Social medical care before and during homelessness in Amsterdam
van Laere, I.R.A.L.

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chapter 1

Introduction
Model of social medical decay and research questions
Personal motivation for this thesis

Since 1995, I have been working as an outreach doctor for homeless people in Amsterdam. During work, I meet homeless patients, colleagues, organizations, policy makers and politicians, and their problems. I have been trying to disentangle the complex of homelessness, problems and care provision, in order to get an overview of what is needed to improve social medical care for those in highest need.

To me, our homeless patients, their problems and their journeys to find support, are a continuous source of inspiration and exploration. Therefore, my practice based knowledge and experience with life and death in the streets of Amsterdam are the foundation of my academic search to better understand social medical care before and during homelessness. This thesis is a scientific account of my journey.

People experiencing homelessness are in a chronic state of social and medical crisis. Due to a lack of basic social needs such as housing, income and healthy living, they often accelerate down a deteriorating path complicated by addictions, and worsening mental and physical health. In terms of care, the interaction between social and medical problems' demands simultaneous support by social and medical workers. When the basic social needs for a homeless person are repaired, the path towards care for addiction, mental and physical problems becomes possible. 1, 2

People may get lost when they have no guidance. Often the road leads to indolent and destructive activities, reduction of income, accumulation of social and financial debts, and finally, the loss of housing. The journey of losing the basic social supports may take many directions, depending on the point of departure and the associated “baggage”. 3 Possible destinations include independent living, assisted living, shelter housing, prison time or a residential facility for addiction, mental and/or physical health problems.

Homelessness is a major and serious public health problem. It is stated that for homeless people, the life expectancy averages about 45 years, similar to the lifespan in Dickens’ time. Too often, the structure of health services creates an actual barrier to recovery and, as a result, contributes to a downward spiral of deteriorating health and health choices. 4 Homeless populations are 3-4 times more likely to die prematurely than the general housed population, according to studies in Australia, Canada, Denmark, the Netherlands, Sweden and the US. 5-7 Therefore, in rich countries, where the life span of homeless people is almost half that of the general population, the health services do not seem to contribute to the promotion of health. It is essential, therefore, to obtain knowledge on how to prevent people from becoming homeless and how to improve the health of homeless persons.

Although a considerable amount of medical literature on homelessness and health is available, little scientific research contributes to the guidance in the development and organization of programs to prevent homelessness and to actually improve the health of homeless people. 7-10 Studies involving homeless populations face difficulties and restrictions in definition, sampling, stages of homeless investigations, ethics, privacy, validated instruments and the reliability of results. 11, 12 Using such terms as ‘homeless’, ‘homeless person’ and ‘homelessness’, Stephen Hwang and co-workers in Toronto, Canada, 10 found 4,564 abstracts and 258 articles which they systematically reviewed. They used the criteria: use of an intervention, a comparison group, and the reporting of health related outcomes. Forty-five articles, less than two percent, were useful to comment on the effectiveness of interventions. Effectiveness was proven for (assertive) case management linked to other services and monetary incentives, for homeless persons with mental illness, substance abuse problems or tuberculosis. These interventions improved symptoms and care adherence, and a decrease in substance abuse and hospitalization. In the Netherlands, the Municipal Public Health Service in Utrecht studied the effect on street drug users who received housing and case management in three hostels. After a two year follow up, less social and medical problems were noticed. 13

9 In the Anglo-Saxon literature the terms health problems and medical problems usually refer to the physical condition, and might exclude addiction and mental health problems. In this thesis we speak of medical problems as those problems – addiction, mental and physical – that are in need for an integral approach. In terms of health care in general, addiction and mental health problems might be excluded, as specialist care for these problems is mostly provided in separate clinics by separate medical professionals. Therefore, we rather speak of medical care to include all medical problems potentially present among people in highest need.
Thus, homelessness is a major public health problem for which little scientific evidence is available on how to prevent homelessness and how to improve the health of homeless people. Based on the experience with outreach care for homeless people in Amsterdam, we want to improve scientific knowledge on how to provide social medical care before and during homelessness for those in highest need. Thus, the ‘street’ provides lessons for public health.

