Social medical care before and during homelessness in Amsterdam
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General discussion and conclusions
This thesis explored strategies to help prevent people from experiencing social medical decay. Hereto, we aimed to address:

1. What are the characteristics of people at risk of social medical decay?
2. How can we find and identify these individuals?
3. How can we help them before and during different phases of homelessness?

In order to find the answers, various phases of social medical decay were studied, addressing five 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?
5. What are the characteristics, social medical problems, and mortality of homeless adults admitted at a shelter-based convalescence care facility in Amsterdam?

This chapter will reflect on the results of the five studies, will discuss strengths and limitations of the studies, and finally, offer recommendations on how to improve social medical care before and during homelessness in Amsterdam.

**Model of social medical decay**

The pathway into social medical decay is represented by subgroups of individuals who find themselves in a progressive state of social and medical decay: the housed at risk of eviction, the recently homeless, the long term homeless, and mortality among homeless people. In the different phases, the characteristics (sex, age, country of birth), social problems (low income, financial difficulties, and/or homelessness), medical problems (addiction, mental and physical disorders; and the combination = tri-morbidity), and mortality, are shown, where available. The results of the five studies are summarised in table 1.

Between 1997 and 2008, of the different samples, point prevalence information was collected at a variety of sites and from various data sets provided by the housing associations, nuisance control care networks, popular street hang-outs, day centres, social assistance centres, emergency shelters, general shelters, a shelter-based convalescence care facility, GGD patient records, and the Amsterdam Population Register. Data for the housed at risk of eviction were collected through case workers of housing associations and nuisance control care networks by the use of their own client records. For the recently homeless, data were collected by social science students using structured face-to-face interviews, and for the long term homeless and shelter-based convalescence care users, GGD outreach doctors conducted structured face-to-face consultations on the job.

### Table 1 Phases of social medical decay, research groups and results

<table>
<thead>
<tr>
<th>Code A (yellow) At Risk of Eviction</th>
<th>Code B (orange) Recently Homeless</th>
<th>Code C (red) Long Term Homeless</th>
<th>Code D (purple) Death*</th>
</tr>
</thead>
<tbody>
<tr>
<td>nuisance group n=190</td>
<td>before / during homelessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SMR= Standard Mortality Ratio; na = not available</strong></td>
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</table>

| single male | 49 / 61% | 88% | 84 / 82 / 88% | 83% |
| single female | 16 / 13% | 12% | 16 / 18 / 12% | 17% |
| mean age (years) | 39 / 41 | 38 | 43 / 45 / 38 | 45 |
| Dutch | 49% / na | 48% | 68 / 63 / 37% | 53% |
| Surinam/Antilles | 19% / na | 18% | 12 / 22 / 28% | 15% |
| social problems | 71 / 54% | 81 / 68% | 100% | 100% |
| medical problems | 23 / 82% | 76 / 74% | 100% | 100% |
| addiction | 30 / 61% | 48 / 20% | 54 / 63 / 45% | 78% |
| mental | 33 / 72% | 56 / 63% | 61 / 26 / 21% | 21% |
| physical | 11 / 2% | 22 / 24% | 92 / na / 52% | 100% |
| tri-morbidity | na | na | 33% / na / 7% | 13% |
| Mortality* | na | na | *(n=74) 20% | *(n=83) 13% |
| Overall SMR ** | na | na | 6.6 | 7.5 |

* Up till November 2008, mortality data were collected among 364 homeless patients visiting the GGD Outreach Dr. Valckenier Practice facilities between April 1997- November 1999; and, up till March 2008, among 629 homeless patients using a shelter-based convalescence care facility between January 2001- October 2007.
**SMR= Standard Mortality Ratio; na = not available

### Overview of the five sub-questions and answers

1. What are the characteristics and social medical risk factors of households at risk of eviction in Amsterdam? (Chapter 2)

The magnitude of the evictions problem and the households at risk of eviction in Amsterdam was explored. We identified these households by narrowing down the numbers to focus on only those in the process leading to an execution of an eviction by following the major causes of evictions: rent arrears and housing related nuisance. In Box 1, the numbers for the situation in the Netherlands and Amsterdam in 2007 are outlined.
Box 1: Numbers in the process leading to evictions, related to rent arrears and nuisance, in the Netherlands and Amsterdam in 2007

| Evictions in the Netherlands | 2007, in the Dutch social rent sector, (2.4 million dwellings), 237,000 households had rent arrears, 22,605 received an eviction court order and 8,530 were evicted (78% for rent arrears, 5% for nuisance / anti-social behaviour, 4% for illegal cannabis production, 10% for illegal subletting and 2% for ten specified reasons). Overall, 3.6 evictions per 1,000 social rent dwellings took place.
A notional register to report ‘serious’ rent arrears, housing related nuisance, and (the numbers in the process leading to) evictions by tenure, and the proportion of the evicted that becomes homeless, is not available.

| Evictions in Amsterdam | In 2007, Amsterdam had 743,000 citizens and 379,000 dwellings of which 286,000 were dwellings (75%) in the social and private rent sector. An estimated 32,000 households experienced rent arrears, based on a reported 17% of the households with rent arrears of three months or longer in the four big cities in the Netherlands. Among the households with rent arrears, 3,200 were served with an eviction court order, and 825 households were evicted in the social rent sector; this figure corresponds with 4.4 per 1,000 social rent dwellings. In eleven out of fourteen city areas, nuisance control care networks dealt with 1,855 households, of which for 678 nuisance was reported. For the total city the number of housing related nuisance cases and the proportion that subsequently became evicted, and homeless, is not available.

