VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons

Case Study Inventory

Document Control

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1   Introduction

Health promotion for disadvantaged persons is a crucial objective for achieving inclusive growth under the Europe 2020 strategy. Furthermore, the 2009 Communication 'Solidarity in Health: Reducing Health Inequalities in the EU'[1] and the Regulation (282/2014) of the European Parliament and Council[2] stress the identification of evidence-based good practices for health promotion and reducing health inequalities. At the national, regional and local levels, there are a number of pertinent practices and approaches, but these are not always assessed and disseminated in a systematic way at the European level. Our project seeks to address this.

The 'VulnerABLE' pilot project aims to find the most effective policy strategies for improving the health of vulnerable and isolated groups. To support this, the project has compiled 31 case studies of existing strategies from across the European Union.

This 'case study inventory' summarises the results from this exercise, as well as providing the full text of the case studies. Its purpose is two-fold:

- Firstly, it is a resource for policy-makers and healthcare professionals who wish to promote health equity and deliver a more inclusive service, by learning from the approaches identified;
- Secondly, it is an important foundation for subsequent stages of the VulnerABLE project, as we will:
  - Undertake capacity-building activities at regional and national level to spread awareness of the practices among officials and health professionals; and
  - Base the final policy recommendations from the project on the findings from these case studies.

2   Methodology

Step 1. 'Scoping' and development of the 'longlist' (111)

To develop the inventory, the project team first conducted a 'scoping exercise' of practices from across the European Union that promote health and prevent health problems for people living in vulnerable and isolated situations. The main methods employed were desk research and the recommendations of key interest groups, such as the Advisory Group and individuals proposed by the European Commission.

Sources for the desk research included the European Portal for Actions of Health Inequalities, the Drivers for Health Equity project, best practices identified by the European Institute for Gender Equality (EIGE), a review by the UCL institute of health inequality[3]: a WHO Review of Social Determinants of Health in the EU, the Northern Periphery programme and the Correlation network, among others.

This scoping exercise resulted in a 'long list' of 111 potentially relevant practices. For each practice, the following information was collected:

- Title
- Main aim and objectives
- Country of implementation
- Lead organisation[s]

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[1] http://ec.europa.eu/health/ph_determinants/socio_economics/documents/com2009_en.pdf
[2] http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014R0282&from=EN
[3] http://www.instituteofhealthequity.org/projects/eu-review

- Type of lead organisation: political authority/project consortium/private business/non-profit NGO/another type)
- Geographical coverage: either local, regional, national or transnational across European countries
- Thematic focus: We divided good practices into two thematic areas – those that tackle inequalities in health status and those that promote access to healthcare services for isolated and vulnerable groups. In some cases, practices embody both elements.
- Target Group – Primary: Each practice showcases an approach that focuses on improving the health among one or more of the following nine target groups:

  - Children and families at risk of poor health, including lone parents;
  - Those with physical, mental and learning disabilities or poor mental health;
  - In-work poor;
  - Those living in rural/isolated areas;
  - Long-term unemployed and inactive;
  - Older people;
  - People with unstable housing situations (homeless);
  - Prisoners;
  - Victims of domestic violence and intimate partner violence.
  - Target Group – Secondary
  - Other comments
  - Website

Within the long list, the researcher also provided an initial judgement of the practice's relevance, objectives, outcomes and impacts, on the basis of information and evidence available. The full longlist is available in the Annex at the end of this document.

Information collected and included in each case study fiche

As part of the research, the following information was collected for each case study, and is reflected in the structure of all case studies in this report: This structure is therefore used in the following sections:

- Main objective and specific aims of the practice;
- Relevance for the 3rd EU Health Programme objectives;
- Target group(s);
- Thematic focus of intervention in relation to reducing health inequalities;
- Key activities;
- Geographical scope;
- Intersectoral dimension (policy areas the practice cuts across);
- Duration;
- Lead organisation;
- Partners;
- Main sources of funding;
- Evidence base for implementation;
- Evaluation of the practice
- Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness;
- Outputs and outcomes;
- Success factors;
- Innovative features;
- Obstacles and lessons learnt;
- Potential for transferability and sustainability; and
- List of references.

Slight changes might occur given the differences in the information found and available for each case study.

Step 2. Developing the initial shortlist (47) of practices

To develop a shortlist of practices, we identified the main countries and target groups covered in the long list. Following the geographical/target group assessment, we assessed each practice in the long list, based on:

1. The **relevance of its thematic focus** to one or both of these objectives: improving access to healthcare services for isolated groups and/or on tackling inequalities in health status;
2. The judgement by the initial researchers of the practice's **relevance, objectives, outcomes and impacts**, on the basis of information and evidence available;
3. The practice's **coverage** of an underrepresented area of Europe (North/South/East/West) or an underrepresented target group.

Based on these three criteria, the project team reviewed the practices, and shared an **initial shortlist** of around 47 practices with the European Commission and its Expert Group on Social Determinants and Health Inequalities. In doing so, the team ensured a good balance between target groups and areas of the EU within the shortlist.

Step 3. Assessing the shortlist to agree the final case studies (31)

Once the shortlist of 47 practices was refined (building upon the feedback of the Expert Group on Social Determinants and Health Inequalities and the European Commission), the project team conducted further research on the practices to assess each one and arrive at a final list of 31 case studies. Based upon the available evaluation evidence, the team assessed the practices and generated a 'quality score' for each. The primary criteria for this assessment is summarised in the table below.

Table 1.   Primary assessment criteria for good practice examples: quality score

Name of criterion	Nature of criterion	Points available (total available – 27)	Extra notes (where relevant)
Relevance to target group	Must be targeted at vulnerable and isolated groups or address the needs and risk that are mostly/disproportionately faced by these persons.	5	Here, the team automatically gave 5 if the practice was targeted explicitly at one of the nine target groups identified for the project. The team gave 4 if it was mainly targeted at one of the nine groups. Note that all practices scored relatively highly against this criterion, given that they had already made it into the shortlist.
Thematic focus	Primary objective of the practice is to: • Improve access to health care; • Address inequalities more generally; Do both of the above.	5	Note that all practices scored relatively highly against this criterion, given that they had already made it into the shortlist.

Name of criterion	Nature of criterion	Points available (total available – 27)	Extra notes (where relevant)
Effectiveness and efficiency	There is robust evidence to suggest the practice is effective i.e., has met its aims and objectives. Within this, short-term and long-term effectiveness should be explored to ensure that they achieve results are maintained over a certain time period. For a practice to be considered efficient, good results should be achieved compared to the scale of resources deployed and in a reasonable timeframe.	5	Here, the assessment specifically focused on the level and quality of evidence available to demonstrate effectiveness and efficiency.
Sustainable	The ability to be maintained over a longer time period without a disproportionate injection of additional resources.	5	This assessment was based first and foremost upon the available evidence of sustainability, but also more generally the lifespan of the project and the level of actual investment
Transferability to other contexts	Examples selected should show good potential to be transferable to other national contexts. This will be especially important in considering access to care within very different care systems.	5	Practices scored particularly highly if they had already been transferred to other countries.
Innovation	Available evaluation evidence suggests that there is something innovative or unusual about the approach	2	Although not a core criterion worth 5 points, this was an important additional criterion, which made it feasible for more recent practices to be included.

In assigning quality scores, the project team worked closely together to ensure consistent interpretation and application of the assessment criteria.

Once all 47 practices had been quality-scored, they were ranked accordingly; largely, the final 31 case studies are those that ranked the highest. However, in some cases, the team made substitutions to improve the balance across the nine target groups of the project and to guarantee a geographically balanced sample of countries[4], including, where possible a good mix of EU Member States from the North, East, South and West[5].

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[4] Case study 1, *POAT Salute*, from Italy, was included upon the request of DG SANTE.
[5] According to the UN Geoscheme.

The quality score given to each of the 31 case studies will be indicated in the following section (section 3).

3 Case study inventory

3.1 Initial findings from the case studies

This inventory contains 31 case studies, all of which aim to improve access to health care for one of the nine target groups of the project; to address inequalities in health status; or both. Specific approaches include:

* Setting up mobile health and outreach services to reach out to vulnerable groups;
* Reforming the delivery of healthcare to make it more appropriate to the needs of vulnerable groups (for example, by sensitising professionals);
* Tackling the lifestyle factors that contribute to poor health;
* Addressing the root cause[s] of poor health[6] for a particular group;
* Raising awareness and engaging communities to empower individuals to take greater control of their health;
* Improving general understanding of the needs of particular groups (through research and engagement).

3.2 Coverage of results

A summary table of case studies is given below, covering their title, primary target group, country of implementation and geographical coverage. A quality score, on the basis of criteria set out in Table 1, is also included for information.

Table 2.   Summary table: Final case studies

	Title	Target Group – Primary	Country	Coverage	Quality score
1	POAT Salute	All	Italy	Regional	14
2	Sure Start (Biztos Kezdet)	At-risk children and families	Hungary	National	24
3	Family centres	At-risk children and families	Sweden	National	23
4	Schutzengel	At-risk children and families	Germany	Local	22
5	Food aid and healthy nutrition programme: DIATROFI	At-risk children and families	Greece	National	20
6	SLAM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach	Having physical, mental and learning disabilities or poor mental health	UK	Regional	20
7	Special Olympics Youth Unified Sports programme	Having physical, mental and learning	Transnational	Europe wide	20

According to the UN Geoscheme.
and employment, the experience of domestic abuse, etc.

	Title	Target Group - Primary	Country	Coverage	Quality score
		disabilities or poor mental health			
8	I See! About Soul and Body for Women with Intellectual Disabilities[7]	Having physical, mental and learning disabilities or poor mental health	Czech Republic	National	16
9	Openemd Munich	In-work poor	Germany	Local	18
10	Empregosaudavel	In-work poor	Portugal	National	17
11	«Let's Live Healthily» part of Project mura	Living in rural/isolated areas	Slovenia	Regional	23
12	Mallu does the rounds	Living in rural/isolated areas	Finland	Regional	23
13	Mobile health care fund	Living in rural/isolated areas	Romania	Regional	19
14	Building Healthy Communities Programme	Living in rural/isolated areas	Ireland	National	18
15	Sortir de soi sortir de chez soi	Long-term unemployed and Inactive	Belgium	Regional	17
16	Action nutritionnelle dans une épicerie solidaire	Long-term unemployed and Inactive	France	National	19
17	Healthy Ageing Supported by Internet and Community	Older people	Transnational	European	20
18	Health promotion and prevention of risk – action for seniors (Pro-Health 65+)	Older people	Poland	European	17
19	Our life as elderly	Older people	Transnational	European	16
20	Drug consumption rooms (DCRs)	People with unstable housing situations (homeless)	Denmark	Regional	25
21	Find & Treat, London	People with unstable housing situations (homeless)	UK	Regional	25
22	Housing First	People with unstable housing	Transnational	European	25

[7] Czech: Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením

	Title	Target Group - Primary	Country	Coverage	Quality score
		situations (homeless)			
23	Ombolt	People with unstable housing situations (homeless)	Denmark	National	24
24	Danish model on food systems in correctional facilities	Prisoners	Denmark	National	24
25	Community-based Health and First Aid in Action	Prisoners	Ireland	National	23
26	Prison Inreach and Court Liaison Service (PICLS)	Prisoners	Ireland	Local	22
27	Health education for social prosperity	Prisoners	Bulgaria	National	22
28	Multi-agency risk assessment conferences (MARACs), United Kingdom 2003–14	Victims of domestic violence and intimate partner violence	UK	National	22
29	Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen - MIGG), Germany 2008–11	Victims of domestic violence and intimate partner violence	Germany	Regional	20
30	Care for Maternity At-Risk Programme	Victims of domestic violence and intimate partner violence	Spain	Local	20
31	Curriculum 'Violence against women and children' — victim protection in Vienna's hospitals Austria, 2001–14	Victims of domestic violence and intimate partner violence	Austria	Regional	19

There is relatively even coverage of (primary) target groups, as summarised below.

Table 3.   Target group coverage of the case studies

Group	Number of practices
All	1
Children and families at risk of poor health, including lone parents	4
Having physical, mental and learning disabilities or poor mental health	3
In-work poor	2
Living in rural/isolated areas	4
Long-term unemployed and Inactive	2
Older people	3

People with unstable housing situations (homeless)	4
Prisoners	4
Victims of domestic violence and intimate partner violence	4
Grand Total	31

Although there is some bias towards practices from Northern Europe, the geographical balance between different regions of Europe (Northern, Southern, Eastern, Western) is also relatively even. For each region, there are at least five case studies; in addition, there are four case studies that are transnational.

Table 4.   Country coverage of the case studies

Group	Number of practices
Austria	1
Belgium	1
Bulgaria	1
Czech Republic	1
Denmark	3
Finland	1
France	1
Germany	3
Greece	1
Hungary	1
Ireland	3
Italy	1
Poland	1
Portugal	1
Romania	1
Slovenia	1
Spain	1
Sweden	1
UK	3
Transnational	4
Grand Total	**31**

4 All target groups

This practice has a more general target group than the remaining practices in this report. A summary table of this practice is given below, which outlines the title, main aim and objective, country and geographical coverage.

Table 5.   Practices targeting all groups

	Title	**Main aim and objective**	**Country**	**Coverage**	**Quality score**
1	POAT Salute	The project aims to strengthen the capacity of the public administration to address health inequalities by targeting deficits in knowledge and skills among health care workers.	Italy	Regional	14

This practice does not exclusively target any of the nine vulnerable groups identified for the project, but instead aims to strengthen the capacity of the public administration in Italy to address health inequalities in general, by targeting deficits in knowledge and skills among the health care workers.

The full case study is given below.

4.1 Case study 1: POAT Salute

Name of practice: 'Plan for Re-organisation and Capacity Building' - POAT Salute

Country: Italy (South: Calabria, Sicily, Puglia, Campania)

4.1.1 Main objective and specific aims

The POAT Salute refers to the 'Plan for Re-organisation and Capacity Building' of Southern Italy's health care systems. The Plan addresses deficits in knowledge and skills that limit the actions and effectiveness of health systems. The overall objective is to increase regional administration and governance capacity to implement and evaluate health sector interventions that affect the socio-economic development of the geographical areas involved[8].

One of the specific aims of the Plan is to strengthen the capacities of the public administration to act on social inequalities in health by developing and promoting tools and interventions to address technical and specialist needs in this area. A pilot project in Sicily for example, which was part of the Plan, focused on strengthening health-authorities' capacities to evaluate interventions and their impact on different socio-economic groups, and to apply the equity lens systematically in health programming.

4.1.2 Relevance for 3rd EU Health Programme objectives

By focusing on strengthening the capacities of the public administration to improve the design and implementation of health-related policies and interventions, the Plan contributes to the broad objectives of the EU Health Programme. It supports more efficient, innovative and sustainable health systems that improve the health of EU citizens, reduce health inequalities and facilitate access to health-care.

Since POAT Salute receives EU Structural Funding, it also reflects how different EU programmes have joint policy objectives and how EU funding can be used to improve Member States' health systems and health equity.

4.1.3 Target groups

The Plan addresses the general population in the four 'Convergence' regions (those with a GDP/capita of less than 75% of the average of the average GDP/capita of EU-25, that is Calabria, Sicily, Apulia, and Campania) that it covers.

There is a special emphasis in the Plan on ensuring that public administrations have the capacity to identify and address the needs of the 'weaker' sections of the populations in these regions, as identified by socio-economic or geographical indicators.

4.1.4 Thematic focus of intervention in relation to reducing health inequalities

The main focus is on developing the tools and capacities that are required by and within health systems to ensure that health and health related services are effective and efficient and address the real needs of people, particularly of vulnerable people, in these regions.

It also reflects how the health sector can work with other sectors to provide comprehensive and accessible services (e.g. integrating health information and population systems, linking health and social services, improving e-health).

4.1.5 Key activities

- The four regions covered by the POAT-Salute assess the main needs within their regions to improve the responsiveness and effectiveness of their health systems and design and carry out interventions. Those are linked to four

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[8] http://poat.agenas.it/anode.aspx?id=43

horizontal lines of action (common to all four regions, and relating to Italy's National Operational Programme under the Structural Funds) and four vertical lines of action (pathways for technical assistance tailored to the need of individual regions that are in line with their Regional Operational Programmes).

- The horizontal lines of action involve strengthening the tools needed to carry out, monitor and evaluate interventions, networking relevant parties involved in health policy within the region and improving the quality and dissemination of information systems within the region.
- Vertical lines of action can involve: monitoring and evaluation of health technologies; developing models and tools to work with epidemiological data and linking this to geographical information; innovation and computerisation in the health sector; supporting health communication activities, participation in relevant national, international projects and research initiatives.
- Among some of the specific actions that the regions have developed under the Plan are those that help to identify specific vulnerabilities that can be corrected by health planning activities. They entail strengthening capacities within the health system to read and interpret the populations' demand for health and basing health services on the indications obtained, measuring impact and effectiveness of services implemented and improving them. Regions have in this respect designed activities that support the organisation, preparation and access to regional sources of information required for epidemiological analyses. They have also taken measures to integrate health and demographic information systems and apply evaluation models to assess the social determinants of health across a person's life-course that includes health information, social co-variates, and geographic indicators. Such tools can be used for an interim analysis of the mechanisms of vulnerability.

In the case of Sicily, the region has implemented ICT health innovation projects to mentor and train local health authorities as a way to improve, innovate, or create computer networks critical to interpreting health needs. Another region, Campania, has implemented measures to update and integrate existing information bases to facilitate the exchange of data and information.

More broadly, the four regions have also taken measures to develop the knowledge base and skills of the health administration in relation to e.g. health impact assessments, application of surveys and scenario-building for policy choices in the health sector. Initiatives have also focused on networking relevant entities in the four regions to ensure cooperation and the exchange of experiences and good practice, to disseminate information and to raise awareness among health workers.

4.1.6 Geographical scope

The 'Plan for Re-organisation and Capacity Building' - POAT Salute covers the four 'Convergance' regions of Southern Italy: Calabria, Sicily, Puglia, Campania.

4.1.7 Intersectoral dimension

At national level, the Plan is a collaboration between the Ministry of Health and the Department of Public Services. It also reflects a collaboration between a wide range of entities at the regional level, such as health and service providers, epidemiological/statistical observatories, the ICT sector.

4.1.8 Duration

The Plan was approved in July 2010, running until the end of the 2007-2013 Structural Fund programming period. (It is likely that the Plan, or elements of it are receiving funding under current ESIF (European Structural and Investment Funds) Programmes but this must be verified, as currently no documentation was available.

4.1.9 Lead organisation

POAT Salute was proposed by the Italian Ministry of Health, who requested funds under the National Governance and Technical Assistance Programme (PON GAT). The Office for the Training of Personnel in Public Administration in the Department of Public Services approved the Plan.

4.1.10 Partners

The Ministry of Health was the coordinating body, and worked with three other organisation that were entrusted to provide training and technical support to specialised entities in the individual reference areas of the POAT. These three organisations were:

- FORMEZ PA – association with legal personnel for private law, centres for service, support, education and training
- National Agency for the National Health Services
- A temporary group of companies A.T.E.SO, who won a competition to provide specific supporting services.

4.1.11 Main sources of funding

'Plan for Reorganisation and Capacity Building' POAT Salute received 11,000,000 in Structural Funding. It fell under Italy's National Governance and Technical Assistance Programme (PON GAT), which received approximately 276 million Euro, 108 million Euro under the European Regional Development Fund.

4.1.12 Evidence base for implementation

The Plan was developed to address the fact that convergence objective regions have lower levels of health than the rest of the country, leading to a greater demand for health care. This can be related to poorer socio-economic conditions in the region, the determinants of health in the regions and their distribution.

It was also based on the realisation that the technical and specialist deficits and organisation problems faced by the public health administration affect in particular the most vulnerable population groups, and that regional health services in the regions covered by the plan fail to protect the health of their citizens, as indicated by passive patient mobility, inefficient and ineffective expenditure and varying and often poor quality of services.

4.1.13 Evaluation: Has the practice been evaluated?

No public information is available.

4.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

POAT Salute is tailored to the changing needs of the four regions where it is implemented, and thus specific initiatives and outcomes vary according to the location and needs.

4.1.15 Outputs and outcomes

The main outputs and outcomes of the programme are the following:

- Technical support to the development of an electronic health dossier and of social and health services delivered at people's homes;
- Support in the geographical analyses of health status of people living in polluted/contaminated areas' within each region and support to the digitalisation of the health sector within each region;
- Support in the organisation and access of local information hubs to evaluate urban health and its determinants;

- Support in the analysis of Health Technology Assessment methodologies, with development of monitoring and evaluation systems on efficacy, safety, costs, social impacts of health technologies that also takes into account the differential impact on people from different socio-economic backgrounds;

Overall POAT, also thanks to the involvement of regional authorities in its development, provides a detailed mapping of the weaknesses of the health system in Italian southern regions. POAT, however, does not focus necessarily on infrastructural flaws or shortcomings in services, but rather on the scarcity of knowledge, skills and capacity that limit the range of action and impact of the health system, which can help identify areas for improvement in access to healthcare services.

4.1.16 Success factors

The main success factors of the intervention can be summarised as follows:

- The central and strong role that the Ministry of Health played in coordinating the Plan and the strong participation and active response of the main parties involved;
- The involvement of regional institutions in developing the Plan, which provides a timely and accurate map of the weaknesses of the health system of southern Italy;
- The fact that the focus of the Plan is not on infrastructure or on gaps in performance, but on deficits in the knowledge and skills that limit action. In this respect the Plan represents a more strategic use of Structural Funds and helps to deliver services by improving competencies and skills that are essential to effective health management;
- The strong participation and active response by regional epidemiological and statistical bodies.

4.1.17 Innovative features

The POAT Salute demonstrates an innovative use of EU Structural Funds to support health systems and to address health inequalities. While the Italian National Strategic Framework's objectives and priorities did not explicitly refer to social and health care, the responsible Authorities recognised that this is linked to the concept of quality of life and well-being and to the socio-economic development of the country, which are addressed. Improving capacities within health care systems and improving health equity were therefore considered relevant operational priorities.

It is also innovative in its use of Structural Funding to improve tools and build the capacities of health administrators to identify and reduce health inequalities, rather than using the funds to provide more health infrastructure more broadly.

4.1.18 Obstacles and lessons learnt

A key obstacle in the implementation of this programme was the ability to apply the emerging data and epidemiological analysis in concrete health planning, especially in times of economic crisis when financial resources are scarce. In addition to this, the success of this programme as a whole was dependant on a number of factors, including:

- The quality of the different interventions funded under the programme;
- How willing administrations were to receive the information compiled;
- The capacity of the beneficiary administrations to absorb the information learnt;
- The attitude of the sectors to cooperate with the health administration and to set up synergies.

4.1.19 Potential for transferability and sustainability

The underlying principles of the Plan, or the way in which Italy has applied ESIF funds, as well as the types of activities introduced to improve the effectiveness and efficiency of health systems in its southern regions, particularly to address specific vulnerabilities, is highly transferable. Notwithstanding this, the obstacles relating to funding would need to be addressed.

In relation to the POAT Salute programme, the responsible Managing Authority indicated that they are strongly motivated to support similar activities in future, attesting to the sustainability of the Plan and its strongest elements.

4.1.20 List of references

Equity Action. Structural funds and health inequalities – Italy. Report produced under Equity Action WP 5. 2013

See: http://fundsforhealth.eu/sf-in-your-country-and-region/sf-per-member-state/?aid=906&sa=1

5 At-risk children and Families

There are four case studies of approaches that target at-risk children and families. A summary table of these practices is given below, which outlines the title, country and geographical coverage of each.

Table 6. Practices targeting at-risk children and families

	Title	Main aim and objective	Country	Coverage	Quality score
2	Sure Start (Biztos Kezdet)	The Sure Start programme is provided to families with children aged 0-5. Sure Start premises, called "houses" in Hungary, provide mothers - or other caregivers - and their children with planned activities delivered by trained staff (e.g. activities to encourage and promote children's physical development, communication and emotional stimulation).	Hungary	National	24
3	Family centres	In 'family centres', universal access to healthcare is provided, as well as information and support (e.g. information for pregnant women, parenting counselling, training for unemployed parents and welfare guidance).	Sweden	National	23
4	Schutzengel	This project aims to improve access to services and quality of services to children from families in difficult social situations. It offers support and services to families, e.g. local midwifery and paediatric services, peers support meetings. Support is provided through family midwifes, social workers and volunteers.	Germany	Local	22
5	Food aid and healthy nutrition programme: DIATROFI	A programme delivering free school meals for children in deprived areas of Greece.	Greece	National	20

Three of these (Family Centres, Schutzengel and Sure Start) focus on increasing access to a range of services for 'at-risk families', who tend to be defined as those from lower socio-economic groups. These services include healthcare, but frequently they are also combined with social welfare, educational and recreational activities. The fourth practice (DIATROFI) is different in that, rather than offering health services per se, it seeks to tackle inequalities in health status by providing free school meals in deprived areas of Greece.

The full case studies are given below.

5.1 Case Study 2: Sure Start (Biztos Kezdet)

Name of practice: Sure Start (Biztos Kezdet)

Country: Hungary

5.1.1 Main objective and specific aims

The Sure Start programme is provided to families with 0 to 5 year-old children. Sure Start takes place in 'Children Houses'- centres specifically set up by the project- in the 36 most deprived sub-regions in Hungary. It provides mothers or other caregivers and their children with various capacity building activities delivered by trained staff.

The programme aims to reach families from diverse backgrounds to promote mutual learning and support as well as integration of children and parents facing multiple disadvantages into the community. Due to very limited day-care opportunities for young children before they enter the compulsory educational system at the age of five, Sure Start Hungary wants to reach children during the early years and strengthen parenting capacities, also providing advice and support to women seeking employment.

Four specific objectives of this programme are:

- to ensure the optimal development of the child;
- to establish a good relationship between parents, children and service providers;
- to strengthen cooperation within the local community; and
- to foster good relationships between professionals involved in the delivery of related child services.

5.1.2 Relevance for 3rd EU Health Programme objectives

This programme is relevant to objective one of the 3rd EU Health programme:

Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, in that it allows children and families to access services (educational, employment, capacity building) that in turn affect their health.

5.1.3 Target groups

The target group of this initiative is children and families (including at risk groups such as lone parents) facing multiple disadvantages.

A secondary target group is long-term unemployed and inactive mothers.

5.1.4 Thematic focus of intervention in relation to reducing health inequalities

The programme has been specifically developed to support children and their families to reduce health, social and education inequalities in the most deprived regions in Hungary. It operates mainly in settlements where early education services are not available and addresses inequalities in child development and health by providing high quality services to groups with little or no access to these. Sure Start provides various forms of support for families during children's early years, which means that the health benefits are evident for the whole family.

5.1.5 Key activities

The programme is still ongoing, and the following key activities are being implemented:

- Activities to encourage and promote children's physical development, communication and emotional stimulation, independence, attention, memory,

major motor skills and sense of direction. This is mainly done through play (play groups) by encouraging the will and aptitude for discovery;

- Providing a safe area and play materials for children to develop;
- Setting up and running parenting classes as well as self-help groups and personal consultations;
- Assistance for parents seeking employment and support in using ICT services; and
- Access to the washing facilities, child care and snacks provided for children.

5.1.6 Geographical scope

National, with a focus on the most deprived micro-region within Hungary.

5.1.7 Intersectoral dimension

The programme is based on cooperation between local social, healthcare, education, child welfare institutions and services.

5.1.8 Duration

The initial piloting started in 2004 and the full programme is ongoing.

5.1.9 Lead organisation

The Ministry of Human Capacities[9], Hungary.

5.1.10 Partners

The Sure Start Children Houses have different forms of management – ranging from municipalities, religious organisations, NGOs and CSOs, coalitions of NGOs/CSOs and municipalities.

5.1.11 Main sources of funding

115 Sure Start Children Houses have started to operate in Hungary (49 operate under the local Hungarian financing system, 66 in the framework of EU funded projects). Specifically, the project has received funding from ESF/Norwegian Fund until 2012. After that, Sure Start received further state financing for 3 years[10].

