principal components factor analysis. Items cross loading on more than one factor and single item factors were removed. This procedure grouped and simplified the original 366 items to a simpler number that were used for the final descriptive analysis.

### **2.4.2. H&D-U**

A descriptive analysis of the main indicators from each item of-Module 2 (H&D-U) and of the total scores on each scale was performed. The establishment of criteria to determine the instrument's quality was not deemed necessary because they are sufficiently well-known and will not be used in a per city analysis because the sample would not be representative.

## 3. RESULTS

### 3.1. The Projects

This part reports the main results of the H&D Modules by first describing how the different projects and services function (Module 1) and then describing the users of these projects (Module 2).

**A total of 57 projects from the 10 capitals were reported.** Each project had unique aspects reflecting the social context of the project. The details of what may be important in Athens or Rome may be very different from what are required in Copenhagen and will be determined by many factors - the organisation of the ordinary health and social care system of the country, the role of the family, the impact of the wider economy (e.g employment, welfare ) and the legal system. Nevertheless there are a number of broad principles that are common across countries, that for example: people need access to housing, shelter, food, and clothing and to a basic minimum standard of health care.

#### 3.1.1. Presentation of the projects

The reported projects were also common in a special way: nearly all of them were very young projects. 41 were started in the period 1990 – 99 and only 3 before 1980. We cannot know if it is simple coincidence that all local co-ordinators have chosen very young projects, and if so, whether this represents a preference for presenting the newest projects or whether it reflects new needs of the excluded people who demand a new kind of – and a greater number of – projects corresponding to these needs. Whatever the reason, it is indisputable that during the last 10 years at least 43 new projects concerning excluded mentally ill people have sprung up in ten capitals across Europe. Furthermore, these projects share many common characteristics.

It could be like this:

#### **Athens.**

Non-governmental humanitarian organisation which offers medical and social help to homeless people with psychosocial problems, drug addicts, alcohol addicts, refugees, immigrants and ex-prisoners. Based in a poor neighbourhood within Athens. Paid employees comprise just a quarter of the staff, the remaining 75% being professionals who volunteer their assistance (doctors, psychologists and social workers). The project tries to provide medical care for socially weak people . Component services include psychological support and social care, a mobile unit and needle exchange programme. Users are recruited through self demand as well as referral from social and health services and the police. The project collaborates with other similar projects to meet the multiple needs of the users. (DOCTORS WITHOUT BORDERS, Piano 5, Athens 104 44, Greece. Established 1996)

Or this:

### **Copenhagen.**

A non-governmental organisation which offer medical help to homeless people. The care is offered from and in a mobile unit. The project's daily leader is a nurse. It is the project's job to offer direct nursing to socially excluded people who live on the street and who, for various reasons, cannot manage to contact the established system. In addition to providing direct help, the project has a main aim of establishing contact between these people living on the street and the established social and public health systems in order that they may obtain the correct and optimal treatment. ("Nursing on Wheels", Frederiksborggade 42, I., DK-1360 Copenhagen K, Denmark. Established 1998).

But it could also be like this:

### **Berlin.**

Set up to provide outreach, shelter and basic health provision for children and young people (aged 12-17) in crisis. It offers a service to children and adolescents who are sleeping rough on the streets and have multiple needs associated with drug and alcohol misuse, mental health problems and family problems. The projects slogan is: "The first step is concrete help, an offer of a place to sleep, something to eat and hygiene service, everybody can go whenever he or she wants". („Beratungs- und Krisenunterkunft“ of Pfefferwerk, Schönhauser Allee 39 B, D - 10435 Berlin. Established 1997)

Or this:

### **Paris.**

The "rest beds" (lits repos) offers a 15-day respite accommodation with an associated medical service for people suffering less severe physical ill health. The service provides nursing care for clients whose illnesses are not sufficiently severe to warrant admission to hospital. It is not properly a medical place, but a "like at home" place of care. A medical doctor (general practitioner) supervises all admissions provides treatment, and follow-up. Attention is also given to hygiene, health screening and preventive interventions. The service has good links with the local public hospital where users can be referred if necessary. (LITS REPOS GORGES DUNAND, 18, rue de l'Aude F - 75015 Paris. Established 1998).

These four examples are typical of all the 57 projects. Most provide both social and health care, have good working links with public organisations and are staffed predominantly by volunteers.

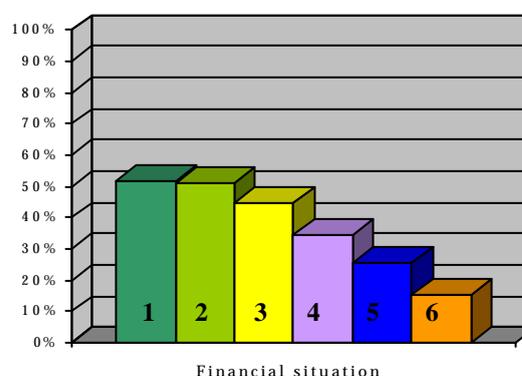
### **3.1.2. Financial situation (public/private)**

The funding sources utilised by the analysed projects are detailed in Table 3.1.

The majority receive money from more than one entity, usually combining public and private monies. One in four projects charge a user fee for their services.

Table 3.2.: Financial situation

	YES	
	Frequencies	Percentage
1. Public subsidy, grants &/or aid.	30	51.6
2. Private grants	32	51.2
3. Public money (direct)	26	44.8
4. Institutions or private foundations	20	34.5
5. Charges paid by users	15	25.8
Membership dues	9	15.5

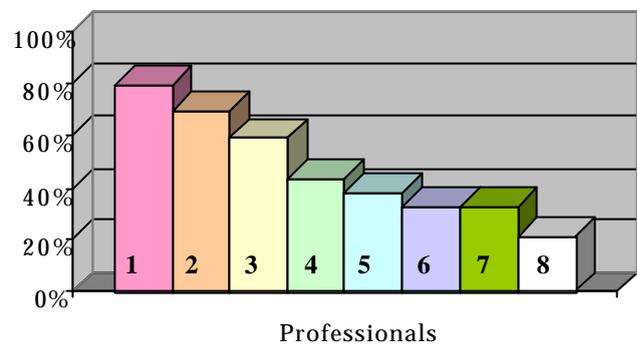


### 3.1.3. Professionals

Many different types of professionals collaborate in the projects, although most are of the social or psychosocial nature. Medical professionals appear in one of out of every three services and in many cases only as part time employees. Table 3.2 also shows the large number of volunteers who help to carry out these projects. Even though they have goodwill and solidarity, there are important issues that concern this group: What training do they have? To what point is it possible to maintain services that collaborate with such high numbers of volunteers, who have no salary, no specific training, and lack full dedication to the project?

Table 3.3: Professionals

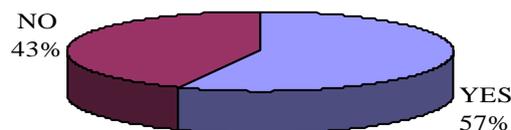
	YES	
	Frequencies	Percentage
1. Social Workers	46	79.3
2. Volunteers	40	69.0
3. Psychologists	34	58.6
4. Nurses	25	43.1
5. Educators	22	37.9
6. General physicians	19	32.8
7. Psychiatrists	19	32.8
8. Occupational therapists	12	20.7



More than half of the projects dedicate some time to professional training and development and/or supervision. This data is important for two reasons. First, throughout the EU the academic curricula training these professionals lack specific focus on this social theme. And secondly, the tasks that the professionals of these services must perform require specialised and continuous training that keep all staff current on new techniques and allow them to become better professionals.

Table 3.3: Professionals training and supervision

	YES	
	Frequencies	Percentage
Time for training and/or supervision.	33	56.8

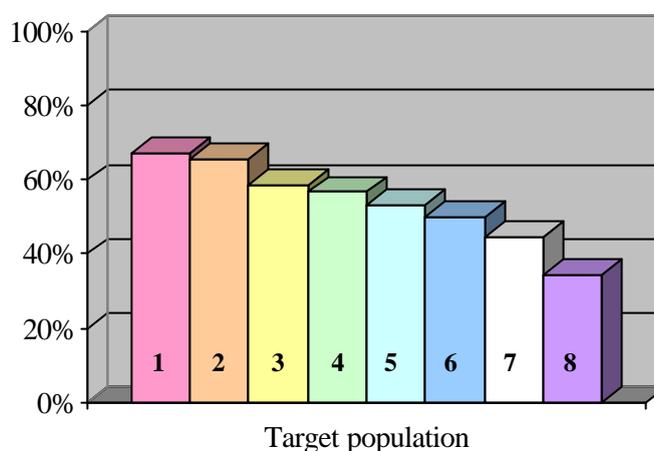


### 3.1.4. Target population

The target population of the projects included in this study truly reflect H&D objectives. The projects work with people who are clearly socially disadvantaged with important health problems and vulnerabilities. Although the traditional services tend to target one category of the disadvantaged group (i.e. services for drug addicts, services for the homeless, etc.), the data in this area shows the real situation: the socially disadvantaged are a complex group with multiple problems, not different target populations with distinct problems. In the future, the services must begin to seriously consider the multiple diagnoses that characterise socially disadvantaged populations.

Table 3.4: Target population

	YES	
	Frequencies	Percentage
1. Homeless people	39	67.2
2. Homeless & mentally ill people	38	65.5
3. Mentally ill people	34	58.6
4. Alcohol addicts	33	56.8
5. Drug addicts	31	53.3
6. Immigrants	29	49.9
7. Former prisoners	26	44.7
8. Non-specific: "excluded people"	20	34.5



### 3.1.5. Health promotion and treatment

One of the main aspects of the H&D Project was to determine the how the services promote and intervene in the health of the socially disadvantaged. Several innovative models were reported:

**Rome:** A direct-access , low-threshold health service initiated to meet the needs of foreigners not covered by the national health service. It provides basic health care to all excluded groups including nomads, homeless and irregular immigrants. Initially the service was aimed at immigrants, especially those who had entered the country illegally or who were without full legal documents. To these were added other vulnerable groups, in particular nomads and the elderly, who experienced difficulty with normal access to health services and in whom the onset of any kind of illness can lead to further social exclusion. Where possible patients are put in touch with public health services. Where this is not possible the service attempts to answer the need within its own structure (Ambulatorio Caritas Via Marsala 97, Rome. Established 1983)

The maintenance of therapeutic focus is essential and the persuasive, encouraging approach has at times to be tempered by more coercive strategy if we are to make any impact on outcome. Stabilisation requires access to the full range of specialist assessment and treatments provided for any mentally ill person, including admission to hospital if necessary.

**Brussels:** The “*accès aux soins*” grew from a medical service based in the Central Station in Brussels. This service has later spread in different Brussels stations with the help of a social service. The social side of the project got integrated in MSF. Later, on request of the increasing amount of patients, the project turned into a fixed centre offers medical and social welfare consultations for any persons, especially homeless people, political refugees, and illegal immigrants.

The service has a number of different goals.

First, it provides essential care and takes all measures necessary for the immediate health of the user, linking to the public hospital system as necessary.

Second, it takes advantage of the administrative laws and work on the access to health care for under privileged people.