The Amsterdam Court House dealt with 4,848 eviction court orders in both the social and private rent sector. The bailiffs assisted in a factual eviction for 1,303 households, the vast majority for rent arrears and a small group for nuisance. The eviction rate in the total rent sector was 4.6 evictions per 1,000 dwellings.

| Sources: | Dutch Housing Association social rent sector (www.aedes.nl), Amsterdam Bureau of Statistics (www.os.amsterdam.nl), Amsterdam Court House (sector Kunsten) (www.rechtspraak.nl), Amsterdam Federation of Housing Associations (www.poct.nl), GGD Amsterdam (www.potentiamsterdam.nl), Amsterdam Housing Effect Management (Boulevardwijk Dienst Wonen) (www.os.amsterdam.nl).

We sought information about social services that help clients with rent arrears and nuisance problems. Case workers of 12 housing associations and 13 nuisance control care networks filled out questionnaires that provided information about households at the brink of eviction. Questionnaires for the rent arrears group and nuisance group revealed the following. Of 275 households with rent arrears, 132 were evicted. Of 190 nuisance households, 136 were evicted. Of 275 households with rent arrears, 132 were evicted. Of 190 nuisance households, 136 were evicted. In both groups, the largest household group were single male tenants between 25-44 years. For those reporting rent arrears, social problems were reported in 71% of the cases, medical problems in 23%, independent risk factors for eviction were being of Dutch origin (OR 2.38 (1.30-4.36)) and having a drug addiction problem (OR 1.58 (0.96-2.39)). For nuisance households, social problems were reported in 54% of the cases, medical problems in 82%, and it was found that financial difficulties were a risk factor for eviction in this sub-group (OR 8.04 (1.05-61.7)).

In response to the findings above outlining the characteristics of those most threatened by rent arrears and/or nuisance, services should reach out and offer integrated social and medical care.

2. How effective is the signalling and referral system for households at risk of eviction in Amsterdam? (Chapter 3)

We studied the functioning of the signalling and referral system to find and help those at risk of being evicted. Questionnaires completed by case workers of 12 housing associations (for rent arrears) and by case workers of 13 nuisance control care networks (for nuisance) were used. The signalling system used to identify those who are at high risk of eviction, was evaluated by examining the extent of problems that were identified by the case workers. The referral system was evaluated by comparing the identified problems with the assistance contacts.

For 275 households with rent arrears, housing associations reported social problems in 19% (7%), of which 94 (48%) were in contact with social assistance. Medical problems were reported in 62 (23%) households of which 18 (29%) were in contact with medical assistance. House visits by housing associations resulted in a much higher identification of problems, and were associated with a reduced eviction risk (relative risk 0.57 (95%CI: 0.43 to 0.75)).

For 190 nuisance households, nuisance control care networks reported social/financial problems in 103 (54%), of which 13 (13%) were in contact with social assistance. Medical problems were reported in 155 (82%), of which 142 (92%) were in contact with medical assistance.

In response to the “silent” signal of rent arrears, housing associations in Amsterdam should conduct more house visits to identify underlying social and also medical problems. In response to the “loud” signal of nuisance, despite the high occurrence of medical assistance (92%), financial support was insufficient. Households at high risk of eviction should be actively signalled and assisted by local networks providing housing, social and medical care. Only an integrated approach can keep more people off the streets.

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? (Chapter 4)

To identify recently homeless adults, (defined as “last housing lost up to two years ago and legally staying in the Netherlands”), we collected data on the streets, day centres and night shelters in Amsterdam. In April and May 2004, social science students conducted 120 interviews and collected data on demographics, self reported pathways into homelessness, social and medical problems, and service use, before and after becoming homeless.

Of the 120 recently homeless adults, 88% were male, 50% were born in the Netherlands, and 25% in Surinam/Netherlands Antilles. The average age was 38 years old (range 18-67 years old). The mean duration of homelessness was 23 weeks. Before homelessness, 81% reported social problems (financial debts 61%, domestic conflicts 46%) and 76% reported medical problems (substance addiction 57%, gambling 18%, mental health problems 56% and physical health problems 22%); 38% reported contacts with any type of social service and 27% with any type of medical service. Despite these contacts, they were unable to remain housed. During homelessness, financial problems (68%), mental health problems (63%), and the use of social services such as shelters and benefits agencies (83%) was reported. A decrease was reported for substance addiction (20%), gambling (3%) and the use of medical services remained low (27%).
The main reported pathways into homelessness were evictions 38%, relationship problems 35%, prison 6% and other reasons 22%. Compared to those who reported relationship problems as a pathway into homelessness those who reported eviction were slightly older (average age 39.6 versus 35.5 years; p=0.08), and belonged more often to a migrant group (p=0.025). They also reported living alone more often (p=0.001), more financial debts (p=0.009), more alcohol problems (p=0.048) and more contacts with debt control services (p=0.009). The relationship group reported more domestic conflicts (p<0.001) and tended to report more drug (cocaïne) problems.

In all pathways into homelessness, the recently homeless fit the overall profile of the homeless population in Amsterdam: single (Dutch) men, around 40 years, with a mix of financial debts, addiction, and mental and/or physical health problems. Contacts with services were fragmented and did not prevent homelessness. For homelessness prevention, systematic and outreach social medical care should be provided continuously before and during homelessness.

4. What are the characteristics, social medical problems and mortality of homeless adults visiting the GGD Outreach Dr. Valckenier-Practice? (Chapter 5)

This study aimed to describe homeless patients who visited the GGD Outreach Dr. Valckenier-Practice at different sites during three time periods: group A (n=364) April 1997- Nov 1999; group B (n=124) Sept-Dec 2000; and group C (n=137) Feb-May 2005. During outreach activities data were systematically collected and included the personal characteristics, pathways into homelessness, medical problems for all three groups, and the reasons for encounter and mortality for group A only.

The homeless patients visiting the GGD Outreach Dr. Valckenier Practice’s primary care facilities in Amsterdam, were mainly male (85%), in the 30-49 age group (60%), and of Dutch origin (37-68%) or from the former Dutch colonies Surinam/Antilles (12-28%). The three major pathways into homelessness were relationship problems (28-31%), financial debts/evictions (21-37%), and after leaving prison (8-23%). Between the three groups, the average length of homelessness varied from 2 to 7 years. In all groups, one quarter of the homeless patients reported alcohol dependency, one third drug dependency, one fifth to nearly two thirds reported mental health problems, and over half reported physical conditions.

In group A (n=364), one third presented tri-morbidity, reflecting a high burden of disease, and 20% had died by 2008, ten years after the first encounter. The overall standard mortality rate was 6.6; 5.9 for men, and 13.3 for females. Multivariate analysis showed a significantly increased risk of death for individuals with problems related to HIV, alcohol addiction, asthma/COPD, drug addiction, and (univariately) for liver cirrhosis and diabetes.

Homeless patients in Amsterdam, most commonly male, between 30-49 years old and of Dutch origin, were in poor health. In outreach practice, predictors of early death should be acknowledged and targeted social medical care be provided.

5. What are the characteristics, social medical problems and mortality of homeless adults admitted in a shelter-based convalescence care facility in Amsterdam? (Chapter 6)

This study analysed the profile and dynamics of shelter-based convalescence care users in Amsterdam over a period of seven years. Hereto, data on the characteristics of ill homeless adults, medical conditions, referral pattern, length of stay, whereabouts after discharge, and mortality, were collected during outreach care provision in a shelter-based convalescence care facility in Amsterdam from January 2001 through October 2007.

Six hundred twenty nine individuals accounted for 889 admissions to the convalescence care facility. Eighty-three percent were male and 53% were Dutch born and 18% were of Surinamese/Antillean origin. The mean age was 45 years old (SD 10 years old). Upon admission, the primary physical problems presented were skin disorders (39%), respiratory disorders (34%), digestive disorders (26%) and musculoskeletal disorders (14%). Common chronic medical problems included addiction (78%), mental health disorders (21%), hypertension (16%), HIV infection (11%), and liver cirrhosis (5%).

Referrals went through general hospitals (21%), GGD drug clinics (20%), day centres for the homeless (14%), primary health care (8%), GGD Safety Net department (7%), addiction/mental health clinics (6%), and others (6%), and 18% were homeless self referrals. The median length of stay was 20 days, the average length of stay was 47 days, and 41% stayed for up to two weeks. After (self) discharge, 63% went back to previous circumstances (streets, overnight shelter, prisons; including those suspended/arrested due to misconduct), 10% improved their housing situation, and 22% went to a medical setting.

By March 2008, one in seven convalescence care users (n=83; 13%) were known to have died. Among 82 users (for 1 person data was incomplete), 74 were male, the mean age was 52.7 years old (SD 10.7 years old; range 32-77 years old). Overall, the convalescence care users died seven and a half times more often than their housed counterparts with comparable sex and age in Amsterdam; the standard mortality rate was 7.5 (95% CI: 4.1-13.5), for males it was 7.6 and for females 6.5. Survival analysis, with correction for age and sex, showed an increased mortality risk for those with HIV, with a hazard ratio of 3.5 (95% CI: 2.1-5.7); dual diagnosis 2.2 (95% CI: 1.3-3.9); cirrhosis of the liver, 2.1 (95% CI: 1.0-4.6); mental illness, 1.6 (95% CI: 1.0-2.6); and malignancy, 7.8 (95% CI: 3.5-17.2). Over the years, fewer men were admitted with significantly more self neglect, personality disorders and cocaine use. Lengths of stay increased and less self-discharge was noted during the study period.