5.1.12 Evidence base for implementation

The Sure Start programme[11,12] was first developed and implemented in the United Kingdom at the end of the 90's to tackle child poverty and social exclusion of children from disadvantaged communities with limited access to services. In the UK around 500 local groups, comparable to the Hungarian Children Houses, have been founded to reach some 4 million children. Sure Start has subsequently been adjusted to the Hungarian context and implemented since 2004. Initially, the programme was piloted in 5 different locations –a city, a town, a village, and isolated areas with high unemployment rate.[13]

5.1.13 Evaluation: Has the practice been evaluated?

Sure Start (Hungary) was also included in a descriptive and exploratory qualitative study that aimed to capture key information from implementers and end users on the effectiveness of early childhood development programmes to tackle social and health inequalities. This study was carried out by University College London and Eurochild,

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[9] http://www.kormany.hu/en/ministry-of-human-resources/news/funding-doubles-for-sure-start-children-s-homes

[10] http://ec.europa.eu/social/BlobServlet?docId=13452&langId=en

[11] http://www.publications.parliament.uk/pa/cm200910/cmselect/cmchilsch/130/130i.pdf

[12] http://www.ness.bbk.ac.uk/

[13] http://www.tulipfoundation.net/en/programs/bg/programs/ssr_sure_start_regional-75/

with the support of EuroHealthNet, as part of the European FP7 research project DRIVERS[14]. Methods used to evaluate the programme included quantitative data collection from other reports, interviews, and focus groups.

Information gathered via the above study highlights that Sure Start is externally evaluated every two years following a detailed indicator system. The evaluation assesses the socioeconomic context of the children and their families as well as children's development and success later on in kindergartens and schools.

The programme is internally assessed by measuring the development of every child every 6 months, the results of which are shared with parents. In 2009, 2010, 2011 and 2013 studies on the outcomes of the programme were published by the committee which was set up to evaluate it and in 2012 a civic report on children's chances was also published.

5.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Most of the accessible information on the effectiveness of the programme is available via a study carried out as part of the European FP7 research project DRIVERS[7]. Collected evidence is mainly based on qualitative approaches.

5.1.15 Outputs and outcomes

The Sure Start programme currently reaches around 12,000 children and parents in 115 sites across Hungary. The types of services offered range from educational activities, socialising opportunities for children, to employment search support for parents and more practical access to facilities such as IT equipment or washing facilities. The Sure Start houses offer a safe space where children, in particular those facing multiple disadvantage, can be ensured the right developmental opportunities that will increase their social and educational success later on in life. At the same time, parents are supported via various capacity building activities that can have an impact on their children's lives. Given the scale of the programme, and the varying needs of individual beneficiaries, outputs and outcomes differ on a case by case basis.

5.1.16 Success factors

The involvement of the interest groups was a vital part of the implementation of Sure Start in Hungary. to ensure that the programme was transferred to the Hungarian context efficiently, various committees of professionals and interest groups were set up[15].

5.1.17 Innovative features

Two of the most prominent innovative characteristics of Sure Start are identified as:

- The multi-service collaboration between different actors and sectors to achieve a holistic approach to the health and well-being of families: The programme brought together health services, child and social services as well as services to support employment;
- The approach to eradicating child poverty included not only services to support the child in its development, but also practical ways to improve the socio-economic status of the parents.

5.1.18 Obstacles and lessons learnt

When initially setting up the programme in Hungary, communication between the different professional groups and interest groups involved was often difficult, due to different terminologies used and attitudes. In addition, the programme's approach

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[14] www.health-gradient.eu
[15] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/pr_uk_en.pdf

required professional knowledge of early development, which was not readily accessible or available[8].

One of the lessons learnt is that at least 5 years are needed for a programme such as Sure Start to begin running smoothly and having an impact. This is partly due to the fact that it has to achieve a change in attitudes of professionals, community members, and the target group, as stated in a Peer Review report published in January 2015 "*As the programme should and can enhance and facilitate the cooperation of local actors, especially various service providers, it has to play an active, initiating role in such co-operations*"[2]. It is vital to have a constant flow of funding to ensure service continuity and a high impact on cooperation between sectors and different actors.

5.1.19 Potential for transferability and sustainability

Sure Start in Hungary was adapted from the original UK Sure Start programme, showing the possibility for transferability. Recently, the Tulip Foundation, a Bulgarian charity encouraging social responsibility, set up a new programme to introduce the Hungarian Sure Start to civil organisations from Central and Eastern Europe to identify opportunities for introducing the programme in other counties in the region[6].

There is also clear evidence for sustainability. After the end of European Funding in 2012, the programme has been funded by the Hungarian government. Sure Start Children Houses are now listed in the national legislation for protection of children as a basic service for child welfare, which guarantees sustainability of state funding[2].

5.1.20 List of references

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Deven, F. (2006). Sure Start - Synthesis Report. Peer Review and Assessment in Social Inclusion. Accessible at: http://ec.europa.eu/employment_social/social_inclusion/docs/2006/pr_uk_en.pdf

Background study on Sure Start (Hungarian): http://gyermekneveles.tok.elte.hu/6_szam/pub/koscsone.pdf

A detailed evaluation of the programme thus far including quantitative and qualitative data analysis: Szomor Éva – László Noémi: A magyarországi Biztos Kezdet Program alapelvei és működése a kezdetektől napjainkig. Összefoglaló tanulmány. 2014. (prepared in the framework of TÁMOP 5.2.1. measure). This document is not available online but might be available on request.

5.2   Case Study 3: Family Centres

Name of practice: Family Centres

Country: Sweden

5.2.1 Main objective and specific aims

Family Centres is a long standing initiative started in Sweden in the 1970s and has become increasingly popular in recent years, being replicated in the majority of the Nordic countries. These 'Family Centres', aim to provide "a service model that brings together the services that promote the well-being and health of children and families on the basis of a promotive and preventive approach"[16].

The fundamental principle of a Family Centre is to build and continuously promote a link between the well-being of a child and the well-being of his/her parents, taking into account the parents' material, economic, social and emotional resources to provide the best possible quality of life to their offspring. As such, Family Centres promote the strengthening of the marital relationship between the couple, the continuous development of their parenting skills and their active participation in society. At the same time, universal access is provided by way of low-threshold information and support in response to health and social needs, but vulnerable and isolated groups can also access more specialised services. Finally, Family Centres act as a meeting and socialising point for all families irrespectively of their socio-economic, cultural or ethnic background, thus tackling social exclusion and isolation.

Specific aims of this initiative include:

* Supporting parents and nurture their caring and educating skills and abilities;
* Cultivating and fostering the social networks of both parents and children;
* Serving as a meeting venue for families;
* Building and promoting working models that are appealing and encourage the active participation of both parents and children;
* Promoting the identification of social, physical and mental risk factors as early as possible;
* Developing and fostering cross-sectoral and multi-sectoral collaboration between the different sectors brought together under the Family Centre initiative;
* Developing partnerships and collaboration opportunities with the third sector to improve health of children and families;
* Facilitating the exchange and dissemination of research- and evidence-based knowledge.

5.2.2 Relevance for the 3rd EU-Health Programme objectives

Family Centres are relevant for objective one and four of the 3rd EU-Health Programme, as this initiative brings together health and social care services in a single space to facilitate universal access to basic services, thus contributing to the promotion of healthy lifestyles:

* Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle;
* Facilitate access to better and safer healthcare for Union citizens.

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[16] Kekkonen, Montonen and Viitala (eds) (2012) http://norden.diva-portal.org/smash/get/diva2:700870/FULLTEXT01.pdf

5.2.3 Target group(s)

The main target group for this initiative is children and their families, with a special focus on lone parents as a risk group.

5.2.4 Thematic focus of intervention in relation to reducing health inequalities

Family Centres provide access to healthcare and other relevant services targeting families and children in one place, thus promoting universal and simplified access. Furthermore, it undertakes health promotion activities with a view to addressing health inequalities between families.

5.2.5 Key activities

Family Centres provide several activities for parents and children, clustered around the following services:

- Maternity health care service: Provision of health services and information for pregnant women;
- Child health care services: Provision and access to health services for children;
- Open nursery school / kindergarten: Accessible to all families within the programme, it enables the engagement of parents in their children's education and recreational activities, as well as meeting other families and exchanging experiences and knowledge;
- Social welfare preventive activities and operations – Provision of specific services to improve the socio-economic situation of the family, including parenting counselling, training for unemployed parents, and welfare guidance.

5.2.6 Geographical scope

This national programme covers all Swedish regions and municipalities. Over the years, the same model has been replicated in other Nordic countries (Iceland, Denmark, Finland and Norway).

5.2.7 Intersectoral dimension

Family Centres bring together several sectors into a single initiative, cutting across Health (through maternity and child health care services), Social Care (through social welfare preventive activities and operations) and Education (through nursery and kindergarten facilities available for the families involved in the initiative).

5.2.8 Duration

The first Family Centres appeared in the 1970s in Sweden, they are an ongoing practice both in this country and in other Nordic countries.

5.2.9 Lead organisation

Family Centres take a decentralised approach, and are implemented in the regions by the local authorities (municipalities) and health care providers.

5.2.10 Partners

Partners for the Family Centres initiatives vary within each municipality, and include third sector organisations relating to social and educational services.

5.2.11 Main sources of funding

The Family Centres initiative is funded by public funds provided by the Swedish regional and local authorities. The total budget has not been disclosed.

5.2.12 Evidence base for implementation

The establishment of Family Centres was based upon several pieces of evidence and social developments that have occurred since the 1970s, a decade when the wellbeing of children gained a significant momentum. In Sweden, a national debate stirred by

multiple instances of child neglect and a lack of child provision tools identified the need to provide parents with resources and tools to enable them to exercise a healthy and competent parenthood. It also provided them with adequate and decent standards of living, which resulted in lower numbers of harmed children[17].

At the same time, open nurseries began to open throughout Sweden, as isolation was regarded as negative for the health of a child.[18] In Gothenburg, for example, a deeper connection between social services and open nurseries was made, making them accessible to all families with children – this became known as the Gothenburg Method and was the starting point for today's Family Centres[19].

5.2.13 Evaluation: has the practice been evaluated?

The Family Centres initiative has been subject to several evaluations over its life course.

The 2009 evaluation of the Family Centres activities in the Swedish region of Västra Götaland showed that Family Centres are considered a low-risk, universal investment which benefits both children and their parents and contributes to the integration of vulnerable groups – in particular immigrants- who are able to mingle with the local community and learn Swedish during the process. By employing qualified, experienced staff, parents felt that Families Centres provided the support they need to achieve all the competences supported by this initiative.

The same evaluation showed that bringing together different services under one roof has contributed to an increase in health promotion and the decreasing of health inequalities between families with children. The high demand and overcrowding of the existing Family Centres, however, suggests that regional authorities and healthcare services must carefully plan the opening of future Centres, to reach as many vulnerable groups as possible within the region.

5.2.14 Effectiveness: evidence of outputs, outcomes, results and effectiveness

The Family Centres initiative is effective, having been transferred, adapted and implemented in the other Nordic countries[20]. Its implementation has contributed to a greater emphasis in child and social policies in the North of Europe, ensuring that parents (especially the ones from lower socio-economic backgrounds and vulnerable groups) have access to essential and universal maternal, health and childcare services and are counselled and equipped with the adequate tools to give their children the best possible start in life. The recommendations made in the region of Västra Götaland suggest that the initiative has potential for further development and improvement, in view of extending into every single municipality within the region.

5.2.15 Success factors

The Family Centres initiative has successfully contributed to the universality and equal access to health and social services in Sweden and the other Nordic Countries. As mentioned above, the evaluation in the region of Västra Götaland has shown a great involvement from target groups in this initiative and how it has contributed to break the disadvantage cycle in terms of access to healthcare, isolation and social exclusion. At the same time, the initiative started with the collaboration between different sectors, which have actively contributed to its design and implementation, evolving from the Gothenburg Method into the actual framework model.

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17 http://norden.diva-portal.org/smash/get/diva2:700870/FULLTEXT01.pdf (p. 16)
18 Gustafson, 1983
19 Bing, 1997
20 Kekkonen, Montonen and Viitala (eds) (2012) http://norden.diva-portal.org/smash/get/diva2:700870/FULLTEXT01.pdf

5.2.16 Innovative features

While this long-standing initiative does not seem to have evident innovative features, it has contributed to reduce health inequalities and social exclusion by bringing people together, promoting the sharing of knowledge and experiences among professionals and parents and also between families. It has also promoted a preventive approach to health and education, taking forward the premise of enabling parents to give children the best possible start in life, whilst ensuring access to healthcare for those vulnerable groups.

5.2.17 Obstacles and lessons learnt

The evaluation from Family Centres in Västra Götaland pointed out that there is a smaller number of fathers accessing the facilities and services provided by the Family Centres than the number of fathers taking up parental leave in that region, which is linked to the fact that most children in the programme are under 1 year old and, at that particular age, there are more mothers benefitting from maternity leave[21]. This issue is reflected on the recommendations of the evaluation, in which further dissemination of the existing services in particular to fathers is advised.

Another important lesson learnt relates to the need of further advocating for the open pre-school method to be accessible and available to all children, thus making Family Centres a more equal initiative and contributing to its further development.[22]

5.2.18 Potential for transferability and sustainability

The Family Centres initiative is evidently transferrable, as seen by the several replications in the other Nordic countries. While there is uncertainty whether the local and national funding would be sustained, it has been recommended that the practice continues and is geographically extended within Sweden.

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21 Abrahamsson A, Bing V, Lofstrom M (2009)
http://www.vgregion.se/upload/Folkh%C3%A4lsa/rapporter/Family%20centre.pdf
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5.3 Case Study 4: Schutzengel - Support for Young Families in Difficulty

Name of practice: Schutzengel (Guardian Angel) - Support for Young Families in Difficulty

Country: Germany

5.3.1 Main objective and specific aims

This participatory project aims to prevent the development of physical and/or psychological problems in babies and toddlers of vulnerable parent/carer(s) through:

- Improving parent/carer health related behaviours and enhancing their social resources by helping them prepare for pregnancy and child-birth and providing social counselling to deal with problems like stress, violence and aggression, and debt;
- Improving living conditions and encouraging participants to become more involved in their communities by participating in activities and in district committees, and by promoting networks that can support parent/carers, e.g. district day centres.

Guardian Angel works with families to support parents and children in everyday life and in crisis situations. Service providers, volunteers and other parents aim to help parents address difficulties in a sustainable manner.

Due to the project's strong networking with governmental and non-governmental institutions, families in need of support can be quickly and efficiently referred to the appropriate services.

5.3.2 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objective one of the 3rd EU Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle in that provides health and social support to families with very small children, to give them a good start to life.

5.3.3 Target groups

The project is targeted at pregnant women and parents/carers with children 0-3 years of age, in difficult social situations. This includes people with very low income, single parents/carers and migrants with complex social care needs. These groups may be underserved by routine antenatal and postnatal care and support.

5.3.4 Thematic focus of intervention in relation to reducing health inequalities

Guardian Angel is an early childhood intervention that aims to give children in deprived families and communities the best possible start in life.

The first three years of child's life are of critical importance to the life-course of the child. Stresses linked to social deprivation can have a big impact on unborn and very young children, perpetuating disadvantage. This project therefore aims to provide accessible, low threshold assistance to parents with difficulties, and to provide them with the support, knowledge and the services they need to raise healthy and secure children, to break the chain of disadvantage that can maintain and exacerbate health inequalities.

5.3.5 Key activities

Guardian Angel is a nonprofit organisation that supports young families by offering early assistance. It was founded as a club in 2000 by 12 citizens, and now operates in four sites across Schleswig-Holstein. Guardian Angel was initially a voluntary project

but has grown to employ 16 full-time staff in addition to over 20 volunteers. The key activities carried out are detailed below.

Links with local midwifery services

The Guardian Angel project has close links with local midwifery and paediatric services. The family midwife works with a local hospital to support young women/families during pregnancy and after birth. This support extends beyond the usual limit of routine insurance funded postnatal care. The midwife also carries out preventive early care and helps women/families who are often stressed and overwhelmed by worries and health problems, compounded by a new-born baby.

Parents Café/Meeting Points

- The first Parent/carer café that was established in Flensburg is situated within two apartments donated by the housing cooperative in Flensburg. Parents Café's/meeting points provide parents with the opportunity to meet, to discuss their experiences with peers, and to share coping strategies, tips, etc. Collective breakfasts are held within the cafes promoting social networks and healthy eating.
- Activities carried out in and around the cafes include baby massage, courses to combat stress and outdoor physical activities.
- Specialist health advice is given by midwives and pediatricians, who offer consultations in the cafés.

Coordination of the parent cafes and oversight of educational learning of children aged 0-5 years is provided by the kindergarten Adelby.

Family Guardian Angels

A ' family companion', originally employed by the Protestant church but later by the project itself, supports young families in collaboration with the parish especially in coping with everyday life. Home visits are carried out as part of this process. Where appropriate parents are offered access to courses to help them with coping and resilience, and to combat stress and anxiety.

Professional networks

The initiative is linked into a network of family attendants, midwives and paediatricians that are available to support parents and to offer expert advice. Parents can attend meetings where they can access specialist advice, and meet other parents/carers.

Academy for early years help for professionals and volunteers

Guardian Angel has set up an Academy to strengthen the capacities of its staff and volunteers to provide quality supporting services.

5.3.6 Geographical scope

The project takes place at the local level.

Flensburg Neustadt is an economically deprived post-industrial district in Germany, with 4,500 inhabitants including a high number of socially deprived. It is included in the 'Social Town' funding programme. Many families and single parents in the district face difficult social situations, which can have a negative impact on their mental health and that of their children.

The project has expanded considerably since its inception, now including all counties and cities in Schleswig-Holstein.

5.3.7 Intersectoral dimension

The main policy areas that this project cuts across are health, social welfare and youth policy.
Health and education professionals, communication speakers, external speakers provide the courses and trainings as external consultants.

5.3.8 Duration

Guardian Angel began in 2000 as a 'club'. In 2011 its members founded a legal, two tier organisational structure, which still exists.

5.3.9 Lead organisation

Guardian Angel GmbH

5.3.10 Partners

The Guardian Angel GmbH operates nationally with governmental and nongovernmental institutions and is committed to the development of informal social networks at the local level. Among its partners are the municipal youth and social affairs departments, the Protestant church, the local hospital, local housing cooperative, and local paediatricians and child development experts, as well as health insurance companies.

5.3.11 Main sources of funding

Currently Guardian Angel has an annual budget of half a million euros. The funding comes from two main sources. A large proportion of funding comes from the municipality and central government, via the Youth Office and the Ministry of Social Affairs in Schleswig Holstein. The other half of the budget comes from donations, membership fees and fundraising.

In 2012 the project had a total budget of 538,000 euros. The majority of the budget was made up of membership fees and donations together (36.7 %), followed by other revenue (32.1 %), government grants (28.8 %) and reserves from the previous year (3.4 %t).

5.3.12 Evidence base for implementation

It is widely recognised that early years (0-3 years) are a critical period in development, and have a long lasting impact on the future health of a child[23]. Additionally, evidence supports that interventions which focus on vulnerable pregnant and post-natal women effectively improved pregnancy outcomes and child development[24]. 'Vulnerable' women may include women experiencing socioeconomic deprivation, teenage mothers and women with social or health care needs.

Therefore this intervention targets a group in whom peri-natal interventions have been shown to be effective. The project documentation describes the prevalence of deprivation in the project area. This is associated with a higher prevalence of risk factors for vulnerability and therefore a higher level of need.

5.3.13 Evaluation: Has the practice been evaluated?

The kindergarten, Adelby GmbH, has been responsible for the evaluation of the project.

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[23] UCL institute of health equity. Fair society health lives. UCL, 2010
[24] Field F. The foundation years: preventing poor children becoming poor adults. HM Government 2010

5.3.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The implementation and effectiveness of Guardian Angel has been formally evaluated using qualitative research methods. Structured open interviews were carried out with service users and with Guardian Angel staff (including both voluntary and paid employees).

The interview data was analysed for both consistent and divergent themes to obtain a comprehensive assessment of the impact of Guardian Angel.

The focus of the evaluation was on the following three topics:

- Acceptance of the project
- Prevention and Health Promotion
- Cooperation Networks

Several factors were identified as being key to the success of Guardian Angel:

- Trust – between service users, and between service users and Guardian Angel staff,
- Discretion,
- Informality – afforded by the community settings in which the activities were carried out

Additionally, the person centered approach was valued by service users. Mothers reported feeling included in the action plan and reported appreciation of the service.

A particularly positive aspect of the evaluation was the involvement of all key interest groups. Comparative analysis of the results showed a broad consensus of the various perspectives (service users, staff etc.) The results of the evaluation could provide strong evidence that the project of the Guardian Angels is accessible to the target group, and that prevention, health promotion, and innovative cooperation works effectively.

5.3.15 Outputs and outcomes

The Guardian Angel was started in 2000 by 12 volunteers, and now employs 16 full-time staff while 20 volunteer guardian angels also donate time and skills to the programme, to implement the key activities outlined above. The project has been rolled out across Schleswig Holstein, and there are now four locations where parents can meet and receive services.

5.3.16 Success factors

The success of Guardian Angel is based on the broad support it has received from families, and government institutions and policies (for example, the expansion of family midwives in the Federal Protection Act). This in turn is based on the fact that it grew as a grass root initiative that recognised the need for support services for parents in difficult situations and developed low threshold services to meet that.

A strength of Guardian Angel is that it explicitly engages with the ideas and expressed needs of the families involved, and adapts its support services to accommodate their ideas and needs.

An important factor in the success of the project is the amount of direct personal contact between service users and Guardian Angel volunteers and expert staff. This occurs in various settings – cafes/community, home visits, therefore catering for a variety of needs and wants. The ability of Guardian Angel to carry out outreach work and to visit people at home, increases accessibility.

Guardian Angel also combines health and social support, which is critical for young families, particularly those who are at risk of financial hardship, stress and social exclusion.

5.3.17 Innovative features

Guardian Angel is innovate in that it integrates health and social support, reduces social isolation and promotes wellbeing. The Guardian Angel GmbH is part of local 'child and family' networks, and works closely with the municipality and the state of Schleswig. It engages strongly with local partners. For example the housing cooperative in Flensburg donated two apartments rent free by utilising urban development funds. This is indicative of an innovative approach to project development and sustainability. The apartments were kept in good condition, and enhanced social cohesion in the community. This highlights the positive impact of collaborative relationships between the non-profit sector and local governmental services.

A network of allied professionals, experts and volunteers was created. The impact of these networks is likely to be felt in other areas, e.g. hospitals and daycare, which would routinely provide some of the health and social support to vulnerable families. Additionally, this is likely to improve the image of both the local district and the organisations involved in the project. Cooperation between institutions can be enhanced through frequent contacts and agreements. Essentially it should be noted that the combination of structural, urban and social activities under the project generates synergy effects.

5.3.18 Obstacles and lessons learnt

One of the obstacles that the initiative faces is that the services that Guardian Angel provides are deliberately left open, and the user group is not static, so it is difficult to follow its progress and impacts. A more robust method of follow-up would be useful to demonstrate the impact of Guardian Angel.

A major obstacle for Guardian Angel has also been to get more funding for health promotion activities, beyond those obtained through Youth Services. Although the health insurance funds have anchored health promotion in the Social Security Code, practical requirements make it difficult for a body like Guardian Angel to access these.

A key lesson learnt is that a secure funding source is essential for the success of an initiative like Guardian Angel, since it provides security and facilitates the delivery of objectives.

5.3.19 Potential for transferability and sustainability

With sufficient funding this project is transferable to similar contexts in other regions/countries because it has a solid theoretical basis and has demonstrated evidence of effectiveness through qualitative evaluation. To improve sustainability, sufficient time should be invested in the formulation of objectives of the project in the design phase, including considerations for continuation of the work.

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5.4 Case Study 5: Programme on Food Aid and Promotion of Healthy Nutrition – DIATROFI

Name of practice: Programme on Food Aid and Promotion of Healthy Nutrition – DIATROFI

Country: Greece (EL)

5.4.1 Main objective and specific aims

The DIATROFI programme provides food-aid to tackle food insecurity and hunger, which are proven to affect the health and development of children. At the same time, it promotes healthy eating, as the health and development of children is negatively influenced by food choices and eating habits leading to malnourishment or obesity.

The DIATROFI project has two overarching objectives:

- To provide free, daily, healthy and nutritious meals to students in participating public schools in socioeconomically vulnerable areas across Greece; and
- To promote healthy eating of students and their families.

5.4.2 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objective one of the 3rd EU Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, in that it supports children and families from low socioeconomic backgrounds to adopt healthier lifestyles in particular healthier eating habits.

5.4.3 Target groups

The DIATROFI Programme focuses on primary and secondary public school students (6 - 18 years old) in socio-economically vulnerable areas. Meals are distributed to all students so as to avoid stigmatisation. The Programme also targets parents and the wider school community.

The socio-economically vulnerable areas of intervention are identified using different criteria, including: unemployment rates, lowest taxable income data (provided by regional statistics services), questionnaires administered in schools, and feedback from school principals. The most vulnerable schools in the most vulnerable areas were then targeted

According to data collected and analysed during the 2015-2016 DIATROFI Programme:

- 57.2% of the families who participated in the Programme were facing food insecurity;
- 24.6% of families were experiencing food insecurity with hunger;
- In 15.4% of families both parents had no income source; and
- In 65.1% at least one of the parents had no source of income.

5.4.4 Thematic focus of intervention in relation to reducing health inequalities

Since 2012, and in light of the socioeconomic crisis, DIATROFI supports public school students in socioeconomically vulnerable areas by offering them a healthy, free meal on a daily basis and promoting nutrition via educational material and activities (informational material, such as brochures and leaflets distributed to students, as well as games and presentations).

A healthy diet is essential to the cognitive and physical development of a child. Ensuring that children in vulnerable situations get at least one nutritious meal a day and learn/ make their families aware of the importance of and what constitutes a

healthy diet, is a key measure that can contribute to the reduction of health inequalities.

5.4.5 Key activities

Greek primary and secondary public schools (even all day schools) do not provide meals for students in any income bracket. Therefore, DIATROFI:

- Designs and distributes a healthy nutritional meal to all students in selected schools on a daily basis;
- Implements health promotion activities for students and their families including diverse materials and activities for each specific target group (students of different ages, parents, and teachers);
- Implements strict and continuous monitoring of the process and the quality and safety of the meals (in schools and suppliers), e.g. through unannounced visits and microbiological and laboratory tests;
- Assesses the Programme and its impact through questionnaires administered at the start and the end of the school year and through focus groups and personal interviews with all interest groups (e.g. students, parents, teachers/principals).

5.4.6 Geographical scope

Running nationally across Greece since 2012, the DIATROFI Programme has reached 23 prefectures across Greece, more than 530 schools and 90,000 students and has distributed over 12,8 million meals.

5.4.7 Intersectoral dimension

This programme cuts across two policy areas: health and education, while it also impacts on agriculture, food production and the economic sector (more at a local level). Municipality and other local policy makers are also largely involved in this programme.

5.4.8 Duration

The Programme began as a pilot action in 2012 and is ongoing.

5.4.9 Lead organisation

The Institute of Preventive Medicine Environmental and Occupational Health (PROLEPSIS), which is a National level NGO.

5.4.10 Partners

Stavros Niarchos Foundation (main funder); the schools in which the programme is being implemented.

5.4.11 Main sources of funding

Stavros Niarchos Foundation (founding donor of the DIATROFI Programme) and numerous additional donors and supporters (organisations, foundations, companies, individuals, etc.)