Third it redirects people who wish it to the various corresponding centres. Fourth, to lobby public authorities and qualified institutions in the fields of medical and social assistance. Medical consultations are provided by general doctors, and social consultations are provided by social workers or nurses. Thanks to different partnerships it is possible to allow free consultations by specialists, free biological analyses, or to give drugs free.

( ACCES AUX SOINS (MSF), Brussels. Established 1988)

In all centres and within project group meetings, there was considerable discussion about the relative merits of specialisation versus generalist approaches. For the present, generalist provision, aimed mainly at basic care needs seems the most relevant with links as necessary to specialist secondary health care services. The possible exception is in the field of mental health where there is some disquiet about the level of available expertise given the high rates of severe mental illness, alcohol abuse and illicit substance use. Only one project mentioned dental care/treatment as a component service.

The analysis of the included projects can be found in Table 3.5 and provides a very positive picture. A very large percentage of these services offer treatment of diverse health problems. In addition, among the analysed projects, health promotion activities are also very common.

Table 3.5: Health treatment and promotion actions

		YES	
		Frequencies	Percentage
General health	Promotion	54	93.1
	Treatment	45	77.6
Mental health	Promotion	55	94.8
	Treatment	49	81.0
Drug abuse and addiction	Promotion	48	82.8
	Treatment	22	55.2
Alcohol abuse and addiction	Promotion	51	87.9
	Treatment	48	67.2

Figure 3.1 presents a visual representation of the same data.

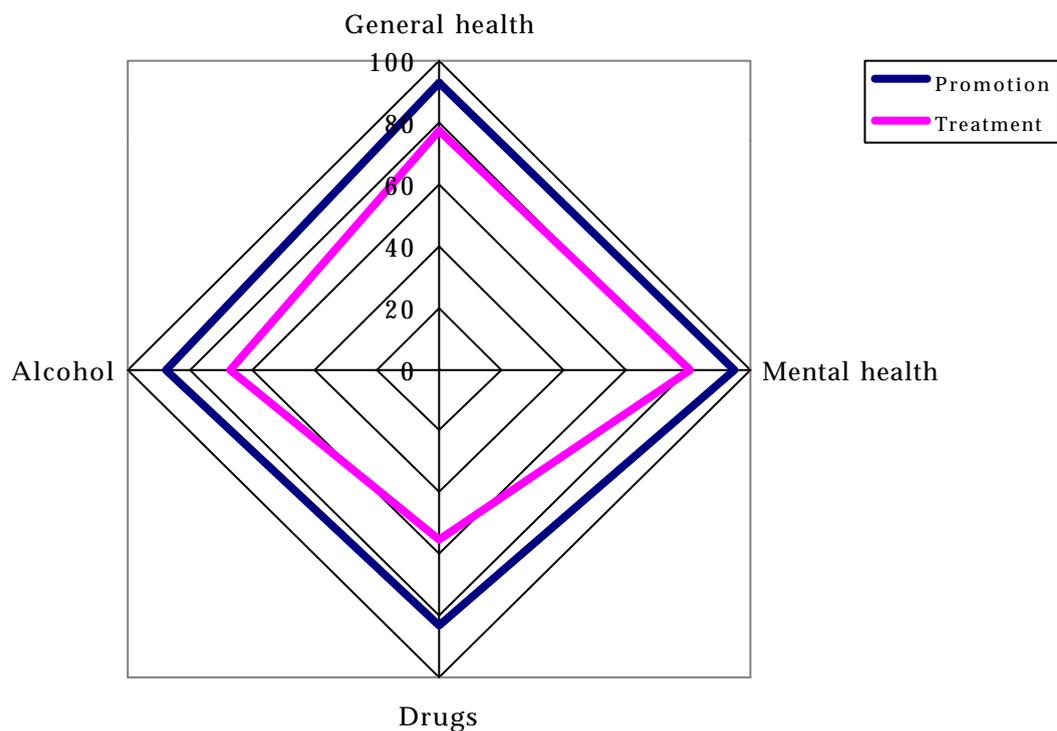
The concentric circles show that compared to treatment actions, health promotion activities are employed by a greater percentage of the projects.

Among the studied services, there is less relative intervention in the alcohol and other drug abuse area. This may be due to the centralised vision of the present services which divide the population into drug users, alcohol users, etc.

It is important to note that even though the projects included in this study are some of the most open and global within the European context, a division of the socially disadvantaged group based on their main problems still exists.

Such a separation makes holistic treatment of the person and continued care and follow-up more difficult. In addition, using this model, the responsibility for treatment falls on one type of professional or centre instead of being shared among all the care-providers.

Figure 3.1: Health treatment and promotion actions



### 3.1.6. Housing

#### *Emergency shelter.*

One of the biggest problems of people who suffer from severe social exclusion processes is related to access to adequate, dignified housing. Therefore it is logical that the services designed to improve the health status of this population would include information and networking activities targeting this issue, as well as direct housing assistance. Emergency shelter provision was identified in all countries and shared a number of common features. All provide a crucial safety net, have beds immediately available, ask few questions and impose no referral or treatment requirements on their customers; Many offer some assistance with clothing, provide a free meal and washing or laundry facilities. Length of stay is short - a day or two at most but a few offer longer stay if necessary. Although many (perhaps the majority) of the users suffer from mental illness and/or substance use disorder, only one project reported this as a target population.

While emergency shelters are common in all 10 capitals, those selected in the Health & Dignity project either target a unique population or make some special provision beyond that usually encountered in such settings. Of the 10 projects (some are registered in two categories) 2 were specially directed at children under 18 (Helsinki and Berlin); 1 provided a women only service (Copenhagen); 1 provided general medical care in addition (Paris); 1 an integrated ward & hostel (Berlin) and 3 big all round shelters (Rome, Paris, Madrid)

**Berlin:** Weglaufhaus, an incorporated non-profit & voluntary association, is an anti-psychiatric institution for homeless survivors of psychiatry. It works to give empowerment through a supportive environment; advice and support when coming off psychiatric drugs; co-operation of survivors of psychiatry and other professionals and international networking.. The Weglaufhaus is a result of the survivor movement to create an alternative to psychiatry. But it is also a response to the deinstitutionalisation process in Berlin to avoid the dismissing of former patients of psychiatry on the streets. The Weglaufhaus is the first institution which was created and is run by survivors of psychiatry in co-operation with other professionals. User control is assured by veto of survivors. (Weglaufhaus, Berlin. Established 1996)

In addition to small homely shelters, the large direct access hostel is still a prevalent model across Europe. For example:

**Madrid:** A public "Shelter Center" housing 275 persons. It is for the homeless or uprooted, socially excluded people of both sex, who live on the streets. It offers: maintenance of basic needs, personal care and hygiene, clothing, hairdressing, nursing care, administration of medications, treatment and recovery, attention by podologist, specific convalescent attention and in-center medical follow-up. (St. Isidro In-Take Center, CASI. Madrid. Established 1985)

Smaller, more specialised shelters are gradually emerging:

**Helsinki:** The Emergency Shelter is aimed at young people under 18 years irrespective of their domicile and are designed to prevent them from spending the night on the streets. The shelter was started because of the need to develop open care remedial services for children and youth, and also to enhance preventive measures. The basic principles of the Emergency Shelter operations focus on voluntary attendance or self-referral, and humane and impartial service. The operations of the Emergency Shelter aim to support young people in personal crisis and also their families in their child rearing tasks. Activities are a form of preventive child protection work with two key aims: to prevent or minimize the number of street children, and reduce institutionalization of troubled youth by supporting the families' own resources.

The Youth can contact the Emergency Shelter either by coming in or calling on the phone. Besides being open, i.e., relying on voluntary attendance by youth, the operations strive to be humane and impartial, and drug free. The approach of the staff here is based on short-therapy principles focussing on solutions and resources (EMERGENCY SHELTER FOR YOUTH OF THE FINNISH RED CROSS, Helsinki. Established 1990)

There is no doubt that it is important to built up specialist systems for homeless and excluded persons. But it could be a risk if only there are focused on the smaller specialised shelters. Some groups could be forgot, especially such groups which are not profiting of what the specialised institution offer. Those groups could be excluded in a system concerning about effectiveness and ambitious goals.

Some of the night-shelters are combined with a day-centre. This combination provides scope for meaningful activity and possibility to offer social advice and help during the time when offices and ambulatory are open. The day-centres typically offer basic help and advice. Two centres also provide special work-training.

### ***Residential care – model homes.***

While they are effective providers of shelter, food and support, emergency shelters are rather poor at the tasks of health care or of helping with resettlement. Many severely mentally ill people are too disabled to live independently and need long-term shelter and rehabilitation. A selection of 8 housing projects were identified from a wider selection of long-term residential care provision. All are small, homely apartments with help or training in daily living skills and a level of care “tailored” to the needs of the residents; 7 of the 8 specifically mention mental illness as a criteria for admission. Most have an aspiration to help the user gain or regain skills to manage in more independent settings, however most in fact provided long-term secure tenancies with little throughput. Many describe themselves as part of a wider deinstitutionalisation process in their country. There tends to be rather more rules and regulations than in the shelters particularly concerning consumption of alcohol and illicit drugs.

The philosophy of care ranges from an explicit focus on treatment and rehabilitation on the one hand (e.g. “The difficulty with the users is how to teach them to live and behave as members of the society” - Guest house ARGO, Athens) to providing accommodation free from any ‘therapeutic’ goal on the other (e.g. “ No therapeutic treatment is carried out in the house. The institution belongs to the users. Their rooms are their homes. Here is it legal to live with a alcohol or a drug problem” - Caroline Amalie Collective House, Copenhagen).

**Rome:** This public project is part of the local area health authority. It provides care for homeless ex-psychiatric hospital patients. 20 places are available in a number of apartments. It is part of a care and treatment programme of the Rome B Local Area Health Authority. Its users are patients suffering from serious and enduring mental illness, some of whom come from long-term stays in psychiatric hospitals or clinics and who have neither family support nor fixed abode. Other patients have come from difficult family situations.

The Lunghezza project was officially started in 1994 but it is important to note that its beginnings are to be found in the early 1980s when the Mental Health Department began to be involved in the first de-hospitalization of patients from the Rome psychiatric hospital. (Lunghezza, Via della Rustica 218, Rome. Established 1994)

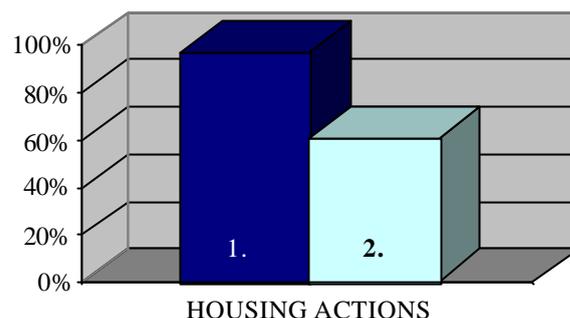
**Helsinki:** established in 1995, in a period when, in the whole of Finland, the number of psychiatric hospital beds were drastically reduced The aim of the supportive accommodation is to offer the tenants a chance for achieving a better quality of life, using the capabilities of multiprofessional teamwork (i.e. social - and health care in collaboration). The starting point is that the tenant is the manager of his own life. The support for each tenant is as far as possible individually designed to suit his particular skills and needs. (KULOSAARI RESIDENTIAL CARE FACILITY, Helsinki).