The shelter-based convalescence care facility has been flexible and responsive to the needs of the users and services available. These findings reconfirm the need for early identification and support for those homeless people with a high risk mortality profile.
Strengths and limitations

The major technical obstacle to the study of the nearly homeless and homeless people lies in the fact that conventional censuses and surveys are premised on the assumption that almost all persons can be reached and queried in their dwellings, a premise that is untenable by definition when dealing with the nearly homeless and homeless people. Consequently, our model of social medical decay and the five sub-populations presented in this thesis are incomplete and biased. In Amsterdam, a central register of defined vulnerable citizens (those at risk of social medical decay) and their actual whereabouts is not available. Although we lack such a register, for which fundamental research is needed to understand the relationship between poverty, welfare problems and social exclusion; people at risk of social medical decay are known to be found in many specific places and settings, and thus accessible for these research purposes. For practical reasons, among others, we did not include people at risk of eviction in the private rent sector.

Furthermore, the causes and consequences of eviction remain shrouded in a degree of mystery partly because of the practical and ethical problems posed in attempting to research such issues. In particular, while it would be highly desirable to track and interview a cohort of households subject to eviction, there are obstacles to identifying, tracing and contacting such households following eviction. However, given the circumstances, we used point-prevalence information to draw a picture of people who find themselves in several phases of social medical decay. For each study we will comment on the strengths and limitations.

Regarding the households at risk of eviction (chapter 2 and 3), the Amsterdam networks for rent arrears and nuisance and those agencies involved at some point in the eviction process all had a different approach to providing and reporting their activities. One obstacle in reporting the data was the fact that agencies only recorded information that is pertinent to the provision of their service information. Combining the information into a meaningful and complete dataset was not an easy task considering the multitude of problems among households at risk and the different services available. Nevertheless, following earlier studies related to evictions in Amsterdam, it was possible to present the magnitude of the numbers in the process leading to evictions and the households at risk in Amsterdam.

The evictions studies have several limitations. Although all the Amsterdam housing associations participated in the study, two of them provided the majority of the completed questionnaires. We do not know if the other ten housing associations completed a questionnaire for all of their tenants presented to the bailiffs during the study episode. Underreporting and selection bias are likely. However, based on an estimate of the number of households at risk of eviction and the households at risk in Amsterdam, it was possible to present the magnitude of the numbers in the process leading to evictions and the households at risk in Amsterdam.

The strength of the study among the recently homeless is that the provision of outreach care and the collection of prospective data were done by the same individuals. During the study period of seven years, data were collected systematically, and in most cases, the diagnoses assigned by specialists in general hospitals and GGD clinics were scored by the same outreach doctor.

The evictions study among the nearly homeless has several limitations. First, the sample was a selection of homeless people who were in contact with service providers and who knew the routing towards admission for convalescence care. Therefore, the data can not be generalised to the total ill homeless population, including those out of reach of services in Amsterdam. Second, underreporting of medical conditions is likely due to limitation of record distraction of often voluminous medical records, and due to unshared information among multiple medical service providers. Third, the mortality rate might be higher than reported here due to incomplete data in the population registrar and GGD electronic patients records, e.g. death of unidentified corpses, loss to follow up, and illegal immigrants who are not included in the official death statistics.

Answer to the central questions

1. What are the characteristics of people at risk of social medical decay in Amsterdam?
2. How can we find and identify these individuals?
3. How can we help them before and during different phases of homelessness?

Characteristics of people at risk of social medical decay in Amsterdam

In Amsterdam, of the people at risk of social medical decay, the vast majority were found to be single men aged 25-54 years with social medical problems. These problems concerned maintaining or obtaining housing due to financial mismanagement and/or conduct disorders that interact with medical problems of addiction, mental, and physical health (tri-morbidity). Prior to becoming homeless and throughout the different phases of homelessness, the demographic profile remained the same: single men, half were born in the Netherlands and one in five was of Surinamese / Netherlands Antillean origin, and social and medical problems tended to mount until early death.
Among the 275 housed at risk of eviction due to rent arrears, again, the majority were living single and were of Dutch origin. More than half experienced social problems, a quarter was known to have medical problems, and it was found that drug addiction problems significantly increased the risk of eviction. Home visits by social housing associations significantly reduced the risk of eviction. Despite the fact that half of those involved in the study had contact with social services and one third with medical services, they were not able to remain housed. Likely due to underreporting, information on physical problems is lacking.

Among the 190 housed at risk of eviction due to housing related nuisance, it was found that one third also had financial mismanagement issues, two thirds had addiction problems and one third had mental health problems. Financial mismanagement was a significant risk factor for eviction. Despite a high occurrence of medical assistance (92%), financial support was insufficient. Information on physical problems was most likely underreported.

Of the recently homeless individuals (n=120), two thirds reported financial problems (the average debt was 5,000 Euros), one in five reported gambling problems, and three quarters reported medical problems. Forty percent of the recently homeless were homeless due to eviction. Before the eviction they were more often living single, belonged more often to a migrant group, and had more financial and more alcohol related problems than those who were homeless due to other reasons. Despite that four out of five evictees were having contact with debt control services, evictions were not prevented. One third of the recently homeless were homeless due to relationship problems and they reported more domestic violence and, often, cocaine problems. Before and during homelessness, one quarter reported physical problems. Overall, contacts with medical services were very low.

Long term homeless patients presented more medical problems than those threatened with homelessness and the recently homeless. Among the three different groups of ill homeless patients who visited a GGD outreach doctor in the last decade (n=625), 50-80% suffered from addiction, 20-61% were having mental health problems, and 50-100% presented a combination of physical health problems (skin, pulmonary injury, cardiovascular, cirrhosis, epilepsy, HIV, Hepatitis B/C, cancer). The wide range in the prevalence of problems might be the results of the fact that these data were collected on three different sampling sites and therefore included homeless persons with different characteristics, such as the duration of homelessness.

Homeless patients who had died during the course of the study had reached the end stage of social medical decay. Their mortality profile was mainly single (white) males with an average age of 50 years old and with progressive tri-morbidity. A significantly increased risk of death was observed among homeless individuals with problems related to HIV, malignancies, alcohol addiction, cirrhosis of the liver, mental illness, mental health disorder and addiction, chronic pulmonary conditions and diabetes. Overall, homeless patients had died 6.6 to 7.5 times more often than their housed counterparts in Amsterdam.

How can we find and identify these individuals?

In daily practice, when identifying vulnerable people, their social medical profile and their (potential) pathways into social medical decay should be acknowledged. Consequently, defined warning signals of vulnerability should actively be picked up by professionals in housing, social, medical and correctional services.

Prior to an individual experiencing homelessness, in the general housing sector, landlords and service providers should be sensitive to the ‘silent alarm’ of rent arrears, and the ‘loud alarm’ of nuisance (chapter 2 and 3).

The income sector (unemployment, disability) should detect vulnerable people with unmet support needs among those applying for and/or receiving benefits and/or debt control assistance.

During homelessness, the shelter sector (volunteer services, day centres, emergency and general shelters for homeless people) and specific income sector (benefits and debt control programs for homeless people) should prioritize their assistance actively and consciously at the most vulnerable with the profile described above. Both before and during homelessness, professionals in the judicial sector (police stations, courts, prisons and correctional institutions) and in the medical sector (primary care, general hospitals, addiction and mental health clinics, and GGD outreach care programs for vulnerable inhabitants) all have the possibility and responsibility to detect those with the profile described above.

In contrast, in the medical sector, there is often both a failure to identify problems related to deficiencies in patients’ social support systems and a lack of knowledge of referral possibilities outside the medical system.

To quote what Dr. Querido, professor of social medicine at the University of Amsterdam, already stated in 1955: ‘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.’ Today, in 2009, the divide between medicine and social care still exists.

How can we help them before and during different phases of homelessness?

The study results provided in this thesis relate in several ways to current policies and projects undertaken, and the responsibilities and competences of the workforce. To place the study results into perspective we describe recent policies and projects that aim to support the most vulnerable people in our communities. In the Netherlands, the Social Support Act (WMO) was introduced in 2007. This Act specifically includes a performance field to serve those threatened with homelessness, the residential and factual homeless people. This performance field is named Public Mental Healthcare; in Dutch: Openbare Geestelijke Gezondheidszorg (OGGZ). The OGGZ, developed itself as a harm reduction ‘patchwork-system’ for vulnerable people with multiple problems, who, stepwise and increasingly, harm themselves, their social networks, if any, and society. In response, specific social and medical services appeared, stepwise and increasingly, in fragments.

In 2006, as a preamble to the Social Support Act, the Dutch Government and the four big cities (Amsterdam, The Hague, Rotterdam and Utrecht) introduced a Social Relief Plan to reduce homelessness and to improve the condition of those who are homeless. As a guideline to translate the Social Relief Plan to the local situation, the objectives and methods were presented in a so called City Compass. In table 2, the OGGZ objectives, target groups, ambitions, and performance indicators, are shown. The target groups, ambitions and the performance indicators are based on a so called five step OGGZ ladder. Along this ladder, each step down represents a growing burden of multiple and interacting problems, and a growing need of multiple services and professionals to reduce harm. The last step reflects the setting of the factual homeless. The steps down the OGGZ ladder are compatible with the different phases of social medical decay postulated in this thesis. However, in the Social Support Act, the Social Relief Plan and the City Compass, the dominant approach is a social support perspective, rather than a social medical care perspective. The implications of this dominance will be discussed below.

On 1 January 2007 the Social Support Act (Wet maatschappelijke ondersteuning=Wmo) came into force in all municipalities in the Netherlands. Under the Act, the municipalities are now responsible for setting up social support. The aim of the Act is participation of all citizens to all facets of the society, whether or not with help from friends, family or acquaintances; the perspective is a coherent policy in the field of the social support and related areas.

An overview of the OGGZ projects in Amsterdam

In line with the Social Support Act and the Social Relief Plan to support the most vulnerable, in 2007, the local government in Amsterdam presented its OGGZ projects, ambitions and interagency agreements. The following are mentioned:

- The projects are summarized in Table 3. The footnotes show some data related to the eviction prevention practice, the care and nuisance support practice and the homeless care management. Following the results of this thesis, people in social medical decay, their pathways between settings, their problems and service contacts can vary and overlap over time. Therefore, the OGGZ projects and performance indicators are all interconnected.

### Table 2: Reduction of Homelessness: the Dutch Government’s Public Mental Healthcare (OGGZ) Objectives, Target Groups and Ambitions

<table>
<thead>
<tr>
<th>General Objectives</th>
<th>Increase life expectancy</th>
<th>Prevent avoidable deaths</th>
<th>Improve the quality of life</th>
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<tr>
<td>Objectives performance field OGGZ:</td>
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<tr>
<td>reduce homelessness</td>
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<tr>
<td>improve the condition of people threatened with homelessness (a)</td>
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<tr>
<td>reduce the related public nuisance</td>
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<td>Target Groups:</td>
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<td>Households at risk of eviction</td>
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<td>Ex-prisoners (c)</td>
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<td>Ex-residential clinic users (d)</td>
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<td>Residential homelessness</td>
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<td>Factual homeless / street youth (e)</td>
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<tr>
<td>Ambitions (performance indicators)</td>
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<tr>
<td>30% eviction rate reduction in the social housing sector between 2005 and 2008 (1)</td>
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<tr>
<td>Monitor the number of evictions in the social housing sector (1a)</td>
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<td>Monitor persons who become homeless and use shelters within 30 days after an eviction (1b)</td>
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<td>Minimise homelessness after release from prison (2)</td>
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<td>Monitor persons who become homeless and use shelters within 30 days after prison</td>
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<td>Minimise homelessness after residential clinic discharge (3)</td>
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<tr>
<td>Monitor persons who become homeless and use shelters within 30 days after clinic discharge</td>
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<td>Provide housing for 65% of the homeless by 2010 and assign a case worker to all homeless people in the four big cities by 2010 (4)</td>
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<tr>
<td>Monitor persons with an intake an individual care plan (4a)</td>
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<tr>
<td>Monitor persons for whom housing, income and care is realised; stable mix (4b)</td>
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<td></td>
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<tr>
<td>Monitor public nuisance reduction between 2006 and 2013 (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor persons with an individual care plan and 5 or more police contacts within a year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 3: Public Mental Healthcare (OGGZ) Projects and Ambitions in Amsterdam, according to the Social Relief Plan

<table>
<thead>
<tr>
<th>OGGZ project</th>
<th>Ambition (as stated in September 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prevention of evictions due to rent arrears, Early Reach Out to support the most vulnerable, in 2007, the local government in Amsterdam presented its OGGZ projects, ambitions and interagency agreements. The footnotes show some data related to the eviction prevention practice, the care and nuisance support practice and the homeless care management. Following the results of this thesis, people in social medical decay, their pathways between settings, their problems and service contacts can vary and overlap over time. Therefore, the OGGZ projects and performance indicators are all interconnected.</td>
</tr>
<tr>
<td>2</td>
<td>Housing variety (between independent living and the streets)</td>
</tr>
<tr>
<td>3</td>
<td>Care and Nuisance support networks</td>
</tr>
<tr>
<td>4</td>
<td>Central shelter service for homeless people</td>
</tr>
<tr>
<td>5</td>
<td>Follow-up care ex prisoners / multiple offenders</td>
</tr>
<tr>
<td>6</td>
<td>Central field director trajectories for homeless people</td>
</tr>
<tr>
<td>7</td>
<td>Central coordination street field work</td>
</tr>
<tr>
<td>8</td>
<td>Independent housing after shelter living (field trial exit)</td>
</tr>
<tr>
<td>9</td>
<td>Central one stop OGGZ service for income and health care</td>
</tr>
<tr>
<td>10</td>
<td>Park polis (health insurance for the hard to reach factual homeless)</td>
</tr>
<tr>
<td>11</td>
<td>Increase services (housing, income, activities and health care)</td>
</tr>
</tbody>
</table>

### Source:

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Recommendations for social medical care before and during homelessness

After studying the OGGZ projects, relevant documents and annual reports, it is very difficult to obtain a total overview of the target groups and their social medical problems, and effective methods to find and help those in highest need. Despite the Social Support Act, that aims at a demand driven and integrated approach by services, the various OGGZ project reports are presented solitary, and the contents show an incomplete and fragmented picture of the different target groups described. That is to say, in the Early Reach Out reports (OGGZ project 1) data on the characteristics of the households reported and their social medical problems are not presented. In the Care and Nuisance support reports (OGGZ project 3) data of ethnic backgrounds, financial mismanagement and rental debts are missing and the data of medical problems presented are related to the total group of care and nuisance households reported. It is unknown if medical doctors were involved in the assessment and diagnosing of the medical conditions. Furthermore, the overlap of households known to both OGGZ projects 1 and 3 is unknown. In the homeless case management reports (OGGZ project 6) the pathways into homelessness are not presented, hence the overlap with the households in OGGZ projects 1 and 3 is unknown as well. In all projects data on the physical problems and mortality are missing.

To obtain an overview of all target groups and to analyse data related to the OGGZ performance indicators, it is of importance to disentangle data of people and their problems, the settings and timing between settings and the process steps during service interventions, and the size and nature of services available. Based on this comprehensive overview of people and their care needs, the size and nature of services, and budgets, can be approximated.