5.4.12 Evidence base for implementation

Greece's persistent economic crisis has led to an increase in unemployment and wage cuts, which in turn appears to have resulted in increased household food insecurity. It seems to impact heavily on food availability especially for children and young people in socioeconomically vulnerable areas. According to the European Directorate report on Human Rights, the number of European children at risk of poverty and social isolation is continuously increasing due to the economic recession (FRA, 2012). This is particularly the case in Greece where it is estimated that 686,000 children (35.4%) face that risk (UNICEF 2014). The statistic seems paradoxical compared to the increasing rate of childhood obesity. Yet, childhood obesity and child malnutrition are

two sides of the same coin (OECD, 2014). Adverse economic conditions can prompt unhealthy eating choices, further endangering the health of children and adolescents (WHO, 2012).

In 2012, repeated articles were published in the Greek press about fainting episodes due to hunger among students in poor area primary schools. Prolepsis Institute was asked by the Stavros Niarchos Foundation to propose a programme that would address this worrying and alarming phenomenon.

With the support of the Foundation, DIATROFI was first implemented as a pilot action in 2012 and has continued to date, building on its previous pilot action.

During the 2015-2016 school year a total of 2,104 schools applied to participate in DIATROFI, corresponding to an estimated 262,000 students (19% of the total student population in Greece). Combined with the Programme's data on food insecurity and quality of life, this indicates the need. Unfortunately the current available funds cannot cover the huge demand in Greece at the moment.

5.4.13 Evaluation: Has the practice been evaluated?

Evaluation of this practice, as reported by the programme leaders, is achieved through a rigorous process. Outcome and impact evaluation takes place at all stages of implementation, with a published evaluation expected at the end of 2017.

5.4.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The DIATROFI programme has been ongoing since 2012, with a large number of outputs and outcomes, summarised below.

5.4.15 Outputs and outcomes

During the 2014 - 2015 school year and based on 14,697 matched pre-post questionnaires completed by parents upon entrance to the DIATROFI Programme and at the end of the school period, the main outcomes include the following:

- There was a significant reduction in food insecurity. The average index of food insecurity decreased by 10%. More specifically, 18.1% of the families facing food insecurity at the start of the Programme, did not at the end and 37.3% of the families who faced food insecurity with hunger at the start, did not at the end.
- The Programme effectively addressed weight problems: 16.4% of students who were obese at the beginning reached a normal weight at the end. 33.7% who were overweight at the beginning reached a normal weight at the end. 40.2% who were underweight at the beginning reached a normal weight at the end. 33.4% of students who did not attain normal weight at the beginning, reached a normal weight at the end.
- Healthy dietary choices increased: 73.1% of the students who did not consume fruit now do so while 52.4% of the students who did not eat raw vegetables now do. Approximately, 77.9% of the students who did not consume milk or yogurt now do, and 33.8% of students who did not consume whole wheat bread now do.

In terms of outputs, the following was reported by the lead organisation:

Since 2012:

- 530 schools participated in the Programme
- More than 90,000 students participated in the Programme
- More than 12,300,000 meals have been distributed
- 2,586 schools applied to join the Programme

In the school year 2015-20

- 247 schools (from across 14 regional areas of Greece) participated in the Programme, reaching children;
- Over 1,750,000 meals were distributed throughout participating schools;
- 2,100 applications were received from schools to join the Programme.

5.4.16 Effectiveness

The DIATROFI Programme contributes to the fight against food insecurity and childhood obesity. Significantly, the results so far indicate that among schools participating in the Programme, food insecurity has decreased, the number of underweight, as well as overweight and obese children has decreased, and children's eating habits have improved. The Programme also assists the families of the students financially in an indirect way, as food is provided to children during school hours.

The duration of the tenure in the Programme appears to be a significant parameter that affects food security status. Other parameters such as parents' unemployment or family affluence status also affect the Programme outcomes. The Programme appears to have a more significant effect in areas that were initially in a worse situation, in terms of food security, compared to the rest of the served areas.

Finally, throughout the implementation period, Prolepsis has managed to attract more donations than originally expected, increasing Programme sustainability.

5.4.17 Efficiency

Products distributed in the framework of the Programme are custom made (not available in the market), with strict quality criteria and custom packaging providing messages for healthy nutrition. These products are made available to DIATROFI for less than 50% retail value of related products available in the market. Moreover, Prolepsis Institute has managed to reduce the total cost of a meal during the implementation period as a result of better agreements between the suppliers and the Institute, while increasing the daily quantity and nutritional value of food provided to students.

According to an independent Programme Evaluation conducted in July 2014 by Deloitte, the Programme overall was estimated to have almost doubled the initial economic activity of the companies involved in the programme[25].

This is based on the initial scope of the project, which was expanded through additional funds that were pooled to provide free means at even more schools.

5.4.18 Impact

According to the Programme participants of the school year 2014-15, 18% of the families that faced food insecurity at the start of the school year, no longer faced it by the end of the year. Similarly, 37% of the families that faced hunger at the start of the school year did not face it at the end and 93% of the parents reported that their child adopted a more healthy diet.

Furthermore, the Programme assisted the participating families financially in an indirect way and boosted students' school performance. 91.2% of parents reported that the Programme helped their family financially. They also reported that the Programme positively affected: the student's school concentration (65.5%), school attendance (67.4%), their interest during class (68%), and the student's attitude in schools (65.2%). Additionally, the school principals, teachers and parents of the

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[25] Stavros Niarchos Foundation (2014) "Diatofri Program Evaluation", page 49. Available at: http://www.snf.org/media/4427555/SNF_Nutrition_Program_Assessment.pdf

students have reported that school dropout has decreased, social cohesion, collegiality and solidarity have been strengthened within the school community and also educational achievements, cooperation and communication between parents and the school was improved.

5.4.19 Success factors

The main success factors of the Programme, as identified by the lead organisation, are:

- High quality standards in all steps of implementation and strict monitoring procedures helped to ensure the objectives were relevant to the intended outcomes;
- Adopting an inclusive approach through the participation of all school students regardless of income to avoid stigmatisation;
- Using the opportunity of the free meals to promote healthy nutrition via educational activities addressed to all children, school teachers, parents;
- Regular communication with all beneficiaries and cooperation with schools on a daily basis - regular feedback to improve the Programme (e.g. adjustment of meals, change of procedures when needed, etc.)
- The evaluation of the Programme is regularly conducted using internationally recognised methods and standards, and using both quantitative and qualitative methodology. The results help improve the Programme going forward;
- Continuous awareness raising among a large number of donors (private companies, organisations, foundations, citizens) helps financially sustain the programme;
- The credibility of the project and awareness raising activities have attracted over 300 volunteers that have helped in all stages of the Programme, ensuring its sustainability.

5.4.20 Innovative features

Among the innovative elements of the DIATROFI Programme is its two-fold objective, namely to decrease food insecurity, while promoting healthy nutrition. Food insecurity in the form of moderate or severe hunger directly affects the health and development of children. Similarly, unfavourable economic conditions can negatively influence food choices and eating habits, further threatening the health of children and adolescents. Several epidemiological studies have identified obesity as an indicator of poverty, as it generally affects the lower socioeconomic class, and Greece has one of the highest rates of adult, adolescent and childhood obesity in the EU. The Programme hence responds to both food insecurity of children and childhood obesity as two sides of the same coin by supporting students and their families in a sensitive, transparent and accountable manner.

The DIATROFI Programme also reinforces or introduces new dietary habits and eating patterns of students, such as the consumption of fresh fruit, vegetables, white milk and whole grain bread, at school as well as at home. In addition to the healthy meal itself, the Programme promotes healthy nutrition to all interest groups, including activities and the distribution of educational material relevant for the students and their families, teachers and canteen owners.

Furthermore, the quality and safety of the meals along with the sound implementation of the Programme is constantly monitored and assured through daily visits to the schools, food sample analysis and regular visits to and inspections of the suppliers.

Because of extensive evaluation of outcomes and impact, the Programme provided an opportunity to collect data on health indicators for a large number of students in Greece. This enables the lead organisation to make comparisons at a population level of health status among children and young people.

5.4.21 Obstacles and lessons learnt

In the realisation of such a large-scale Programme several challenges were identified by the lead organisation. These included:

- Challenges in selecting the schools having the highest need, and designing the appropriate health promotion activities for students of different ages;
- Design of healthy meals at a low cost;
- Organising logistics (transportation, food storage) over wide geographical coverage;
- Limited funding from the start of the Programme;
- The ongoing demand for the Programme: Currently there are over 2000 pending applications for inclusion in the project.

Given its longstanding implementation, the DIATROFI programme has evolved and gained important knowledge and lessons learnt concerning the successful implementation of school-based food aid programmes, including:

More specifically a school based food aid programme should consider:

- The importance of having a longer intervention period: One school year is not enough to change eating habits, or to improve sustainable healthy diets;
- Adopting an inclusive approach: Ensuring the participation of all students, not just those coming from a lower socio-economic background. This helps to avoid stigmatisation;
- Implementing a specific evaluation plan for reviewing Programme efficacy and effectiveness from the outset: This provides helpful measures to ensure objectives are being met and gives the opportunity of reviewing programme processes to increase outcomes and impacts;
- Developing dietary planning: In view of providing a healthy and high-quality meal, which meets the age- and gender- specific dietary needs of students;
- Complying with and implementing strict quality standards and facility auditing procedures: This ensures the quality and safety of the food suppliers and of the distributed meal (ex. microbial and chemical test and sensory-based checks);
- Implementing multifaceted approaches for the promotion of healthy nutrition targeted to all parties involved (students, teachers school canteen owners or other relevant school staff and families, including childcare providers other than parents);
- Employing an interdisciplinary team implementing the Programme, and allowing for regular communication with participating schools;
- Conducting regular teacher training and reinforcing the promotion of healthy eating in the framework of existing educational Programmes; and
- Raising awareness of the Programme in the local community and reinforcing a sense of solidarity, with the goal of preserving social ties and developing volunteerism.

5.4.22 Potential for transferability and sustainability

Given its longstanding implementation, and scale, the DIATROFI Programme is a transferable practice. The Programme or its practices can be transferred either in different regions of Greece, or abroad, adjusted to the specific needs and context. Furthermore, although the DIATROFI Programme is designed for schools, it can be transferred into other contexts (e.g. hospitals, workplaces, municipalities, etc.), with the overarching aim of providing healthy food to vulnerable populations.

5.4.23 List of references

DIATROFI website, Scientific documentation, http://diatrofi.prolepsis.gr/en/what-we-do/scientific-documentation.html

Petralias et al, The impact of school food aid program on household food insecurity, European Journal of Public Health,216: 26(2), 290-296;

Stavros Niarchos Foundation (2014) "Diatofi Program Evaluation". Available at: http://www.snf.org/media/4427555/SNF_Nutrition_Program_Assessment.pdf

6   People with physical, mental and learning disabilities or poor mental health

Three case studies showcase approaches that target people with disabilities or poor mental health. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 7.   Practices targeting people with disabilities or poor mental health

	Title	Main aim and objective	Country	Coverage	Quality score
6	SLaM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach	The project aims to promote the recovery approach in hospital wards and to better prepare patients for hospital discharge through developing more positive relationships between staff and service users. This is done through peer support training to staff and service users within psychiatric units, using the 'Tree of Life' model.	UK	Regional	20
7	Special Olympics Youth Unified Sports programme	This programme provides health services for children and adults with intellectual and physical disabilities. It helps them to participate in sport and live active lifestyles contributing to health and well-being, mainly through trainings combining young people with and without disabilities. Parents and families are also involved in the creation of an environment of social inclusion and integration.	Transnational	Europe wide	20
8	I See! About Soul and Body for Women with Intellectual Disabilities[26]	This project produces easy to understand information for women with intellectual disabilities about sex and the female body to support them to make informed choices about sex, relationships, and their health.	Czech Republic	National	16

Broadly speaking, these practices aim to address key issues that can cause poor health status among people with disabilities and mental health issues. The precise focus of these practices differs widely, reflecting to some extent the diversity of this target group.

One (SLaM) seeks to change the *delivery* of healthcare to mental health patients, by improving the relationships between staff and service users in psychiatric units. Another (Special Olympics programme) aims to improve the health status of children and young people with intellectual and physical disabilities, by helping them to participate in sport. The last practice seeks to improve health awareness among women with mental disabilities in the Czech Republic, by producing easily understandable information about sex and the female body. The rationale here is that this will support them to make informed choices about sex, relationships, and their health[27].

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[26] Czech: Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením
[27] This practice also aims to equip these women with the tools to recognise abuse and sexual violence.

The full case studies are given below.

6.1 Case Study 6: SLaM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach

Name of practice: SLaM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach

Country: United Kingdom (UK)

6.1.1 Main objective and specific aims

The main objective of the programme is to promote the recovery approach as well as compassion on hospital wards and better prepare patients for hospital discharge through developing more positive relationships between staff and service users. Within this, the programme has specific aims, including:

- To collaborate with service users who are trained and paid to run workshops;
- To promote the recovery approach to mental health among hospital wards, reinforced by working with service users to co-facilitate the workshops; and,
- To build more positive and collaborative relationships between staff and service users by getting to know the person behind the job or the diagnosis.

6.1.2 Relevance for 3rd EU Health Programme objectives

This programme is relevant to objective three of the 3rd EU Health programme:

- Facilitate access to better and safer healthcare for union citizens, in that the programme trains health professionals to provide better care and support to victims of domestic violence.

6.1.3 Target groups

The primary target group of this programme is people with a physical or learning disability and mental health problems, but more broadly it also provides support for older people and anyone who may benefit from the support the programme offers.

6.1.4 Thematic focus of intervention in relation to reducing health inequalities

The programme focuses on improving access to healthcare by improving relationships between patients and health professionals with the goal of supporting a patient to manage their health condition.

6.1.5 Key activities

The 'Tree of Life' model is a type of narrative therapy which was first implemented in Zimbabwe to help counsellors better engage with communities who had experienced significant trauma. The model provides an opportunity for people who have experienced trauma or problems in life to talk about the positive aspects of their life, through the metaphor of a tree, rather than specifically focus on the problem, which can be traumatic in itself.

Health professionals at SLaM have used the 'Tree of Life' model to develop a local programme which supports their service users. The programme involves working with service users across adult acute wards and psychiatric intensive care units (16 wards in total) to co-facilitate in the delivery of the 'Tree of Life' workshops for patients recovering in inpatient wards. Health professionals trained ten facilitators from the local community who had past experience of using mental health services to co-lead two hour workshops which are held every six weeks.

Under the guidance of health professionals and service user co-facilitators, participants are asked to draw a symbolic tree: the roots of the tree symbolise their past, the ground symbolises their present, the trunk symbolises their skills and abilities, the

branches symbolise their hopes and dreams, and the leaves symbolise the special people in their life.

Once the group has completed their drawings, they are asked to present their drawings to one another, alongside a certificate recognising the other person's hopes, dreams, skills and strengths. After this, the drawings are displayed together in the wards, representing a forest symbolising a collective sense of strength.

6.1.6 Geographical scope

Regional: this programme was implemented within a regional health system in South London, United Kingdom.

6.1.7 Intersectoral dimension

This programme focuses solely on the area of health policy as it is targeted at service users on in-patient wards.

6.1.8 Duration

The programme initially ran over two years (2014 and 2015) but was extended by SLaM to run until the end of March 2016.

6.1.9 Lead organisation

The programme is led by the 'Tree of Life' team at South London and Maudsley NHS Foundation Trust (SLaM). SLaM provides a wide range of mental health services in the UK, including inpatient care for around 5,000 patients a year, as well as community care for around 45,000 people.

6.1.10 Partners

The programme is supported the Maudsley Charity, a charity organisation which supports research, education and investment in mental health and wellbeing.

6.1.11 Main sources of funding

The programme was initially funded by the Maudsley Charity over a two year period, including both delivery of the programme and evaluation. However, in 2015, it was announced that the programme's funding would be extended by SLaM until the end of March 2016.

6.1.12 Evidence base for implementation

The 'Tree of Life' is based on narrative therapy and informed by key systemic and narrative principles that focuses on culture, heritage, spirituality, strengths and hope. It was originally developed in Zimbabwe as a means of helping traumatised communities find a safe place to discuss their problems to overcome problems and building strength within communities. Since its development, the model has been used in a range of local contexts within other countries, including South Africa, Australia, the United States, Sweden and England.[28]

The value of the model is its primary focus on the person, rather than their illness or symptoms. This is achieved through the concentration and identification of strengths and abilities of the self and others, which are collectively utilised by participants.[29]

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[28] Dulwich Centre (2016), The Tree of Life. Available at: http://dulwichcentre.com.au/the-tree-of-life/

[29] Read, P. (2014), Working with communities that have experience trauma – Using the Tree of Life Concept. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-peter-read.pdf

In terms of SLaM's 'Tree of Life' programme, the model was seen as an effective way to address the challenges faced by patients recovering in an in-patient ward as well as engaging a large ethnic minority demographic.[30]

6.1.13 Evaluation: Has the practice been evaluated?

There are some published documents which provide quantitative and qualitative information on the programme, including programme monitoring and anecdotal evidence on participant experiences. However, overall, there is limited evaluative information available on the outcomes of the programme.

6.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Information has been collected by SLaM on some of the outputs and outcome of the programme. This includes delivery of the following outputs:

- Training of 10 facilitators from the local community who have experience of using mental health services to deliver workshops;
- Delivery of workshops across 16 wards;
- Delivery of 'Tree of Life' workshops to nearly 450 service users and 230 member of staff, including 75% of participants representative;

It also includes information on the following outcomes for service users. For example, all participants completed a self-report survey after completing the workshop rating the programme positively; achieving 89% of the maximum score possible. Staff were required to complete a survey both pre- and post-workshop. Similarly, the programme was found to achieve positive outcomes for staff. This showed a statistically significant positive change on five of the eight questions relating to attitudes to recovery and relationships with service users.

During the evaluation, the study also conducted qualitative research into the experience of staff through focus groups and identified themes such as equality, empowerment, rapport and trust building as the key positives to emerge from the workshops.[31]

6.1.15 Success factors

Evidence of the success factors of the programme is limited. However, the 'Tree of Life' model is valued for its approach in engaging members of the community in delivery of projects.[32]

6.1.16 Potential for transferability and sustainability

As a concept, there is strong evidence demonstrating the transferability of the 'Tree of Life' model. It has been implemented in a wide range of countries and settings, to address a range of issues. This includes the following examples:

- In Norway, the 'Tree of Life' model has been adapted into couples courses to support 40 couples with their relationships;[33]

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[30] South London and Maudsley NHS Foundation Trust (SLaM) (2016), Supporting service users. Available at: http://www.supportslam.org.uk/why/supporting-service-users/the-tree-of-life
[31] Fraser, J. (2015), The Tree of Life – Workshops on the Adult Acute and PICU Wards across SLaM. Available at:
http://www.slam.nhs.uk/media/386137/Summary%20poster%20of%20Tree%20of%20Life%20project.pdf
[32] Read, P. (2014), Working with communities that have experience trauma – Using the Tree of Life Concept. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-peter-read.pdf
[33] Zahl-Olsen, R. (2012), How we use the Tree of Life as a metaphor in couple courses in Scandinavia. Available at: http://dulwichcentre.com.au/couple-course-tree-of-life-norway-rune-zahl-olsen.pdf

- In Sweden, the 'Tree of Life' model has been adapted to work with children who face various difficulties or who been through traumatic experiences;[34] and,
- In Australia, the 'Tree of Life' model has been adapted to work with migrant women to tell their stories of migration.[35]

There is evidence that SLaM's 'Tree of Life' programme is sustainable. Funding for the initial period of the programme (over two years) was extended into the following year. The programme has also been nominated for external awards from the National Mental Health Positive Practice Awards and recognised for is exemplary practice by the Race Equality Foundation.

6.1.17 List of references

Dulwich Centre (2016), The Tree of Life. Available at: http://dulwichcentre.com.au/the-tree-of-life/

Fraser, J. (2015), The Tree of Life – Workshops on the Adult Acute and PICU Wards across SLaM. Available at: http://www.slam.nhs.uk/media/386137/Summary%20poster%20of%20Tree%20of%20Life%20project.pdf

Read, P. (2014), Working with communities that have experience trauma – Using the Tree of Life Concept. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-peter-read.pdf

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STTARS Women from Burma Group (2009), Exploring the tree of life with women from Burma. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/Tree-of-Life-Burma.pdf

Vennstrom, T. and Magnusson, K. K. (2014), Tree of Life Sundbyberg, Sweden. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-in-sundbyberg.pdf

Zahl-Olsen, R. (2012), How we use the Tree of Life as a metaphor in couple courses in Scandinavia. Available at: http://dulwichcentre.com.au/couple-course-tree-of-life-norway-rune-zahl-olsen.pdf

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[34] Vennstrom, T. and Magnusson, K. K. (2014), Tree of Life Sundbyberg, Sweden. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-in-sundbyberg.pdf
[35] STTARS Women from Burma Group (2009), Exploring the tree of life with women from Burma. Available at: http://dulwichcentre.com.au/wp-content/uploads/2014/01/Tree-of-Life-Burma.pdf

6.2 Case Study 7: Special Olympics Youth Unified Sports programme

Name of practice: Special Olympics Youth Unified Sports programme

Country: Europe Wide

6.2.1 Main objective and specific aims

The main objectives of the practice are to help children and young people with intellectual and physical disabilities participate in sport, contributing to healthy lifestyles, as well as increase their social integration into the community.

6.2.2 Relevance for 3rd EU Health Programme objectives

The practice is relevant to objective one of the 3rd EU-Health Programme:

- 'Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle'.

6.2.3 Target groups

The main target group of the programme are people with physical, mental and learning disabilities or poor mental health.

6.2.4 Thematic focus of intervention in relation to reducing health inequalities

The focus of the intervention is the organisation of sport activities, combining players with and without intellectual disabilities to favour integration among them. The intent is also to give people with disabilities the opportunity to connect with the wider community, building social capital, improve social integration and physical activity.

6.2.5 Key activities

The Special Olympics Unified Sports programme combines players with and without intellectual disabilities[36] on the same sports teams for training and competitions. The programme is targeted at young people aged 12-25 and it is financed by substantial grants obtained by Special Olympics International. The majority of Youth Unified teams are involved in playing football and basketball, however, teams are also found in other sports e.g. volleyball, handball and table tennis.

Regular trainings are organised, as well as competitions within the countries and abroad. This offers athletes with disabilities and partners the opportunity to travel and represent their local communities in the competitions.

Parents and families are involved in the activities, often volunteering in providing support to the events organised in various ways.

The coaches have a crucial role in promoting the active participation of athletes and partners and create an environment of social inclusion and integration. They have not only a role as trainers, they also promote team spirit. Coaches also acquire particular importance in the eyes of the players and become models of behaviour to them.

6.2.6 Geographical scope

The programme takes place in 58 countries in Europe and Eurasia[37].

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[36] In the sources consulted, players with intellectual disabilities are called 'athletes' and players with no disabilities are called 'partners'.

[37] Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France ,Georgia, Germany, Gibraltar, Great Britain, Greece, Hungary, Iceland, Ireland, Isle of Man, Israel, Italy, Kazakhstan, Kosovo, Kyrgyz Republic, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland,

6.2.7 Intersectoral dimension

The programme cuts across two main policy areas: health and social inclusion, given its focus on physical activity and improving social integration of people with disabilities.

6.2.8 Duration

Special Olympics Youth Unified Sports was developed in 2005, merging two previously existing programmes, Special Olympics school curriculum 'SO Get into It' and Special Olympics Unified Football. The programme is still running[38].

6.2.9 Lead organisation

The lead organisation is Special Olympics Europe Eurasia Foundation, a not for profit organisation based in Dublin. It supports Special Olympics programmes at the national level in 58 European and Eurasian countries as well as cross-border activities and programmes.

6.2.10 Partners

Partners in the programme at global level are: ESPN, U.S. Department of Education, Kim Samuel and the Samuel Family Foundation, King Baudouin Foundation, Perfect Sense, Y&R, Burson-Marsteller, The Coca-Cola Company, WWE, NBA, MLS Works, Uniqlo, Seiko, NIRSA, NFHS, Euro League, UNICEF, UEFA, FIFA Football for Hope.

6.2.11 Main sources of funding

The programme was funded by Sport Olympics partners; no further information is available regarding the costs of the practice.

6.2.12 Evidence base for implementation

The practice was created on the basis of the pre-existing programmes - Special Olympics school curriculum 'SO Get into It' and Special Olympics Unified Football. No information was found showing that the implementation of the programme was based on evidence of effectiveness. However, the evaluation of a pre-existing programme - Special Olympics Unified Football – shows that the programmes were effective in improving athletes' integration in the communities and improving their physical activity and sports skills[39].

6.2.13 Evaluation: Has the practice been evaluated?

An evaluation of the practice was conducted by the University of Ulster in Northern Ireland in August 2010. The assessment covered five European countries: Serbia, Poland, Ukraine, Germany and Hungary. 200 qualitative interviews were conducted and information was gathered on 55 teams. The interviews were conducted with athletes, with and without disabilities, coaches, parents and representatives of the local community.

The objectives of the evaluation were to examine the strength of the programme and evaluate the impact on social inclusion of the participating athletes. The evaluation provided analysis on the effectiveness and outcomes of the programme, further described below.

Portugal, Romania, Russia, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan.

[38] Special Olympics Research Overview, Special Olympics 2015
http://media.specialolympics.org/resources/research/Special-Olympics-Research-Overview.pdf;
[39] An Evaluation of A Unified Sports® Football Pilot Project,
http://www.specialolympics.org/Sections/What_We_Do/Research_Studies_Description_Pages/Unified_Sports_Europe.aspx

6.2.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Through the evaluation mentioned above, information was gathered on the effectiveness and impact of the programme. The evaluation reported positive effects arising from participating in this programme. The replies provided and experiences reported were very similar among the different countries analysed.

The athletes reported multiple positive effects:

- Building social capital and improving social integration:
- The athletes reported to have made friends with other athletes and with partners. Communication opportunities and skills were also enhanced thanks to the participation in the trainings and competitions. The participation in the programme also offered athletes the opportunity to interact with people outside their families and usual networks.
- The opportunities to travel for competitions also provided athletes with the opportunity to interact with new people, have new experiences, improve their independence and visit new places. As a result in many cases communication skills were improved, as well as self-confidence.
- Developing physical fitness and sport skills:
- Most of the athletes reported an improvement in their sport skills, as a result of the participation in the trainings and competitions; abilities in the games, ability to play in a team and fitness capacity were improved. This was reported to be the results of the coaching and playing with the partners. Some of the athletes also reported that, thanks to the participation in the programme, they had developed soft skills that might turn out to be helpful in finding a job in the future.

The impact of the practice on social inclusion and personal development of the athletes that emerged from the evaluation was therefore very positive. Many partners (i.e. players with no disabilities) reported a change in their attitude towards people with disabilities. This can positively contribute to a change in the way the wider society sees people with disabilities and in turn help improve their inclusion in the wider communities. Partners also reported improvements in their sport skills and development of soft skills.

The effects on the partners were slightly more contained; while friendships were established and new attitudes and behaviours produced, the relationships developed thanks to the programme were more limited in terms of number and of relevance.

Even if not all parents actively participated in the programme, the ones who did reported very positive effects of the practice. They confirmed the views and findings from the interviews to the athletes and partners. Also new relationships were reported to have established among parents and families of the athletes and partners. Support, educational and advocacy networks were established. This allowed in particular the parents of the athletes to acquire an increased support in their day-to-day life and gave them an increased confidence in advocating for their children rights.

The community representatives interviewed also recognised the benefits of the programme to the participants and to the wider community.

6.2.15 Success factors

A number of elements were recognised as success factors needed to achieve the objectives of the programme:

- Culture of inclusion: the programme seeks to involve athletes, partners, their families and wider community in the activities carried out. This approach challenges discrimination and promotes a culture of acceptance and inclusion of people with disabilities in the communities;

- Established position in the community: the programme benefitted from previous activities carried out by the Special Olympic clubs over the years; networks of support to the activities were therefore already established in the local communities and regions;
- Enduring programme: long lasting programmes enable the development of strong bonds among athletes, coaches and partners.
- Focus on a shared interest: athletes' and partners' participation is motivated by their interest in the chosen sport. This allows differences between them to become less important and increase their focus on commonalities.