Most follow the tradition of treatment and training in daily activities in more private and more homelike settings. The environment is changed but it is a question if the methods of working is changed as much as it could be.

In conclusion, all but three of the projects included supervised housing or access to the supported housing market for very dependent people. The results in this area are encouraging because they show that almost all of the analysed services dedicated to promote and improve their users' health have already incorporated housing access and maintenance as one mean to carry out their goal.

Table 3.6: Housing actions

	YES	
	Frequencies	Percentage
Information, networking or referred to other services	56	96.6
Direct help	35	60.3



### 3.1.7. Work

Even though the majority of the projects provide some type of information or networking connection in this area, very few – only one in three – carry out direct interventions that improve the labor situations of their users. Two projects were specifically aimed at providing sheltered work and re-training for homeless people with mental health problems. Both were quite restrictive in terms of admission criteria, excluding clients with severe alcohol or drug dependency, violence and severely impaired self care skills.

For example, the Association for rehabilitation and integration (ARIA – Lisbon) provides training in gardening, food preparation, restaurant and bar work. Clients must be over 16, live in the intervention area and be autonomous in personal hygiene, medication management and in touch with psychiatric services. A similar retraining programme for homeless and other socially excluded people including the long-term unemployed was described in Madrid (Fundación San Martín de Porres Proyecto EFOES, Madrid. Established 1990). The fact that employment plays an important role in the integration of a socially disadvantaged person and given the numerous social and health benefits of a stable labor situation, there is a clear need for wide-scale implementation of occupational programs within these services. In addition, job programs would receive political support and backing, especially in countries with a history of being flexible and integrative with the socially disadvantaged population, such as those within the H&D Project.

Table 3.7: Occupational actions

	YES	
	Frequencies	Percentage
Work: information, referrals, etc..	52	89.7
Work: direct assistance	18	31.0

### 3.1.8. Outreach, case management and networking

Engagement of the homeless and other socially excluded mentally ill person in treatment is never easy. It often takes a long time and services must be prepared to go to where the homeless people congregate. We also need to accept the fact that help with welfare and practical support may be all that can be achieved in the short term but that this basic attention is not enough on its own.

Given the focus of many of the projects on homeless populations, it is perhaps surprising that only 10 projects provided a significant outreach activity. There are a range of models. Some of the projects focus mainly on health, and some on social interventions. This difference is reflected in the staff. Most streetworkers are educated social workers, fewer are nurses. Psychologists more often seen as supervisors. Psychiatrists are also present in some teams but are typically seen as a specialist resource, providing limited street work and a greater involvement in supervision or expert consultancy. Many projects also use voluntary workers.

**London:** This public sector service for homeless people with mental health problems is a good example of a multidisciplinary team that provides health and social care with an active street outreach programme. It was designed as a multidisciplinary team in recognition of the often complex needs of homeless people with mental health problems. In order to ensure that their service is as accessible as possible to their target client group, JHT have developed a robust network of contacts in other local agencies (hostels, day centres, health/medical centres) working with homeless people. (Joint Homelessness Team (JHT), London. Established 1991)

Many of the people targeted by outreach programmes are suspicious of authority and most have actively rejected contact with public services. Methods of engaging these people are still being worked out, but all acknowledge the importance of a slowly-does-it approach, working through the provision of simple support in a framework of mutual respect before moving on to offer specific treatments.

**Lisbon:** there are two teams constituted by voluntary people that goes every nights to the streets of Lisbon, in order to distribute some food and clothes, and also to talk and listen to the homeless. (COMUNIDADE VIDA E PAZ, Lisbon.)

**Brussels:** is a psychosocial service of street-corner work with the homeless people in Brussels. The team of Diogènes consists of five street-corner workers working part-time and a co-ordinator working full-time. Workers include one criminologist, one male nurse, one social worker, one sociologist and two psychologists. From the methodological point of view, the service is based on three great principles: 1) To work on the homeless people's territory, for example: in the street, in the stations, in the subway stations, in a pub 2) To respect rules and values of homeless people, to regard themselves as " guests " on their territory and not to carry a value judgement. 3) To respect demands of the people and to work only starting from their demands without never imposing a solution. To respect any demands for which there is an answer even if this request seems to be a pretext for something else. One of the principal goals of the project is to create a bridge between the world of the street and the integrated social world. To create links between homeless people and the existing social associations and institutions. So, Diogènes tries to put homeless people in contact with services from the psycho-medico-social sector, likely to answer their demands. Moreover, the project aims at informing the existing services about the needs and demands of the homeless people. (Diogenes, ASBL Bruxelles, Established 1995)

➤ **Outreach**

This way of constructing the street-work and the methods of working seems to have been developed in several cities independently of each other. It appears to be particularly valuable as a means of bridge-building between people living in the streets and the “normal help and treatment system”. All these services emphasise the importance of supplementing but not replacing the ‘normal’ system of health and social care and the goal of eventually re-integrating the user in society. It is important to continue doing experiments in this field; no certain method has yet been described and a lot of questions remain unanswered – and not often discussed in the text of the projects. Is outreach street-work a kind of “compulsion cleaning the street?”, “does street work encourage people to stay on the streets?” or even “to come on the street?”

➤ **Network**

Practically all of the studied centres report networking activities, however, it is important to note that as of yet there is no structured network in existence in any of the cities of the study. In any case, less structured partial service networks appear to have served this function, however very few are global and include all, or even the majority, of the available resources in the city (public and private, social and sanitary, etc.). According to the analysis, there seems to be high levels of collaboration between the professionals of the different centres, but the networking does not reach into the higher levels of the organisation (with town councils and ministries, etc.) Therefore the brief conclusion is the existence of high level co-working but not networking. Networking implies a need to depend on a common structure and shared objectives that allow for authentic work to be carried out via that network.

➤ **Case management**

Secondly, more than half of the projects incorporate case management, or very similar intervention, strategies. The case manager is responsible for the global intervention program: sanitary, psychosocial, labour, housing, etc. In fact, the case manager is the true networking organiser in each case. Instead of trying to create structured networks which may depend on public organisation, case management is a more feasible alternative. The present situation of the studied projects shows that they integrate into unstructured, flexible networks within their organisation that constantly change as new projects appear and other older programs are phased out. The projects analysed here tend to utilise a network of current resources that is less structured and independent from public powers through the individual intervention plan co-ordinated by a case manager. This person knows the resource network and forms of access better than the users. The case management focus permits more flexible intervention, and such flexibility is required in work with the socially disadvantaged population. He/she facilitates access to the resources of any type that are included in the individualised treatment plan (permanent, transitory, social, sanitary, public, private, etc.), and thus the network. Collaborating in this way allows the professionals to take maximum advantage of the general assistance network and does not require the development of a special services network targeting this population. Almost every project that employs a case management intervention style bases their work with their clients on the Assertive Community Treatment model. The case manager and team do not only co-ordinate the resources indicated by the user’s individualised treatment plan, in addition they speak out and actively defend the rights of the socially disadvantaged in the political arena against public and private entities that have the power to halt treatment progress.

Table 3.8: Networking, case-management and outreach

	YES	
	Frequencies	Percentage
Networking: Information	57	98.3
Case management + ACT	35	60.3
Outreach	19	32.8

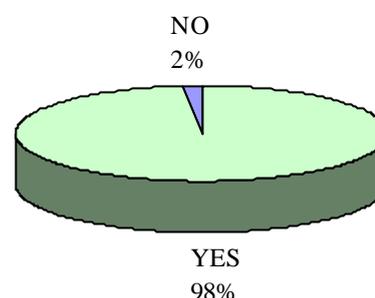


Figure 3.8-b: case management + act

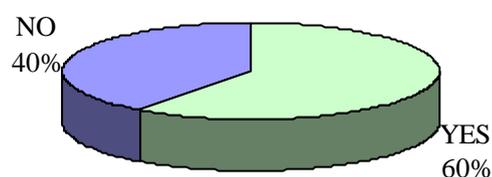
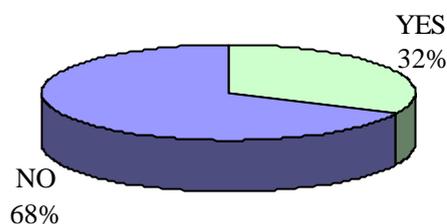


Figure 3.8- c: outreach



The centres and projects studied report that once contact is established with the client, an individualised intervention plan is designed and assigned a case manager. They say that the current resources network functions adequately, especially when more alternative projects are put in contact with mainstream programs and the client moves closer and closer to the normalised sanitary and social services network. At present, many people who suffer from social exclusion processes do not access the sanitary and/or social services for different reasons. Therefore the most severe current problem is how to guarantee equal service access to everyone in the population. The only alternative that has proven to help overcome this problem is to look for the users in the places where they are most likely to be found (the street, the subway, the emergency shelters, etc.) and work intensively with them on-site to establish contact and “hook” the client. In other words, outreach activities that facilitate initial contact, the “hook”, and treatment start-up should be employed in combination with the case management and ACT methodology. Some cities have adequately developed these service methods, the START program in London is one example (see project descriptions), however, the majority of the European cities involved in the H&D Project do not have sufficient resources to be able to guarantee equal sanitary and social services access to the entire population. Without a doubt, this is an important point for further study by those who are responsible for these types of projects in the EU.

### 3.1.9. Integrated models

Homelessness, exclusion, mental and physical health problems, drug and alcohol addiction and social problems are mixed together in the life of the population we are concerned about. These complex problems require the input from many agencies. But while there is general agreement that such complex problems are best dealt with by services which integrate health and social care, there were surprisingly few examples of such integration. Maybe project-worker is not so aware about this part of their work – maybe they are afraid of being “total network”, which not allow the user his or her autonomy. Maybe a lot of the services of this reason are more fragmented than necessary.

Yet, some of the projects are very aware of the importance of integrated models.

**London:** The START team was originally set up as the Mental Health Team for single homeless people, as part of the government’s Homeless Mentally Ill Initiative (HMII). START is an effective multidisciplinary team comprising psychiatrists, social workers, community psychiatric nurses, an occupational therapist, trainers and an administrator who between them offer a range of services to single homeless people in the three London boroughs. START’s clients may be experiencing a wide variety of social, physical and psychological problems, but the one common difficulty they all experience is gaining access to mainstream services. Although START’s priority client group is the long-term homeless who have no current or recent contact with services, they also regularly assess people who are unable to access services because they have emotional or psychological problems, and, as a result, are living in direct access hostels. The START service includes: client assessment, case work, counselling, housing advice, referral into specialist services and training for staff in other agencies working with homeless people. Services are delivered in a wide variety of locations, ensuring that the services are as accessible to clients as possible. START works as a complementary service, enabling and improving access to mainstream services for clients, rather than offering an alternative to them. One of its main strengths is the flexibility of its approach to the agencies and clients it works with. It does not work in isolation, preferring to offer a co-ordinated package of care that is tailor-made to the needs of each individual client. Well developed links into the housing sector, primarily through the special needs housing departments of the three boroughs where they work. It delivers its services in a number of locations across the three boroughs, local partnerships are essential. Contact is direct and self-refer, if appropriate, but voluntary sector agencies are the main referral route into the team. (The South Thames Assessment, Resource & Training team (START), London. Established 1991)

It seems that networking gives a more easy and appropriate access to services. Like it is done in this outgoing teams meeting the need of homeless persons in shelters:

**Paris** “Joined with the adult psychiatry department this network aims to promote mental health for population living in the great number of shelter for homeless established in that district. It works to promote the access of homeless to health services and particularly for mental health and to guarantee the equality in the access to health service. It is a team composed from social workers and nurses with a psychiatrist for supervision. They visit different shelters in the district one time in the week, working with professionals and volunteers and meeting the homeless people who need accompaniment and psychiatric care. (RESEAU PSYCHIATRIE ET PRECARITE DE L’ASM , Paris)”.