Since the most vulnerable people are burdened with social medical disease, the choice of data collection should be based on a social medical care perspective. This perspectives would imply a defined position and responsibilities of a medical doctor for the assessment of social medical problems and the making and directing of an individual care plan. However, as aforementioned, to support the most vulnerable people, the Social Support Act, the Social Relief Plan as composed by the four big cities, and the OGGZ performance indicators are based on a social support perspective. The absence of a social medical care perspective is in concordance with the absence of the position and responsibilities of medical doctors in policy documents and in daily practice. All documents found in only one document a reference was made to a medical professional. In the City Compass, page 26, it was stated that for diagnostics on behalf of care that is covered by the Exceptional Medical Expenses Act, the Social Relief Plan as composed by the four big cities, and the OGGZ performance indicators are based on a social support perspective.

Following the above, this means that in the eviction prevention practice, the care and nuisance support practice and the homeless case management practice, medical involvement is not guaranteed, nor systematically provided. Consequently, nearly homeless and homeless people depend on the social medical skills and tri-morbidity knowledge of social and financial workers, and social (mental health) nurses. In Dutch policy parliance the term ‘worrisome care avioders’ (zorgvekkende zorgmijders) is sometimes used for those groups of people who are not seeking care. However, the term could equally be applied to doctors that seem to ignore the social medical needs of the nearly homeless and homeless people. Following the above, this means that in the eviction prevention practice, the care and nuisance support practice and the homeless case management practice, medical involvement is not guaranteed, nor systematically provided. Consequently, nearly homeless and homeless people depend on the social medical skills and tri-morbidity knowledge of social and financial workers, and social (mental health) nurses. In Dutch policy parlance the term ‘worrisome care avioders’ (zorgvekkende zorgmijders) is sometimes used for those groups of people who are not seeking care. However, the term could equally be applied to doctors that seem to ignore the social medical needs of the nearly homeless and homeless people.

Tackling the social determinants of health and the medical issues of nearly homeless and homeless people requires an integral and systematic approach before and during homelessness. The workforce should be knowledgeable about their clients’ characteristics and social medical problems that potentially mount up to evictions, homelessness and premature death. This should imply that in the care processes for nearly homeless and homeless people, doctors should have and active part in the social medical assessment, preventive actions and diagnostic pathways to be taken, and consultation with and referral to medical doctors in the community healthcare network. Therefore, within the OGGZ performance field, medical doctors should play a prominent role in practice, education, research and policy making.

Practice

To reach and support the nearly homeless and homeless people, in all settings, the diagnostic process should be conducted, directed, monitored and followed up by doctors experienced in social medical decay, in close cooperation with social workers, nurses and administrative staff. Consequently, it is recommended to integrate the Early Reach Out support services, Care and Nuisance support networks and the homeless care management networks (OGGZ projects 1, 3 and 6; see table 3). To integrate these networks, the GGD as the central field director, could restore the fundamentals of her safety net role in the community and reposition doctors as directors in the social medical care process before and during homelessness.

Education

To identify problems related to deficiencies in patients’ social support systems and knowledge of referral possibilities outside the medical system, it is recommended to integrate social medical care in the medical curriculum. Doctors in general, and general practitioners and social medicine specialists in particular, should have knowledge how to signal, refer and/or guide vulnerable people in preventable stages.

Through the years, in Amsterdam, GGD doctors experienced with outreach care provision to homeless people have been sharing their social medical skills and tri-morbidity knowledge with visiting medical students and others. These visits are of short duration and therefore have a more observing than participating character. However, a more comprehensive social medical care module can be developed so that medical students, and general practitioners and social medicine specialists in training, can have an active part in providing care to the nearly homeless and homeless people in daily practice. Furthermore, the available expertise among the GGD doctors can actively and systematically be shared with the workforce in the OGGZ projects, in academic settings and e.g. with the mainstream colleagues in city areas where social medical disease is clustered.

Research

Following the results in this thesis, and related to the OGGZ projects introduced, it is evident that an overview on vulnerable people and their unmet support needs should be obtained, regardless their setting. A major problem in researching the health issues of the nearly homeless and homeless people is the lack of an academic basis. As a consequence, much remains to be learned to attain to an understanding how to effectively integrate and target services to find and help the most vulnerable in early stages.

In the Netherlands, encouraging efforts have been undertaken to bridge the gap between practice, research and policy making in public health. Recent efforts are formalised in nine so called Academic Collaborative Centres for Public Health (in Dutch: Academische Werkplaats Publieke Gezondheid). For the OGGZ practice it is essential to collect longitudinal data of the characteristics, social medical problems, and mortality, among the nearly homeless and homeless people. Furthermore, data are to be related to the size, nature and costs of

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services, and the responsibilities and competences of the workforce. These dynamics are best understood by close observation in daily practice.

In addition to the existing data collections related to the OGGZ performance field (see table 2 and 3), a Social Medical Monitor might serve as an integral basis, and a new chance to reduce health differences¹⁰ in the Academic Collaborative Centres for Public Health. In table 4 an example of such a monitor is shown. The social medical monitor could serve as a tool for practitioners in daily practice, to learn how to perform a systematic social medical assessment, and to collect data on the job, prospectively. The data obtained could serve as a first step towards an overview of vulnerable people, social medical problems, and mortality, and the pathways into social medical decay. Hence, performance indicators can be further developed to improve social medical care before and during homelessness.¹⁰³

The knowledge gained in this thesis on social medical care before and during homelessness should find its way through practice, education and research, and thus constitutes an effective public health intervention.

An Academic Collaborative Centre is a long-term partnership between one or more community health services (GGD municipal public health service) and a university. The main purpose is to improve knowledge transfer between practitioners, policymakers, researchers and the education sector. The specific goals are: 1) to strengthen and establish a knowledge infrastructure with an equal balance between science and practice; 2) to support researchers (PhD or otherwise) working in regional or municipal public health departments; 3) to foster high-quality scientific research relevant to day-to-day practice in public health services; 4) to disseminate and implement research results; and 5) to improve the application of evidence-based interventions and methods in regional or municipal public health services. http://www.zonmw.nl/en/programmes/all-programmes/academic-collaborative-centres/

Table 4 Social medical monitor for people at risk of social medical decay

<table>
<thead>
<tr>
<th>DEMOGRAPHICS</th>
<th>MEDICAL PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>sex</td>
</tr>
<tr>
<td>address</td>
<td>date of birth</td>
</tr>
<tr>
<td>postal code</td>
<td>place of birth</td>
</tr>
<tr>
<td>place of residence</td>
<td>country of birth</td>
</tr>
<tr>
<td>Public Service Number (BSN)</td>
<td>ethnic origin</td>
</tr>
<tr>
<td>SOCIAL PROBLEMS</td>
<td>SOCIAL PROBLEMS</td>
</tr>
<tr>
<td>Housing</td>
<td>Medical Problems</td>
</tr>
<tr>
<td>independent (owner-occupier / rent contract)</td>
<td>Addiction</td>
</tr>
<tr>
<td>homeless (hostel / residential clinic / prison)</td>
<td>alcohol</td>
</tr>
<tr>
<td>due to eviction for rent arrears by tenure (social housing / private)</td>
<td>drugs (tobacco, cannabis, cocaine, heroin, speed, pills)</td>
</tr>
<tr>
<td>due to relationship problems leaving a home or being sent away</td>
<td>gambling</td>
</tr>
<tr>
<td>due to eviction for rent arrears during stay in prison</td>
<td>Mental health</td>
</tr>
<tr>
<td>due to eviction for nuisance / behaviour</td>
<td>confused, bizarre behaviour; psychotic</td>
</tr>
<tr>
<td>due to other reasons, such as leaving an institution / clinic</td>
<td>rude, aggressive, conduct disorder</td>
</tr>
<tr>
<td>Income</td>
<td>Self neglect (body mass index)</td>
</tr>
<tr>
<td>ID-card, registration population register (postal) address</td>
<td>poor dental status</td>
</tr>
<tr>
<td>income from legal employment / illegal / none</td>
<td>chronic pulmonary problems</td>
</tr>
<tr>
<td>benefits unemployment / disability (budget / financial debts)</td>
<td>heart vessel disease / hypertension (blood pressure)</td>
</tr>
<tr>
<td>health insurance</td>
<td>cirrhosis of the liver</td>
</tr>
<tr>
<td>Activities</td>
<td>HIV, Hepatitis B, Hepatitis C, tuberculosis</td>
</tr>
<tr>
<td>doubling primary school classes / drop-out high school</td>
<td>cancer</td>
</tr>
<tr>
<td>highest education level with diploma (low, middle, high)</td>
<td>diabetes</td>
</tr>
<tr>
<td>work experience / daily activities / contacts police and jail</td>
<td>epilepsy</td>
</tr>
<tr>
<td>contacts social network family / friends (name, address, phone)</td>
<td>MORTALITY</td>
</tr>
<tr>
<td>MORTALITY</td>
<td>date of death</td>
</tr>
<tr>
<td>date of death</td>
<td>overdose / intoxication</td>
</tr>
<tr>
<td>day of the week of death</td>
<td>suicide / homicide</td>
</tr>
<tr>
<td>time of death</td>
<td>accident / trauma</td>
</tr>
<tr>
<td>place of death</td>
<td>NATURAL CAUSE OF DEATH</td>
</tr>
<tr>
<td>housing status at death</td>
<td>heart vessel</td>
</tr>
<tr>
<td>pulmonary</td>
<td>cancer</td>
</tr>
<tr>
<td>cancer</td>
<td>HIV / AIDS</td>
</tr>
<tr>
<td>other</td>
<td></td>
</tr>
</tbody>
</table>

To obtain an overview on vulnerable people and the dynamics between the different stages of social medical decay, a comprehensive data set should include demographics, three social domains: housing - related to settings and pathways into homelessness - income and activities; and three medical domains: addiction, mental and physical health problems; and mortality by (un)natural causes. The medical problems chosen are those in need of chronic and costly guidance and/or have a significantly increased risk of death. Guided by this social medical monitor, the amount and intensity of the problem oriented social medical care to be provided to the individual should be assessed, initiated, monitored and followed up by professionals skilled and experienced in social medical decay.


Summary

Social medical care before and during homelessness in Amsterdam