Opportunities to travel and compete: travelling enabled both athletes and partners to strengthen their relationships within the teams. It also increased the appreciation of the players by the home communities they represented in the competitions.

Another important element is that the responses provided through the interviews were very similar in the different countries assessed. This clearly shows the effectiveness of the programme.

From the evaluation conducted it also emerged that the programme challenges the existing dominant culture in the wider communities in three main ways:

- creating bonds between people with disabilities and their non-disabled peers, which normally tend to be inexistent given the separation between these groups in the society;
- creating a positive portrayal of people with disabilities, by informing partners and their families of intellectual disability and subverting stereotypes;
- creating relations between parents and therefore support and advocacy networks.

6.2.16 Innovative features

The elements which were considered as innovative in some of the interviewed communities were:

- the culture of inclusion described above
- the fact of mixing athletes with disabilities with their non-disabled peers, which provided unique opportunities for integration and building social capital
- the support from community representatives and institutions, (such as mainstream sporting organisations, schools and local government) appeared to be beneficial for the programme, in terms of funding, in-kind support and the participation of volunteers.

6.2.17 Obstacles and lessons learnt

A number of challenges were faced by the programme including:

- Structures and dedicated areas are necessary to practice, recruitment of well-organised coaches is needed, as well as their training in relation to the knowledge of the programme and communication skills; and
- Sustained funding was also highlighted as necessary in many cases, to allow the programme to continue and remain sustainable.
- Lessons learnt from the start of the practice relate mainly to the expansion of the practice. New sports could be included or expanded depending upon adequate support and funding. The participation of female athletes and partners could also be increased. Furthermore, the idea of involving mainstream schools and teachers emerged as another lesson learnt from the evaluation carried out. Such involvement could increase the impact of the practice in the communities.

6.2.18 Potential for transferability and sustainability

Special Olympics Youth Unified Sports is a long standing practice, which is already present in Europe and Eurasia. Positive outcomes were identified across all the projects, suggesting that the practice could be expanded to new regions and communities.

6.2.19 List of references

Special Olympics official website, http://www.specialolympics.org/ ;

Unified gives us a chance, An evaluation of Special Olympics Youth Unified Sports Programme in Europe/Eurasia, University of Ulster, Special Olympics Unified Sports, August 2010, http://www.specialolympics.org/uploadedFiles/LandingPage/WhatWeDo/Final%20Repo rt%20Unified%20Sports10%20Sept%202010.pdf ;

Serving Athletes, Families and the Community, The Universal Impact of Special Olympics: Challenging the Barriers for People with Intellectual Disability, 2009 Special Olympics, Inc. http://www.specialolympics.org/uploadedFiles/LandingPage/WhatWeDo/Research_Stu dies_Desciption_Pages/Impact%20Policy%20Brief_feb3.pdf ;

An Evaluation of A Unified Sports® Football Pilot Project, Special Olympics Unified Sports http://www.specialolympics.org/Sections/What_We_Do/Research_Studies_Description _Pages/Unified_Sports_Europe.aspx ;

Special Olympics Research Overview, Special Olympics 2015 http://media.specialolympics.org/resources/research/Special-Olympics-Research-Overview.pdf ;

6.3 Case Study 8: I See! About Soul and Body for Women with Intellectual Disabilities

Name of practice: I See! About Soul and Body for Women with Intellectual Disabilities

Country: Czech Republic (CZ)

6.3.1 Main objective and specific aims

The main objective of I See! is to reduce the risk of sexual abuse and violence against women with intellectual disabilities.

The specific aims of the programme are to:

- Provide intellectually disabled women with information about their body;
- Teach them how to recognise risky situations;
- Provide information about sexuality and relationships to women with intellectual disabilities, their families and experts with responsibilities in this field; and
- Through doing so, reduce incidences of sexual violence against women with intellectual disabilities.

6.3.2 Relevance for 3rd EU Health Programme objectives

- This project is relevant to objective one of the 3rd EU-Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, by helping improve intellectually disabled women's knowledge of gynaecological health maintenance and preventing sexual violence (and thereby the health impacts resulting from sexual violence).

6.3.3 Target groups

The target group of this project is women with intellectual disabilities, across the Czech Republic.

6.3.4 Thematic focus of intervention in relation to reducing health inequalities

Those who have been sexually abused have consistently been found to have increased health risks, particularly with regards to mental health[40]. For example, a recent survey of 42,000 women across the EU-28 found high levels of depression and anxiety among victims of sexual violence, particularly when the violence is committed by their partner. 35% of women who had experienced sexual violence at the hands of their partner reported experiencing depression as a result[41]. Another study conducted in the US found that gynaecological, central nervous system and stress-related problems are 50-70% more common among women who have been sexually or physically abused[42].

Research has found that women are more vulnerable to abuse and maltreatment than men, and disabled people are significantly more likely to be victims of abuse that non-disabled people[43]. This means that disabled women are especially vulnerable: recent research conducted in the UK found that disabled women are up to five times more likely to suffer physical or sexual abuse than non-disabled women[44], while another in Canada estimated that between 40 and 70% of all girls with a disability will be

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[40] Mangiolgoi, 2009. The impact of child sexual abuse on health: a systematic review of reviews.
[41] European Union Agency for Fundamental Rights, 2014. *Violence against women: an EU-wide survey.*
[42] Campbell et al, 2002. Intimate partner violence and physical health consequences.
[43] Plan, 2013. Fact Sheet: Violence against Women and Girls with Disabilities.
[44] Khalifeh et al, 2015. Domestic and sexual violence against patients with severe mental illness.

sexually abused before reaching 18 years of age[45]. This increased likelihood of being subject to abuse means that intellectually disabled women are a population group disproportionately likely to experience the negative health effects resulting from sexual abuse, exposing them to health inequalities.

6.3.5 Key activities

The key activities which took place under I See! were as follows:

- Five brochures for women with intellectual disabilities - covering subjects such as pregnancy, gynaecological examinations, sexual violence, relationships and contraception - were produced and distributed, both in print and online;
- Four self-help groups were established, one each in four different cities (Plzeň, Mladá Boleslav, Prague, and Hodonín);
- An online survey gathering the experiences of the mothers of women with intellectual disabilities was run, to ascertain their needs in terms of access to information and services;
- A website containing all the information gathered during the programme was set up; and
- One meeting of an expert working group on sexual violence against women with intellectual disabilities was held. At this meeting, various experts identified weaknesses in the current system for prevention of abuse, and produced recommendations on how these could be addressed.

- Each of these activities were implemented by team members from the Society to Support People with Intellectual Disabilities in the Czech Republic, with support from University of Iceland Centre for Disability Studies researchers.

6.3.6 Geographical scope

This programme is national as it covers the Czech Republic.

6.3.7 Intersectoral dimension

This programme covers three policy areas: justice, social care and health. It aims to reduce rates of abuse by working with not just the potential victims but also professionals whose remit includes dealing with sexual violence(including the police, judges and NGOs), as well as improving women's (sexual) health literacy and preventing the negative health impacts of sexual violence.

6.3.8 Duration

The project ran for one year, from April 2015 to March 2016.

6.3.9 Lead organisation

The project was run by the Society to Support People with Intellectual Disabilities in the Czech Republic (SPMP). This is a non-profit organisation which undertakes advocacy work for people with intellectual and multiple disabilities and their families. It operates across the Czech Republic, with a membership consisting of more than 8,000 people with intellectual and multiple disabilities, their families and professionals.

6.3.10 Partners

The project worked in partnership with University of Iceland Centre for Disability Studies, a research site within the university's Social Sciences Research Institute. Researchers from the Centre for Disability Studies shared their thematic expertise with the team running the project.

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[45] The Roeher Institute, 2004. Violence against Women with Disabilities.

6.3.11 Main sources of funding

The majority of the project's funding is provided by EEA Grants[46], a fund financed by Iceland, Liechtenstein and Norway to address economic inequality within the EEA[47]. This provided the project with 37,703 EUR, out of a total project cost of 42,982 EUR[48]. The remainder of the funding was provided by the partners.

6.3.12 Evidence base for implementation

Project documentation states that women with intellectual disabilities have very limited access to information concerning their bodies, relationships and sexuality[49], and the project website makes reference to a project participated in by the University of Iceland Centre for Disability Studies called *Access to Specialized Victim Support Services for Women with Disabilities Who Have Experienced Violence*[50], which found that a lack of education regarding sex, sexuality and relationships is one of the primary reasons sexual violence against women with mental disabilities happens so frequently.

There is a clear need for an awareness campaign such as I See!, and there is also research which suggests the methods chosen are likely to be effective. A report published as part of the same project mentioned above examined support services in Austria, Germany, the UK and Iceland, and found that the use of peer support and peer networks can play an important role in helping build disabled women's confidence to tackle abuse[51].

Research from elsewhere has also found that increasing people's health literacy can help them manage their own health and improve their health outcomes[52]. Given that the topics addressed by I See! include pregnancy, contraception and gynaecological examinations, it is likely that I See! could raise the health literacy of women with intellectual disabilities in these areas and thereby help achieve better sexual health outcomes for those women, not just by tackling sexual abuse but also through improving their health habits.

6.3.13 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The project's activities have now been completed. Both the activities and their outputs are well documented on the project's website[53], although information on the outcomes achieved or the overall impact of the project doesn't appear to have been collected so far (by either a project partner or a third party).

6.3.14 Outputs and outcomes

- The final outputs of I See! were:

- Five brochures for women with intellectual disabilities were produced and distributed, both in print and online. These covered subjects such as pregnancy, gynaecological examinations, sexual violence, relationships and contraception;

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[46] eeagrants.org
[47] EEA Grants, 2016a. The EEA and Norway Grants.
[48] EEA Grants, 2016b. Increasing Awareness about Sexual Abuse and Violence amongst Women with Intellectual Disabilities.
[49] SPMP, 2015. Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením. (Czech language)
[50] SPMP, 2016. A project from Iceland.
[51] Snæfríðar-Gunnarsdóttir and Traustadóttir, 2015. Access to specialized victim support services for women with disabilities who have experienced violence.
[52] King's Fund, 2013; Edwards et al, 2012.
[53] http://www.spmpcr.cz/

- The personal stories of mentally disabled women and their families were collected via an online survey;
- Four self-help groups were established, one each in four different cities, and met several times;
- A website containing all the information gathered during the programme was set up[54]; and
- One meeting of an expert working group on sexual violence against women with mental disabilities was held. At this meeting, various experts identified weaknesses in the current system for prevention of abuse, and produced recommendations on how these could be addressed.

No evaluation of the project's outcomes has been published to date. However, given the evidenced lack of education or information on sexuality and sexual health previously available to mentally disabled women, and the utilisation of SPMP's national network of over 8,000 mentally disabled women and their families in disseminating the information produced by I See!, there is a reasonable chance that this project will have generated greater knowledge and awareness among both intellectually disabled women and their family members, concerning both management of their own sexual health and the prevention of sexual violence or exploitation. However, a full evaluation would be needed to accurately determine the full outcomes achieved by this project, as well as its cost-effectiveness and any success factors or barriers that affected project delivery.

6.3.15 Innovative features

The methods used by the project are well-established means of collecting information and using it to raise awareness, although the specific targeting of intellectually disabled women for sexual violence support and prevention appears to be fairly novel. The sexual violence projects and research identified during compilation of this case study tended to focus on sexual violence committed against women or adolescents as a broad group. Where disability was a specific focus, issues specific to women with intellectual disabilities were generally not examined[55].

The running of a project with a specific focus on assisting women with mental disabilities has enabled issues which are unique to intellectual disability to be identified and/or addressed, offering support and education to intellectually disabled women which wasn't available before.

6.3.16 Potential for transferability and sustainability

Although the project has come to an end, the materials produced (such as the brochures) through the project remain accessible via the project's website. If the research and dissemination activities of I See! were to be continued, this would depend upon two key factors:

- **Funding**. The project relied upon the EEA Grants programme for funding. for its activities to continue, it would either need to secure further grant funding from the EEA or attract a similar amount of funding from elsewhere. Without this, it is likely that some, most or all of the project's activities would not be able to run again.
- **Expert availability.** For the project to be continued in its present form, experts who dedicated time to directing and/or implementing this project would need to continue to be made available by their respective institutions.

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[54] www.uzvim.org

[55] For example, Snæfríðar-Gunnarsdóttir and Traustadóttir's (2015) report on violence against disabled women does not make a distinction between physical and mental disability, instead addressing all disability as a whole.

To successfully transfer this project to any other national setting, a replica programme would require both the funding and expert availability mentioned above as key factors of sustainability. On top of that, any attempt to run similar activities with beneficiaries (especially the self-help groups) elsewhere would require:

- **Networks for implementation.** The lead organisation in this project (SPMP) is a non-profit organisation with an established national network of workers and contact with a significant number of intellectually disabled women and their families nationwide, which enabled it to disseminate the findings of I See! to a wide range of beneficiaries. To use similar dissemination methods in another national setting, national partners with similar reach would need to be engaged.

6.3.17 List of references

Campbell, J., Jones, A.S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A.C. and Wynne, C., 2002. Intimate partner violence and physical health consequences. *Archives of Internal Medicine*, 162(10), pp.1157-1163.

Edwards, M., Wood, F., Davies, M. and Edwards, A., 2012. The development of health literacy in patients with a long-term health condition: the health literacy pathway model. *BMC Public Health*, 12(130), pp.

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Plan, 2013. Fact Sheet: Violence against Women and Girls with Disabilities. Woking: Plan.

Snæfríðar-Gunnarsdóttir, H. and Traustadóttir, R., 2015. *Access to specialized victim support services for women with disabilities who have experienced violence*. Reykjavik: University of Iceland Centre for Disability Studies.

SPMP, 2015. Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením. Prague: SPMP. (Czech language)

SPMP, 2016. *A project from Iceland* [online]. Prague: SPMP. Available from: http://www.uzvim.org/?page_id=88&lang=en [Accessed 22 September 2016].

The Roeher Institute, 2004. *Violence against Women with Disabilities*. Ottawa: Public Health Agency of Canada.

7   In-work poor

There are two practices in the inventory that specifically target the in-work poor. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 8.   Practices targeting the in-work poor

	Title	Main aim and objective	Country	Coverage	Quality score
9	Open.med Munich	Offers medical treatment to people without medical insurance, with the aim of improving the health of all individuals residing in Germany, including those without legal residence status.	Germany	Local	18
10	Empregosaudavel	A mental health network to promote good mental health among unemployed and temporary workers, by: organising capacity building activities for healthcare and social care professionals; carrying out interventions aiming at reducing health social and economic inequalities; fostering and facilitating cooperation.	Portugal	National	17

The first of these (Open.med Munich) aims to increase direct access to healthcare services for the in-work poor, by offering medical treatment to those without medical insurance. The second (empregosaudavel) is different in that it takes a research-based approach to promoting good mental health among temporary and unemployed workers, by developing indicators and good practices.

The full case studies are given below.

7.1   Case study 9: Open.med Munich

Name of practice: Open.med Munich

Country: Germany

7.1.1   Main objective and specific aims

The main objective of 'Open.med' is to improve access to primary health care for all people in Germany, regardless of their residence status or their income, providing help for individuals who fall through the social security net[56]. The intervention operates under the belief that healthcare is a basic human right that should be available to all.

7.1.2   Relevance for 3rd EU Health Programme objectives

- This intervention relates to objective four of the 3rd EU Health Programme:
- Facilitate access to better and safer healthcare for Union citizens.

7.1.3   Target groups

'Open.med' is primarily targeted at the in-work poor, as well as other vulnerable groups that do not have access to healthcare. This includes people without legal residence status and German and EU citizens (Especially from Bulgaria and Romania) who cannot afford health insurance premiums.

7.1.4   Thematic focus of intervention in relation to reducing health inequalities

This intervention focusses on providing access to healthcare for those who otherwise may not receive any. The horizontal nature of this project means that it spans across numerous vulnerable groups, and is not specifically targeted at just one, although the majority of people who receive support are the in-work poor and those without legal residence status in Germany. Although this project was initially aimed at migrants, it has expanded to help all those without health insurance.

7.1.5   Key activities

The scheme provides an anonymous and free medical and psychosocial consultation service for those unable to obtain health insurance, mainly due to legal, administrative or financial restrictions. The service is provided at a drop-in clinic in Munich, and appointments are not required. The scheme lists the healthcare areas in which it can offer support for[57]:

- Pregnancy
- Children's health
- Access to doctors and nurses
- Prescriptions and medicines
- Sexual health and contraceptives
- Psychological support
- Victims of violence
- Telephone advice on healthcare if an individual cannot attend the clinic in person

7.1.6   Geographical scope

The service is open to residents in Munich, Germany. The service is provided via a free and anonymous drop-in centre situated in Munich.

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[56] http://www.diplomatisches-magazin.de/international-relations-03-2012-en/A1/?PHPSESSID=fabeesumn69ort07o808s2ejp3
[57] http://www.clinicfinder.org/clinics/92?locale=en

7.1.7 Intersectoral dimension

Improving access to healthcare is the primary policy area connected to the intervention.

7.1.8 Duration

This intervention has been in operation from September 2006 to present.

7.1.9 Lead organisation

The lead organisation is Ärzte der Welt (Doctors of the World), which is a non-profit non-governmental organisation.

7.1.10 Main sources of funding

The scheme is largely dependent upon charitable donations for its funding.

7.1.11 Evaluation: Has the practice been evaluated?

There is a brief mention towards evidence of positive impacts from a master's thesis evaluation of the intervention referenced on the 'Ärzte der Welt' website[58], although the writer of the research and the specific details are not published, whilst the web page does not touch upon issues of cost-effectiveness, efficiency, sustainability.

7.1.12 Evidence base for implementation

The evidence base for implementation is based on the fact that as many as 80,000 people in Germany do not have adequate access to healthcare services, despite Open.med's strong belief that healthcare should be regarded as a fundamental right for all individuals[59]. Following this belief that healthcare should be available to all individuals regardless of income, social status or legal status, the intervention seeks to address this issue (alongside comparable initiatives in Berlin, Stuttgart and Hamburg) by targeting vulnerable groups through the provision of a free and anonymous healthcare drop-in centre in Munich.

7.1.13 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Based on the evaluation information made available, patients were largely satisfied with the support that they received through the intervention, both in terms of the medical assistance that was provided and the attached communication and counselling offered by the clinic[60]. When asked what has changed for them since they became involved with the project, 87% now said that they have access to a doctor when they needed it, 90% have access to the necessary medicine and treatment, and 92% stated that they had a better understanding of their own health conditions[61].

7.1.14 Success factors

Participants in the evaluation stated that they were grateful for the fast, free and un-bureaucratic assistance that enabled them to gain much needed access to healthcare advice and treatment[62]. The service is also an anonymous drop-in centre, which means vulnerable individuals who otherwise would not be able to access healthcare, are able to receive the treatment that they need.

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[58] http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html
[59] http://www.aerztederwelt.org/start/news-details/article/muenchen-openmed-hat-mein-leben-gerettet.html
[60] http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html
[61] http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html
[62] http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html

7.1.15 Obstacles and lessons learnt

Given the situation of the vulnerable people the intervention is supporting, the clinic has to deal with a wide range of different medical requirements from many different groups of people. Therefore to deal with this situation more effectively, the clinic has introduced special consultation times dedicated specifically to women, children, patients with mental illnesses and disabled patients, in addition to general consultations, to better accommodate for the needs of these particular groups during these sessions.

7.1.16 Potential for transferability and sustainability

The potential for transferability and sustainability is dependent upon the availability of long term and reliable charitable funding to provide the service for targeted vulnerable groups, and the voluntary expertise that would be required to deal with the healthcare needs of vulnerable groups in a secure and effective manner, including doctors, nurses and interpreters. The evaluation does state that 'Open.med' holds the potential to become a model project for other organisations and similar projects to follow[63].

7.1.17 List of references

Ärzte der Welt (2014) 'Bestnoten für open.med'. Online. Available at: http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html

http://www.clinicfinder.org/clinics/92?locale=en

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[63] http://www.aerztederwelt.org/projekte/projekt-details/article/bestnoten-fuer-openmed.html

7.2   Case study 10: Emprego Saudavel (Spain)

Name of practice: Emprego Saudavel / ES

Country: Portugal

7.2.1   Main objective and specific aims

The main objective of this project is the setting up of a mental health network to promote good mental health among the unemployed and temporary workers, and develop indicators regarding determinants of mental health and good practice among these populations with the ultimate goal of contributing to better political decision-making on mental health in all policies. Taking into account a Mental Health in All Policies (MHiAP) approach, Emprego Saudavel adopts a multisectoral perspective through the involvement of multiple sectors of society – ranging from health care services to social welfare benefits. This project seeks to reduce mental health inequalities associated with employment instability and the economic crisis, recurring to capacity-building, mental health promotion and mental disorder prevention mechanisms, interventions at the workplace and for the unemployed. Likewise, it promotes the use of evidence-based information for policy-making and improvement of services coordination.

Emprego Saudavel's specific aims[64] are:

- Contribution to better informed decision-making of policy makers through the integration of existing data from the different sectors involved in the project, and identification of relevant indicators about mental health impact of economic crisis;
- To promote positive mental health of specific vulnerable groups among employed and unemployed people through interventions to reduce health inequalities and negative health effects of economic and social inequalities;
- To contribute to capacity-building in health and non-health sectors on mental health promotion and mental health disorder prevention in the perspective of mental health in all policies (MHiAP);
- To improve the dialogue between interest groups, social security services, regional health authorities, primary health care, local mental health services involved in the support of vulnerable groups;
- Exchange experiences of good practices and scientific knowledge strengthen bilateral relations between Portugal and Donor States;
- To build a sustainable network on mental health promotion.

7.2.2   Relevance for 3rd EU-Health Programme objectives

Being focused on mental health promotion for unemployed and temporary workers, this project is relevant for Objective one of the 3rd EU-Health Programme:

- **Promote health**, prevent diseases and foster supportive environments for healthy lifestyles taking into account the **'health in all policies' principle**.

7.2.3   Target groups

Emprego Saudavel has as its main target groups:

- Temporary workers and professionals from temporary work agencies, from human resources departments of organisations and from safety and occupational health. Target organisations are temporary work agencies and private organisations who integrate temporary workers (e.g., call-centres);

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[64] http://www.empregosaudavel.org/en/goals/

- Unemployed people receiving social benefits for less than 18 months and first-job seekers; professionals from public employment centres, (within the Employment and Professional Training Institute/IEFP), from local authorities (municipalities/city-halls), and health professionals (general practitioners and mental health professionals), local mental health services, primary health care units, and social security agencies (within the Social Security Institute/ISS).

7.2.4 Thematic focus of intervention in relation to reducing health inequalities

This project seeks to reduce health inequalities experienced by in-work poor, i.e. temporary workers, and unemployed/inactive people, who struggle more often than permanent workers with mental health issues due to lack of job security and the impact this has on their quality of life – health-, economic- and social-wise.

7.2.5 Key activities

Emprego Saudavel is an ongoing project. So far, it has implemented a number of key activities, such as:

- Capacity-building activities aimed at healthcare and social care professionals, taking into account the principle of (Mental) Health in All Policies (MHIAP). These interventions seek to prepare the targeted professionals to assist and deal with people experiencing mental health issues both in the workplace and within an unemployment situation.
- Interventions seeking to reduce health, social and economic inequalities experienced by the main target groups. These interventions are subjected to assessment and evaluation procedures to measure and improve their effectiveness.
- Using the existing data gathered from the sectors involved in the project (mental health, unemployment, social security and employment) to influence and improve decision-making processes, particularly regarding the impact of mental health issues in the economic and social crisis.
- Promoting the support of the targeted vulnerable groups in this project by fostering and facilitating cooperation initiatives between the different interest groups (e.g. municipalities, employment training services, etc.), social services and regional health authorities on the topic of mental health.
- Knowledge and good practices sharing initiatives between the different Portuguese regions and also the Donor States Involved in this project (Iceland, Norway);
- Fostering of bilateral cooperation among the Portuguese interest groups involved in this project and its Donor States (Iceland and Norway), through:

    - The creation of communication strategies and study visits of the Donor States to Portuguese mental health institutions, employment centres, universities and municipalities;
    - Capacity-building and training workshops on mental health and other relevant topics for all parties involved;
    - Organisation of the project's final conference (taking place on 27 October 2016), where the final results and outcomes of Emprego Saudavel will be presented;
    - The creating of common project websites, newsletters and scientific publications;
    - Creating a sustainable, effective and fully-functioning network on mental health promotion targeting temporary workers and unemployed citizens, making use of the outputs of the project and the built cooperation relationships between partners.

7.2.6 Geographical scope

The project Emprego Saudavel is run at national level in Portugal, covering all the regions.

7.2.7 Intersectoral dimension

Emprego Saudavel has an intrinsic intersectoral dimension by cutting across two policy areas: health and employment. Not only does it address mental health issues on temporary/precarious workers, it provides capacity-building tools to the professionals who work directly with these groups in terms of health promotion and (mental) disease prevention within the workplace and in an unemployment context.

7.2.8 Duration

2015 – October 2016

7.2.9 Lead Organisation

The lead organisation in this project is the Faculty of Medicine of the University of Lisbon (Faculdade de Medicina da Universidade de Lisboa (FMUL)).

7.2.10 Partners

National partners include town halls and medical centres/hospitals across Portugal, as well as regional health authorities, public health and employment institutes and universities. Mental health associations are also involved as consultant partners.

7.2.11 Main sources of funding

This project is partly funded by the Financial Mechanism of the European Economic Area of the European Economic Area Grants (EEA Grants 2009-2014). The grant value is not publicly available.

7.2.12 Evidence base for implementation

Previous studies on the negative effects of temporary work and unemployment on mental health shows that absenteeism caused by mental health issues represents 40% of work absences, with 70 million days of work days lost per year and an annual cost of £808 billion[65]. In addition, 'presenteeism', defined as bad quality of work and decrease in productivity associated with mental health problems, represents 1.8 times more than absenteeism.

The international financial crisis that erupted in 2008 and the complex political and socioeconomic consequences led to difficult life conditions. Currently, in Portugal, unemployment rate estimate is 12.4%[66]. Unemployment status is a well-established social determinant for poor mental health. Also the effects of unstable working conditions as in temporary employment are reflected beyond the individual, extending at family and professional levels.

Recent official data of the National Statistical Institute[67] reveals that in the first trimester of 2015, unemployment rate (13.7%), among women (14.4%) continues to surpass men (13.1%), reflecting the discrepancy between genders. The rate of employed people slightly increased, with men (56.9%) faring better than women (46.6%). By having a gender health-equity oriented strategy, in terms of mental

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[65] Cooper & Dewe, 2008
http://occmed.oxfordjournals.org/content/58/8/522.full.pdf+html?sid=8bde37e7-8a70-43c1-b2a4-b01fb070ae6e
[66] (INE, 2015)
https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_destaques&DESTAQUESdest_boui=224671324&DESTAQUESmodo=2
[67] https://drive.google.com/file/d/0B5u5-x4nFqPzOFZWc01sb3JQdTA/view

health and social gradient in health, Emprego Saudavel gives special attention to the characterisation and reduction of these differences. Furthermore, it takes into account that both genders have different assets and resilience, to assure that both get the same skills and opportunities, empowering them to cope effectively with the insecurities of a temporary job or unemployment.

Temporary employment is associated with the increase of all causes of mortality and deaths, namely those resulting from alcohol consumption and smoking-related cancer[68]. Progressive downgrading of job quality has been exacerbated by wider changes that took place recently in labour market, namely a large percentage of workers being precarious or temporary. On the other hand, a move from temporary to permanent employment is associated with a lower risk of mortality[69]. About 23% of the adult population in Portugal suffers from mental disorders, one of the highest prevalence in Europe, according to a national epidemiological community based mental health study performed in 2009-2010[70]. The study also indicates 50% probability of people suffering from at least one psychiatric disorder during their lifetime. Considering the working population, 49% of self-reported diseases associated with work are related to problems of stress, depression and anxiety[71]. Good mental health is a basic condition to the social and economic development of a country, and to achieve sustainable community strategic goals[72].