I could look like that a solution is networking: different workers who know each other and cooperate; from through umbrella teams and to full integration of different projects.

### 3.1.10. Presentation of the projects

A few projects offer specific services to this population. One, for example provides advice about access to medical help by telephone: “the project aims to answer to the need of care and treatment for homeless and heavy poor people through a free access phone (RESO, Paris).

## **3.2. Case Studies**

### **3.2.1. Profile of the persons in contact with the projects:**

A total of 26 case reports were provided (46% of all projects presented at least one illustrative case study)

- These reports concerned 15 men and 11 women.
- The age for men vary from 25 to 65 year old (mean-ages 40.6 years) and for women from 18 to 73 year old (mean-age: 36.5 years).
- Women presented more severe problems : 7 (64%) of the women are reported suffering from a psychosis compared with just 4 (27%) men.
- For both sex, four out of five are reported homeless when the contact was established and one out of five had a life-time history of having slept 'rough' on the streets.
- The majority of men (10 (66%)) had problems abusing alcohol, drugs or both compared to only 4 (36%) of the women.

Apart this statistical information the stories naturally also tell about the persons using the different projects in a more qualitative way, showing the complexity of every person's history and of the situation just before the contact was established.

***It is stories where physical health problems such as tuberculosis, broken limbs and bad eyesight is combined with exclusion and homelessness, such as here:***

- Mrs H, a 30 year old lady was mediated in February 2000 by the ambulance. The staff of the ambulance told us that she was in a precarious state: she suffered from a hepatitis B, was polytraumatized and polytoxicomaniac, bulimic and presumably schizophrenic. Since Mrs. H. was homeless, had no health insurance and was in urgent need of medical as well as social help, she was immediately admitted to the medical shelter. When Mrs. H. was admitted in the Krankenstation she had already lived three years homeless in the streets.
- It was a cold night in January when at 3 am the police rang the bell. They brought with them an old toothless man, directly from the street. He had a plastic bag filled with papers, broken eyeglasses and half of a roasted pullet, he was neglected and confused. His German was quite bad because he had been long-time in Poland and he could just hear on with one ear.
- Mr W. was a man 57 years old. He had severe tuberculosis and a non identified problem in his hip. We learned in the medical file the tuberculosis had been known about for several months but it was impossible to take care of it because he went out of every place where he could be helped.
- John came in 1992 to the office. He, a middle-aged man, was in a very bad state from alcoholism and he had a broken arm. He had no social assistance and needed treatment. He was very depressed and drank all the day long.
- A 50-year-old man who has never been married and has no children. For six years he has lived on the street He has been very visible on the city scene, with a shopping cart full of his belongings packed in plastic bags. in a way, like to converse, but he also gives the impression that he does not want anyone to interfere in his affairs. He consumes rather large amounts of alcohol. During the last 3-4 years, he has had problems with swollen legs and loss of breath. He could have gone to the doctor in spite of not having a health insurance card, but on his own initiative he could not get himself to register his needs, or else he did not dare to - it is not clear which reason is precisely correct: he is very vague about it.

***It is also the stories about mental health problems, confusion and mental illness and about mental disturbing like personal disorder and non-acceptable behaviour***

- Since 1974 he – a 35 year old man - had been several times - for the duration of some months - in psychiatric hospitals. Since 1980 he began to live permanently in hospitals and children's homes. He was labelled with a lot of different diagnosis's, such as Schizophrenia, Gille-de-Tourette-syndrome, Aspergers and double diagnosis (drug addiction and psychosis). Since 1991 he has been homeless.
- 37-year-old divorced woman with a 17-year-old son. Until 1998 she lived together with her son in a fine, modern apartment. However, he had lived outside the home for several periods of time, because his mother's mental illness made it impossible for her to care for him. She was evicted from her apartment in 1998, because she refused to pay the rent. She believed that she was under surveillance with video cameras and microphones in her apartment, and that people came in and out of her apartment when she was not at home or when she slept.
- As Joanna, 73 year old, lived on the streets she was unable to care for herself properly. One of the manifestations of her poor mental health was her neglect of personal hygiene. She exhibited this by drinking and washing her face in toilet water that had faeces in it. Her condition was stabilised with medication, but she continued to need support from the local Community Mental Health Team in conjunction with START.
- During the past ten years John, 25 year old, has slept rough for long periods of time. This has been interspersed by short periods in cold weather shelters and direct access hostels. The longest period John has managed inside has been one year. He has always been evicted from his accommodation because of violence, rent arrears and a lack of commitment to living in a shared space. John is a multi-substance user. His main drugs of choice are alcohol, methadone and crack. He also abuses prescribed medication. His paranoia is thought to be drug related.
- Adrian 40 year old, was brought up by his natural parents and appeared to have a normal childhood. Adrian had been sleeping rough for fifteen years and was well known to Outreach teams. His behaviour was observed to be erratic and he was observed agitatedly and angrily shouting at himself and passers by.

***For the women about pregnancy while living in the streets and about prostitution. For the men about criminality and imprisonment.***

- First contact in April 2000 : Laetitia is coming spontaneously thinking there was here only social help and not personal support. She told us volunteers : “I am pregnant”. She is a very young woman, 18 year old.
- He - 46 year old - explained that he had recently been discharged from prison after serving a two-year term for handling drugs and that while in prison he had been transferred several times due to problems of aggressive behaviour. He was not able to remember the kind of drugs administered to him by prison doctors but it was clear that he had received psychiatric treatment while an inmate in various prisons.

***Also addiction to either drug or alcohol or both is a common problem:***

- Most of the time he, a man in his middle 30s has been living in hostels and shelters for homeless people, psychiatric hospitals and sometimes also in squats. Nearly nine years altogether he has been in prison and forensic psychiatry because of thefts and still today he is in danger of a new imprisonment because of another ca. 1000 offences (mostly thefts). strong alcoholism and gambling addiction.
- 31-year-old, unmarried man who at present lives on the street. He sleeps either at a night café, where he can sleep sitting in a chair or lying on the floor, or outside on a bench or a warm grate. He drinks massively and uses illegal drugs, as much as he can get a hold of and no matter what kind.
- November 1999: First contact with the Service. Luís, 32 year old, asked for support for food, housing and personal documents. He also related his drug problem and asked for therapeutic support.
- Maria, a 29 year old woman, was interned in Hospital because of a pneumonia. During the intern she had alteration behaviours, like trying to commit suicide. Consequently, she was interned in Psychiatry and Mental Health Department. She had a personality disorder: Borderline. Maria was born in Lisbon, in 1971. When Maria was 19 years Maria started her drug consumption. Maria becomes a prostitute in order to earn some money, with her husband consent.
- After Maria abandoned her children, she started living in the street.
- At the age of 16 he began to use drugs, mainly marijuana, and to mix with 'bad elements' at school. Since 1996 Daryl, now 33 year old, has slept rough and stayed in various direct access hostels. He spent four months as an involuntary inpatient

Many respondents told of going in and out of different institutions, from shelters to psychiatric wards, prison, shelter and so on. For most, the private network are, if one exists at all, composed of other people living the same way and very seldom with family.

**3.2.2. Intervention processes as they was shown in the case-stories**

Complex problems seems to give major problems in receiving the treatment in the ordinary systems whether this treatment is necessary to cure or just to help the sufferer live in a tolerable degree of health and dignity

- During the course of a couple of days in November, he was in contact with the social system so he could receive welfare money, and with the system for narcotics treatment, where he started methadone treatment. He was also referred to an ordinary somatic out-patient ward that hospitalised him for treatment for his boil.  
After a short period of hospitalisation, he was released, but during the next two months he suffered two attacks of coronary thrombosis in his legs and one attack of pneumonia.  
In April, he was beaten up and his jaw broken in several places. Because of the poor state of his teeth and thus the risk of serious infection, the optimal treatment could not be carried out. During the same period, he took great amounts of drugs while receiving methadone. Because of this abuse and the disturbing behaviour it caused, he was released from the hospital several times, in spite of not having completed treatment.

The main purpose asking each of the 57 projects involved in this research program to present a personal life history and the history of the process of intervention of one of their users was to be able to describe examples of good practices. Most of the stories show a good standard of social and health care using well-known methods. Most offer help with basic needs and tackle the most impending problems first. Typically, these interventions are tied to a commitment from the user to make an effort to change their behaviour or life style in a way that might improve their condition in the longer term.

- November 1999: First contact with the Service. Luís asked for support for food, housing and personal documents. He also related his drug problem and asked for therapeutic support. The Service supported him at various levels:
  - food and housing support;
  - economic support in order to obtain personal documents;
  - orientation for drug treatment in Centro das Taipas;
  - orientation for OFIP Project (Orientation, Formation and Professional Integration Project).

Now a year later, Luís is a swimming teacher.

He earns sufficient money to have his own apartment, and lives with his girlfriend with whom he has a stable relationship. He re-established his contact with his daughter and she spends the weekends with him. He still goes to Centro das Taipas for treatment with Antaxone.

- Together with Mrs. H. the staff designed an individual programme of assistance:
  - basic recuperation and regeneration
  - general health test (Mrs. H. worried to be infected by HIV)
  - making accessible regularly subsistence benefits, organise her health insurance
  - applying for a new identity card
  - psychological consultations and talks focused on her experiences of assaults, her phobia and the bulimia
  - confronting her drug problem
  - designing an occupational perspective
  - searching for an adequate housing or supervised residence

The rehabilitation program had as main objective the development of personal and professional capacities of Maria, in order to give her personal, social and professional autonomy to be integrated in active life. It was expected from Maria changes in her behaviour, communication and intellect. This program took 2 years to be completed.

Secure settings are sometimes what is demanded to give a person the possibility to come back to ordinary life.

- Mrs. H. increased during the time in the medical shelter her general and mental health. During her stay she didn't consume alcohol nor drugs. Mrs. H. had begun to reappraise her bad experiences and to make a cautious contact with her mother. She had integrated herself more and more into social life and developed concrete plans about her future. After three months she moved into another supervised residence.
- In the beginning the main task was to solve his existential problems, his various problems and needs: his retirement pension, his property, new clothes, eyeglasses, hearing aid, subsistence benefits, perspectives ... It was hard to talk to him about all this in a constructive way because he was not able to accept thoughts, ideas and help from others. Instead he often stuck to his images of the apocalypse, his vocation as agent of god, his self-overestimation and distrust in everybody. The socio-psychiatric service assessed the client after quite a few starting-problems and stated a diagnosis that comprised "worsening of his personality", "slightly mannered acting", "dyed hair" and "a women's hat". Because of this they induced a legal tutelage. The tutor was not able to get in contact with the client and couldn't do much in consequence. The client left the Krisenhaus after four months in a good mood, with an own flat, new eyeglasses, retirement pension, new suit and a "women's hat".

And it seems to be not only sufficient to some but even so efficient that it brings people back to normal life.

Another strategy could be that of acceptance, awareness and helping to minimise the damage of the life as a excluded, homeless person with a drug-using problem. To give this kind of support a clear well-defined strategy is requisite, knowing what to do, why and be aware not to confuse the process with hidden resocialisation measures:

- The only stable holding place for John during the last ten years has been The London Connection. During this time he has had three keyworkers, who have provided crisis intervention when John has overdosed. They have also referred John to 16 housing options, four community mental health teams, and one team for learning difficulties. Apart from referrals, the majority of interventions from keyworkers have been harm minimisation around physical health and safer drug use. He remains on the homelessness circuit, and is currently placed in a rolling shelter.
- Maria is 31 years old and suffers from chronic schizophrenia. During the whole of the first part of the project Maria came regularly to the day centre but took no part in the various activities, established no significant relationship with users or staff and showed no motivation towards changing her way of life. It seemed as if she came only to please Patrizio, who was interested in socialising and taking part in the activities. At the present time Maria has a cleaning job in a centre for homeless people and also in a garage where she also attends to the green area surrounding the building.
- The contact was tentative to begin with and without any real strategy. After the first year, a trusting contact had been established and real planning for the further effort could begin. At this time, Uffe H. gradually began to be interested in returning to a more ordinary way of life. An initiative was made that started gradually and gave the user time to feel secure and slowly get used to talking to others, to imagine other ways of living, and to co-operate in changing his life.

It doesn't means that nothing should be done. It is not a kind of laissez faire attitude. Sometimes it is necessary to offer treatment voluntary or not voluntary in psychiatric hospital:

- The team was divided, some were afraid, other, the nurses of the team for homeless, said they must do something new with him. Slowly however always in his miserable look, he got a strong relationship with the nurses. He never wanted a psychiatric treatment . He had always a lot of burns, wounds, which can not get better with his alcoholism. He was too far in his alcoholism and in his violence to hear anything and he attacked even the nurse and the social worker they who are his best support. After a time we decided to manage a compulsory hospitalisation. After the hospitalisation he was much better, coming very often, calm, less or not drunk. He could speak a bit about his story, his sadness, how he was depressed, how he was ashamed and could not be in contact with his parents. He talked about the other experiences of psychiatry and the violence of them.
- A full needs assessment was carried out, which confirmed clear symptoms of psychosis. Hospital admission was recommended, but Sharon would not go voluntarily. She was admitted involuntarily. As a result she is now linked in to community mental health services, and is on psychiatric medication. She is also keeping her outpatients appointments at the hospital. As a result of her illness, Sharon missed three months of college. She is planning to return and complete her course .

To other with more complex problems it could be non-sufficient:

- The first phase of contact: This period was characterised by establishing a good contact to Thomas (working on perspectives and mobilising the resources). In hospital Thomas got psychiatric drugs. But he also used in a kind of self therapy different natural drugs. Since 1993 Thomas lived in a single apartment. The apartment was kept by the tutor even during the periods, when Thomas had been admitted to the hospital. In 1995 Thomas got in touch with his family. The role of a case manager is very important to form the process into direction of health and development.  
To be able to do the work as a case manager it had been necessary to get the agreement of the authorities. A special financial funding of this work were together found.
- Since 1996 Daryl has slept rough and stayed in various direct access hostels. He spent four months as an inpatient of St Thomas' under Section 3 of the Mental Health Act. On discharge he lived in temporary accommodation in Lambeth (south London) before moving into a Thames Reach project in January 2000. However, he began to refuse to take his medication. Daryl has been in hospital for approximately one month. He is on medication and appears to be quite calm and rational at present, although he continues with his fixed delusions. Our relationship with him has improved and Daryl has encouraged his keyworker to visit him. He is presenting no problems on the ward, and he has escorted leave each day. He knows he can come back to his flat when he is discharged. We are hoping to establish a working relationship with Daryl so that we can continue to work with him on discharge to ensure that he maintains his medication programme.

All intervention is not activities. The way to establish communication also with severe excluded and disable persons are important.

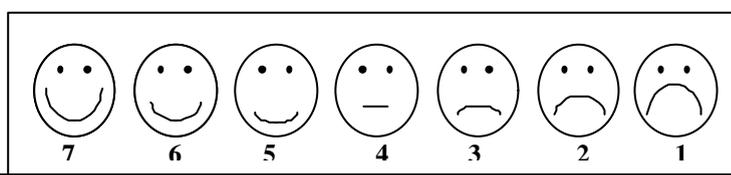
### **3.3. Users' Health and Dignity Status**

The information regarding the Users' Health and Dignity Status (quality of life, self-esteem, and service satisfaction) was gathered through 333 interviews with H&D Project users using H&D Module 2. The following data summarises the most important results by variable: Quality of Life, Self-esteem, Service Satisfaction, and Health.

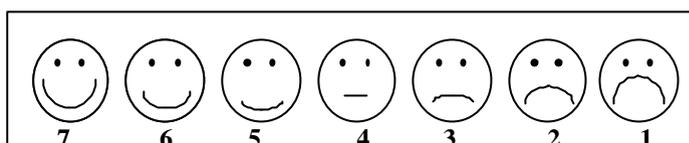
#### **3.3.1. Quality of Life**

Table 3.9 shows the results item by item in descending order based on the mean score obtained on each item.

Table 3.9: Items of Quality of Life Questionnaire (QLQ, Baker & Intagliata, 1982)



<i>Number. Item</i>	N	7 (%)	6 (%)	5 (%)	4 (%)	3 (%)	2 (%)	1 (%)	MEAN	S.D.
<b>House/apartment/place of residence (1)</b>	337	14.8	21.1	21.7	14.5	7.4	5.6	14.8	4.45	1.96
<b>Neighbourhood (2)</b>	334	14.4	20.4	17.1	20.7	10.5	9.6	7.5	4.49	1.79
<b>Food (3)</b>	337	17.8	19.3	22.6	16.0	13.1	5.6	5.6	4.73	1.71
<b>Clothes (4)</b>	337	16.0	29.1	21.1	14.8	7.7	7.1	4.2	4.93	1.64
<b>Health (5)</b>	337	11.6	16.6	20.2	17.2	13.9	10.1	10.4	4.23	1.83



Number. Item	N								MEAN	S.D.
		7 (%)	6 (%)	5 (%)	4 (%)	3 (%)	2 (%)	1 (%)		
House or apartment mates (6)	316	18.4	17.7	22.0	18.0	7.6	8.2	7.9	4.65	1.81
Friends (7)	321	24.6	22.4	16.2	15.6	7.5	5.6	8.1	4.92	1.86
Family (8)	329	14.9	14.3	15.8	11.9	8.5	11.2	23.4	3.88	2.17
Other people (9)	336	16.7	27.1	23.5	13.7	8.6	5.4	5.1	4.93	1.65
Job/work/day programming (10)	321	11.8	14.0	22.7	13.4	12.8	10.3	15.0	4.08	1.93
Spare time (11)	334	12.3	16.8	19.2	16.2	14.4	12.0	9.3	4.23	1.84
Spare time in community (12)	325	11.4	16.6	19.1	17.2	12.0	12.0	11.7	4.15	1.88
Services and facilities in area(13)	334	16.5	18.3	18.0	16.2	13.2	8.4	9.6	4.45	1.88
Economic situation (14)	336	5.7	6.3	13.7	16.1	11.3	12.2	34.8	3.03	1.92

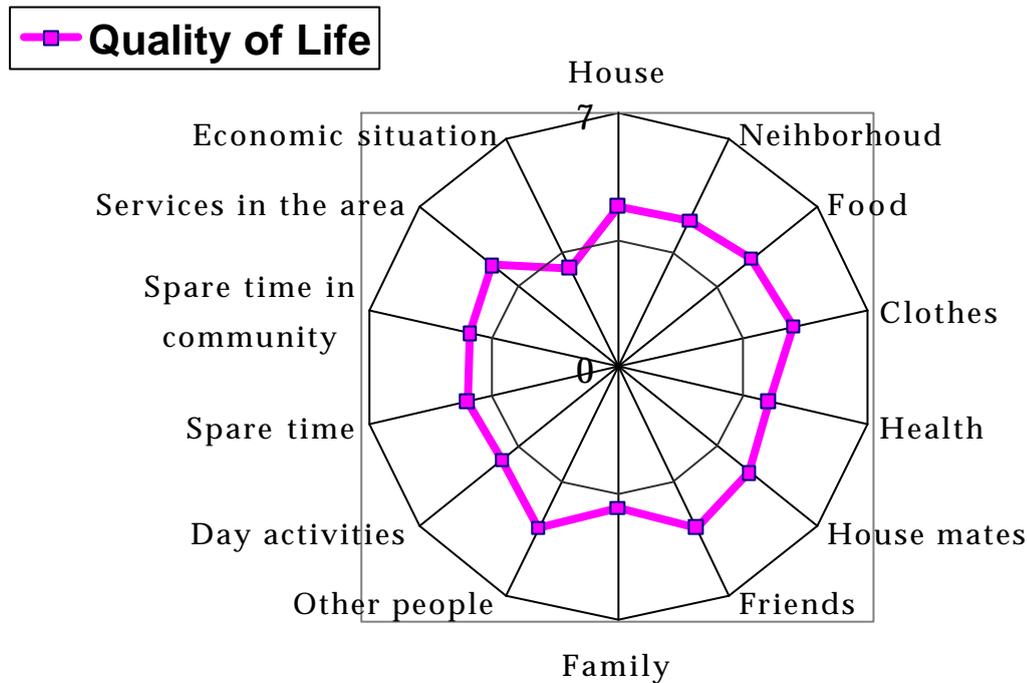
When the items are categorised and analysed, there are high levels of satisfaction with basic needs like food and clothing, and although at a lower level, housing. The users are also fairly satisfied with their social environment: friends, others (probably centre staff), and house or flatmates. At the other end of the scale, users are least satisfied with their economic and family situations, which coincides with current definitions of exclusion in these two primordial aspects. In between these broader variables, users with their neighbourhood, health, and use of free time descend with respect to the users satisfaction with them. It is very probable that their relative satisfaction with their health was impacted by service use, and this must be taken into account when analysing the scores on this item for the group in this study.

Table 3.10: Quality of Life (percentiles)

Interval: 7- 98	
Percentile 25	50.0
Percentile 50	63.0
Percentile 75	71.0
N	283
MEAN	61.30
S.D.	14.76

In general terms, there is moderate satisfaction (61/98) with 50% of the sample scoring more than 63 points and only 25% scoring less than 50 (the average level of the scale). The distribution approximates that of the housed population who do not suffer from severe social exclusion processes, even though the present population maintains lower scores across all items, especially on the variables that relate to their families and economic situation, as noted above.

Figure 3.2 Quality of Life variables: shows a visual representation of the same results.



### 3.3.2. Self-esteem.

The results of this variable are important because the studied population suffers from severe social exclusion processes. Though only two items from the Rosenberg scale were used in the questionnaire, the tendency is clear. The interviewed users have medium to medium-high levels of self-esteem. Again, it is possible that such data are the result of a service effect or a possible protective cognitive bias. In any case, such high levels of self-esteem are encouraging. Current programs may be effective, and different interventions can be developed in this area. Even after all that have lived through and suffered, these people still maintain their personal dignity and have not abandoned their self-worth.

Table 3.11: Self-esteem (Rosemberg, 1976)

Items	N								MEA N	S.D.
		7 (%)	6 (%)	5 (%)	4 (%)	3 (%)	2 (%)	1 (%)		
Feeling about the satisfaction with yourself? (15)	337	13.4	16.6	22.3	16.3	11.3	8.3	11.9	4.32	1.87
Feeling about the respect that you have felt for yourself? (16)	336	22.3	20.2	19.6	14.9	7.1	8.6	7.1	4.81	1.85

### 3.3.3. Satisfaction with services.

This group of variables has produced the best results when compared with others in this part of the H&D Study. It is very probable that the lack of attention provided to this population by the traditional services has influenced the high satisfaction level obtained from the H&D Project users. In any case, these satisfaction levels can be one measure of results of the interventions by the analyzed projects directed at this population and the problems they present. Such a high satisfaction with the service reflects good resources and also their effectiveness.

Table 3.12: Satisfaction with services (CSQ, Atkinson et al., 19XX)

Number. Items	N	1 (%)	2 (%)	3 (%)	4 (%)	MEAN	S.D.
Services that helped you deal more effectively with your problem. (6)	332	2.4	10.5	47.3	39.8	3.24	0.74
Recommend the service. (4)	335	6.6	8.1	41.8	43.6	3.22	0.86
Satisfaction with the service(overall) (7)	333	3.0	12.6	48.6	35.7	3.17	0.76
Re-use of the service (8)	331	9.4	11.5	32.0	47.1	3.17	0.97
Satisfied with help received (5)	332	6.6	11.4	44.6	37.3	3.13	0.86
Quality of service you have received (1)	335	5.4	20.9	45.4	28.4	2.97	6.84
Services met your needs (3).	333	4.5	26.7	42.6	26.1	2.90	0.84
Kind of service you wanted (2).	335	10.7	16.7	45.7	26.9	2.89	0.92

The distribution of the satisfaction levels show that 50% of those interviewed scored more than 25 points (high level satisfaction) and only 25% scored less than 22 (medium level satisfaction). The whole sample is grouped in the medium-high levels of the scale.

Table 3.12: Satisfaction with services (percentiles)

Interval: 8- 32	
Percentile 25	22
Percentile 50	25
Percentile 75	28
N	326
MEAN	24.70
S.D.	4.67

### 3.3.4. General and mental health

The results obtained regarding the users' health status, gathered from the GHQ-28, show a status that approximates that of the general population who receive primary attention and services. The four sub-scales appear to be equal, although the socially disadvantaged group studied here shows anxiety symptoms and insomnia are slightly more common. Figure 3.3 shows a visual representation of data that corresponds to the four sub-scales, while Table 3.13 presents the same data and includes the distribution percentiles for each scale.

Figure 3.2: GHQ-28 sub-scales.

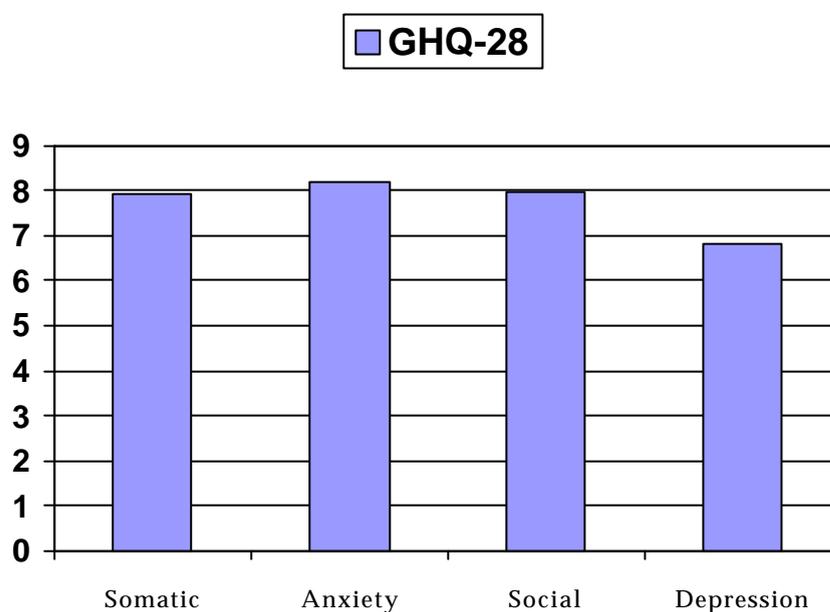


Table 3.13: Health status (GHQ-28, Goldberg, 1982)

	N	MEAN	S.D.	Percentiles:		
				25	50	75
Scale A: Somatic [ 0- 21]	327	7.92	4.61	4.0	7.0	11.0
Scale B: Anxiety & Insomnia [ 0- 21]	333	8.17	5.09	4.0	8.0	12.0
Scale C: Social [ 0- 21]	329	7.97	4.22	6.0	7.0	11.0
Scale D: Depression [ 0- 21]	324	6.79	6.21	1.0	5.5	11.0

**Suicidal ideation** : It is interesting to note that one in three interviewees has had important ideas about suicide at least once in his/her life. This rate is much higher than that found in the general population, and in any case is always a good indicator of the general mental health status of a specific sample.

Table 3.14: Suicidal ideation

	N	0 (%)	1 (%)	2 (%)	3 (%)	MEAN	S.D.
<i>Found that the idea of taking your own life kept coming into your mind?</i>	327	47.9	20.4	13.9	14.5	0.95	1.11

Using the GHQ-28, it is possible to analyze the sample for possible cases. With a score of 5 positives, the results are encouraging. The number of cases in the sample approximate the number of cases found within the general population receiving primary attention and services. On the other hand, the results are not so close to those obtained in previous studies of the socially excluded population. Thus it seems that the H&D user sample falls in the middle ground, a point between the two extremes. In some countries, such as Spain, this point appears to be much closer to the general population than a homeless sample in Madrid (Muñoz, 2000).

Table 3.15: GHQ-28 positives

NUMBER OF POSITIVES	
Interval (0- 28)	
< 5 Positives (%)	39.9
≥ 5 Positives (%)	60.1
N	306
MEAN	8.82
S.D.	7.50

## CONCLUSIONS:

In this report we have presented an overview of current practice in the development of models of care for homeless and severely disadvantaged people in 10 capital cities in Europe. Three limitations need always to be born in mind when considering the report.

First, the 57 projects reported in this study are a highly selected sample of the available resources within each capital.

Secondly, the size of this 'pool' of available resource from which to choose the final 6 projects varied enormously from one country to another, with some capitals having to omit many interesting projects while others struggled to find as many as 6 services at all.

Finally, these projects were chosen by local experts, from the wider pool on the basis of their local knowledge and their subjective judgement of 'good practice' that was itself defined in terms of a consensus statement with quite broad parameters. Attempts were made to deal with the worst of these problems of variability by standardising the way information was collected and presented at the three consensus workshops (Copenhagen, Rome, London & Berlin).

With these caveats in mind, a few broad conclusions are warranted.

In the majority of capital cities, **mainstream services remain fragmented and poorly coordinated**: physical health care is provided separately from mental health care, substance abuse services provided separately from either and basic housing and welfare support delivered from yet more organisations and agencies. Housing departments, medical services and psychiatric services often serve different geographical sectors of the city.

Improving services for socially excluded people with mental health **problems requires strategies to reduce these barriers of poverty, isolation, service fragmentation and hostility**. In general, the services described in this project all go some way to addressing these barriers. All capitals include essential services that cover the basic needs for food, shelter and clothing. But much of the housing effort remains stuck at the point of providing emergency shelter only with relatively little provision for the higher dependency 'move-on' accommodation that so many of their users need.

Many severely mentally ill people will never regain a sufficient level of function to be able to live independently and need long-term shelter and rehabilitation.

The problem of the accumulation of people with chronic mental illness in homeless shelters and hostels has been a concern for at least 20 years and we are hardly much further on, with a continuing scarcity of long-term, high support accommodation in the community.

Given that the majority if not all users of these services were long-term unemployed, it was also surprising that so little was reported concerning services and interventions targeted on employment. It is likely that these were missed by the survey as we are aware of several model programmes for supported job placements, social firms and sheltered workshops in the participating countries. It is also apparent, however, that many of these employment projects have stringent inclusion criteria, requiring participants to be in a stable mental state, to reside locally and to be compliant with institutional rules and regulations – all of which serve to exclude the population of interest in our survey.

**Engagement of the homeless mentally ill person in treatment is never easy. It often takes a long time and services must be prepared to go to where the homeless people congregate. We also need to accept the fact that help with welfare and practical support may be all that can be achieved in the short term but that this basic attention is not enough on its own.**

The maintenance of therapeutic focus is essential and the persuasive, encouraging approach has at times to be tempered by more coercive strategy if we are to make any impact on outcome.

Early clinical experiments involving specialist outreach teams have been encouraging.

These teams operate on 'case management' principles, carrying out comprehensive needs assessments and then providing services to meet these needs either directly through members of the multidisciplinary team, or more usually, by accompanying the user to a range of service providers. The teams are typically manned by staff with a social work or nursing background with back-up support from psychiatrists, psychologists and other mental health professionals. This back-up support is ideally provided by staff who are employees of a major public-sector institution (e.g. hospital clinic) who work part-time with the outreach team and thus facilitate access of their clients to the wider facilities of the larger institution.

Such programmes have been successful with severely disabled patients who have a past history of failing to engage with mainstream services. Although broadly successful, there are several aspects of practice that remain to be resolved.

**First, it seems that lengthy and labour intensive efforts are needed to engage homeless people in treatment.** It is not clear whether the 'softly does it' approach is actually superior to a more coercive intervention. One recent study of admissions of street homeless people to psychiatric hospital suggests that compulsory admission can produce good outcomes and that it does not necessarily alienate them from future care.

**Second, while there is consensus that a multidisciplinary approach is best, there is little data on which therapeutic options are essential and how these should be arranged.**

For example, given the high levels of co-morbid substance dependency, are teams better off training all their front-line staff in substance abuse treatment or is it better to employ one or two highly trained specialists within the team? These questions highlight the importance of ongoing training and support.

Many of the more successful outreach teams have links with universities and schools ensuring both continuing training and support for their staff but also usefully raising the profile of the outreach model within important academic institutions.

# H & D

Project development  
Follow-up  
Future action

# 1. H&D PROJECT PRESENTATION

**PROJECT : 1998 / PRO / 2097**

**PROMOTED : by Mental Health Europe : MHE - W.F.M.H.**

**FINANCIAL SUPPORT : of European Commission, DG V / E / 1 Public Health**

## TEAM :

- Josée VAN REMOORTEL, MHE Executive Director (B)
- Luigi LEONORI, Psychologist, MHSE Co-ordinator and project Executing (I)
- Thomas CRAIG, Psychiatrist, Prof. St Thomas Hospital, Research Director (UK)
- Manuel MUNOZ, psychologist, Complutensis University Expert (E)

## PARTENAIRES

(B)	DIOGENES	Bernard HORENBEK
(D)	DER PARITATICHE	Patrizia DI TOLLA
(DK)	UDENFOR Projekt	Preben BRANDT
(E)	A.E.N.	MariFe BRAVO
(F)	EMMAUS	André LACROIX
(FIN)	F.A.M.H.	Pirkho LATHI
(GR)	S.S.P.M.H.	Panayotis SAKELLAROPOULOS
(I)	S.M.E.S.-IT	José MANNU
(P)	A.R.I.A.	Fernando SILVA
(UK)	HOMELESS NETWORK	Ceri SHEPPARD

**THE MAIN SUBJECT AREA : V/F/3 : *Health promotion: Public health information, education and training.***

## TYPE OF PROJECT

- Creation and operation of networks
- Communication
- Evaluation and review
- Co-ordination of activity
- Seminar
- Feasibility studies
- Symposium

## METHODS

- Primary prevention
- Data collection
- Training
- Social reintegration
- Public information
- Exchanges of information and experience
- Health education

The project is complementary to a project previously supported by the EU Commission: « MHSE preliminary survey ».

## TIMETABLE

Start : 1 Mai 1999  
Duration : 20 months  
End: 31 December 2000.

## BUDGET

Total budget : 327.089 €  
Co-financing : 119.180 €  
Commission support : 207.909 €

## 2. STATEMENT OF PROJECT

### ➤ OBJECTIVES

1. Observing and evaluating the mental, physical and social health needs of disadvantaged people.
2. Recording, analysing and assessing diverse good practices and methods in several European cities.
3. Providing local, regional and European health policy makers with appropriate methods and indications, which best «proximity» approaches, meeting the health needs of this group of citizens.
4. Promoting support and developing an interdisciplinary and inter-sector-based collaboration between welfare Organisations, charity Associations and public health services for a new partnership and action.
5. Developing local network and structuring the European MHSE network, and liasing this network with other European networks working in the health sector.
6. Publicising the results. Opening an Internet Forum and promoting training for social and health workers.
7. Preparing a feasibility study for the transnational pilot project: “HEALTH IN THE STREET”, in order to bring health promotion, education and prevention where they are: on the street, in the subway, and for circulating information and facilitating assess to health care.

### ➤ DESCRIPTION OF TASKS

1. Director of project priority and specific task is the internal supervision of the project, in connection with the co-ordinator and expert for preparation, realisation and evaluation: guaranteeing the proper and consistent development of the project, fulfilling its objectives; participating in meetings: preparatory, monitoring and assessment meetings and the various seminars.
2. European co-ordinator of project specific task will be: organising, co-ordinating the project at the European level: choosing the European cities where the study will be carried out by the respective local co-ordinators ; defining, with the project Leader, and the academic expert the criteria defining “good practices”; organising meetings, the drafting and the publication of the report; preparing the follow up.
3. Local Co-ordinators role will be: selecting the centres which will participate in the initiative, choosing and preparing the interviewer, taking part in the meetings and the final seminar, preparing the local reports in English and contributing to the elaboration of the pilot-project.
4. The academic expert specific task will be: preparing and controlling the methodology; analysing data included in the local reports, preparing the final report and its publication; participating in the meetings and the final seminar

## ➤ SEQUENCE OF WORK / TIMETABLE

### 1<sup>st</sup> PHASIS :                    PREPARATION                    Mai – December 1999

1. **First May**, starting point of the project. Many contacts among the MHSE network in order to define the European capital cities and local co-ordinators.
2. **May 6-8 Copenhagen**: preparatory meeting. The local co-ordinators received the whole documentation of the project, in order to prepare the instruments and the evaluation criteria of the good practices. Participation in 5<sup>th</sup> MHSE European Seminar: “Dialogue & Exclusion”
3. **October 29-31 Rome** : complementary meeting, in order to present a first list of possible candidate centres having common and comparable features, drafting a common observation checklist, deciding the action dead lines; local preparation and local information report.

### 2<sup>nd</sup> PHASIS :                    IMPLEMENTATION                    November 99 – August 00

1. Observing and collecting data about the needs and good practices, with practical examples of health education and formation.
2. **February 18-20 London**: monitoring meeting for the whole team, for presenting the needs and their indicators, the good practices as well as the common and different methodologies in the health formation, providing accurate indications for the preparation of the local reports.
3. **Mai 12-15 Berlin** : evaluation meeting, presenting local reports, preparing the final seminar.

### 3<sup>rd</sup> PHASIS :                    DISEMINATION & FOLLOW UP                    Sept. – Dec. 2000

1. **September 28-30 Athens, final seminar** : preparing the final report on: “Living in Health – Where people are” with the participation of the project team and representatives from all the centres which have participated in the initiative.
  - Presenting the LOCAL REPORTS.
  - Proposing the enlargement of the initiative to other 5 European countries that have not been capable of taking part in the first phase.
  - Discussing the pilot project: “Living in Health – Where people are!”, from the indication of the study and constitution of a cross-boarder team for elaborating the pilot project.
2. **October – December** :
  - Publishing the results and dissemination.
  - **Elaborating – presenting the Commission the H&D2 project “The Health & Dignity in the streets”**, proposing the enlargement of the initiative to other 5 European countries that have not been capable of taking part in the first phase and for the other 10 propose exchanges program..

## ➤ COMMUNITY DIMENSION AND ADDED VALUE

The paramount interest of the MHSE project “LIVING in HEALTH” and therefor its added and complementary value to other community initiatives (for instance “Megapoles” program) resides mainly **in the contribution of “the exclusion practitioners”, i.e. these health and social operators who are daily involved in the field and who have a very close vision about the reality, with all the problems, difficulties, solutions.** They can indicate, observe, evaluate -with the help of university experts- the health needs of the disadvantaged groups, and at the same time, they may propose and promote efficient health-reinsertion education/prevention practices.

## ➤ RESULTS OF THE ACTIVITY

1. Analytical review of the differentiated needs of the human person in his/her comprehensive dimension and focusing the priorities as to health / well being of the individuals and society. (regrouping and listing according to their importance)
2. “File of valid practices” with comparative evaluation of the methodological and pragmatic input of the assistance associations in formation, education and health development.  
As appendix :
  - Presenting practical formation examples ;
  - Comparative evaluation of the financial input / support of the public authorities, or civic solidarity.
  - Extension of the local networks.
3. Permanent and specific formation through participation in colloquia and seminar, for the participants of the initiative.
4. Developing and structuring the MHSE network, carried out jointly by the people who already take part in MHSE liaison groups, in various member States : B – D - DK – E - F – FIN - GB – I – P. This will be also useful for developing and making this grassroots’ MHSE network more operational. Therefor this network can be definitively structured in order to facilitate liasing, exchanging and participating in Community and cross-boarder projects.

## ➤ ACTIVITY EVALUATION AND FOLLOW-UP

### EVALUATION

1. Internal evaluation of the action : the monitoring of the initiative all along the various phases will be carried out on a regular basis by the Head of the Project and the Director, through a monthly meeting.
2. External evaluation of the action : this evaluation will be entrusted to the *Complutense University* (Madrid), in order to guarantee the validity of the results, through a careful preparation of the methodology, a true and standard implementation of the surveys, and the comparative analysis of the data.

## FOLLOW-UP

Observing, analysing and regrouping the health needs at the street: according to the population (youth, mentally ill, elderly, migrants) and according to the categories and priorities: arranging in order the answers to provide.

- Pilot-Project: the indications resulting from the whole initiative and particularly the observation carried out in some capital cities, will be used as the basis of the feasibility study and for elaborating a cross-boarder pilot-project, taking into account the diverse realities, traditions and cultures.
- Aim of the project : promoting this dimension : « WHERE THEY ARE » : the health formation–education-development of the most disadvantaged categories of citizens.

## ➤ **USING AND DISSEMINATING THE RESULTS**

1. The participants themselves will be the first disseminators and multipliers of these practices in their daily work in the different European countries.
2. Bulletins and News Letters : the indications, resulting from this initiative, will be disseminated in the bulletins of the institutions and the appropriate magazines. A MHSE liaison page might also be contemplated.
3. MHSE web site: we plan to open for 20 months during the initiative, and for the future if possible, a www “professional page”, which can become an exchange and reflection FORUM for good practices, for developing the MHSE network, and establishing partnership in the Community and for concrete initiatives.

## ➤ **METHODOLOGY**

### 1<sup>st</sup> PHASE : PREPARATION

After the feasibility result, carried out by the whole team, obtaining the means for making it operational:

1. Timetable: defining a timetable with deadlines.
2. Selection criteria: defining common criteria to be followed while selecting the good practices.
3. Common checklist: preparing a common checklist of observed needs and good formation practices.

### 2<sup>nd</sup> PHASE : IMPLEMENTATION

1. Observing the needs and good practices, as well as collecting data and examples of health formation.
2. Analysing data, drafting local reports and sketching local evaluation.
3. Synthesis and evaluation, for underlying the common and different indicators used by the different centres for their health formation, with accurate indications for the preparation of the final seminar.

### 3<sup>rd</sup> PHASE : DISSEMINATION and FOLLOW-UP

1. Preparation of the final report and the follow-up to give to this initiative.
2. Final Seminar and publication of the report.
3. Pilot-Project : «Living in Health – Where they are ».

### 3. OUTCOME

#### ➤ GENERAL

##### Local Level

1. Four study & exchange sessions in : Copenhagen, Rome, London, Berlin.
2. Visiting innovative projects 'good practices' and having a debate with the workers and users, where the sessions take place.
3. Local report for each of the 10 capitals.
4. Improving & increasing interdisciplinary and pluralist networking.
5. Local awareness and circulation of information about the situation of persons living in great social and health precariousness and progressive local circulation of the final report.

***N.B.*** : *this item could be developed further if the foreseen remaining part of the H&D2 project is supported by the Commission's funding.*

*Two initiatives, complementary to H&D, have been launched:*

- *In Brussels: after the feasibility study, the MHSE-N has been actively working for the implementation of the project: "mobile psychiatric unit".*
- *In Madrid : the AEN, in collaboration with the University, continues the research in other Madrid's institutions.*

##### European Level

1. Participating in 5<sup>th</sup> European MHSE Seminar: "Dialogue & Exclusion", in Copenhagen: 7-9 May 1999
2. Organising, participating and carrying out the 6<sup>th</sup> European MHSE Seminar: "Living in Health and dignity", Athens, 28-30 September 2000, where the results of the study have been presented and discussed.
3. European report/dossier "*Health & dignity*": a comparative presentation of the context, an analysis of needs and their indicators, a comparative evaluation of the methodological and pragmatic input by the assistance associations in health training, education and development.
4. Extension and development of the European network.

***N.B.*** : *a very important result of the H&D project: what has been a mere informal MHSE network will provide itself with a legal association structure MHSE-EU (International non profit making organisation, AISBL in French) for a more efficient implementation of the projects and initiatives in the field of health and exclusion.*

### Theoretical Level

1. Priority : health prevention/promotion in mental health, furthering the knowledge of the differentiated needs of the person as a whole while highlighting the priorities of the homeless mentally ill.
2. Heighten the awareness and understanding of the connection between health, dignity and precarious social and health situations.
3. Permanent and specific training for the project's participants by means of seminars and workshops.

### Practical Level

1. H&D Newsletter: information and suggestions coming out of the work of the project will be circulated in newsletters and magazines. A MHSE Liaison letter is also part of this plan.
2. H&D Web Site: exchanging experiences, reflections, information

## ➤ ABOUT RESEARCH

### Results

- a) Methodology had been created
  - Criteria for evaluating good practices
  - Criteria for evaluating quality life & satisfaction degree
  - Instruments
- b) Local & European reports are redact
  - Presentation of 57 "good practices" of 10 capital cities
  - 10 local reports
  - 1 European report
  - Documents annex

### Future projects

- a) Improving the research instruments & adapted to **H&D2 research/action** focusing study in “**access**” to health & social services trough observation, analysis & evaluation of outreach & mobile units & mental health promotion in the street”
- b) Proposing the H&D2 extension of the 1<sup>st</sup> research action to 5 other capital cities of EU about “**outreach & mobile units**”
  1. Compile a register of the various practices of “mobile outreach units” in several European capitals, their “streetwork” practices
  2. Identify the “users/seekers” and the “non-users/non-seekers” on the street : old and new categories of excluded persons in unstable health and social conditions.
  3. Analyse the “needs” of users (non-users) and professionals (voluntary and volunteer).
  4. Evaluate the “responses/services” offered in the various countries regarding:
    - a) basic assistance: for basic needs, food, clothing, shelter
    - b) health assistance: basic medical services for critical cases
    - c) mental health assistance: services offered for the mentally ill on the street
  5. Study what and if there exists a correlation between “deinstitutionalisation” and “presence” on the street and/or “abandonment and cronification”...
  6. Analyse if there is a political impact of these practices with regards to social policy & regional and European health and to evaluate it.

## ➤ ABOUT TRAINING & EXCHANGES

**Results** promotion of continuum & specific training:

- a) Participation in 5th MHSE Seminar on Copenhagen (Mai 99)
- b) Organisation & realisation of 6th MHSE Seminar on Athens (September00)

**Future action**

- a) Dissemination of results and information in public sessions, conferences..., publications, booklet and internet...
- b) **Training & Exchanges program:** the training project will consist of training sessions (courses) based on the exchange of ideas and experiences concerning outreach. A five day course geared to professionals working with homeless and mentally ill people, both locally and internationally. They will present their experience in depth as well as creating a practical workshop about this topic.

This initiative could be multiplied and adapted to various European cities interested in training. For instance, in Madrid it is possible to create a partnership between Complutense University, Autonoma University and AEN. In Madrid, it would be possible to introduce a request for financing at the University, to the AEN, to various foundations (F. Caja Madrid, F. ONCE, Disability People F. Regional and Local Authorities, Pharmaceutical Companies...). Other cities could offer a similar service : Lisbon, Berlin, Rome, Copenhagen, London ...

## ➤ ABOUT NETWORK

**Results**

- a) Increasing of local networking
- b) Improving European MHSE network

**Future action**

- a) Improve MHSE network, creating a new **SMES-EU** (Santé Mentale Exclusion Sociale - Europa) international & non-profit association for study, research and action. Its aim will be the promotion of positive mental health, the civil and health rights and social solidarity with all disadvantaged and discriminated persons, for reasons of poverty and mental illness. At the same time working towards social rehabilitation with special emphasis on the social and health dimension in its study, research, action and training programmes.
- b) Create new meetings space (on line) & 7<sup>th</sup> European MHSE Seminar (Lisbon).

#### 4. H&D EUROPEAN SEMINAR ATHENS 28-30/9/2000

*"A decent society is one in which the institutions do not humiliate people benefiting from their services.*

*A civilised society is one in which it's members do not humiliate one another".*

(A decent Society, Avishai Margalit, philosopher)

This quote from A. Margalit was the leitmotif that inspired the discussions, reflections and exchanges of the 6th Seminar. The experience of humiliation is sometimes ours as well, but the experience of "**permanent**" **humiliation**, which harms and destroys has always been particular to "excluded" people. We assigned ourselves ten reasons to prepare and realise this seminar. The throngs of numerous participants confirmed that most of these reasons corresponded to the interests of the interveners : **220 inscriptions**, despite the fact that the number of participants was limited to 180.

The participants arrived from **19 countries**, **20** including Greece, the host country, with **80 interveners**.

These numbers speak for themselves, as on the occasions of past MHSE seminars, to illustrate the interest this European forum of reflection and exchange has aroused. Since 1992 we have proposed this theme which has found a large resonance in the daily preoccupations of those who work in the field of mental health and social exclusion. As soon as possible we will make the documents of the seminar available to those who are interested. Rather than present a dissatisfying synopsis of one or another of the speeches from the seminar in this short space, I prefer to underline two findings of our research in the H&D project, presented at the seminar by professors Thomas Craig and Manuel Muñoz.

They may provoke thought and discussion about:

**Outreach** : between aptitude and method:

Even if only **33%** of the 55 centres studied work with outreach, the demand to exit from within the institutions, to go "where they are" (on the fringes of society) and this manner of bridging the gap between the institutions and the users is being felt by the workers in this sector.

**Networking** : **98%** of the centres studied say they work in a network. Important data, but what can we interpret refers especially to the work in collaboration among the workers in the field, than a true network between various institutions in the health and social sectors, public and private. These two themes constitute the priority objectives of the work and projects of MHSE for.

**Volunteers** : one last item of data to conclude: **69%** of those who work in these centres are "volunteers". At the outset of work on the seminar, Prof. Sakellaropoulos posed a fundamental question to orient the role of lobbying in local, regional, national and European health & social policy makers: We, who work in the "voluntary & volunteer sector", do we not run the risk of serving as an alibi for the deficiencies of a health and social policy which is ambitious and coherent in the face of the consequences at stake (in world-wide application) mondialisation ?

## 5. FINDINGS AND RECOMMENDATIONS

The study “Living in Health and Dignity”, as well as the various cross-national meetings in Copenhagen, Rome, London, Berlin and the European Seminar in Athens, gave us the opportunity of presenting and evaluating some sixty “good” (innovative and efficient) practices in 10 European capital cities, as well as testing the satisfaction degree of the “users”, and to think about the possible evolution of the intervention strategies in favour of disfavoured persons who, at risk of being socially excluded, live in a situation of great social and health precariousness.

This research/action has allowed us to reach a certain number of findings and recommendations:

1. **Integrated articulated and deepen research and knowledge.** A first requisite felt by the staff of the interviewed centres is the need for promoting, at the level of research and training, a constant and deepen knowledge and analysis of the structural phenomenon of social exclusion which reaches in a serious way disadvantaged and marginalised persons through poverty, psychic suffering and mental illness. Political programmes, intervention schemes and daily practices which deal with this group of the population still transpire too much “lack of knowledge” about “social and health” implications. And the consequence, in the daily life, is the division/separation of the skills in “cares”/taking charge, social interventions and the skills for health or medical care. This separation in the daily practice reproduces the separation between the social sector and the health sector in the field of knowledge as well as in the political action and daily practice.
  - *Developing research in an interdisciplinary way and therefor also research and knowledge in this manner is the first prerequisite for overcoming the obstacles between the social and health fields and consequently between the services. Therefor interdisciplinary dimension is a sure and efficient antidote against fragmentation.*
2. **Primary and secondary prevention:** the importance of the place that should be given to prevention in dealing with social exclusion as well psychic suffering and mental illness is a preoccupation which is not reflected in the practices and politics aiming at disadvantaged and vulnerable people. The Centre’s’ staff notices that in their daily practice they mainly have to face secondary prevention strategies, because of an almost absolute lack of concrete political schemes for primary prevention, which would be consistent with the invested human and economic resources in the field of social integration and health promotion. A first requisite felt by the staff of the interviewed centres is the need for promoting, at the level of research and training, a constant practice.
  - *Investing in prevention: the exclusion process is very rapid, inversely to the inclusion of the excluded persons, and it requires an intensified investment in energy, time and resources*
3. **Permanent specific and deepen training:** there is no “skill or qualification” without the conjunction of “knowledge” and “experience”. Vocational specific cross-disciplinary training is one of the most frequently necessities and demands presented by the Centre’s’ staffs, including all the professions. This request for training concerns also the volunteers’ transformations, voluntary transformations as well as the migratory and massive movement of people, the rapid change of the communication level favoured by the new technologies. Linked to the need for

formation and qualification, there is the need for reading the “needs “ in their “inter-vision” (internal) background and supervision (external): these elements have been mentioned several times, mainly because of the complexity of the social request, linked to the health request and vice versa, as well as the strong involvement of various aspects linked to the affectivity and emotional sphere of the people who work in this field.

➤ *Acquiring more professionalism and new techniques: “experimental” training schemes should be developed, because of the rapid and complex evolution of the exclusion process, due to the social political economic and technical transformations.*

4. **Networking:** developing and enhancing the synergies through networking at the informal, structural and institutionalised levels for a better co-ordination and complementarity of the different practices and services. A very high percentage of the staff states that they network and the positive effect of staff networking is mutual knowledge. But it is necessary also that the institutions recognise themselves inside the network while maintaining their identity and specificity, in order to promote an integrated and articulated strategy. In this regard, we would propose a “federation of services” which could efficiently develop program and common action

➤ *Co-ordination and partnership: enhancing co-ordination, together with collaboration between social services and health services, is a very important element for the appropriateness of the intervention strategies. Without any further delay, new partnership criteria should be set up: health and social, public and private in programming as well as in the intervention field.*

6. **Flexibility and creativity:** flexibility, the ability to adapt the services and structures to the needs (explained or not) of the excluded persons living in great precariousness is recognised as one of the basic primary features, which should be mainly focused upon by the institutional services. In fact, the preference of these persons to use private services can mainly be explained by the greater capacity for flexibility and tolerance of the social private and charity services.

➤ *Supporting innovation in creativity in order not to continue repeating “assistance” services (ie. repairing and palliative ones), but rather to innovate, adapt and transform present practices and services for adapted and integrated answers.*

6. **Outreach and a culture for “proximity relationship”:** a very high percentage of the staff feels the need for enhancing Outreach (go and meet) dimension as a method, but mainly as a “decent” respectful approach ability, which goes out of the institution (enclosed physical and mental space) and which establishes a bridge, a link between the ones who are inside and the ones who are outside.

➤ *Supporting and enhancing the mobile and cross-disciplinary teams. Providing emergency services where these services are needed and where the homeless are, but in the view of reducing/limiting the reciprocal obstacles in order to facilitate access to citizen social and health services.*

7. **Empowerment:** as to “taking in charge”, we notice mainly that the focus is on basic needs and first necessities. Treatment and scarce health interventions for homeless patients are mainly pharmacological ones. In some way, the “medication” culture should be changed, into a new culture of “doctor-patient relationship”.

➤ *Believing in the possibilities, even if they are residual, of each and everyone for facilitating the “re-appropriation” of their own personal skills, abilities, possibilities. Rather than “taking the place of”, “leaving the place to...” so that each one can find back his/her unique and own place within society, and becomes therefor “included”, with his/her difference.*

## THANKS

*Lots of individuals, professionals, associations and institutions have been thoroughly involved or became just aware of this initiative. Certainly because "To live in Health and Dignity" concerns all of us.*

*We would like to express our cordial thanks to all those who, directly or indirectly, have allowed, facilitated and supported the implementation of this initiative.*

*And more particularly we thank the persons who are the very subjects of this project and to whom we would like to dedicate it.*



## ANNEX LIST

of Professionals and Projects  
participating in this study

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