**How we meet homeless people in Amsterdam**

For the history of social medical care in the Netherlands, and the role of doctors for the poor, we refer to the work of Dr. Arie Querido (1901 – 1983). He was the founder of the Mental Hygiene Department of the Municipal Public Health Service (in Dutch: Gezondheidsdienst = GGD) in Amsterdam, before he became a professor of social medicine at the University of Amsterdam in 1952. In his article ‘social case work and the practice of medicine’ Querido states:

“Modern medicine, entering into the understanding that it has to deal with persons and not with organs, that the person is indivisible and inseparable from his relations and allegations, comes to the recognition that it has to be comprehensive, rational and humane. Therefore, it is impossible to cut away one part of the problem and to leave it to experts who work independently from the physician. If the medico-social work has remained undeveloped or is developing separately from medicine, the fault may be laid at the doctor’s door, but there is no reason to accept this situation.”

GGD doctors that have followed Querido did not accept this situation and they have been responding to the unmet needs of the community. During the last three decades, the emergence of underserved populations such as street drug users, homeless individuals, alcoholics and psychiatric patients, has been a major challenge for public health officials. A process of designing, building and constantly adapting specific services for these underserved populations has been provided by the GGD in close cooperation with local leaders, and social and medical partners, and the police, in the community.

**Dr Valckenier**

In the 1980’s, GGD doctors and case workers started providing outreach medical care for homeless people. In the beginning, the activities took place in the streets, under bridges and nomadic areas. A few years later at several locations, drop-in hours were established in shelters, hostels and day-centres. It became clear that a growing and visible population of homeless people was in need of primary care that could not be provided in normal general practice surgeries. In response, on request of the Amsterdam Association of General Practitioners (AHV) and a health insurance company (AGIS), the GGD Outreach Dr. Valckenier Practice was established in 1992. The practice is named after the Valckenierstreet in Amsterdam, the location where GGD health workers reside and from where outreach activities are provided. Registration at the Dr. Valckenier practice is arranged through the Welfare Department, social service unit for homeless people (Dienst Werk en Inkomen = DWI Amsterdam). At this unit, homeless people can request a postal address and benefit payments, premiums for health insurance (AGIS), as well as financial debts, are handled automatically.

Homeless people can visit the Dr.Valckenier practice during office hours, and in case of illness can be admitted to one of the shelter-based convalescence care facilities. In response to a growing need for social medical care, in 1997 the Ambulatory Medical Team (AMT) was introduced to visit homeless patients in the streets, social agencies, shelters, prison and clinics. Outreach doctors and care coordinators have been guiding homeless people with their social and medical problems, linking them to needed medical and social services. At thirteen relief locations in Amsterdam about 750 homeless patients are guided for a total of 3,000 consultations, 475 shelter-based convalescence care admissions and 450 general hospital admissions per year.

In our experience, during the social-medical assessment of homeless people, the helper needs to focus on the unique journey, the problems they have collected and the steps to be taken in order to repair the basic support structure. The social problems homeless people encounter are practical problems with obtaining and holding a personal identification card, social benefits, debt control, health insurance, a permit for transportation and a permit to access services. Without these basic supports, homeless people can easily lose their way. It is highly likely that they will get lost in addictions, be rejected by the community due to untreated mental health issues and find themselves without a safe, hygienic place to live. On average, such a sad journey ends after four to five decades.

**Objective**

The aim of this thesis is to describe the journey of social medical decay. Hereto, households at risk of evictions and homeless adults during different phases of homelessness were identified, to find out the pathways into homelessness, personal characteristics, social and medical problems before and during homelessness, mortality, and the contacts with services in Amsterdam. The findings should contribute to the scientific knowledge for prevention and reduction of homelessness, and the provision of social medical care before and during homelessness for those in highest need.
The journey of social medical decay

The steps into social medical decay before and during the different phases of homelessness are described in this thesis. We designed a model, see figure 1, representing the different steps through various boxes.