7.2.13 Evaluation: Has the practice been evaluated?

An evaluation of Emprego Saudavel's Healthy Employment (HE) Project is undertaken and described in the 'Mental Health and Wellbeing Impact Assessment: Final Report' (2016)[73]. The HE Project involved collaborating with various partners to maximise mental wellbeing for both professionals and unemployed individuals via community-based interventions[74]. A Mental Wellbeing Impact Assessment (MWIA) was employed by the Faculty of Medicine at the University of Lisbon for the evaluation, and involves collating community profiling, literature review and stakeholder views. The evaluation focuses specifically on the capacity-building intervention component of the HE Project which targets professionals from different health and non-health sectors (public and private institutions) dealing with unemployed individuals.

7.2.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outcomes from the project were presented in the final conference in October 2016. No publication on this conference has been released to date.

Overall, the findings from the evaluation of the HE Project indicate that it holds great potential to impact positively on the mental wellbeing of professionals. The project

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[68]Kivimäki et al., 2003
http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.573.1533&rep=rep1&type=pdf
[69] Kivimäki, et al., 2003 http://aje.oxfordjournals.org/content/158/7/663.full.pdf+html
[70] Caldas de Almeida & Xavier,
2013 http://www.fcm.unl.pt/main/alldoc/galeria_imagens/Relatorio_Estudo_Saude-Mental_2.pdf
[71] HSE, 2008 http://www.hse.gov.uk/statistics/overall/hssh0809.pdf
[72] Heitor dos Santos & Pereira Miguel, 2009 https://www.ensp.unl.pt/dispositivos-de-apoio/cdi/cdi/sector-de-publicacoes/revista/2000-2008/pdfs/rpsp-1-2009-1/01-2009.pdf
[73] COOKE, A., COGGINS, T., VIRGOLINO A., CARREIRAS, J., BACELAR-NICOLAU, L. & HEITOR M. J. 2017 . Mental Health and Wellbeing Impact Assessment: Final Report. EEA grants Healthy Employment Project. The impact of a community-based intervention on the mental wellbeing of professionals working with unemployed individuals.
http://empregosaudavel.org/en/publicacoes/
[74] Emprego Saudavel. 2017. http://empregosaudavel.org/pt/

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most effectively engaged professionals working directly with unemployed individuals, although professionals at different working levels were approached. Stakeholders states that the HE Project improved the capacity of professionals to confidently recognise emotional or mental health distress in both themselves or others.

Future iterations of the HE project should direct attention towards enhancing various components of mental wellbeing considered as priority areas, such as enhancing people's belief in their own capabilities and self-determination, healthy lifestyles and conflict resolution, to name a few. The MWIA evaluation recognised the indicators used for monitoring performance and evaluation of outcomes of the project, however, the evaluation suggested further indicators in future rollouts to measure the impact on mental wellbeing, both in subjective and objective terms.

7.2.15 Outputs, outcomes and potential success factors

There are numerous outputs generated by Emprego Saudavel's work. In relation to the HE Project specifically, the following outputs can be identified:

- Training sessions for the unemployed to promote mental health among unemployed people. These were held from 8 – 18 March in Sines, and 28 March – 18 April in Loures.
- National workshop on capacity building in mental health – Inter sectorial dialogues, held at Lisbon University School of Medicine during April and May 2016. The event featured several experts, decision-makers, national and international partners, stakeholders, researchers, student and the general public. The following issues were discussed: unemployment and temporary work, mental health literacy, flagging and referring people at risk, engagement at work, and identifying and preventing burnout.
- Two Mental Wellbeing Impact Assessment Workshops in May and July 2016, held again at the Lisbon University School of Medicine. These workshops focused on the impact assessment of the HE Project's intervention on mental health and wellbeing of unemployed people, and professionals engaging with this sub-group.
- Several presentations on the HE Project at national and international congresses and conferences. For instance, the HE project participated in the European Academy of Occupational Health Psychology Conference in Athens in April 2016.

Further planned outputs to strengthen the bilateral collaboration and ties between Portugal and the Donor countries (Norway, Iceland and Liechtenstein) are:

- The development of training and good practices manuals
- Evidence-based information fed into policy-making processes
- Development of mental health equity impact assessment methodologies
- Recommendations for dissemination
- Identification of a minimal set of indicators
- Exchange of experiences and knowledge[75].

7.2.16 Success factors

Emprego Saudavel has benefitted from the participation of multiple interest groups in the workshops and conferences that have been organised within the framework of the project.

Emprego Saudavel has organised events that have focused on the several mental health-related issues. One of the workshops focussed on burnout and stress from the

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[75] https://www.linkedin.com/company/emprego-saudavel

perspective of healthcare professionals, with the aim of alerting to its causes, effects and how to prevent it. Likewise, the International Meeting on Healthy Employment gathered national and international partners from the various sectors involved in the project (experts health, social care, policy makers, university researchers) to exchange good practices on mental health promotion and prevention, as well as to debate and have parallel working sessions on issues such as precarious employment and unemployment. Such activities show a deep involvement of all interest groups in the implementation of the project, contributing to the final results that were presented in October 2016.

Furthermore, the study visits from the Donor States involved in the Emprego Saudavel project (Norway and Finland) to Portugal have contributed to the strengthening of the collaboration and exchange of good practices between the partners and third parties involved in the project, possibly paving the way for further partnerships on the fields of (mental) health promotion and social care / social services.

The Final Conference of this project, which took place in October 2016, allowed a better understanding of this project's outcomes and their scope, as well as the impact of the activities developed on the project's beneficiaries.

7.2.17 Innovative features

While the project does not highlight innovative aspects of mental health promotion, the employment of a mental health in all policies approach to establish a sustainable cross-sector network between northern and southern European Regions, and the planned development of mental health equity impact assessment methodologies are elements worth considering once implemented.

7.2.18 Obstacles and lessons learnt

A major obstacle to the HE Project, as identified in the evaluation but also applicable to the wider work being undertaken by Emprego Saudavel, is the current adverse economic climate. This poses significant challenges to mental health and unemployment, and creates a more unstable atmosphere within which Emprego Saudavel's work is increasingly required. The short-term funding of the HE programme in this context limits the capacity of their work to have a significant impact on peoples' wellbeing in the longer-term.

The MWIA evaluation also revealed a series of lessons to be learned based on the HE Project's outputs. It was found that participating in the training sessions offered by Emprego Saudavel's HE Project was more difficult for unemployed people who struggled to afford the travel costs; thus, locating the HE projects in accessible centres with good public transport links will improve the reach of their work. Furthermore, the importance of engaging strategic politicians, policy makers and managers at the earliest possible point was emphasised. This will gain effective support for the organisation's goals and ensure wider implementation of their policy recommendations. It was suggested that this could be achieved by raising awareness among senior managers around the cost benefits for their respective organisations, which in turn would improve their understanding and commitment to the project. Smaller workshops were also recommend to enhance skills development of participants.

7.2.19 Potential for transferability and sustainability

This project has potential for transferability. The network activities developed within the context of Emprego Saudavel – not only among the Portuguese interest groups (healthcare institutions, employment agencies, municipalities, etc.) but also between Portugal, Norway and Iceland can be adapted and transferred to other European

regions and countries. Likewise, projects similar to this one can be replicated and co-financed through the other sources such as the European Structural and Investment Funds (ESIF).

At the same time, the identification and gathering of good practices in this project can contribute to the creation of a European database on good practices on mental health promotion, and be shared throughout the other European countries, thus contributing to sustainable initiatives and frameworks on mental health within the context of health equity and social inclusion.

7.2.20 List of References

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8   Living in Rural and Isolated Areas

Four practices seek to improve the health of people living in rural and isolated areas. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 9.   Practices targeting people living in rural and isolated areas

	Title	Main aim and objective	Country	Coverage	Quality score
11	«Let's Live Healthily» Part of Project Mura	Project piloted in Slovenia's Pomurje region which is deprived compared to the rest of Slovenia and has a lower life expectancy. The aim is to promote healthy lifestyles among adults in rural communities through health promotion workshops.	Slovenia	Regional	23
12	Mallu does the rounds	The Mallu bus was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas; health monitoring services, pharmacy tasks are provided and small operations are carried out. These services are delivered through an integrated mobile facility, a converted mobile caravan.	Finland	Regional	23
13	Mobile healthcare fund	Mobile health programme travels to remote places and provides family planning, social support, health education essential drug supply for emergencies and the very poor, pharmacies, transport for vaccination programmes, and training for health care professionals.	Romania	Regional	19
14	Building Healthy Communities Programme	This programme brings together several community run projects aiming at tackling health inequalities. Various activities are organised, such as: training modules for community health representatives, creation of peer support networks, and training on community development approaches to health.	Ireland	National	18

Two of these (Mallu does the rounds; Mobile healthcare fund) involved mobile health services, which travelled to remote areas to provide access to a range of preventive and curative treatments. As part of the other two practices, health promotion and community engagement activities were carried out, to improve the health status of rural residents.

The full case studies are given below.

8.1 Case Study 11: Building Healthy Communities Programme

Name of practice: Ireland: Building Healthy Communities Programme

Country: Ireland

8.1.1 Main objective and specific aims

The Building Health Communities Programme brings together several community-run projects that share the objective of tackling social and health inequalities using community development approaches. It includes, for instance, research into support for single-parent families and integrated support for rural communities in the region of Offaly.

The Building Healthy Communities programme has the following key aims[76]:

- To promote the principles and practice of community development in improving the health and well-being of disadvantaged communities;
- To build the capacity of community health practitioners to draw out practice and policy lessons from their work;
- To inform and support policy initiatives addressing the links between poverty and health;
- To explore mechanisms for effective, meaningful and sustainable community participation in decision making regarding health.

8.1.2 Relevance for 3rd EU Health Programme objectives

This programme is relevant to objectives one, three and four of the 3rd EU-Health programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, by creating community support to people in vulnerable situations and building capacities of service providers and end users;
- Contribute to innovative, efficient and sustainable health systems, by investing in community development and care; and
- Facilitate access to better and safer healthcare for Union citizens, by improving access for vulnerable groups such as people with disabilities or those living in isolated areas.

8.1.3 Target groups

The programme primarily targets people who experience poverty and social exclusion, in particular those living in rural or isolated areas. Within this target group, specific focus is given to vulnerable sub-groups including at risk children and families (with a particular attention to lone parents), people with disabilities, ethnic minorities, people who have mental health issues and their families, asylum seekers and refugees.

8.1.4 Thematic focus of intervention in relation to reducing health inequalities

The Building Healthy Communities programme has used a range of community development approaches to address poverty and health inequalities within different communities. These include engaging with beneficiaries within communities to raise awareness, provide opportunities to explore different community development approaches, and awaken the consciousness of organisations as to the reasons for inequalities and poverty in their communities. Some of the projects funded by the programme have also specifically worked on facilitating access to healthcare for disadvantaged groups (e.g. people with disabilities or living in isolated areas).

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[76] www.combatpoverty.ie/health/2006_BHC_FundedInitiatives2005-2007.pdf

8.1.5 Key activities

The programme was divided in two main phases to carry out various initiatives. For the first phase of the programme thirty-four initiatives were funded. Based on learning from this first experience, a second phase of the programme ran from 2005 to 2008 with 10 more initiatives funded (eight for three years and two on an annual basis subject to the availability of funding).

As the programme included many different projects, a large number and range of different activities were organised to meet the overarching objective of tackling social and health inequalities in the community. These include the following:

- Health impact assessments and targeted interventions to help a specific community such as older people, 'family day' events, awareness-raising sessions, focus groups;
- Development of health information DVDs, training modules for community health representatives, creation of peer support networks, training on community development approaches to health and on Irish healthcare and policy systems.

8.1.6 Geographical scope

National: the programme covers various regions and municipalities across the Ireland.

8.1.7 Intersectoral dimension

The programme primarily targets health policy, involving the health and social sectors, together with civil society.

8.1.8 Duration

The project ran over the 2003-2008 period.

8.1.9 Lead organisation

The lead organisation was the Combat Poverty Agency, which has been over the years integrated into numerous government departments. From 1 May 2011 the division moved to the Department of Social Protection[77].

8.1.10 Partners

There were ten projects in this programme supported by the Department of Health and Children and the Health Service Executive. These were run in partnership with the following organisations:

- OPEN - One Parent Exchange Network (www.oneparent.ie)
- CAN (www.canaction.ie)
- Schizophrenia Ireland (www.sirl.ie)
- Irish Deaf Society (www.deaf.ie)
- Galway Refugee Support Group
- Fatima Health Initiative and Fatima Groups United
- Galway Traveller Support Group
- Cáirde (www.cairde.ie)
- West Offaly Integrated Development Partnership
- Fettercairn Community Health Project.

8.1.11 Main sources of funding

Combat Poverty launched the Building Healthy Communities programme in 2003, in partnership with the Department of Health and Children and the Health Service Executive, from which it received financial support.

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[77] http://www.combatpoverty.ie/

8.1.12 Evidence base for implementation

The programme was based on key policy documents that provided vital information for context and focus. These included:

- Primary Care Strategy (2001) A New Direction. Quality and Fairness – a health system for you.
- National Intercultural Health Strategy, 2007—2012.
- National Strategy for Service User Involvement in the Irish Health Service, 2008—2013.
- Towards 2016: Ten-year framework social partnership agreement 2006—2015.
- National Action Plan for Social Inclusion 2007—2016.

8.1.13 Evaluation: Has the practice been evaluated?

Phase 2 of the Building Healthy Communities programme was evaluated by CLES Consulting (Centre for Local Economic Strategies[78]). The main aims of the evaluation were:

- To assess the degree to which the programme's aims and objectives, and the resources committed to their achievement, were appropriate, realistic and met;
- To identify the strengths and weaknesses of the programme;
- To capture the main learning for policy and practice on community development approaches to tackling poverty and health inequalities;
- To analyse and provide evidence of the contribution of the programme to tackling poverty and health inequalities;
- To identify and elaborate the key policy issues arising from the work and make specific policy recommendations on tackling poverty and health inequalities arising from the Building Healthy Communities programme and
- To identify mainstreaming opportunities for the programme.

8.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

There is some evidence that the programme has had positive outcomes for those experiencing poverty and health inequalities. However, this conclusion is based on reporting exercises and research conducted by the projects implementers themselves. The evaluation report highlights that better indicators should be created to allow for a more objective measure of impact.

8.1.15 Outputs and outcomes

Outputs were varied and included among others recommendations for action; guidelines for health professionals and official policies to ensure health equality; newsletters and website.

The programme generated various positively evaluated outcomes such as:

- The creation of a representative group of stakeholders and end users led to the development of capacity for both individuals and organisations involved;
- Individuals from specific communities gained knowledge and awareness of the social determinants of health, and became confident as a result of project activities. This enabled people to have their voice heard more clearly on issues related to the project;
- Increase in interest groups' policy influencing skills and strategies;
- Development of new partnerships aiming to tackle social and health inequalities (e.g. with national and government organisations, including government departments, the HSE and the National Economic and Social Forum);

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[78] http://www.cles.org.uk/

- Improved health outcomes for disadvantaged communities such as improvements in the ability of disadvantaged communities to access health services and to have a voice in how these services were delivered; adopting an increased sense of safety and well-being and uptake of physical exercise;
- Development of new opportunities for networking, sharing of good practice and reflective practice.
- Strengthened collective voice among community health professionals and participants which led to a greater ability to engage with statutory health services.

8.1.16 Success factors

The main success factors of the projects funded by the Building Healthy Communities Programme are

- the flexibility and the capacity to adapt the framework to different circumstances;
- having a community health worker in place to work on developing the initiative within the community;
- the ability to implement promotion and awareness raising activities such as networking and publications.

8.1.17 Innovative features

The evaluation of this Programme highlighted a number of innovative features which contributed to its success. The innovative features all centred around the development of targeted actions to address the specific health needs of the target group, namely:

- Establishing national networks such as the National Ethnic Minority Health Forum and the 'Women Together Network' to allow dialogue between the target groups and community health professionals, and gather views on policy changes;
- Implementing specific targeted actions which increase access to healthcare by the target group, for example promoting Irish sign language to address health inequalities in healthcare services experienced by the Deaf community;
- Organising community led health impact assessments of selected accommodation sites to look at the link between health and accommodation among the 'travellers' target group;
- Community development and interagency approach to support rural communities in the region of Offaly to counter disadvantage and address quality of life issues. A wide range of locally based initiatives arise from prioritised needs identified by local communities[79].

8.1.18 Obstacles and lessons learnt

Given the scale of the programme, a number of obstacles were identified in the evaluation reports:

- **Resources and capacity**: Funding and capacity of the implementing organisation where at times not sufficient;
- **Participation and engagement**: As some projects relied on volunteers, the level of implementation depended on their availability;
- **Scale of intervention:** It was particularly challenging to deal with those projects that needed to be implemented in different geographical areas or in contexts with wide differences in available resources;

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[79] http://www.offalyldc.ie/index.php/building-healthy-communities.html

- **Managing unexpected changes**, for example budget cuts and changes to legislation.

At the same time, the scale of this programme allowed for a number of lessons to be learnt during the implementation process, notably:

- **Importance of awareness raising and networking within the community**: increasing the level of understanding and awareness of the principles of community development helped the programme to be successful. It created a positive partnership between the community organisations and statutory agencies;
- **Value of a strategic, evidence-based approach to supporting community development**: the programme did not only provide funding, but also strategic support during implementation. Furthermore, projects were supported in carrying out research to serve as a basis for implementation of activities;
- **Complexity of the health agenda:** Given the scale of the programme and the number of areas it cuts across, it is evident that community development approaches to tackling health inequalities require sustainable funding, investment and time.
- **Attribution and development of indicators**: As it was difficult to show if and how the community development approaches implemented by the projects improved the conditions of disadvantaged communities, more work around developing indicators to evaluate impact is important.

8.1.19 Potential for transferability and sustainability

There is potential for transferability, although this is likely to be through mainstreaming programme services.

The programme itself was scaled up in its second phase, funding an additional 10 projects across the country. Projects achieved or exceeded their original objectives and the outcomes achieved represent good value for money, particularly as the programme has operated at a variety of scales, national and local, among some of Ireland's most disadvantaged communities. However, national funding was not sustained for this initiative, highlighting how economic and political circumstances can negatively affect sustainability. Aspects independent of funding (networking, dissemination of policy recommendations, etc.) might nevertheless be sustainable, and in a few cases projects have been able to secure additional funding through local partners.

8.1.20 List of references

http://www.combatpoverty.ie/publications/EvaluationOfTheBuildingHealthyCommunitiesProgramme_2009.pdf

www.combatpoverty.ie/health/2006_BHC_FundedInitiatives2005-2007.pdf

8.2 Case Study 12: Mobile Health care Fund

Name of practice: Mobile health care Fund

Country: Romania

8.2.1 Main objective and specific aims

The overarching objective of this practice is to provide poorer people living in rural areas with primary healthcare services, health education and counselling, social support, essential medicine supply, and transport to vaccination centres. In addition, the practice aims to provide supplementary education to children (music, dance, drawing, ICT classes), as well as training for health care professionals working in rural areas.

8.2.2 Relevance for 3rd EU Health Programme objectives

The practice relates to objective one and four of the 3rd EU-Health Programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle; and
- Facilitate access to better and safer healthcare for Union citizens.

8.2.3 Target groups

The target groups of this project are children, elderly and other vulnerable groups living in rural and isolated areas.

8.2.4 Thematic focus of intervention in relation to reducing health inequalities

This long running practice is a collection of projects aimed at various vulnerable groups living in rural areas in Romania. People living in remote and rural areas that are not reached by the national health and social services can receive health and social support through this practice, helping to improve access to healthcare and their health status.

8.2.5 Key activities

The practice was initiated in 1991 by the Relief Fund for Romania (RFFR) - a British charity - located in Bacau, in the Romanian region of Moldavia. Two projects were first launched: Mobile Health Care (addressed to the isolated, poor rural communities in Podu Turcului and Racaciuni areas) and Play Therapy Project (for institutionalised children and adults).

In 1995 Fundatia de Sprijin Comunitar took over the two projects. RFFR remained the main partner and funder. Since then, the activities and projects were expanded to include the following activities:

- Integrated services for the elderly: home care services are provided in Bacau and rural areas[80], day care services are provided in two centres (Bacau and Motoseni-Fintinele); residential care services are provided in one residence that hosts 35 people (where nursing care is ensured for the very ill, difficult to assist at home);
- Integrated services for children and families: day centres ('Glue Clubs') are available for children in the following locations: Bacau, Panu, Godinesti, Fantinele, Podu Turcului, Dealu Morii and Colonesti. Supplementary education, leisure activities, social support and counselling is also provided for families;

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[80] Huruesti, Vultureni, Motoseni, Stanisesti, Rachitoasa, Colonesti, Dealu Morii, Glavanesti, Gaiceana, Corbasca and Podu Turcului

- Training and support activities: educational grants are provided to 110 children across Romania, to allow them to enrol in high school. Training to staff and volunteers is provided to support the children and their families.
- Additional educational services are provided to children: After school supplementary education takes place for children whose parents work longer. This provides children with a safe space to socialise and learn; and
- Fundraising and income generating activities: various social events (for example community gala's, exhibitions, campaigns and charity concerts) are organised to collect funding for the activities carried out within this practice.

8.2.6 Geographical scope

This programme covers all of Romania with a particular focus on the poorer rural areas of the country (mainly in the Moldavia region).

8.2.7 Intersectoral dimension

This programme covers two policy areas: Health and education. The practice is mainly related to health, given the focus on healthcare services. However part of the activities relate to education given the supplementary education activities carried out for children and the provision of training to healthcare professionals and volunteers.

8.2.8 Duration

The practice started in 1991, on a much smaller scale, and it is still ongoing.

8.2.9 Lead organisation

Fundatia de Sprijin Comunitar (Community Support Foundation) is now the lead organisation. In 1997 it took over the activities initiated a few years before by the Relief Fund for Romania.

8.2.10 Partners

Partners of the Programme are: the Relief Fund for Romania (RFFR), Vodafone Foundation Romania, and the Romanian Ministry of Labour, Family and Social Protection.

Other partners are identified as: County Council Bacau, MMFPS, CAS Bacau, City Council Bacau, DGASPC Bacau, Prefect Office Bacau, County Educational Department Bacau, County Hospital Bacau, numerous schools and High Schools, Peace Fund USA, Ratiu Family Foundation UK, Christlike Solidaridad Germany, Erste Stiftung Austria, Rommaniahjelpen Norway, Herrod Foundation, Espoir Roumanie, Mana@Mana Stiftung, Switzerland; and the local Councils of all regions and cities involved.

8.2.11 Main sources of funding

Relief fund Romania is the main funder; Vodafone Foundation also provides grants for some of the activities. Other additional funding is provided by the Romanian Ministry of Labour, Family and Social Protection.

8.2.12 Evidence base for implementation

The aim of the practice is to provide health and social services to people living in remote and rural areas, with a lower economic status, to improve their health conditions. The practice was introduced in rural areas where the government wasn't able to provide social and health services to citizens. Starting as a small practice, with only one caravan providing mobile healthcare services, Fundatia de Sprijin Comunitar developed to become a major public utility provider in rural areas of Romania. Evidence of its effectiveness was provided by the success of the pilot projects, as the population groups who were assisted experienced an improvement in their basic health conditions.

Research[81] also shows that access to healthcare is of paramount importance for people's health status and well-being. Healthcare services should be available, adequate to needs of the population, affordable and free for the individuals who do not have the means to pay. This enables the prevention of diseases, the detection and treatment of illnesses, but also to increase the quality of life, to reduce the likelihood of premature death and to increase life expectancy.

8.2.13 Evaluation: Has the practice been evaluated?

No independent evaluations were found to be publicly available. However monitoring data was collected by the lead organisation, and is described below.

8.2.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Data reported indicate the exact number of beneficiaries per year of activity. This data shows that between April 2014 and July 2015 the total number of beneficiaries reported was 10,873[82]. In relation to outputs and outcomes, data reported in the period 2004-2015 highlights the following:

- 730 elderly people made use of home care and day care service;
- 1674 children were helped in Glue Clubs, summer schools and special campaigns;
- 416 young people received grants and benefited from volunteer programmes;
- 466 families were helped through social support, community transport and specialist doctors;
- 1253 people attended training programmes.

8.2.15 Innovative features

The main innovative feature of this programme consisted of the capacity to provide services in rural and remote areas where the national authorities were not able to fully operate to meet the health and care needs of people living in those areas. Significant improvement to their health was reported.

8.2.16 Success factors

On the basis of the programmes data and outcomes, a number of success factors can be identified:

- **Funding**: financial support to the activities allowed to obtain the supply of equipment (caravan, cars, medical equipment, essential drugs) which was essential to provide assistance;
- **Personnel and volunteers**: the human capital was a unique resource that permitted to provide the vast array of services.

In addition, Fundatia de Sprijin Comunitar managed to collect an increasing amount of funding over the years and to train its own volunteers and professionals. This allowed the organisation to expand to new rural areas and to increase the number and types of services provided.

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[81] WHO Health Impact Assessment, The determinants of health, WHO http://www.who.int/hia/evidence/doh/en/; The relationship between the supply of primary care physicians and measures of health, J. Robst, G. G. Graham, Eastern Economic Journal, Volume 3, No 3, Summer 2004, http://college.holycross.edu/eej/Volume30/V30N3P467_486.pdf; Access to Health Services, Healthy People 2020, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/About-Healthy-People
[82] The same total number of beneficiaries was provided for April 2013 - March 2014.

8.2.17 Potential for transferability and sustainability

The practice responds to the specific needs of people living in Romania's poorest rural areas as well as gaps in service provision. Given certain similarities with other rural areas in Europe, this practice could be used as a transferable model. The activities and services provided could in principle be transferred to other rural and isolated areas, depending on the willingness and capacity of the local actors to provide similar services as well as availability of funding.

Given the high number of funding organisations and programmes, as well as the duration, the practice appears to be sustainable in the long term. In addition, the programme is not reliant on one single source of funding, and has involved the local and regional governments of the rural areas concerned.

8.2.18 List of references

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The Relief Fud for Romania LTD Report for the year ended 31 March 2014, 2014 http://www.relieffundforromania.co.uk/trustees_report15a.html;

Fundatia de Sprijin Comunitar website, https://sites.google.com/site/fscengleza/about-us;

Wonca Europe, http://www.woncaeurope.org/content/242-foundation-community-support-alternative-solution-medical-and-social-problems.

8.3 Case Study 13: Let's Live Healthily!

Name of practice: Let's Live Healthily!

Country: Pomjure Region, Slovenia

8.3.1 Main objective and specific aims

The main objective of the 'Let's Live Healthily!' programme is to promote healthy lifestyles by encouraging people to take an active role in health promotion and protection and by providing them with the necessary skills and knowledge to achieve this. The programme focuses specifically on: healthy nutrition, physical activity, a drug-free life, safe road behaviour and the promotion of a safe environment; enhancement of social well-being and mental health; supporting the early detection of cardiovascular disease.

8.3.2 Relevance for 3rd EU Health Programme objectives

This programme is relevant to objective one of the 3rd EU Health programme:

• Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle

8.3.3 Target groups

The programme grew out of a pilot project, overseen and funded by the Murska Sobota Institute of Public Health, that was initially targeted at the adult population in nine rural communities in the Pomurje Region of Slovenia.

8.3.4 Thematic focus of intervention in relation to reducing health inequalities

Promoting health by addressing lifestyle issues (diet, physical activity, smoking, drinking, drug use, etc.) within the most vulnerable sectors of the population is one important approach to reducing health inequalities.

The rural region within which this project takes place lies in the north east of Slovenia that was traditionally characterised by agriculture, livestock and the textile industry, which faces high levels of unemployment (since many of the factories in the region could not compete in a globalised word and had to close), low average levels of education, a high level of rural population and high poverty rates.

The Regional Institute of Public Health (Murska Sobota) identified specific vulnerable populations in the region who were not sufficiently reached by universal policies. These include pregnant women, children, elderly, Roma, members of the Hungarian national minority group and school drop outs. They are the target groups of specific health promotion actions that are being implemented in parallel to the 'Let's live Healthily! programme.

After the start of the 'Let's Live Healthily' programme, the Pomjure Region developed and implemented a regional action plan that identified five main areas where health promotion interventions could contribute to a reduction in health inequalities. This was in in 2004. Promoting healthy lifestyles was one of the five key areas, alongside awareness raising, increasing community capacities, supporting vulnerable groups and supporting a clean and healthy physical environment. The 'Let's Live Healthily' programme was integrated into the regional action plan.

Other regions across Slovenia have subsequently taken up the Pomjure region's approach to designing and implementing an action plan on health inequalities.

8.3.5 Key activities

Activities developed and implemented under the 'Let's Live Healthily!' programme differ per region and community. They are based on an analysis of the health related needs of each particular region and community. The activities are selected on the basis of what is most likely to interest each community. They are also culturally adjusted. Examples of low-threshold community and outreach measures being implemented are:

- Workshops on healthy cooking;
- Joint walking tours with the vulnerable groups;
- Communal gardening initiatives; and
- Measuring risk factors for Cardio Vascular Diseases (CVD) in shopping centres.

Each community generally had its own well-equipped public village house where many of the activities (workshops, lectures, events etc.) can take place.

8.3.6 Geographical scope

This regional initiative began as a pilot project in nine local communities in the Pomurje region, and was subsequently rolled out to 50 other communities within the region. Due to the success and impacts of the project, it has subsequently been expanded to other regions in Slovenia.

8.3.7 Intersectoral dimension

The programme has involved the health, education and social sectors as well as regional and local administrations and planning boards. The analysis of the situation in each region at the outset is based on information gained from other regional and local interest groups. Undertaking a situation analysis became recognised as a tool to initiate cooperation between sectors that may see the same health problem from different angles, and agree to take collective ownership of that problem.

8.3.8 Duration

The initiative began as a pilot project in 2001 to promote healthy lifestyles in nine local rural communities. Since 2010 it has been successfully transferred to local communities in all Slovenian regions and is ongoing.

8.3.9 Lead organisation

Murska Sobota Institute of Public Health

8.3.10 Partners

Relevant local actors like schools, police stations and NGO's working in the regions.

8.3.11 Main sources of funding

The initiative was initially funded by the Murska Sobota Institute of Public Health. Its implementation across other regions in Slovenia was funded by other regional health institutes and the Ministry of Health, as it became part of the National Health Programme. Since all regional institutes were merged in 2014 into the National Institute of Health, it is now responsible for the Programme.

8.3.12 Evidence base for implementation

The pilot project was initially designed on the basis of evidence gathered indicating that mortality rates due to CVD were much higher, and access to health care were lower than the average in Slovenia, due to the lower average number of medical doctors in the rural population of Pomjure. The region has also faced environmental problems and de-population. Such indicators showed that the Pomjure region faced social and health inequalities vis-à-vis other Slovenian regions.

The available data also indicated that the poorer health of the adult population of the Pomurje, particularly of the inhabitants of local rural communities, can be largely attributed to poor lifestyle habits. They were in particular susceptible to insufficient use of preventative health care services, exposure to passive smoking and unhealthy nutrition habits during pregnancy and childhood[83].

8.3.13 Evaluation: Has the practice been evaluated?

The initial pilot project was evaluated showing excellent results that indicated that it was very well-received among the target group, and that the selected approach had been successful[84]. It was therefore taken up as a strategic objective of the regional action plan to tackle health inequalities in the Pomjure Region, and transferred across Slovenia. According to the project's Action for Health Report, an internal evaluation conducted found that almost all process and outcome indicators were achieved. More activities were conducted than stated in the original action plan (no further details documented, however), and the project measured an improvement in lifestyle indicators amongst adults in the Pomjure region.

8.3.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and outcomes

The 'Let's Live Healthily' programme has been continuously implemented over 12 years in 50 local communities in the Pomurje region and successfully transferred to all other regions in Slovenia as part of the National Public Health Programme. It has not only impacted the lifestyle of the participants but also enhanced social cohesion and capacities in the communities where it is implemented.

8.3.15 Success factors

A key success factor of the pilot project and Programme is its bottom up approach, which reflects the needs, desires, specificities and capacities of the communities and the regions. It was important to culturally adjust and implement the programme to the needs and interests of the local communities.

Another key success factor was that it relied and built on local resources and capacities, adopting a partnership approach, as well as setting realistic objectives which can be met within the local context.

8.3.16 Innovative features

The pilot project was the first to recognise and address the issue of health inequalities in Slovenia.
Historically, this had not been a political issue, since solidarity and equality were much appreciated social values, but the transition from the former planned economies to capitalism increased differences between socio-economic groups.
Given the limited financial and human resources, the pilot project and the subsequent programme, recognised that it would not be possible to address health inequalities in the region by making an impact on important social determinants such as employment, education and housing conditions. Nevertheless, actions could be taken to address unhealthy lifestyles, which were a significant driver of health inequalities in

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[83] Action-For-Health. The strategic approach to health inequalities in the Pomurje region and Slovenia, 2013
http://www.nijz.si/sites/www.nijz.si/files/uploaded/the_strategic_approach_to_health_inequaliti es_in_the_pomurje_region_and_slovenia.pdf, page 25; SURS. Slovene Regions in Figures. Ljubljana: Statistical Office of the Republic of Slovenia, 2008; Buzeti T et al. Health inequalities in Slovenia. Ljubljana: National Institute of public health, 2011
[84] More information has been requested from the lead organisation.

the   region.

The innovative feature was the recognition that actions taken to influence people to improve their lifestyles had to be based on an understanding of the situation at the local level, and that they had to grow out of and build on local capacities and resources, since solutions would not be imposed by outside institutions or powers.

8.3.17 Obstacles and lessons learnt

Throughout the implementation of the pilot project in the Pomjure region, and more recently in other regions of Slovenia, a number of lessons learnt were identified:

- The importance of setting realistic, S.M.A.R.T. (specific, measurable, attainable, relevant and time-bound) objectives. Particular attention was dedicated to defining these at the start of the project. Very often it takes years to measure the effect of health promoting activities. To persuade policy and decision makers to support health-promoting activities, it is important to create objectives with outcomes that can be visible in a short time frame, e.g. a year. Unrealistic objectives set over long time-frames risks de-motivating interest groups and funders (political supporters). Strategic objectives can be modified on the basis of the experiences and results of implementation;
- Successful health-promoting measures must be tailored to the target group and be acceptable to them; the uptake of activities must be done by the target group themselves;
- To ensure sustainability, it is crucial to build on available infrastructural resources and tailor actions to existing human and financial resources. Investing in the development of human resources is a crucial precondition to implementing and rolling out the programme. It is important to build an expert team with knowledge of health promotion but also involve different but complementary fields (medical doctors, nurses, anthropologists, food and nutrition specialists, environmental health specialists, teachers, etc.);
- Involving interest groups outside of the health system in the analysis of health problems in the region is an effective way to build alliances and increase the commitment of regional partners to work on shared objectives.

8.3.18 Potential for transferability and sustainability

The intervention has proved highly transferable, as reflected above. The key lessons learnt also reflect what is needed for transfer to be successful and the programme to be sustainable.

8.3.19 List of references

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Buzeti, T, Maucec Zakotnik J. Health and Development in Slovenia. Programme MURA. Centre   for   Health   and   Development,   2008 http://www.eu2008.si/fr/News_and_Documents/Fact/March/0310_publikacija.pdf

8.4 Case Study 14: Mallu does the Rounds

Name of practice: Mallu does the Rounds

Country: Finland (FI)

8.4.1 Main objective and specific aims

'Mallu does the Rounds' is a mobile service offering social and health care for geographically excluded residents in rural areas of Finland. The scheme was created in response to significant challenges in supplying cost-effective care to dispersed populations[85] and improve access to medical services for the rural population. The specific aims[86] of the mobile service are to:

- Meet the needs of vulnerable or isolated groups (e.g. the elderly) living too far away from stationary service locations.
- Reduce social exclusion and rural poverty by developing basic services in remote locations.
- Improve the health and wellbeing of residents
- Importantly, another goal of the scheme is to collect vital information about rural healthcare needs, to support future rural health policies.

8.4.2 Relevance for 3rd EU Health Programme objectives

This programme is relevant to objective four of the 3rd EU Health programme:

- Facilitate access to better and safer healthcare for Union citizens.

8.4.3 Target groups

The Mallu bus scheme targets those living in rural and isolated areas of Finland, and 'as a matter of principle', the bus does not exclude anyone from using the service. Nevertheless, given Finland's rapidly ageing rural population[87], the mobile health care service is, in particular, a vital service for elderly people with problems travelling to other health centres. The first pilot tests in 2011 reported that as many as 65% of the patients were aged 65 or older[88].

8.4.4 Thematic focus of intervention in relation to reducing health inequalities

There are clear inequalities in health outcomes between rural and urban locations; in Finland, these inequalities are intensified by the types of people who live in these areas[89].

The Mallu bus aims to facilitate access to healthcare, and contribute to the main goals of the EU's rural development policy (2014 – 2020) by balancing the territorial development of rural economies and communities (as per the sixth priority of the policy). By collecting and logging data from patients, it will become easier to

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[85] ENRD, 2016: https://enrd.ec.europa.eu/sites/enrd/files/fi-mallu-does-the-rounds-gp_web.pdf
[86] Ibid.
[87] In 2012, 18.5% of the Finnish population was over the age of 65 and 5% of the population was over the age of 80. This is above the OECD average of 15% and 4%, respectively. By 2050, 27% of the Finnish population will be over the age of 65 and 11% of the population will be over the age of 80, which signals faster ageing than the OECD average (OECD Publishing, 2013: https://www.oecd.org/els/health-systems/Finland-OECD-EC-Good-Time-in-Old-Age.pdf)
[88] Goodmill Systems, pg.1: http://www.goodmillsystems.com/assets/pdf/Goodmill-CaseStudy-MobileHealthCare.pdf
[89] Finland's population is concentrated in regional growth areas. There has been a worrying trend of depopulation of rural heartlands and sparsely populated areas, particularly by younger age groups. This has led to the average age and the number of elderly people being higher in rural areas. http://enrd.ec.europa.eu/enrd-static/fms/pdf/37448B72-F3EE-62E1-0A7E-0B02E422CB46.pdf

understand the needs of the rural community. Future national policy decisions regarding health and social care may also benefit from the data.

The project is also vital to support the independent living of elderly residents in this area, given that, at the inception of the project in 2011, Eksote had a higher proportion of over 65 year olds than the Finnish average[90],.

8.4.5 Key activities

The Mallu bus pilot project was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas. This is delivered through an integrated mobile facility – a converted mobile caravan – which would visit sites on a fixed route at least once every fortnight.

The service required patients to book appointments online and over the telephone, but the vehicle stays at the site for as long as is required (for an hour onwards).

Via the mobile services, nurses provided a coordinated set of medical care including:

- Pharmacy tasks e.g. flu vaccinations and other injections
- Small operations e.g. removing stitches, ear rinsing
- Monitoring services e.g. blood pressure and blood sugar level measurements
- Providing general advice
- Collect data on activities to provide evidence on the service needs of residents.
- Occasionally, the bus would have themed services, for example to promote awareness of diabetes. These have been organised with the prevention of future social and medical problems in mind, promoting health and wellbeing.[91]

In addition to this on-board computer and broadband equipment enabled nurses to:

- Connect to centralised patient systems to find histories and medical information
- Link to more specialised staff at healthcare centres who could provide knowledge on specific issues.

8.4.6 Geographical scope

The Mallu project is a regional initiative, covering the South Karelia district and its nine municipalities in the Imatra and Lappeenranta sub-regions.

8.4.7 Intersectoral dimension

This programme cuts across two key policy areas: health and rural development. The practice is mainly related to health, given the focus on improving access to healthcare, but the use of a mobile service that can travel to remote and isolated areas of Finland aims to also facilitate development in these areas. In part, the scheme also cuts across a third dimension: technological development. By collecting data on patients, the Mallu bus can build on the success of its services by introducing telemedicine, such as video-conferencing or remote patient monitoring[92].

8.4.8 Duration

The bus started its operations in November 2010 as a seasonal influenza vaccination service. After securing funding, a pilot project began in July 2011 touring South

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[90] Tepponen, M. and Heiskanen K., 2012:
http://ilpnetwork.org/new/bower_components/wordpress/wp-content/media/2012/08/y_06_1705_Tepponen.pdf
[91] Ibid.
[92] In Finland, there has already been moves towards telehealth, e.g. in Oulu Arc located in Northern Finland, http://www.transnational-telemedicine.eu/countries/finland/

Karelia and bringing nurses' services closer to residents. This ran for two years, until August 2013[93].

Since the evaluation, the project has developed into an integrated, multiform service – the vehicle has been replaced to enable the expansion of services.

8.4.9 Lead organisation

The lead organisation is the South Karelia Social and Health Care District (Eksote), a political authority whose mission is to promote the health and wellbeing of residents across nine municipalities (with an overall population of approximately 133,000 people)[94].

8.4.10 Partners

The Mallu-bus operations involve a number of different actors and interest groups. To enable the service to remain flexible and easily accessible, one of the main requirements of the project is effective coordination between partners. The project offers the opportunity for cross-sector collaboration between various local social and health care agencies, as well as with village associations, municipalities and private companies. In addition, themed days are organised in cooperation with national third and public sector agencies such as sports federations, national charities and the social insurance institution, Kela[95].

Recently the bus has started to offer a bigger range of health care services including dental care, mental health and substance abuse services and physiotherapy[96]. This also means that the district is liaising with a number of specialist care providers such as dental nurses, physiotherapists and psychotherapists.

8.4.11 Main sources of funding

During the two years of the pilot project, the Mallu bus service had two sources of funding and the total project cost was €112,000[97].

- The EU contribution to the project, from the European Agricultural Fund for Rural Development (EAFRD), was €48,000[98].
- The remaining money was sourced from Rural Development Programme (RDP) of Mainland Finland (2007 – 2013) – in this case, The Southeast Finland Centre for Economic Development, Transport and the Environment (ELY Centre) had awarded South Karelia €2,209,028 in overall funding[99].

8.4.12 Evidence base for implementation

The concept of a mobile healthcare service was developed in response to the challenges that exist in supplying health and social services to isolated areas and / or dispersed populations. Specifically, because of the large costs associated with running multiple healthcare facilities, providers need to locate their main facilities in centralised sites (i.e. the town centre). This means that rural residents, workers and visitors need to travel into towns if they need any form of medical attention which comes at a personal cost for them, be it in money or time. Furthermore, a high proportion of rural areas in Finland are populated with elderly people (aged 65 or over) who may not be able to travel to the fixed site locations as easily as other

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[93] Wikström-Koikkalainen *et al.*, 2014, pg. 6
[94] Ibid.
[95] Tepponen and Heiskanen, 2012
[96] Ibid, pg. 5
[97] ENRD, 2016
[98] Ibid.
[99] Wikström-Koikkalainen *et al.*, 2014, pg. 9

residents. This is particularly problematic as elderly people are more likely to have more complex and frequent medical needs than other groups of people.

The implementation of the Mallu bus began with the development of a Mallu-car pilot in Eksote in 2010. The initiative has gone through three iterative development phases since 2010, as illustrated in Table 1.

Each development cycle included problem identification, action planning, implementation, evaluation, and reflection. The insights from each phase were fed into the planning of the next phase and the action plan was modified. From 2011, the Mallu bus has been implemented as a mobile nurse clinic, stopping at villages throughout the district. Phase 3 offered an 'integrative' focus which led to the creation of a multiform mobile health and social care service[100].

Table 10. Development phases of the Mallu bus (adapted from Järvi et al., 2013)

Implementation phrases	Characterisation	Year
Phase I: Pre-study and pilot phase	Assessment of initial customer needs; testing the functionality of the required technologies; testing service logistics, routes and staging posts; experimenting with various health and social services offerings; assessing possibilities for broader applicability; identification of co-creation networks and partners	Autumn 2010 – mid-2011
Phase II: Single service segments	Emphasis on single service segments (e.g. a reception unit, dental care); coordination of health and social service delivery; operational integration to the health and social services system; focus on the accessibility and complementarities of services	Mid-2011 onwards
Phase III: Integrated service solutions	Multiform mobile health and social services; enabling integrated service solutions; enabling integrated care pathways; focus on substitutive forms of service delivery.	Late 2013 onwards

8.4.13 Evaluation: Has the practice been evaluated?

In 2013, at the end of the pilot stage, an evaluation of the Mallu-bus service was undertaken by Wikström-Koikkalainen *et al* (2014).

8.4.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and outcomes

Project results have illustrated that the Mallu bus provides cost-efficient and easy-to-access healthcare for areas in which residents are unable to access a dedicated healthcare centre. In this instance, the bus:

- Covered an area with at least 100 000 potential patients, thus making valuable contributions to the wellbeing and health of people in rural areas.
- Devolved care to nurses to improve the efficiency of doctor's regional health centres: over time the nurses aboard the Mallu bus absorbed a number of other functions including issuing prescriptions and conducting preliminary assessment to avoid unnecessary doctor appointments.
- Collected data on activities which are being used by health authorities to improve their existing service network design.

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[100] Järvi *et al.,* 2013

There has been a very positive reception to the Mallu bus; according to surveys and feedback, ageing citizens living away from town centres, in which the health centres are located, are satisfied with services offered in a mobile form[101].

8.4.15 Success factors

There were three factors which were essential for the success of the programme: close collaboration with local interest groups (e.g. village associations) volunteers and personnel as well as having a pilot phase to test the routes.

- Close collaboration: to effectively communicate the service to the target group, the bus had to cooperate with local village associations and other agencies to disseminate information, make finding the services easy, and ensure residents were up to date[102].
- Volunteers and personnel: The running of the bus requires a number of personnel including a driver, nurses and specialists. In the areas the buses were set up, there also needed to be volunteers on hand to help set up, ensure connectivity and help residents etc.
- Pilot phase: During the early stages of the project, it was noted that in sparsely populated areas, demand turned out to be limited, and so – after gathering feedback from the local residents[103] – these areas were excluded from the route. The staging points and the time schedule of the bus were determined during the inception phase and helped to identify associated issues such as technical requirements, leases, available facilities and customer needs.

8.4.16 Innovative features

The main innovative feature of this programme consisted of the capacity to provide services in rural and remote areas where the national authorities were not able to operate, to meet the health and care needs of people living in those areas.

8.4.17 Obstacles and lessons learnt

One of the main requirements for any mobile service is an online data and phone connection which will work in the more remote locations. To ensure connectivity, the van is equipped with a Goodmill router system that includes up to four different commercial mobile broadband connections, and uses two SIM-cards from the main two operators in Finland[104].

A less manageable obstacle is weather: Finnish weather varies greatly in temperature; it can be anything from -30 to +30 degrees Celsius. to be able to carry out the service intended, the Mallu bus had to be adequately equipped to warm and cool even in harsh conditions, and organisers had to ensure there was suitable temperature regulation of the waiting rooms at stopping points[105].

8.4.18 Potential for transferability and sustainability

The success of the bus and information gathered is already being used to support the development of other ideas for rural services that could be delivered through cooperation between more health authorities, leading to a more extensive and larger mobile provision in South Karelia and nationwide[106]. For example, the Mallu bus has provided an example of how a mobile labour service centre could operate in the same

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[101] Tepponen and Heiskanen, 2012
[102] Wikström-Koikkalainen *et al.*, 2014, pg. 64
[103] Residents with cars were more likely to travel into the village centre to treat all affairs (e.g. banking, health centre, pharmacy) Mallu bus
[104] Goodmill Systems, pg. 2
[105] Tepponen and Heiskanen, 2012
[106] ENRD, 2016

district in Finland. The Tellu-pilot was carried out in 2012, and targeted residents in the surrounding municipalities of South Karelia. The bus offered professional advice on topics such as setting up businesses, service and support for life management, rehabilitation opportunities and the development of professional skills[107]

Moreover, this model is replicable in other countries and regions as long as informed decisions are taken about the route planning of the service. In Finland, the bus is not affected by municipal borders in areas that have chosen Eksote to offer their health and social care service, and so the organisers were able to plan a route that crosses a number of remote regions spread out across nine municipalities[108]. Without the cooperation of multiple health authorities and village associations, the mobile service would be unable to deliver the most cost effective or extensive service for its clients.

The model has also proven its sustainability; it has been running since 2010 and has continued to develop. The introduction of dental health care services from spring 2013 onwards shows a way that the scheme can evolve. It sustains itself financially as patients pay a surcharge to have their teeth checked, cleaned or evaluated for treatment at a predetermined location[109]. Thus, the 'Mallu does the rounds' project has proven to be a simple and cheap solution for offering social and healthcare services in large and sparsely populated areas throughout South Karelia.

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[107] See Wikström-Koikkalainen *et al.*, 2014, pg. 20-21 for more information about the Tellu project.
[108] Tepponen and Heiskanen, 2012
[109] Wikström-Koikkalainen *et al.*, 2014, pg. 34

terveydenhuollon-kuntayhtyma-mallu-kylilla-2-loppuraportti.html   [Accessed   23 September 2016]

9   Long-term unemployed and Inactive

Two case studies highlight approaches that target the long-term unemployed and/or inactive. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 11. Practices targeting the long-term unemployed and/or inactive

	Title	Main aim and objective	Country	Coverage	Quality score
15	Action nutritionnelle dans une épicerie solidaire	Project aimed at setting up shops for vulnerable groups to access fresh fruit and vegetables, and gain employment.	France	National	19
16	Sortir de soi sortir de chez soi	3-month programme for unemployed women to prepare them to re-enter the workforce. For instance, sessions are organised to inform the participants about the local labour market, and training and employment opportunities; or sessions providing an overview of the services offered by relevant public actors in the area of integration and employment.	Belgium	Regional	17

Both practices focus on addressing inequalities in health status, rather than offering direct access to healthcare services. The first practice (Sortir de soi sortir de chez soi) relates to both health and employment, aiming primarily to train and support unemployed women to re-enter the workforce. Part of the training programme includes a health module, meaning that there is a specific health aspect, as well as a focus on improving the participants' self-esteem and employment outcomes.

The second practice (Action nutritionnelle) subsidises fruit and vegetables in particular shops, to make it more affordable for those on low incomes to lead a healthy lifestyle. Unemployed people are also able to do short work placements in the shops. Whilst the practice is not targeted solely at the unemployed or inactive, these groups can benefit from its activities and, in so doing, potentially improve their health.

9.1 Case Study 15: Action nutritionnelle dans une épicerie solidaire

Name of practice: Action nutritionnelle dans une épicerie solidaire (Nutritional action in a solidarity store)

Country: France

9.1.1 Main objective and specific aims

The programme aims to improve access to healthy food for citizens who are poor or at risk of poverty, by providing them with healthier products at a reduced price. Another overarching aim of this practice is to provide employment to the long term unemployed in the community.

9.1.2 Relevance for 3rd EU Health Programme objectives

The practice is relevant to objective one of the 3rd EU Health Programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, by improving access to healthy food for citizens.

9.1.3 Target groups

The target group are people at risk of poverty, inactive people, in-work poor, and long term unemployed.

9.1.4 Thematic focus of intervention in relation to reducing health inequalities

This practice supports population groups within a community, who require food support to maintain a healthy diet. It also combats the lack of access to fresh fruit and vegetables among those with lower economic status by providing food at a reduced rate.

9.1.5 Key activities

The main activities identified in the practice consist of setting up local social and solidarity stores, where population groups with low incomes can buy food at a reduced price (10%-20% of the normal price), and where customers are encouraged to eat more fruit and vegetables . Two types of stores were developed by the project:

- Solidarity stores: Usually run by individuals or associations, and generally funded by private capital; and
- Social stores: Usually run under the responsibility of public entities (the local town administration), and are publicly funded.

Access to such stores is based on socioeconomic criteria, and is established by each individual shop, depending on the socio-economic context it is operating in. This way help is provided to those groups who require food support to maintain a healthy diet.

The programme also employs people who have difficulties in finding employment, and are identified as long term unemployed. The stores provide short work placements to help with product collection and selling.

Promotional and support activities are provided to the stores by A.N.D.E.S., a French national non-profit association, supporting the creation of solidarity shops and fostering a network of similar initiatives at national level. The main supporting activities are:

- Help with setting up social and solidarity stores, through the development of business plans, analysis of the local market and demand, and providing general advice;
- Promotion of the solidarity store network to public and private partners;

- Development of services for solidarity stores, in particular providing workshops and training to store managers, employees and volunteers;
- Development of national and local partnerships with the food industry, supermarkets and local farmers, for the supply of quality products;
- Creation of sites where to collect and store the products (mainly food products) donated by the partners and selected from the wholesale markets (vegetables and fruit that are left over, since they are not marketable anymore);
- Provision of information and communication services to the shops; and
- Provision of training to individuals to be employed to sort vegetables in wholesale markets.

9.1.6 Geographical scope

National: the activities carried out by A.N.D.E.S. take place in France, in most of the regions.

9.1.7 Intersectoral dimension

The practice cuts across health, social inclusion and employment policies, given its focus on healthy food, integration of lower socio-economic population groups and placement of long-term unemployed.

9.1.8 Duration

The programme is in place since 2008 and it is still on-going.

9.1.9 Lead organisation

The lead organisation is A.N.D.E.S., the Association Nationale de Développement des Epiceries Solidaires.

9.1.10 Partners

Partners of the programme are:

- Public partners: the French Ministry of Work and Social Dialogue, the French Ministry of Nutrition, Agriculture and Fishery, the Conseil national des missions locales, some Regional Councils[110];
- Associations: Ashoka France, Chênelet Insertion, Le CODES, Dons Solidaires, La FAGE, La Fédération Nationale des Paniers de la Mer, France Active, Lire c'est Partir ;
- Companies: AJS Blackfox, Axa, Boehringer Ingelheim, Comexposium, Deloitte, Einhell, Exel GSA Ecofi Investissement, Ferrero France, GNIS, Heineken, L'Oréal Luxe, Lesieur, Massogarden, Monoprix, PepsiCo, Rostaing, Spear & Jackson, Simply Market, Softinnov, Premier tech ;
- Foundations : Fondation Bonduelle, Fondation Brageac Solidarité, Fondation Carrefour, Fondation Coca-Cola La Fondation Cultura, Fondation Daniel et Nina Carasso, Fondation MACIF, Fondation Monoprix, Fondation PSA Peugeot Citroën, Fondation RTE, Fondation Simply, Fonds Groupe SEB, Fondation Veolia Environnement, Fondation Vinci, Fonds français pour l'alimentation et la santé.

9.1.11 Main sources of funding

The main sources of funding come from fees paid by the members of the A.N.D.E.S. association, as well as other public resources, sponsorships, revenues from services

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[110] Le Conseil Régional d'Ile-de-France, Le Centre Régional de Valorisation et d'Innovation Agricole et Alimentaire (CERVIA Ile-de-France), Le Conseil Régional Poitou-Charentes, Le Conseil Régional Provence-Alpes-Côte-d'Azur, Le Conseil Général des Bouches du Rhône, Le Conseil Général des Pyrénées-Orientales, Le Conseil Général de la Vienne, Le Conseil Général du Val de Marne.

provided to third parties, revenues from publications, events organised, and journal articles.

9.1.12 Evidence base for implementation

Research studies have shown that providing subsidies and support to lower income citizens can improve the health and well-being of these categories of people:

- Evidence[111] is available on the link between higher disposable income and better health conditions;
- Research[112] also shows that the proximity of fresh food retail stores can reduce overweight and improve health conditions of people.

9.1.13 Evaluation: Has the practice been evaluated?

A quantitative study has been conducted, by an independent organisation: the Haut Commissariat aux Solidarités Actives contre la Pauvreté. The study analysed whether the programme increased the amount of fruit and vegetables consumed by the target groups.

9.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and results

500 solidarity and social stores have been created in France to date, with 120,000 and 170,000 clients visiting the stores every year. Each store serves on average 100 households per year.

A network has been created between the food industry and A.N.D.E.S., which ensures the distribution of fruit and vegetables to the solidarity and social stores every year. Since the start of this programme, four collection sites were created to collect food products donated by the partners and collected by A.N.D.E.S.' personnel.

A total of 85 inactive people were employed in the collection sites, and 67% had positive results in terms of employability, for example access to a job at the solidarity stores and elsewhere, transition to a job and motivation to search for new job opportunities[113].

Outcomes

The evaluation conducted by the Haut Commissariat aux Solidarités Actives contre la Pauvreté analysed the consumption of fresh food (fruit and vegetables) among the stores' customers through a series of questionnaires submitted to the customers and to a control group, consisting of people having access to stores where no fresh products were provided,

This evaluation showed that the consumption of fresh food had increased among clients of the stores with 43% of the customers having declared that they ate at least two pieces of fruit per day (compared to 23% of users not having access to fresh food). 52% of the customers also declared that they ate fresh vegetables every day (compared to 30% of the control group). The consumption of other types of food products (fish, meat and dairy) wasn't found to differ significantly between the two groups of customers. The study also showed that in some cases the consumption of

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[111] *How Are Income and Wealth Linked to Health and Longevity?*, Laudan Aron, Lisa Dubay, Sarah M. Simon, Urban Institute, Centre on Society and Health, April 2015, p.4, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf;
[112] *Access to healthy food and why it matters: a review of the research*, Judith Bell, Gabriella Mora, Erin Hagan, Victor Rubin, Allison Karpyn; Policy Link, The Food rust, 2013, p.12, http://thefoodtrust.org/uploads/media_items/access-to-healthy-food.original.pdf;
[113] This data are provided in the A.N.D.E.S. website, http://www.epiceries-solidaires.org/;

fresh products was limited by the lower budgets of clients visiting the stores, and by the limited number of times the clients could access the stores. Other factors hindering the consumption of a higher amount of fruit and vegetables are the lack of knowledge on how to prepare these products, the lack of space for storage at home, and the lack of knowledge on the health benefits associated with such produce.

9.1.15 Success factors

The factor contributing to the success of the programme is the capacity of A.N.D.E.S. to create long lasting collaborations with a vast number of public and private partners. The partners do not only provide funding to the lead organisation, but also allow A.N.D.E.S. to carry out its activities, through agreements and other forms of support. The collaboration with food industry allows the stores to have an adequate supply of products. The partnership with public organisations like the Ministry of Work and Social Dialogue, the Ministry of Nutrition, Agriculture and Fishery and the National Council of Local Missions (Conseil national des missions locales), allows A.N.D.E.S. to carry out many of its promotion and support activities.

Another important success factor, focusing on the target group, was the capacity to provide people with access to healthy food, allowing them the choice to select the products they want to consume, without fear of stigmatisation.

9.1.16 Innovative features

A number of innovative features can be identified in this practice:

- The attempt to support people with lower socio-economic status, without stigmatisation. This is ensured by the fact the solidarity shops look like regular shops and people have the choice to buy what they need and pay for their purchases . At the same time the stores constitute places for socialisation, where the needs of the users are heard and answered as far as possible;
- A wide network of public and private partners acting in coordination to provide support to the social and solidarity stores and ultimately to their customers;
- Initiatives to re-integrate long-term unemployed in the labour market have been incorporated into this project. This provides individuals with knowledge and motivation to re-enter the labour market.

9.1.17 Obstacles and lessons learnt

One of the main difficulties A.N.D.E.S. encountered in supporting the social and solidarity stores was the necessity to ensure an adequate quantity of good quality food. Working to overcome this challenge, a preferential network of organisations that provide food donations has been set up.

9.1.18 Potential for transferability and sustainability

500 stores have already been created in France and similar entities exist in Belgium, Luxembourg, Austria, Romania and Greece. This shows that the programme can be transferred to new countries. The practice can also be considered sustainable, given that it is running since 2000 and that the network of stores created, partners found and funding provided have been increasing over the years.

As shown by the high number of existing partnerships, key factors that would allow further expansion of the practice to new countries are the existence of political support, the capacity to create a supply network and partnerships, and adequate funding.

9.1.19 List of references

A.N.D.E.S. website, http://www.epiceries-solidaires.org/retour_des_rencontres_nationales_2009.shtml

L'épicerie solidaire est un lieu de promotion de la santé, Denis Dangaix, La Sante de l'Homme 395, Mai-Juin 2008, http://inpes.santepubliquefrance.fr/SLH/articles/395/06.htm#
How Are Income and Wealth Linked to Health and Longevity?, Laudan Aron, Lisa Dubay, Sarah M. Simon, Urban Institute, Centre on Society and Health, April 2015, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf ;

Access to healthy food and why it matters: a review of the research, Judith Bell, Gabriella Mora, Erin Hagan, Victor Rubin, Allison Karpyn; Policy Link, The Food rust, 2013, http://thefoodtrust.org/uploads/media_items/access-to-healthy-food.original.pdf;

How Are Income and Wealth Linked to Health and Longevity?, Laudan Aron, Lisa Dubay, Sarah M. Simon, Urban Institute, Centre on Society and Health, April 2015, p.4, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf;

9.2   Case Study 16: Sortir de soi, sortir de chez soi

Name of practice: Sortir de soi, sortir de chez soi (Coming out of one's shell, leaving the house)

Country: Belgium

9.2.1 Main objective and specific aims

The programme aims at increasing self-esteem in women who are inactive or have been unemployed for a long period, with the objective of improving their mental health, informing them about health services and rights, and answer to the questions they might have on these topics. The ultimate objectives are to help these women to re-engage with society and to improve their employability.

9.2.2 Relevance for 3rd EU Health Programme objectives

The practice is relevant to objective one of the 3rd EU Health Programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, by improving women's health and informing them about the subject.

9.2.3 Target groups

The target group are women, who are inactive or have been unemployed for a longer period of time.

9.2.4 Thematic focus of intervention in relation to reducing health inequalities

Given that part of the training programme is focused on improving health knowledge, this practice can improve the health status and well-being of this target group.

9.2.5 Key activities

The main activity consists of training and information sessions, which last about three months (around 49 hours in total). A total of 12 sessions are held with each group, with each session lasting between two and six hours.

The programme is developed around different modules:

- An information session, where the participants get to know the trainers and experts;
- A few sessions are focused on improving the image of oneself and self-esteem-animated by an expert in the field;
- A subsequent number of sessions are dedicated to the questions from the participants, regarding the topics that are relevant for them, such as the household, the children, their health and their rights as citizens;
- One session is dedicated to the presentation of the C.P.A.S. (Centre Public d'Action Sociale) services (support to the households in need, training opportunities and employment services);
- One session is dedicated to informing the participants about the local labour market, training and employment opportunities. This session is animated by the Forem (Public Employment Service of the Wallonia Region), the A.L.E. (Local Employment Agency).
- An overview of the services provided by relevant public actors in the area of integration and employment is also provided, to improve knowledge among the target group.

9.2.6 Geographical scope

This is a regional programme, taking place in the Brabant Wallon province, in the Wallonia Region of Belgium.

9.2.7 Intersectoral dimension

The programme cuts across health, social inclusion and employment policies, given the population group targeted. Also, the training programme includes information sessions on public services and employment services available in the Province.

9.2.8 Duration

The programme is in place since 2007 and it is still on-going.

9.2.9 Lead organisation

The lead organisation is the Office for Equal Opportunities (Cellule Egalité des Chances) of the Brabant Wallon Province.

9.2.10 Partners

Partners of the programme are: the C.P.A.S., the Forem, the Mission Regionale pour l'Emploi, the Guichet Sociale of Nivelles, the Centre for Mental Health of Jodoigne, the Ouvre-Boite Association and the Association de l'Autre côté du Miroir.

9.2.11 Main sources of funding

Core funding is provided by the Brabant Wallon Province.

9.2.12 Evidence base for implementation

Research[114] shows that improving self-esteem can lead to better mental and physical health. Positive self-esteem is considered as a basic feature of good mental health, but also a defence against negative influences. Furthermore, positive self-esteem is associated with healthy functioning, as reflected in aspects such as satisfaction, achievements and success. A low self-esteem can, on the contrary, be a causal factor for mental disorders such as depression, anxiety, eating disorders, but also other high-risk behaviours.

Research[115] also indicates that actions carried out at local level to improve mental health of citizens can have a positive impact on the well-being and health of the targeted population. The local authorities are the closest to the citizens and can interpret their needs in terms of social and health assistance. Furthermore, local interventions can improve the social integration and employability of the target groups and provide a higher return to the society in the long term, in terms of health care and social welfare.

9.2.13 Evaluation: Has the practice been evaluated?

No evaluation of the practice is publicly available. An evaluation was conducted internally, through questionnaires submitted to the participants, which provided input to the improvement of the programme offered[116].

9.2.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Limited public data is available regarding the outcomes, outputs and results of this practice.

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[114] *Self-esteem in a broad-spectrum approach for mental health promotion*, M. Mann, C. M. H. Hosman, H. P. Schaalma, N. K. de Vries, Health Education Research, Theory and Practice, Oxford University Press, Vol.19 no.4 2004, http://her.oxfordjournals.org/content/19/4/357.full;
[115] *Mental Health in Local Policies*, Policy Brief, EU Joint action on mental health and well-being, K. Nikolaj Japing and A. Lara Montero, European Social Network, http://www.mentalhealthandwellbeing.eu/assets/docs/publications/PolicyBrief%20Local%20authorities.pdf
[116] This is mentioned in the informative documents published by the Centre local de promotion de la santé of Brabant Wallon Province, http://www.clps-bw.be/sante-et-bien-etre-des-familles/decrire-une-experience?experiencePk=131;

Currently, the available data shows that:

- In 2007 24 women attended the programme in the municipalities of Wavre, Perwez, Genappe and Orp-Jauche[117];
- In 2011, four women attended the training in the municipalities of Ittre, Haut-Ittre and Virginal. After the training all of them were motivated to search for an employment and three of them managed to secure employment[118].

Additional information on outcomes, outputs and impacts has been requested to the organisation.

9.2.15 Success factors

Funding provided by the Province of Walloon Brabant was essential in order to undertake the workshops. There were also several other partners involved in the project that contributed towards it success. Coordinating the social welfare services provided by the C.P.A.S has been particularly important. This involved a presentation of the C.P.A.S during the workshops to inform participants of what social assistance is available to them. Building partnerships between the additional project partners outlined in 9.2.10 enables 'Sortir de soi, sortir de chez soi' to achieve its aims in a sustained manner that extends beyond the workshops themselves. The importance of these partnerships is further underlined by the fact that the organisation requires access to information on who is benefitting from Social Integration Income, or is enrolled in a Local Employment Agency, or is unemployed, as this comprises their target group.

9.2.16 Innovative features

The main innovative feature is the offer of different types of information and services to the target group, taking into consideration their particular needs and the socio-economic environment in which they live. The result is a very specific offer that can potentially be very effective in addressing the health and social needs of the target group.

9.2.17 Obstacles and lessons learnt

The main obstacle identified was the difficulty to reach the specified target group, and to convince them to take part in the programme, given their lack of integration in the society and their separation from the wider communities.

9.2.18 Potential for transferability and sustainability

The practice appears to be transferrable to other regions and countries, provided that the necessary funding is available. Other critical elements are the support of local public authorities and the availability of skilled personnel to lead the information sessions and provide training to participants.

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[117] Rapport Annuel 2007, A. Adriaenssens, C. Gigante, D. Kupperberg, D. Parys, Ministère de la Communauté française, Direction de l'Égalité des Chances, p. 52, http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&file=fileadmin/sites/sdec/upload/sdec_super_editor/sdec_editor/documents/Rapport_d_activites/Rapport_activite_2007_DEC.pdf&hash=c4452840ae40036c263c75c97580a00557ef9e8d;

[118] Bulletin d'Informations Communales, Nos trois villages, Claude Debrulle, April 2011, p.7, http://www.ittre.be/ma-commune/services-communaux/information/bulletin-communal/archives/2011-2012/bulletincommunal91-2011-04.pdf

9.2.19 List of references

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Rapport Annuel 2007, A. Adriaenssens, C. Gigante, D. Kupperberg, D. Parys, Ministère de la Communauté française, Direction de l'Égalité des Chances, p. 52, http://www.egalite.cfwb.be/index.php?eID=tx_nawsecuredl&u=0&file=fileadmin/sites/sdec/upload/sdec_super_editor/sdec_editor/documents/Rapport_d_activites/Rapport_activite_2007_DEC.pdf&hash=c4452840ae40036c263c75c97580a00557ef9e8d;

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10   Older People

Three practices in the inventory seek to improve the health of older people. A summary table of these practices is given below, which outlines the title, main aim and objective country and geographical coverage of each.

Table 12. Practices targeting older people

	Title	Main aim and objective	Country	Coverage	Quality score
17	Healthy Ageing Supported by Internet and Community	Project to empower older people in Europe to take care of their own health both virtually and in peer groups. Besides helping older people on a person-to-person basis, this project also aims to make services more cost effective and increase their quality through cooperation between regional service providers, and policy recommendations regarding communal elderly services.	Transnational	European	20
18	Health promotion and prevention of risk – action for seniors (Pro-Health 65+)	Project to increase the quality and responsiveness of care and services available to older people within four themes: competence development and staff recruitment; health and social services; housing and services; networks.	Poland	European	17
19	Our life as elderly (OLE II)	Preventative home care visits with older people who do not have support from social services	Transnational	European	16

These practices have a differing emphasis. One (Healthy Ageing Supported by Internet and Community) seeks to tackle the lifestyle factors that contribute to poorer health among the elderly. The other two practices focus more on healthcare services themselves; one of these (Health promotion and prevention of risk) aims to reform service delivery by enabling health professionals to care effectively for older people; the other involves preventative home care visits for older people who do not have support from social services.

The full case studies are given below.

10.1 Case Study 17: Healthy Ageing Supported by the Internet and the Community (HASIC)

Name of practice: Healthy Ageing Supported by the Internet and the Community (HASIC)

Country: Europe-wide

10.1.1 Main objective and specific aims

HASIC is an EU Health Programme-co-funded project that sought to empower and improve the lifestyle of seniors (65+ years old), making it healthier through better dietary habits, physical activity, moderate alcohol consumption and opportunities for social interaction. Besides helping them on a person-to-person basis, this project also aimed to make services for older people more cost effective and increase their quality through cooperation between regional service providers, as well as through policy recommendations regarding communal elderly services.

Through the initiatives developed and implemented, HASIC expected to increase awareness of the challenges that are often experienced by older people that can lead to social exclusion and health loss, and prepare healthcare professionals to provide better assistance to senior citizens both as a group and on an individual basis. At the same time, it sought to provide vulnerable older people with tools and mechanisms for self-management and an increase in their quality of life and healthy years.

10.1.2 Relevance for 3rd EU-Health Programme objectives

The activities and outcomes developed in the HASIC project are relevant to the 3rd EU-Health Programme, particularly to objective one: "promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle".

This is achieved by promoting a healthier lifestyle for older people by tackling factors such as unhealthy dietary habits, physical activity, alcohol consumption and isolation.

10.1.3 Target group(s)

The main target group of the HASIC project was older people who were at risk of social exclusion or suffering a decrease in their health due to unhealthy lifestyles.

Secondary groups included:

- current and future social and health care professionals who are working, or interested in working, in elderly care;
- volunteer peer mentor groups (older citizens themselves) from other organisations or associations of older people;
- regional public, private and non-profit service producers, decision-makers and also older people associations.

10.1.4 Thematic focus of intervention in relation to reducing health inequalities

HASIC sought to contribute to the reduction of health inequalities experienced by older people by tackling the factors that contribute to the creation or aggravation of healthy inequalities, such as poorly dietary habits, (lack of) physical activity, alcohol consumption and (lack of) social interaction/engagement among older citizens. Likewise, the activities developed within the context of HASIC meant to decrease healthcare expenses by promoting healthy lifestyles and preventing health problems often experienced by senior citizens.

10.1.5 Key activities

HASIC contributed to the increase of healthy lifestyles of older people through the following activities[119]:

- **Peer groups** and mentoring activities (with aged 65+ individuals), in six countries (six of the seven the partners' countries); they were mainly targeted at older people at risk of exclusion and poor health. The activities were led by mentors who have taken part in HASIC mentor training and lasted several weeks. Different aspects of healthy lifestyle were discussed on the basis of the activities addressed by the HASIC toolkit[120];
- **Qualitative research** activities, in order to collect information about services for 65+ year-old people and their implementation, and ways to increase cooperation between different social and healthcare providers. The main tools used were underlined interviews and focus groups that were organised in the seven partners' countries. Social and healthcare professionals, older people and other relevant stakeholders were involved.
- Network development, with the aim of increasing cooperation between social and health care providers of public, private and tertiary nature. Online platform (the HASICplus Online Platform[121]): development and testing of an online programme, which provides several tools for self-assessment and self-monitoring of health to older people
- A multilingual website, for the promotion of healthy lifestyle for older citizens[122].

10.1.6 Geographical scope

HASIC was a transnational project with implementation in Finland, Norway, Hungary, Spain, Estonia, Germany and the Netherlands.

10.1.7 Intersectoral dimension

HASIC brought together health and social care by tackling factors from both sectors that influence and affect healthy lifestyles (diet, physical activity, alcoholic drinking and social interaction). Another sector that is potentially brought into the picture by HASIC is the ICT, through the development of an easy to understand, user-friendly and accessible online platform targeted at senior citizens.

10.1.8 Duration

The HASIC project started on 01/01/2014 and finished on 30/06/2016.

10.1.9 Lead organisation

HASIC was led by the Turtu University of Applied Sciences (Finland).

10.1.10   Partners

The HASIC project included the following partners:

- University of Tartu (Estonia)
- University of Debrecen (Hungary)
- Hamburg University of Applied Sciences (Germany)
- University of Applied Sciences Utrecht (the Netherlands)
- University of Castilla-la Mancha (Spain)

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[119] HASIC (2016) http://www.hasicproject.eu/en/actions
[120] See par. 10.1.4 for more information;
[121] www.hasicplus.com
[122] HASIC http://www.hasicplus.eu/

- Norwegian University for Science and Technology (Norway)

10.1.11   Main sources of funding

HASIC was co-funded by the 2nd EU Health Programme, with a budget of approximately €1.000.000. The European Commission's contribution was of €616.063.00.

10.1.12   Evidence base for implementation

Publicly accessible information on the project does not point to specific references on an evidence base used for its development. HASIC has been implemented on the basis that "supporting empowerment and self-management helps people to learn to control the risks of their health and to maintain their healthy lifestyles. In addition, the right knowledge and support of a peer group help older people to maintain healthy life and to prevent exclusion[123]." Furthermore, the project was developed taking into account the scarcity of knowledge about preventing health issues and social exclusion of senior citizens in an effective way.

10.1.13   Evaluation: has the practice been evaluated?

The Final Project Report that was made available to the research team provides a comprehensive summary of the project and describes the outputs and main results of project. The evaluation occurred throughout the project and used both qualitative and quantitative methods. It was proven that there is a need for mentor training, peer group activities and ICT solutions in health promotion work among the elderly. Overall, the objectives of the HASIC project are evidently valuable and relevant across Europe, with further development of preventative elderly care services required.

The research carried out within the project showed that there is a wide variety of services available to older people in each country, but links between different services are often weak. Availability of preventative services is limited and users find services often out of date. Also, a lack of skilled professionals to motivate people to live in a healthy way was identified.

- From the evaluation it emerges that, with regard to the objective of enhancing the quality, customer orientation and cost-effectiveness of older people's services, the project was successful in raising awareness around these issues in all seven partner countries. The Final Report highlights the challenges involved in cooperating across "seven countries, [with] seven different working cultures and seven different national languages". However, the regional and European-level policy recommendations were effectively disseminated and series of events with high numbers of participants were organised around Europe.
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- More specifically in relation to the management of the HASIC project itself, the evaluation states that the financial management was successful, with all partners spending their budgets at a reasonable rate. Specific output indicators identified in the evaluation of the project are outlined subsequently.

10.1.14   Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The main outputs of the project were the following:

- <u>Toolkit for healthy ageing</u> – a document for the use of peer mentors, healthcare and social care professionals, students or anyone interested in healthy ageing and willing to contribute to older people's healthier lifestyles. The toolkit comprises self-management abilities and exercises per each topic discussed

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[123] http://www.hasicproject.eu/en/node/31

(loneliness, physical activity, alcoholic drinks consumption, social engagement, etc.). The toolkit can be downloaded on the project's website[124];

- A mentor education programme and a toolkit were developed for elderly volunteers, professionals and students. The aim was to provide the target groups with the skills and knowledge needed for health promotion to the elderly. The toolkit was produced on the basis of the education programme experience; it contains theoretical and evidence-based information on elderly's health with a holistic approach; the toolkit also contains various instruments which can be used in practical health promotion work. The training programme was carried out in each of the partners' Member States;

- A series of <u>workshops</u> was held among regional service providers;

- After the workshops, each country made the <u>analysis of the qualitative data</u> and a national report was written with key results. The key results were then compiled in a single report. Results were presented in Debrecen Meeting in March 2016 where the participants debated and reached Policy recommendations about preventive services for 65+ at the EU-level;

- <u>Policy recommendations</u> for regional preventive services for 65+ were drafted on the basis of the results of the research and the workshops; they were disseminated through national workshops in each country. For instance the 'Super Senior Week' was organised in Finland in May 2016, to implement and raise to the awareness the topical questions and issues around services for elderly.

- As a result, at least 358 persons including elderly volunteers and current and future professionals were trained as mentors; 345 older persons participated in the peer group activities; 200 different regional actors (older people, social and healthcare professionals, policy makers and other relevant stakeholders) have taken part in the workshops; 25 000 persons have been active on the HASICPlus website and 500-1000 persons have used three different sections learning about healthy lifestyle and testing their own lifestyle habits.

- In term of outcomes, the main results of the monitoring and evaluation showed that:

  - 75 % of the participants found the education programme useful as it gave them evidence-based knowledge of the main health risks faced by older people, and group leading skills;
  - 75 % of the participants estimated that the peer groups and mentoring activities have supported them to adopt healthier lifestyles;
  - At least 75 % of the users found the toolkit useful in adopting a healthier lifestyle;
  - At least 75 % of the users considered the platform as a functional instrument;
  - The majority of the service providers felt that the network of regional actors is a useful tool to develop older people's services at local level.

10.1.15   Success factors

Besides the main partners, HASIC gathered health and social care professionals, older citizens acting as volunteers to steer peer groups, and private, public and tertiary sector organisations, which helped design and implement the project. The participation of older people in all the activities carried out by HASIC (workshops, peer groups,

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[124] http://www.hasicproject.eu/sites/default/files/documents/Hasic_toolkit%20compressed.pdf

mentor groups) has given them tools to break the isolation cycle and their unhealthy dietary habits, while at the same time encouraging them to be part of the development of services directed at senior citizens by providing first-hand suggestions and giving an account of their daily challenges.

The project activities also helped identify the main issues faced by healthcare systems in the partners' countries when organising the services directed at the elderly. For instance a lack of coordination between different types of services and a limited of preventive services were identified in most countries.

10.1.16   Innovative features

This project was quite innovative as it tackled and addressed the social and health factors that influence and contribute to a healthy lifestyle, bringing together social, health and IT sectors to break the cycle of isolation and health loss in senior citizens. It directly involved older citizens in focus groups and as mentors of peer groups, and sought to bridge the technological gap often present in older societal groups by creating a website targeted at senior citizens that promotes healthy lifestyles. This website also includes a chatroom/forum feature, thus breaking social exclusion and isolation.

10.1.17   Obstacles and lessons learnt

The final report indicates that the use of English appeared to be an obstacle, especially for the volunteers and also professionals. Many users do not master the English language. The translation of the toolkit in other languages is foreseen to overcome this issue.

A major problem faced during the development of the HasicPlus website resulted from the necessity to develop the website in parallel with the development of the HASIC handbook, as well as the content and approach of the mentor training and peer group activities. This had to be done in order to achieve coherence between the different project elements. However, this introduced some time delay in content development and then a redesign of the website structure.

The differences of cultural contexts among the partners' countries proved to pose a challenge for the delivery of the activities. Activities suitable for some countries were not always suitable in all other countries. Project partners had to be flexible in modifying the activities to meet the needs of the target groups on the country they operated.

A major challenge was also recruiting mentors and participants to the peer-groups. This was perhaps due to competing activities among potential participant's aged 65+, for instance similar group initiatives in Norway. Moreover, most group participants were women, as men turned out to be more difficult to recruit to group sessions. In order to overcome this issue, a close cooperation with health- and social services within local municipalities and voluntary organisations was established.

The project consortium also felt that there should be more face-to-face meetings in order to have discussion among partners; more virtual meetings have been organised to overcome this challenge, even though the project team realised that this type of meetings do not really make up for face-to-face ones.

10.1.18   Potential for transferability and sustainability

HASIC ran simultaneously in 7 countries, which shows that the initiatives carried out can be adapted and transferred to other European contexts. The objective of reducing healthcare costs through the promotion of healthy lifestyles and the prevention of

health problems associated with older age, as well as the intention of making services targeting older people more cost effective, has shown that progress has been made towards the sustainability of both health systems and social services.

10.1.19 List of references

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10.2 Case Study 18: Health promotion and prevention of risk – action for seniors (Pro-Health 65+)

Name of practice: Health promotion and prevention of risk – action for seniors (Pro-Health 65+)

Country: Poland (PL)

10.2.1 Main objective and specific aims

The main objective of the project is to prepare a manual for health workers on the most effective health promotion strategies among older people. The research will be disseminated among healthcare professionals to help them improve their care of older people, thereby contributing to sustaining their health.

The specific aims of doing so are:

- Spread knowledge and use of evidence-based methods for promoting health among older people;
- Through doing so, increasing the possibilities for and reducing barriers related to health promotion;
- Increase health literacy among seniors, and extend their healthy lifestyles; and
- Limit the risk of chronic diseases and accidents, increasing people's healthy life years.

10.2.2 Relevance for 3rd EU Health Programme objectives

- This project is relevant to objectives one, three and four of the 3rd EU-Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, by helping improve the healthcare support given to older people;
- Contribute to innovative, efficient and sustainable **health systems**, by supplying institutions and induvial practitioners with advice and guidance on best practice; and
- Facilitate access to **better and safer healthcare** for Union citizens, by improving the service older citizens are receiving from health workers.

10.2.3 Target groups

The target group of this project is healthcare professionals, with a follow-on impact intended for older people (65 years plus).

10.2.4 Thematic focus of intervention in relation to reducing health inequalities

There are significant health inequalities between the senior populations of different Member States. OECD figures from 2008-2010 show that between the highest and lowest ranked EU-27 Member States, the gap in life expectancy at age 65 is 6.3 years for women and 5.1 years for men[125]. Evidence shows that there are inequalities within the senior populations of individual Member States as well. For example, research in the UK found a link between factors such as their educational attainment, income and socio-economic class, and prevalence of health indicators such as longstanding illness, co-morbidities and psychiatric morbidity[126].

This programme doesn't specifically target any particular groups beyond the wider senior population, but it is possible that by addressing older people in general this programme could have an impact upon one or more of the health inequalities that exist within Europe's senior population as well.

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[125] OECD, 2012. Life expectancy and health life expectancy at age 65.
[126] Grundy and Holt, 2001. Health inequalities in the older population.

10.2.5 Key activities

This programme consists of two main strands: research, and implementation of project results. The activities which take place under each of these two strands are as follows:

10.2.5.1 Research

- Analyse previous studies relating to the health status of older people, and factors affecting this;
- Identify and evaluate methods of health promotion; and
- Capture information on the institutions health workers belong to, including their funding, distribution and financial incentives.

10.2.5.2 Implementation of results

- Use the findings from the research stage to prepare a manual on health promotion which can be used by health workers; and
- Produce training materials for institutions undertaking health promotion with older people (including practitioners, policy makers, activists, social workers, journalists etc.).

10.2.6 Geographical scope

This programme is transnational, as the core partnership responsible for running this project involves universities in four countries, and the project's findings have been distributed to health promoting institutions in eight Member States[127].

10.2.7 Intersectoral dimension

This programme covers one policy area: health.

10.2.8 Duration

Pro-Health 65+ activities began in November 2014, and ended in July 2017[128].

10.2.9 Lead organisation

The lead organisation is Jagiellonian University Medical College, the medical school attached to Jagiellonian University.

10.2.10 Partners

The programme has three **associate partners**, which provide senior researchers to assist in both undertaking the research and implementing its findings. Three universities participated in the programme as associate partners:

- Maastricht University;
- Università Cattolica del Sacro Cuore; and
- Universität Bremen.

10.2.11 Main sources of funding

The project is co-funded by the European Union under the Health Programme (2008-2013), which provides it with a grant of 960,165 EUR[129]. The remainder of the project is funded by the main partners.

10.2.12 Evidence base for implementation

No evidence illustrating the project's likely effectiveness is given in the project documentation, and elsewhere there is relatively little evidence currently available on

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[127] Bulgaria, Germany, Greece, Hungary, Italy, Netherlands, Poland and Portugal.
[128] Golinowska et al, 2016a. Pro Health 65+: Project Policy Brief 1.
[129] Heine et al, 2016. Pro Health 65+: Project Policy Brief 5.

the effectiveness of information communication and dissemination campaigns as a means of achieving population health outcomes. McCormack et al's (2013) review of all evidence on communication and dissemination campaigns aimed at clinicians and/or patients[130] found that although a number of studies have been conducted to test different strategies, the strength of evidence produced in all trials the review examined was found to be either low or insufficient to draw a conclusion. While there is some preliminary evidence on the kinds of strategies that might work best, the level of evidence on health outcomes that might be achieved by dissemination strategies targeted at clinicians is poor.

10.2.13 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The work plan for the project includes both an interim and final evaluation. The interim evaluation systematically assessed the project's success in terms of implementation (application of the project plan), results (achieving project objectives) and quality (meeting the needs of the target group). In terms of meeting the objectives, the evaluation lists specific outputs that have ensured it is working towards its ultimate project objective of recommending proven and cost-effective methods of health promotion activities for older populations. This has been achieved, or is in the process of being achieved, namely through research, analysing key European health and aging policies, and disseminating acquired results among health promotion promoters through trainings/workshops. Progress towards meeting specific project objectives is also included in the evaluation. For instance, the establishment of the website is cited as a major milestone enabling the effective coordination of the entire project (WP1).

Three external evaluators also assessed the project, stating that, overall, the amount of information collected and analysed by the project is impressive, and that the project is likely to have an impact on health promotion for older people. Improvements recommended by the experts include better dissemination of information among providers (street-level health promoters), and more concrete policy recommendations.

Some objectives (particularly WP8 and WP9) are still in progress and will be met during the second half of the project. Thus, a final evaluation will be undertaken following the project's conclusion and submitted in the second half of 2017.

10.2.14 Outputs, outcomes and potential success factors

The interim project report illustrates the outputs and outcomes produced by the project between 2014-2016;

- A project website and dissemination website were created;
- A comprehensive analysis of the health status and lifestyles of the elderly and their determinants was carried out;
- An assessment of health promotion interventions was carried out, and recommendations were produced on health promotion interventions for age groups of older population;
- An evaluation of funding mechanisms for health protection and promotion programs for older persons was carried out; this will feed into country profiles analyses, which haven't been completed yet;

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[130] McCormack et al, 2013. Communication and Dissemination Strategies to Facilitate the Use of Health-Related Evidence.

- Research was carried out on health promotion activities targeted at the elderly in Europe and a preliminary report was prepared with diagnosis of major groups of institutions engaged in health promotion programs for the older people;
- A dissemination conference was organised to present the emerging findings of the project. Results were disseminated in external conferences as well;Policy papers and academic articles were published, which provide a good amount of information on research and analysis results for each of the completed work packages[131];

Given the breadth of information covered, it is likely that institutions and individual practitioners receiving the briefs will see the value of the recommendations made by Pro-Health 65+ and will have been given enough information to be able to make practical changes to their own practice. However, the overall effectiveness of the project appear not to be examined in the interim report, so the project's success in realising these outcomes likely won't be known until the final evaluation have been published.

10.2.15   Potential for transferability and sustainability

The nature of the activities conducted, consisting primarily of desk research, means that they could in theory be easily transferred to other settings, undertaken by researchers in other universities or research organisations. For the project to be transferred in this way, or sustained in its current form, sufficient resources would be the key factor for the current leads or any institutions attempting to replicate the project.

- **Funding**. At present the project relies upon the Health Programme for co-funding. for it to continue at its present scale, it would either need to secure further grant funding from the EU or, if this is not possible, attract higher levels of funding from the partners involved in delivery. Without this, it would likely need to be reduced in scale.
- **Expert availability.** For the project to be continued in its present form, experts currently dedicated to directing and/or implementing Pro-Health 65+ will need to continue to be made available by their respective instructions. There is no evident reason why they would be unable to continue working on it in the future, but for the project to be expanded to cover more countries would either require current experts to increase their time commitment to the project, or for a number of new experts to be recruited.
- **Access to institutions.** It is yet to be seen how effective Pro-Health 65+ will be in gaining access to practitioners delivering healthcare and in changing working processes, but this will depend upon the targeted institutions (e.g. government, healthcare providers, NGOs) being receptive to Pro-Health 65+ and willing to act upon the information it supplies them with. One factor which could limit the capacity of Pro-Health 65+'s to exert influence in different countries is national legislation: healthcare sector regulations vary from country to country, which might put limits on practitioners' capacity to change their working practice or use information supplied by Pro-Health 65+.

10.2.16   List of references

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[131] Including: Golinowska et al, 2016b; Arsenijevic et al, 2016; Sitko et al, 2016; Tambor et al, 2016; Kampmeijer et al, 2016; Huter et al, 2016. All publications available from: http://www.pro-health65plus.eu/?Publications

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10.3 Case Study 19: Our Life as Elderly (OLE II)

Name of practice: Our Life as Elderly (OLE II)

Country: Sweden, Faroe Islands, Finland, Norway, and Iceland

10.3.1 Main objective and specific aims

OLE II builds on the work carried out during OLE I, which aimed to identify the needs and wishes of older people. The results from OLE I were used to identify priorities for development in care for older people. OLE II aims to build on the findings from OLE I through the development of services which are responsive to the previously identified needs. Activity in OLE II focused on four key themes:

a) Competence development and staff recruitment,
b) Health and social services,
c) Housing and services
d) Networks.

The main objective of OLE II is to increase the quality and responsiveness of care and services available to older people within the four themes listed above and based on priorities identified from OLE I.

The specific aims of the project are:

1. To translate care and/or service development priorities identified in OLE I into care interventions, therefore changing routine practice in the care of older people.
2. To package these changes in a product format which can be easily adopted by other municipalities.

10.3.2 Relevance for the 3rd EU-Health Programme Objectives

- OLE II is relevant to objectives one and four of the 3rd EU Health programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, by improving health and social services for older people and increasing social inclusion of this target group.
- Facilitate access to better and safer healthcare for Union citizens by developing services based on assessed needs of the older population in terms of health care.

10.3.3 Target groups

The OLE II project primarily targeted older people.

10.3.4 Thematic focus of intervention in relation to reducing health inequalities

This project includes interventions in four thematic areas as detailed below. Although there was not an explicit focus on health inequalities, the project organisers cite various health issues which differentially affect older people, e.g. social isolation, polypharmacy, dementia. Therefore in their aim of changing routine practice in the support of older people's health and social care, they address and aim to reduce these health inequalities.

10.3.5 Key activities

The activities carried out within each of the four thematic areas were built upon the priorities identified in OLE I, and are summarised below:

Competence Development and Staff Recruiting

Competence development and staff recruiting relates to the provision of suitably qualified health and social care professionals who will be needed to care for the increasing number of older people. OLE I identified that potential service users prioritised humanity and consistency in the care they would receive, and that carers should have specific professional knowledge on care of older people, including mental health. OLE I also identified that recruitment into jobs providing health and social care to older people may be negatively affected by poor financial incentives to recruitment and the low status of these jobs. Within this theme the key activities were:

- To organise long-term general marketing of and PR for, careers in professions for care;
- To establish a function for strategic recruiting;
- To establish a function for proactive communication with long-term prospects in for instance the school and employment system; and
- To establish a model for integrated and permanent staff development, The Competence Ladder.

These activities were carried out through the creation of various toolboxes, which could be used by organisations to change their own practice in relation to the activities above. The following toolboxes were created:

- Ambassador toolbox – This toolbox defined the characteristics and role of an ambassador. Suggestions were given for places where the ambassador can fulfil their role of marketing job opportunities in older people care, e.g. schools, job fairs etc;
- Recruiting and introduction of new employees toolbox - The main objective of this toolbox was the strategic recruiting and introduction of new employees in the field of older people health and social care. Its content included guidance on how to start work, initiate strategic recruiting, checklists, an interview template and introduction package.
- The school model toolbox – This toolbox consists of a framework for organising joint activities between school children and residents of care homes. The purpose of the model was to increase intergenerational awareness in the hope that this will create shared empathy. A secondary aim was that this process could positively impact on recruitment to older people health and social care in the long term.
- Competence bank toolkit – this contained guidance that can be used by various organisations in providing care to older people on how to identify the skills needed to support older people care, and how to anticipate and meet future needs.
- Toolbox 'Changing Culture' – This toolbox consisted of a guidance document detailing the best procedures to change an institutionalised culture in nursing homes and day-care centres, based on the Eden Alternative[132].

Health and Social Services

OLE I identified concerns that the provision of health and social care would be challenging in the future, due to the growing numbers of older people requiring care. The importance of communication systems between providers of care was highlighted. In response to these priorities, three health and social care products/interventions were developed:

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[132] The Eden Alternative is an international non-profit organisation which prioritises responsive, person-centred care through a range of methods, including competence development for employees.

- A system was established to include home visits to and risk assessment of older people living in their own homes to promote safety and identify health or social care needs/concerns. Staff with social and medical competences carried out preventive home visits to elderly people and provide them with information about the existing services for elderly people, as well as using risks assessment tools for nutrition assessment and fall risk. Additionally, the staff talks with the elderly about their day-to-day life to identify potential problems. Finally, a guidance document has been produced so as to facilitate the replication of this initiative in other municipalities.
- Improving the safety of medication administration - Careosuel GSM is a computerised medication dispenser. The purpose of the dispenser is to make it easy for older people to take their regular medications at the appropriate time, and to prevent drug administration errors. The use of Careosuel GSM was trialled with older people during OLE II.
- Education Concept: Medical Handling – Training sessions were created to promote increasing knowledge about medicine handling among the staff in home help care services. The project involved pre- and post-training knowledge questionnaires.

Networks

The networks theme of OLE I and II recognised both the importance of social connectedness for mental and physical health, and the risk of loneliness in older people. The benefits of networks were highlighted in OLE I. In response the following activities were carried out during OLE II:

- Building on a pilot web portal created during OLE I, a package was developed to assist other areas in setting up a web based meeting platform for senior citizens;
- A model was established for physical and informal meeting places, to stimulate pensioners to organise activities like educational courses and voluntary activities with cross generation activities.

Housing and Services

The desire to continue living in one's own home was identified in OLE I as a key priority for 'future older people'. A recognised pre-requisite for this is the availability of suitable housing, including provision of housing for people with developing physical care needs. Building on these priorities OLE II encouraged the development of creative property solutions to support the continued accommodation of older people in the community.

10.3.6 Geographical scope

OLE II is a transnational programme, implemented in five Northern European countries (Sweden, Faroe Islands, Iceland, Norway and Finland).

10.3.7 Intersectoral dimension

The main policy areas covered by OLE II are health and social care. However, two additional policy areas are covered by the activities described above – employment (through the competence development and staff recruitment theme) and housing policy.

10.3.8 Duration

OLE II started in 2008 and finished in 2011.

10.3.9 Lead organisation

The lead organisation for OLE II was the City of Luleå – Administration of Social Services, in Sweden.

10.3.10   Partners

Partners of OLE II included regional and municipal public authorities from the five different countries involved in the project, namely:

- Municipality of Bodø, Department of Health and Social Care (Norway)
- Association of Faroese Municipalities (Faroe Islands)
- The City of Oulu (Finland)
- The Nursing Homes in Akureyri (Iceland)
- Municipality of Hafnarfjördur, Department of Social Services (Iceland)
- Health Care Centre and Community Hospital of Southeast Iceland (Iceland)
- Institution of Primary Care Services, Naerverkid (Faroe Islands)

10.3.11   Main sources of funding

This project was financial supported by the Interreg III B, Northern Periphery Programme 2007-2013. The total budget for this project was of € 2 003 371, with a funding request of € 1 074 704.

10.3.12   Evidence base for implementation

OLE II was designed to build on the findings of the first OLE study. OLE I used a combination of interviews, focus groups and surveys to evaluate the attitudes of 'future older people' to health and social care for people aged over 65 years. Participants in OLE I were 'future older people', i.e. people who would reach the age of 65 over the next 10 years. Participants aged 55-65 were recruited.

OLE II considers the priorities identified in OLE I and has created solutions to these issues which can be used in other settings.[133] Specific results within each thematic area are discussed above. Broadly the results of OLE I were:

- New organisational models formed for management and operations.
- Models for national and transnational co-operation, between concerned groups and participating regions, have been established.
- New techniques for the care of our elderly are spread.
- New working models for the care of elderly in smaller settlements and extreme rural areas are designed and in operation.
- Increased attraction of our municipalities in relation to other regions and in a national comparison.

There is little published evidence of the effectiveness of the proposed products/interventions in the project documentation published on the project website. With regards to OLE I there is limited information in the public documentation on the number of people who participated in the project – for example the number of focus group participants is not stated. Similarly, although a survey was sent to a random sample of 200 men and women, the uptake and characteristics of those completing the survey is not documented. This makes an assessment of the generalisability of the findings difficult.

Evidence on the effectiveness of the Eden Alternative, which forms the theoretical basis for the 'Changing the culture' toolkit, is cited. Research published in 1998 cited the adoption of the Eden ideology in a sample of nursing homes in Texas, USA, was associated with improvements in a range of outcomes including a 60% reduction in behavioural incidents and a 48% reduction in staff absenteeism[134].

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[133] http://ourfuture.se/our-results.htm
[134] The Eden Alternative. Eden Alternative Data 1999-2005.
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10.3.13 Evaluation: Has the practice been evaluated?

Evaluations for OLE I or OLE II are not publicly available. Results for OLE I are presented as recommendations at a national and international level within the various thematic areas. Therefore the results for OLE I function as 'corporate needs assessment', documenting the expressed needs and wishes of the participant 'future older people'.

10.3.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

An interim analysis of the outputs produced by OLE II was published in 2009[135]: These products/concepts relate to the four themes of OLE II and are detailed below. There is limited evidence of outcomes associated with the project, i.e. how any of the outputs listed have been put into practice or how effective these are in achieving the aims of the project.

Competence development and staff recruitment

Toolboxes were created to promote staff recruitment to older people health and social care, as described above, and used across the project. There is no documentation of the short term outcomes in terms of impact on staff recruitment or attitudes to employment in older people health and social care. Although these are ultimately long-term objectives of OLE II there is no clear indication of the theoretical basis for these interventions or the proposed method of evaluating impact.

Health and social services

Careosuel GSM –Following initial difficulties recruiting participants to use the product, OLE II reported that user feedback was generally positive. However it was highlighted that the cost of the product could be a barrier to widespread use. The OLE II evaluation does not include details on the number of users, or any evaluation of the impact on drug administration errors.

Home Visits – Home visits were carried out in Luleå, Sweden, as part of OLE II. Older people who received visits in this area reported increased knowledge of the services available to them, and that the visits were generally positive. However there is limited information in terms of the number of visits carried out and the objective change in knowledge.

Education Concept: Medical Handling- Training sessions were developed to promote increasing knowledge about medicine handling among targeted staff in home care services. The project involved pre- and post-training knowledge questionnaires to measure the impact of this activity. However, it is not clear from the project documentation if this educational concept has been administered or what the short and long term impacts of the concept were.

Housing and services

Vintage Housing – OLE II in Sweden collaborated with a local housing agency interested in building houses suitable for older people. OLE II provided insight gained through OLE I, therefore providing guidance and counselling regarding the creation and building of housing facilities which are especially developed and adapted to older people (e.g. wider doorways, removal of some interior walls, adapted bathrooms, existence of common areas to enable social interaction, guest rooms for visiting relatives or friends, outdoor environment). It is reported that the housing agency had built three 'vintage apartments' which follow some of the design specifications suggested by OLE II.

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[135] http://www.keep.eu/keep/project/1549

Networks

Virtual meeting place

Two pilot online spaces had been created during OLE I. Due to the favourable response to these resources, OLE II created a toolbox which could be used by organisations interested in setting up their own online space.

Informal meeting places

The rationale of informal meeting places was to provide a safe space where older people can interact and get involved in social activities, recognising the issue of loneliness and social isolation. The approach adopted in OLE II included involvement of older people, who initiated and participated in activities, the municipality, who provided facilities and staff, and additional administrative staff.

A number of testimonials were provided by users, indicating a positive response to the informal meeting places from both older people and staff involved. Although there is limited information on the long term impact of these interventions, it is evident that municipal support is essential, and future interventions adopting a similar style would require a formal agreement with local municipalities to ensure sustainability.

Success factors

The various 'products' designed, and in some cases piloted, in OLE II were based on findings from OLE I. In this way OLE II explicitly attempted to use the views of interest groups to develop interventions/products for older people.

The very limited presentation of outcomes, i.e. beyond the products/outputs to the impact these have had, makes it difficult to identify how successful this project is likely to be in the wider community.

10.3.15 Innovative features

During the sub-projects contained within OLE II there was evidence of collaboration with external partners. For example the work done with the producers of the medicines administration device, Careoseul GSM and with the municipalities involved in the creation of informal meeting places. This is an innovative approach which is appropriate given the multiple agencies involved in health and social care of older people, and the need for a whole systems approach in tackling better access to healthcare among vulnerable groups.

10.3.16 Obstacles and lessons learnt

Although there is no formal discussion of barriers or lessons learnt within the project, OLE II is built upon the outcomes of its predecessor OLE I. The first aim of OLE II was therefore to translate the information gained in OLE I into 'products' which could be used to change day to day practice and improve the lives of older people in accordance with the wishes expressed in OLE I.

Some of the subproject aims are very ambitious, e.g. changing recruitment patterns into professions caring for older people. There is a lack of theoretical framework and evidence base for such proposed interventions to achieve these aims, which may be seen as an obstacle. Additionally, these aims were complex, system problems and therefore need system based solutions– e.g. recruitment will necessarily involve direct collaboration with the employment and education sector.

The second aim of the project was to 'package these changes in a product format which can be easily adopted by other municipalities'. While a number of toolboxes have been produced to support organisations who wish to use the products piloted in OLE II, there is no information on how these tools have been marketed, what the

uptake of these products has been and what impact the use of these products has had.

10.3.17   Potential for transferability and sustainability

OLE II is a large scale programme containing multiple interventions/products within four thematic areas. Therefore it is unlikely that the whole programme would be transferable without taking into consideration the specificities of a given country/region and the services it provides associated with older people.

10.3.18   List of references

Our Life as Elderly 2 (2011) www.ourfuture.se

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Competence Development and Staff Recruiting Final Report - http://ourfuture.se/__admin/admin/en/competence/Competence_final_Report.pdf

Service for the Elderly Final Report - http://ourfuture.se/__admin/admin/en/service/Service_final_Report.pdf

Relatives and Akin Final Report - http://ourfuture.se/__admin/admin/en/relatives/Relatives_and_Kinship_Final__1.0.pdf

Health Services Final Report - http://ourfuture.se/__admin/admin/en/health/Health_Care_final_Report.pdf

Networks Final Report - http://ourfuture.se/__admin/admin/en/networks/Final_report_Networks_1.0.pdf

11   People with Unstable Housing Conditions

There are four case studies that showcase me thods of improving the health of people with unstable housing conditions (the homeless). A summary table of these practices is given below, which outlines the title, main aim and objective country and geographical coverage of each.

Table 13. Practices targeting people with unstable housing conditions

	Title	Main aim and objective	Country	Coverage	Quality score
20	Drug consumptio n rooms (DCRs)	Drug consumption rooms (DCRs) are dedicated centres where homeless people can take drugs, under the supervision of a nurse. The aim is to reduce the high number of drug-related deaths and incidents created by unsafe and public intake, and to improve access to healthcare and treatment for vulnerable users	Denmark	Regional	25
21	Find & Treat, London	In London a mobile health unit has been funded which travels across the London boroughs and screens homeless people for TB.	UK	Regional	25
22	Housing First	Housing First is a practice model to support homeless people in particularly difficult situations (people with mental illnesses, with problematic drug and alcohol abuse, with high support needs; people experiencing long term or repeated homelessness). The project provides access to permanent housing without any preconditions.	Transnational	European	25
23	Ombolt	A football league for homeless youth, to encourage physical activity, sports and integration.	Denmark	National	24

Two practices (Find and Treat; DCRs) deliver healthcare services to the homeless, although the latter (DCRs) offers a less conventional form of treatment, as it gives the homeless a safe space in which to take drugs and supports them to enter rehabilitation programmes. The other two practices (Ombolt; Housing first) aim to tackle the causes of poor health among the homeless. One (Housing first) provides the homeless with unconditional access to permanent housing, which is seen as a prerequisite for improving their health. This approach has been tried and tested across much of Europe. The other practice (Ombolt) enables the homeless to participate in a football league and be part of a supportive community – with many positive impacts for their health.

The full case studies are given below.

11.1 Case study 20: Drug consumption rooms

Name of practice: Drug consumption rooms[136]

Country: Denmark (DK)

11.1.1 Main objective and specific aims

Drug consumption rooms (DCRs) are dedicated and supervised centres where normally hard-to-reach drug users can inject and, in some cases, smoke and inhale drugs. They were set up as a 'harm-reduction'[137] policy in Denmark to reduce the high number of drug-related deaths and incidents created by unsafe and public intake, as well as to improve access to healthcare and treatment for vulnerable users. The specific aims[138] of the facilities can be divided into two categories: outcomes for drug users using the facilities and outcomes for the wider community.

11.1.2 Outcomes

11.1.3 For clients:

- Reduce the acute risks of disease (HIV, HBV and HCV) transmission by providing a safe environment to inject and dispose of needles in, and by providing education and training for more hygienic drug use;
- Prevent drug-related intoxication and overdose deaths by providing medical supervision;
- Facilitate healthcare access for high-risk drug users and connect them with addiction treatment and other health and social services;

11.1.4 For society

- Contribute to reduction in drug use in public places by improving amenity in areas surrounding urban drug markets;
- Reduce the presence of discarded needles and other public order problems linked with open drug scenes.

11.1.5 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objective one of the 3rd EU Health programme:
- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle.

11.1.6 Target groups

The consumption rooms aim to attract hard-to-reach populations with unstable housing conditions, injecting drugs, particularly vulnerable and marginalised groups who use drugs on the streets and in other unhygienic conditions.

Access is typically restricted to registered users; the criteria for registration includes minimum age (users must be over 18) and local residency[139]. In February 2016, it was estimated that more than 3564 people who use drugs are registered as clients of Danish drug consumption rooms[140].

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[136] Drug consumption rooms are also referred to as supervised (or safer) injecting facilities (SIFs) and supervised injecting rooms (SIRs). However, the more all-encompassing phrase 'drug consumption room' is used here, to take into account that often users are permitted to smoke and sniff illicit drugs in designated outside areas.
[137] Harm reduction policies are designed to reduce and minimise the consequences and risks associated with, in this case, drug consumption. The focus is on the prevention of harm as opposed to the prevention of use itself.
[138] EMCDDA, 2016, pg. 4
[139] Ibid. pg. 3
[140] Kappel *et al.*, 2016, pg. 2

11.1.7 Thematic focus of intervention in relation to reducing health inequalities

Following the National Advisory Council on Drug Policy's recommendation (1984) to change drug treatment policy from primarily abstinence-oriented policies to those with graduated goals, Denmark has implemented a number of harm reduction policies to reach high-risk drug users. These include: needle and syringe programmes (established in 1986); outreach street work; drop-in centres and social support at home[141]. After a change in political climate, the law was finally amended to enable the introduction of the mobile consumption rooms in 2012.

The main focus of drug consumption rooms is on improving access to healthcare. In the immediate sense, this is achieved by providing a safe, supervised and hygienic environment for clients to inject, smoke or inhale drugs. Simultaneously, education and training is provided at the facility to reduce the high number of drug related morbidities and mortalities; according to Foregningen Fixerum, some 300 drug users die from overdoses in Denmark every year – one of the highest rates per capita in Europe[142]. Thus, DCRs aim to improve the health outcomes for Danish drug users by reducing the harms associated with injection and high-risk forms of use.

In addition, a long-term goal of the DCRs is to improve the overall life situation of drug users and provide them with tools for social (re)integration. They aim to do this by facilitating access to healthcare and social care services; providing treatment for users who request it; and tackling a range of associated social problems such as homelessness and access to employment.

11.1.8 Key activities

As illustrated by the typology below (Figure 1.1), the key activities carried out by the DCRs are heavily determined by the function and model of DCR; the organisation and objectives of consumption rooms varies according to the setting in which they are provided. The four Copenhagen DCRs all vary in type: the busiest facility, 'Skyen', offers a range of other services to clients in Vesterbro, whilst the mobile DCR, 'Fixelancen' is the smallest facility and is parked close to Halmtorvet.

Two activities remain fairly consistent among the Denmark facilities:

- Typically, all DRCs provide drug users with: sterile injecting equipment; counselling services before, during and after drug consumption; emergency care in the event of overdose; and primary medical care and referral to appropriate social healthcare and addiction treatment services.
- Copenhagen's fixed-site DCRs all have a similar registration procedure. To gain entry to the DCR, clients must register and formally agree to abide by the house rules; DCRs vary as to how strictly the house rules are enforced. Restrictions as to who can register apply, for example, minors and pregnant women are prohibited from entry. Clients must also accept that staff will intervene in case of overdose. During registration, the client will indicate the drug they plan to consume.

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[141] Houborg, E., 2015: http://www.aths-biarritz.com/wp-content/uploads/2015/11/VENDREDI_HOUBORG.pdf
[142] Rychla, L, 2016: http://cphpost.dk/news/scandinavias-largest-drug-injection-room-opens-in-copenhagen.html

Figure 1.   A typology of drug consumption rooms (adapted from Kappel et al., 2016)

Integrated DCR

In Copenhagen, Skyen (The Cloud) is an example of an integrated DCR

- Typically part of a broader and interlinked network of services e.g. counselling, needle exchange, testing for viruses, sexual health tests and care, psychosocial care, care of homeless people, medical services, education etc.
- Based in drug service centres and so also offer treatments such as opiate substitue therapy (OST).
- Defined as 'one-stop shops' for service users as clients can access a range of services in one location.

Specialised DCR

There are two specalist DCRs in Copenhagen: Sundhedsrummet and H17

- Are purpose-built for DCRs, and often situated near areas of high drug use or stable drug markets.
- Unlike the integrated DCRs, they tend to specialise in only offer injection, smoking and inhaling facilities but are located nearby to other drug treatment services
- Includes the provision of hygienic injecting materials, advice on health and safer drug use, intervention in case of emergencies and a space where drug users can remain under observation

Mobile DCR

The unit 'Fixelancen' is Copenhagen's only mobile DCR

- