



# The Mental Health and Social Exclusion European Network: A Research Activity Report on European Homeless Citizens

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*This report concerns the activities developed by the Mental Health and Social Exclusion (MHSE) Network, an initiative supported by the Mental Health Europe (World Federation of Mental Health). We report some data from the preliminary survey done in five capital cities of the European Union (Madrid, Copenhagen, Brussels, Lisbon, and Rome). The main aim of this survey was to investigate, from a mostly qualitative point of view, the causal and supportive factors implicated in the situation of the homeless mentally ill in Europe. The results point out the familial and childhood roots of homelessness, the perceived causes of the situation,*

*the relationships with the support services, and the expectations of future of the homeless mentally ill. The analysis of results has helped to identify the different variables implicated in the social rupture process that influences homelessness in major European cities. The results were used as the basis for the design of a more ambitious current research project about the impact of the medical and psychosocial interventions in the homeless. This project is being developed in 10 capital cities of the European Union with a focus on the program and outcome evaluation of the health and psychosocial services for the disadvantaged.*

**Keywords:** Homeless, homelessness, European network, European research project, services evaluation, outcome evaluation, social exclusion, mental health.

## The Mental Health and Social Exclusion (MHSE) Network

In the past few decades the number of homeless people in industrialized societies and particularly in Europe has been on the rise and may reach epidemic proportions (Rossi, 1989; Avramov, 1995). Within the homeless population, a marginal group becomes apparent: homeless people who suffer some form of mental disorder. In this study we refer to them as the homeless mentally ill (HMI). Recently, various studies of homelessness conducted in the European Union (EU) have shifted their focus to investigate the prevalence of mental disorders among the homeless (Kovess, Manguin-Lazarus, & Tavares, 1999; Brandt & Munk-Jorgensen, 1996; Cohen

& Crane, 1996; Fichter, Koniarczyk, Greifenhagen et al., 1996; McGilloway & Donnelly, 1996; Vázquez, Muñoz, & Sanz, 1997; Bogdan, Dolgov, & Rotstein, 1998). In recognition of the need in the European Union to devote more attention to the problem of homelessness, especially the homeless mentally ill, professionals in various

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European countries have mobilized to form the Mental Health and Social Exclusion (MHSE) Network.

The MHSE Network began in Rome in 1992 as an initiative of the *European Regional Council (ERC) of the World Federation on Mental Health (WFMH)*, today called *Mental Health Europe*. Coordinated by Dr. Luigi Leonori, the network is an organization of professionals who work closely with the HMI. The objective of the MHSE project is to enhance the understanding of HMI issues and is directed toward psychosocial and health professionals and policymakers in this arena. Through multinational cooperation, the network strives to increase the contact of professionals providing direct attention to the HMI and to coordinate the search for common research methods for use in studying this population. The network also disseminates effective strategies that help identify the problems that affect the HMI, the situations that may be causing or maintaining their situation, and the influence of life circumstances on the mental disorders they suffer.

The MHSE network is focused on two principal aims. Our first interest is centered on the exchange of experiences in order to focus the scope of the HMI problem at the European level. Every two years the MHSE Network organizes a seminar in a different European city: Rome in 1991, Brussels in 1993, Paris, Madrid, and Copenhagen in 1995, 1997, and 1999 respectively. Professionals gather at these conferences to determine useful strategies and common methods to be employed in the systematic study of the HMI. The seminars also define the current state of the HMI in the European Union and attract the attention of powerful lobbyists who bring this matter into the political arena. As a result of the conferences, task forces have been created in different coun-

tries. These groups have begun to survey in their respective countries the centers that provide attention to the homeless in order to further the understanding the HMI problem.

The second focus of our activity is based in research. The network has coordinated interstate research to explore the HMI situation. Some preliminary studies have been conducted in different cities concerning service use and the general HMI condition. The present report provides data from a preliminary survey of the HMI situation conducted in five European cities.

## Preliminary Survey

This preliminary survey was designed to evaluate the psychosocial factors that affect the origin and maintenance of homelessness, HMI use of services, and HMI perceptions of their present situations and futures in different cities. The study was based in Brussels, Copenhagen, Rome, Madrid, and Lisbon. All data were collected between May and July of 1996. These data would be utilized to benefit the HMI by improving the administration of social services and adjusting the health attention directed toward this group, as well as in the design of a more ambitious cross-national study described ahead in this paper.

### Participants

Even though this preliminary survey does not claim to be statistically representative, a sample of the homeless mentally ill was selected in each city based on stratifica-

**Table 1**

Characteristics of the HMI sample in the five cities and total.

