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

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Homelessness is a major public health problem for which little scientific evidence is available on how to help prevent people from becoming homeless and how to improve the health of homeless people. In Amsterdam, health professionals at the GGD* Outreach Dr. Valckenier-Practice provide social medical care to homeless people. Based on the practice experience and several data collections on the job and in addition over the last decade, this thesis explores strategies to help prevent people from experiencing social medical decay. Hereto, we aim to identify:

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 examined using 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 in a shelter-based convalescence care facility in Amsterdam?

In chapter 1, in the introduction, a model is represented by subgroups of individuals who find themselves in a progressive state of social and medical decay. In the various phases, the housed at risk of eviction, the recently homeless, the long term homeless and mortality among homeless people, were examined between 1997 and 2008. Of the different study groups, point prevalence information was collected at a variety of sites and from various data sets provided by the social 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.

In chapter 2, the magnitude of evictions and the households at risk of eviction were explored. In 2003, we sought information about social services that help clients with rent arrears and nuisance, as the major causes of evictions. Based on their own client records, case workers of 12 housing associations and 13 nuisance control care networks filled out questionnaires that provided information about characteristics and social medical problems among households at risk of eviction.

In Amsterdam, over the last years, around 4 households per 1,000 rent dwellings were evicted. Among the 275 housed at risk of eviction due to rent arrears, the majority were single living men, in their late thirties, and of Dutch and Surinamese / Netherlands Antillean origin. More than half experienced social problems, a quarter reported medical problems, and it was found that drug addiction problems significantly increased the risk of eviction.

Among the 190 housed at risk of eviction due to housing related nuisance, it was found that most were single living, and they were in their late thirties. One third had also financial mismanagement issues, two thirds had addiction problems, and one third had mental health issues. Financial mismanagement was a significant risk factor for eviction. Among all households in this study information on physical problems was most likely underreported. 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.

In chapter 3, the effectiveness of the signalling and referral system for households at risk of eviction was studied. The signalling system used to identify those who were at risk of eviction was evaluated by examining the extent of problems that were identified by the case workers for rent arrears and nuisance. 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 71%, of whom 48% were in contact with social assistance, and medical problems in 23% of whom 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. For 190 nuisance households, nuisance control care networks reported social problems in 54%, of which 13% were in contact with social assistance, and medical problems in 82%, of which 92% were in contact with medical assistance.

It was concluded that a provision driven and fragmented approach of assistance led the households in highest need, who were unable, or refrained from asking for assistance, on a pathway towards evictions. In response to the ‘silent’ signal of rent arrears, housing associations should not conduct house visits to identify underlying social and also medical problems that should actively be addressed. In response to the ‘loud’ signal of nuisance, despite the high occurrence of medical assistance, financial support was insufficient. Only an integrated approach can keep more people off the streets.

In chapter 4, the recently homeless were examined. To identify recently homeless adults, defined as ‘last housing lost up to two years ago and legally staying in the Netherlands’, participants were recruited on the streets, day centres and night shelters in Amsterdam. In April and May 2004, social science students conducted interviews and collected data on demographics, self reported pathways into homelessness, social and medical problems, and service use, before and after becoming homeless.

Among the recently homeless (n=120), most were single men, around 40 years old, and of Dutch and Surinamese / Netherlands Antilles origin. Before and during homelessness a high prevalence was reported for financial debts (on average 5,000 Euros), gambling and other addiction problems, domestic violence, and mental and/or physical health problems. During homelessness less gambling and addiction problems were reported. Forty percent of the recently homeless were homeless following an eviction due to rent arrears. Before homelessness, evictees 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. Those who were homeless due to relationship problems (one third) reported more domestic violence and, often, cocaine problems. Before and during homelessness, contacts with services were fragmented and did not prevent homelessness. Both before and during the first phase of homelessness medical contacts were low.

* GGD (in Dutch) = Gemeenschaps- en Gezondheidsdienst = Municipal Public Health Service.
For households with a high risk of homelessness and those in the early phases of homelessness underlying social and medical problems should systematically be identified and adequately supported by social and medical professionals. Therefore, outreach social medical care should be provided continuously before and during homelessness.

In chapter 5, long term homeless patients were studied. Hereto, three groups of homeless patients who visited the GGD Outreach Dr. Valckenier Practice at different sites during three time periods, were studied: group A (n=364) April 1997- Nov 1999; group B (n=124) Sept-Dec 2000, and group C (n=137) Feb-May 2005. Data were systematically collected and included the personal characteristics, pathways into homelessness, the medical problems for all three groups, and the reasons for encounter and mortality for group A only.

The homeless patients (total n=625) were most commonly men, around 40 years old, and of Dutch and Surinamese / Netherlands Antilles origin. The major pathways into homelessness were relationship problems, financial debts/evictions, and after leaving prison. 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 more than half reported physical problems.

In group A (n=364), the reasons for encounter primarily consisted of disorders of the skin as well as pulmonary, digestive and musculoskeletal conditions. Beside these conditions, one third presented a combination of chronic addictions, serious mental health problems and a frail physical condition (tri-morbidity). In group A, 20% (n=74) had died in the ten-year follow-up period till 2008. These homeless patients died nearly seven times more often than their housed counterparts with comparable sex and age in Amsterdam. For homeless females and those in the 18-34 age group, the figures were 13 and 18 times more likely respectively. 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.