- **Box 'safe'**: (code green) signifies that a housed person is capable to coordinate his own social and medical needs and care.
- **Box A**: (code yellow) signifies that a housed person has a warning to leave his home. This person can have or meet problems that make him vulnerable to become homeless. This person most probably needs support from public services to keep his home.1,2,3
- **Box B**: (code orange) signifies that a person did lose his home, and might have hope to return back home. Being recently homeless, the person will be knocking on many doors, and meet or attract new problems that deter or block pathways towards a home.2,1,3
- **Box C**: (code red) signifies that the person is lost and lonely, and definitely depends on public shelters and services.2,3 Being long term homeless, along the road searching for support - a street journey during which he will encounter shelters, soup kitchens, social agencies, clinics and prisons – the person will attract multiple and serious medical problems. He becomes ill and will need to be admitted in a sheltered-based convalescence care facility.2,1,3
- **Box D**: (code purple) signifies that the person is too long and too far away from home. He can not find a way out. The person can not carry the burden of social and medical disease any longer. The ultimate step is death.5,1,3,1,4

**Figure 1** Model of social medical decay

<table>
<thead>
<tr>
<th>'safe'</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>green</td>
<td>yellow</td>
<td>orange</td>
<td>red</td>
<td>purple</td>
</tr>
<tr>
<td>A</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housed people</td>
<td>R</td>
<td>Recently</td>
<td>Long term</td>
<td>Death</td>
</tr>
<tr>
<td>I</td>
<td>homeless</td>
<td>homeless</td>
<td></td>
<td></td>
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<tr>
<td>S</td>
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<td>K</td>
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</tbody>
</table>

Research questions

To explore strategies to prevent people taking the different steps down the pathway of social medical decay, the central question in this thesis is:

What are the characteristics of people at risk of social medical decay, how to find and identify them, and how to help them before and during different phases of homelessness in Amsterdam?

The pathways from boxes A to D were explored by using the following sub-questions:

1. What are the characteristics and social medical risk factors of households at risk of eviction in Amsterdam?
2. How effective is the signalling and referral system for households at risk of eviction in Amsterdam?
3. What are the characteristics, social medical problems and service contacts of recently homeless people before and during homelessness, related to their pathways into homelessness?
4. What are the characteristics, social medical problems and mortality of homeless adults visiting the GGD Outreach Dr. Valckenier-Practice in Amsterdam?
5. What are the characteristics, social medical problems and mortality of homeless adults admitted in a shelter-based convalescence care facility in Amsterdam?

**Methods**

The central question is divided in 'what' and 'how' questions. To answer what-questions a systematic observation of quantitative data, to describe people, social and medical problems, was used. To answer how-questions both quantitative and qualitative data were collected, by using questionnaires and interviews with homeless individuals and relevant stake-holders, to explore the interaction between problems and care. For this thesis, data were collected during outreach activities between 1997-2008. The research samples and study episodes are shown in figure 2. The journey to find the answers, to describe the process of social medical decay, is reflected in five chapters

**Figure 2** Model of social medical decay and research samples

<table>
<thead>
<tr>
<th>Box A (yellow)</th>
<th>Box B (orange)</th>
<th>Box C (red)</th>
<th>Box D (purple)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Risk of Eviction</td>
<td>Recently homeless</td>
<td>Long term homeless</td>
<td>Death*</td>
</tr>
<tr>
<td>chapter 2 and 3</td>
<td>chapter 4</td>
<td>chapter 5</td>
<td>chapter 6</td>
</tr>
<tr>
<td>households at risk of eviction</td>
<td>shelter services + streets</td>
<td>Outreach Dr Valckenier care</td>
<td>shelter based convalescence care</td>
</tr>
<tr>
<td>rent arrears group n=275</td>
<td>recently homeless n=120</td>
<td>group A n=369*</td>
<td>users group n=629*</td>
</tr>
<tr>
<td>nuisance group n=190</td>
<td></td>
<td>group B n=124</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>group C n=137</td>
<td></td>
</tr>
</tbody>
</table>

*mortality is described in chapter 5 regarding group A and in chapter 6 regarding the convalescence care group.
Chapter 2
Preventing evictions as a potential public health intervention: characteristics and social medical risk factors of households at risk in Amsterdam.

Households with rent arrears and households causing a nuisance, as the major groups at risk of losing their home through a formal eviction, were studied to identify risk factors as a point of entry to apply preventive public health interventions. Annual reports of organizations involved in the eviction process, interviews with employees, and questionnaires applied to households at risk to become evicted, were used. The questionnaire addressed the process of eviction, demographics and underlying problems. For the rent arrears group, employees of twelve housing associations completed a questionnaire for 275 households for whom an eviction notice was served, during September and October 2003. For the nuisance group, employees of thirteen nuisance control care networks completed a questionnaire for 190 households that were on the verge of eviction, for whom an “end of intervention statement” was issued (with this statement the boundaries of voluntary intervention are reached and further attempts of the care network involved is terminated, an annulment of the rent contract from the judge can be requested by the landlord) or households that had already been evicted, between January 2001 to December 2003, for other reasons.

Chapter 3
Evaluation of the signalling and referral system for households at risk of eviction in Amsterdam.

We aimed to evaluate the functioning of the signalling and referral system set up for households at the verge of eviction due to rent arrears and nuisance. We describe the problems signalled in the households concerned and the extent of contacts with the relevant support services, from the perspective of 1) housing associations handling rent arrears, and 2) nuisance control care networks handling housing related nuisance, as the major signalling organisations. Interviews, documents and questionnaires were used for data collection on how underlying social and/or medical problems were identified and to what extent contacts with assistance services were existing or initiated. Employees of housing associations and care nuisance control care networks collected data on initial contacts, type of problems and assistance provided.

Chapter 4
Pathways into homelessness: recently homeless adults problems and service use before and after becoming homeless in Amsterdam.

Recently homeless people, the pathways into homelessness, social medical problems and contacts with services, before and after becoming homeless, are described. Social science students conducted interviews with 120 recently homeless people (defined as “last housing lost up to two years ago and legally staying in the Netherlands). Respondents were sampled at popular street hangouts, in day centres, emergency shelters and at a social benefit provider for homeless people, in April and May 2004.

Chapter 5
Outreach care to the homeless adults in Amsterdam: characteristics, social medical problems and mortality between 1997-2008.

Characteristics, status of homelessness, medical problems, reasons for encounter and mortality among homeless adults visiting the GGD Outreach Dr. Valkenier Practice, between 1997-2008, are described. Here, the results of three studies were aggregated. Group A (n=364) was sampled at a day centre and an emergency shelter between April 1997 and November 1999. Group B (n=124) was sampled in a day centre, an emergency shelter and three residence shelters, in the period September-December 2000. Group C (n=137) was sampled at a social benefit provider for homeless people, in the period February-May 2005. To describe characteristics, status of homelessness and medical problems, data of all three groups were used. To describe reasons for encounter and mortality, ten years after the first encounter, data were used of group A only.

Chapter 6
Shelter-based convalescence care for homeless adults in Amsterdam: a descriptive study.

Data of 629 homeless people admitted in a shelter-based convalescence care facility were collected during outreach care provision, between 2001 and 2008. Data included personal characteristics, medical problems, sources of referral, length of stay and whereabouts after discharge, and mortality. Convalescence care user known to have died up till March 2008 are described. Furthermore, the dynamics of the user profile and the facility over a period of seven years were evaluated.

Chapter 7
General discussion and conclusions.

In the final chapter the general findings are discussed and lessons are drawn for social medical care before and during homelessness in Amsterdam.
References


chapter 2

Households at risk of eviction

Preventing evictions as a potential public health intervention: characteristics and risk factors of households at risk in Amsterdam.

Igor van Laere, Matty de Wit, Niek Klazinga