	Madrid (N = 20)	Rome (N = 20)	Copenhagen (N = 18)	Lisbon (N = 12)	Brussels (N = 6)	Total (N = 76)
Male	75%	70%	72%	83%	100%	76%
Mean age (years)	48	48	46	43	37	44
Civil status						
Single	70%	70%	55%	44%	67%	62%
Married	5%	5%	5%	0%	0%	4%
Separated or divorced	10%	20%	33%	33%	17%	22%
Widowed	15%	5%	0%	0%	17%	7%
With partner or living companion	15%	0%	5%	0%	0%	5%
With children	40%	20%	17%	25%	33%	28%
Unfinished (abandoned) studies	60%	60%	22%	92%	67%	56%
Worked throughout life	90%	65%	72%	50%	100%	74%
With present employment	0%	5%	0%	0%	0%	1%
Average time homeless (years)	8.0	10.5	7.7	6.7	2.9	7.2

tion criteria of age (adults, over 18 years old), gender (2/3 of the subjects were men), and place of interview (1/3 on the streets, 1/3 in health centers, and 1/3 in social services).

The criteria for inclusion in the sample were determined by the operational definition of homeless according to the *European Council and FEANTSA* (Avramov, 1995): over 18 years of age and sleeping primarily in one or more locations normally unfit for human habitation, such as the streets, shelters, abandoned houses, and parks, during the last month. The subjects also needed to suffer some type of diagnosed mental disorder (ICD-10 or DSM-IV diagnosis) to be included in the study.

A total of 76 life histories were collected: 20 in Madrid, 20 in Rome, 18 in Copenhagen, 12 in Lisbon, and 6 in Brussels. The characteristics of the final HMI sample are described in Table 1.

### Instruments and Procedures

The preliminary survey instrument (MHSE Evaluation Grid) was designed to provide a common European framework to assess the homeless mentally ill. It was designed to be complemented by the interviewer from different data sources (direct semistructured interviews focused on the subject's life history, archival data, and staff interviews) and covers information concerning sociodemographics (25 items), socioeconomic and early family life history (28 items), the factors that may cause or maintain homelessness (mental and physical health problems, personal economic crises, other stressful life

events, etc.) (88 items), use of services (17 items), and future expectations regarding their homelessness situations (15 items).

### Data Analysis

The objective of this study is not to focus on the quantitative analysis, but rather on the identification of variables and factors relevant to the current condition of the homeless mentally ill in Europe. The present study provides data in terms of percentages found in each city. A statistical contrast test between cities and variables has not been included. A more complete analysis of the data has been presented elsewhere (Muñoz & Vázquez, 1997).

## Main Results and Discussion

An examination of the characteristics of the HMI sample surveyed in this study (Table 1) shows that the first main point of discussion relates to the chronic nature of the homelessness found in across the five cities. The average duration of the homelessness situation for a European mentally ill homeless person averages about 7 years. Homelessness seems not to be as deeply rooted in other non-European countries (Shlay & Rossi, 1992; Muñoz, Vázquez, Koegel et al., 1998). Although the life histories reveal continuous work problems, almost three of every four subjects had relatively stable employment during previous stages of their lives. However, the very few

**Table 2**  
Stressful events during childhood of the HMI (in %).

	Madrid (N = 20)	Rome (N = 20)	Copenhagen (N = 18)	Lisbon (N = 12)	Brussels (N = 6)	Total (N = 76)
Little family support	55%	70%	28%	67%	67%	55%
Abandoned by one parent	15%	30%	55%	50%	33%	35%
Family separated due to behavior problems	15%	55%	28%	58%	17%	35%
At least one parent had alcohol problems	20%	30%	33%	42%	83%	34%
Lived in great poverty	5%	40%	39%	50%	50%	33%
Ran away from home	25%	45%	17%	42%	33%	32%
Suffered abuse	25%	40%	17%	42%	50%	32%
Abandoned at an early age	35%	10%	44%	17%	33%	28%
Family separated during childhood	30%	15%	22%	42%	33%	26%
Family separated due to mental illness	10%	45%	11%	25%	17%	22%
Family separated due to alcohol problems	5%	25%	33%	25%	0%	20%
Institutionalization	35%	35%	72%	33%	33%	43%
Hospitalized as a youth	10%	40%	11%	8%	33%	20%
One parent had mental health problems	10%	15%	28%	25%	17%	18%
One parent was homeless	0%	0%	28%	0%	0%	7%

homeless people with present employment reveals the tendency for the labor situation of European HMI to worsen over time and eventually lead to total unemployment.

#### Remote Roots of Homelessness

According to subject's retrospective memories, the family and social history of the homeless is distinguished by an accumulation over time of extreme vital conditions present since childhood (Craig & Hodson, 1998; Muñoz et al., 1998).

Table 2 shows the principal stressful events suffered by the HMI during childhood. Rupture and abandonment situations within the family are especially frequent. Across the five cities almost half of the subjects had suffered some type of early uprooting (including separation from family, permanent fighting within the home, parent alcoholism, etc.). Early institutionalization is also a common factor among the HMI, a factor given little weight until now. This high rate can be linked to these experiences of abandonment and separation.

The HMI are also characterized by a very poor framework of social and affective support within and outside of the family. Results from the sample indicate that the levels of family communication have been extraordinarily deficient. Another remote factor that may play an important role in the genesis of the HMI situation involves parent alcohol use. One out of three subjects recognized problems of alcoholism in one of their parents. More than half report scarce social support from the family of origin.

#### Perceived Causes

Table 3 provides a summary of the principal causal factors of the homelessness situation as identified by the homeless subjects themselves.

Economic factors are cited by one of every two subjects and is therefore the category with the most subjective weight in the determination of the homelessness situation (Muñoz et al., 1999; Fichter et al., 1996). However, factors relating to the lack of social support appear to hold more weight. Half of the subjects report family

**Table 3**  
HMI attributions of being homeless (in %).

	Madrid (N = 20)	Rome (N = 20)	Copenhagen (N = 18)	Lisbon (N = 12)	Brussels (N = 6)	Total (N = 76)
Financial problems	35%	70%	33%	67%	50%	50%
Family problems	30%	75%	39%	58%	50%	50%
Health problems	35%	20%	33%	75%	50%	38%
Behavior or relationship problems	10%	50%	33%	50%	17%	33%
Personal choice	10%	30%	50%	25%	0%	26%
Legal expulsion from home	5%	15%	22%	25%	50%	18%
Discharge from psychiatric hospital	5%	10%	5%	25%	17%	10%

**Table 4**  
HMI use of social and health services and resources (including economic aids) (in %).

	Madrid (N = 20)	Rome (N = 20)	Copenhagen (N = 18)	Lisbon (N = 12)	Brussels (N = 6)	Total (N = 76)
Knowledge of public assistance centers	65%	75%	50%	92%	33%	66%
Knowledge of private assistance centers	30%	35%	39%	33%	17%	33%
Frequent use of shelters	55%	50%	55%	67%	17%	53%
Frequent use of soup kitchens	30%	55%	28%	92%	17%	45%
Frequent use of medical centers	50%	40%	28%	25%	0%	34%
Frequent use of public showers/bathhouses	30%	40%	11%	58%	17%	32%
Collect a regular pension	55%	45%	61%	25%	17%	46%
Collect an occasional allowance	10%	20%	22%	33%	0%	18%
Frequent mental health centers	50%	40%	0%	42%	33%	33%
Receive pharmacological treatment	50%	50%	33%	42%	33%	43%
Admitted to a psychiatric hospital	20%	50%	33%	58%	67%	41%
Receive psychotherapy	30%	0%	22%	8%	33%	17%

problems as a significant cause of their situation. In addition, one in three subjects identify problems with social relationships as another cause of homelessness. The factors related to a lack of love and affection in childhood appear to continue into adulthood. They are later identified as limited, poor family and social networks, and appear to be main contributors to the homelessness situation.

Although all of the subjects presented serious mental health problems, discharge from a psychiatric hospital does not play an important subjective causal role in the situations of the HMI. Regarding legal expulsion from home, notable differences are apparent between cities. This contrast serves as evidence for the need for further study of the homelessness phenomenon from a cross-cultural perspective.

### Service Usage

The data related to the relationship between the HMI and their knowledge and use of services are included in Table 4.

Public assistance centers are better known than the private services, such as nonprofit and religious centers. The homeless mentally ill in this sample use social services, like soup kitchens and shelters, more frequently than they do health services (including mental health assistance). Almost half of the subjects receive some type of economic support/pension, and one in five receive less-

structured economic assistance. Almost 50% receive some type of pharmacological treatment, while only 17% receive psychotherapy. The differences between cities observed in this realm reflect the varying structures of the mental health systems in distinct states of the European Union. These differences again point to a great necessity to create more ample studies with a cross-cultural focus in order to better investigate with more certain detail the particularities that affect the HMI in Europe.

### Hope: A Positive Illusion?

A final aspect of this survey examines the vision the homeless mentally ill have of their current situations and their expectations for the future.

As shown in Table 5, a majority of the sample labels their situation as "difficult," but very few consider it "unsustainable." In fact, the majority defines their present conditions as "transitory" ones. Hopelessness, therefore, is not an element that characterizes these people, and the margin for intervention is to a good extent secure. A look at the table makes it is clear that majority believe their future situation will be better than the present one. Almost all feel that their futures will not be worse than the hard reality afforded to them in the present. Although this observation may seem obvious, it is not: If hope is one of the main elements that sustains individuals, the homeless mentally ill have at least conserved this basic belief.