It was concluded that a combination of homelessness and specific medical conditions resulted in excess mortality. With respect to homeless people entering the homeless circuit, predictors of early death should be identified and supported as early as possible.

In chapter 6, homeless patients admitted in a shelter-based convalescence care facility were studied. Hereto, data on the characteristics of ill homeless adults, underlying medical problems, referral pattern, length of stay, whereabouts after discharge, and mortality, were collected during care provision in the facility, from January 2001 and October 2007.

Among the convalescence care users (n=629), most were men, around 45 years old, and of Dutch and Surinamese / Netherlands Antilles origin. Upon 889 admissions, the physical problems primarily consisted of disorders of the skin as well as pulmonary, digestive and musculoskeletal conditions. Common chronic medical problems included addiction, mental health disorders, hypertension, HIV infection, and liver cirrhosis. The major referral sources were general hospitals and GGD drug clinics. The median length of stay was 20 days. After (self)discharge, two thirds went back to previous circumstances (streets, overnight shelter, prison; including those suspended/arrested due to misconduct). One tenth improved their housing situation (general shelter and/or rent home), and one fifth was transferred to a general hospital or nursing home.

By March 2008, one in seven convalescence care users (13%) were known to have died. Most were men, and aged around 50 years. Overall, the convalescence care users died seven and a half times more often than their housed counterparts with comparable sex and age in Amsterdam. Survival analysis, with correction for age and sex, showed an increased mortality risk for those with HIV, malignancy, cirrhosis of the liver, mental health disorders, and a combination of addictions and mental health problems. 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. However, these findings reconfirms the need for early identification and support for those homeless people with a high risk mortality profile.

In chapter 7, the general discussion and conclusions, the following questions are addressed:
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?

In the general discussion, the results of the five studies are related to the current policies and projects to support the nearly homeless and homeless people, and the responsibilities and competence of the workforce in Amsterdam. Hereto, policy documents and reports were used in regards the eviction prevention practice as offered by the Early Reach Out support networks for rent arrears (in Dutch: Vroeg Eropaf), the Care and Nuisance support networks for the housed with multiple support needs (in Dutch: meldpunten zorg en overlast), and the Homeless Safety Net and case management practice (in Dutch: GGD centrale intake en veldregie voor OGGZ cliënten).

**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, of Dutch and Surinamese / Netherlands Antilles origin, 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, and social and medical problems tended to mount until early death. A significantly increased risk of death was observed among homeless individuals with problems related to alcohol addiction, drug addiction, mental illness, dual diagnosis, HIV, malignancies, chronic pulmonary conditions, liver cirrhosis and diabetes.

**How can we find and identify these individuals**

In daily practice, identifying vulnerable people, their social medical profile and their pathways into social medical decay should be acknowledged. Consequently, defined warning signals of vulnerability should actively be picked up by professionals in housing, welfare, medical, correctional and homeless services. This means that professionals have to look beyond their own discipline and ‘core business’. Hereto, the workforce needs to be willing and competent to apply a systematic approach to identify their clients’ characteristics and social medical problems that mount up to evictions, homelessness and early death.
How can we help them before and during homelessness

In this thesis, among people at risk of social medical decay, before and during different phases of homelessness, medical problems were increasingly prevalent, and resulted in excess mortality. In the eviction prevention practice and the recently homeless case management practice, medical doctors seemed to play a marginal role. In the outreach care practice, doctors were most commonly involved in tackling the health issues among the long-term homeless, and including convalescence and palliative care, to reduce tri-morbidity harm in the last phases of social medical decay.

The marginal role of doctors before and during the early phases of homelessness is in concordance with the absence of the position and responsibilities of doctors in the relevant policy documents and reports. Moreover, in daily practice, in the Early Reach Out support networks for rent arrears, the Care and Nuisance support networks for the housed with multiple support needs, and the Homeless Safety Net and 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 response to the findings above, strategies to help prevent people from experiencing social medical decay should explicit the position and responsibilities of medical doctors. Tackling the social determinants of health and the medical issues of nearly homeless and homeless people requires involvement of medical doctors in practice, education, and research.

Practice

It is recommended to integrate the Early Reach Out support services, Care and Nuisance support networks and the homeless case management networks. 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. Hereto, doctors should actively be involved in the social medical assessment, preventive and treatment actions, consultation with and referrals to medical doctors in the community healthcare network, and reporting the individual care needs for epidemiological and financial purposes. The workout of the individual care plan and follow up should be performed in close cooperation with social nurses, social workers and administrative staff.

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. A comprehensive social medical care module and residency 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.

Research

Following the results in this thesis, it is evident that an overview on vulnerable people and their unmet support needs should be obtained, regardless their setting. Much remains to be learned about how to effectively integrate and target services to find and help the most vulnerable people in preventable stages. 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 services, and the responsibilities and competences of the workforce. These dynamics are best understood by close observation in daily practice.

The existing OGGZ monitors in the Netherlands are a first step for data collection on the most vulnerable people. However, the basis of these data collections could be adjusted according to a social medical perspective. Hereto, a Social Medical Monitor might serve as an integral basis, see table 1. Such a 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 the total overview of vulnerable people, social medical problems, and mortality, and the pathways into social medical decay.

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