**Table 5**  
HMI description of their current situation and expectations for the future (in %).

	Madrid (N = 20)	Rome (N = 20)	Copenhagen (N = 18)	Lisbon (N = 12)	Brussels (N = 6)	Total (N = 76)
<b>Current situation</b>						
Transitory	90%	40%	39%	67%	83%	60%
Difficult	55%	65%	55%	67%	0%	55%
Bearable	75%	45%	72%	0%	33%	51%
Unfair	50%	50%	11%	33%	17%	35%
Normal	30%	20%	33%	25%	0%	25%
<b>Expectations for the future</b>						
Better or equal than the present	85%	60%	73%	75%	100%	79%
Without hope	5%	5%	22%	17%	0%	10%
Worse than the present	10%	15%	5%	8%	0%	9%

## Health and Dignity Project

These results served as the basis for orienting research in each of the five collaborating cities and for the initiation of a more ambitious project to study the health factors of this population. The data have contributed to the network's current research project "To Live in Health and Dignity" supported by the European Commission (DG V/E/1 Public Health-Project 1998/PRO/2097). In this case the team consists of José Van Remoortel (MHE), John Henderson (MHE), Luigi Leonori (MHSE Project Coordinator), Thomas Craig (St. Thomas Hospital), and Manuel Muñoz (Complutense University of Madrid) as well as by the local coordinators who organize the work of the teams in each city included (Brussels, Berlin, Rome, Copenhagen, Madrid, Paris, Helsinki, Athens, Lisbon and London).

The project has been organized as a grassroots initiative. In other words, it is geared toward practitioners who wish to make their practice more "interdisciplinary" and "intersector-based" in order to develop more adequately the services proposed and to present the indications and recommendations to political entities. In this way the project is conformed as a complementary action of the «Preliminary Survey» presented in this paper. Its main goal is to examine the health outcomes of various social and health services and projects in 10 EU capital cities.

### Aims of the Health and Dignity Project

The project covers the following issues:

1. Observing and evaluating the mental, physical, and social health needs of socially disadvantaged people.
2. Recording, analyzing, and assessing good practices and methods in 10 European cities.
3. Providing local, regional, and Europe-wide health policymakers with appropriate methods and indications that best meet the health needs of this group of undeserved citizens.
4. Promoting support and developing an interdisciplinary and intersector-based collaboration between welfare organizations, charity associations, and public health services for a new partnership and action.
5. Developing local network and structuring the European MHSE network, and connecting this network with other European networks working in the health sector.
6. Publicizing the results, opening an internet forum, and promoting training for social and health workers

7. Preparing a feasibility study for the pilot and transnational project "Health in the Street," in order to bring health promotion, education, and prevention to where they are most needed.

### Methods

The methodology used will be multidimensional in the sense that the project will include some different types of methods in the different moments and contexts of activity of the project.

#### a) Regarding the local context:

- Collecting documents and data on health/mental disease in each capital city (primary and secondary sources).
- Presenting national social legislation about exclusion.
- Presenting national mental health legislation.

#### b) Regarding needs:

- Individualize and evaluate the risk factors, particularly the psychosocial risks, for orienting the innovative projects with the prevention/protection factors.
- Individualize and analyze the health/needs in general and more particularly the mental health needs of socially disadvantaged persons.

#### c) Regarding practices:

- Adopting common criteria for the definition of "good practices."
- Application of these criteria in the "good practices" assessment, specifically the "good practices" in the field of primary prevention (mental health promotion) and secondary prevention (follow-up of mental disorders).
- Presenting a certain number of "presumed" good practices and choosing in each capital city, among the previous ones, six practices specializing in working with socially disadvantaged persons.
- Program evaluation of the six selected practices using a qualitative methodology derived from the program evaluation and outcomes research studies, including staff interviews, group sessions with professionals implicated, visits of experts to the service, etc.
- User survey for collecting quantitative data about outcomes variables: general health status, mental disorders symptoms, general well-being, psychosocial functioning, etc.

#### d) Regarding the European level:

- Comparative summary of the contexts and social legislation about exclusion and mental health.
- Documents and data on mental health/illness with analysis and needs indicators.
- Evaluating the good practices and their methodology.

- Proposing the pilot project "Health in the Street."
- Appendix: data, examples, documents, and videos.

### Expected Results

Results will be presented in the Mental Health and Social Exclusion seminars (e.g., Athens in September 2000). Furthermore, the network will publish quarterly letters and bulletins that include information and indications resulting from this initiative. In this way we invite all professionals and academics working with this problem across Europe to collaborate in the exchange of experiences, reflections, etc.

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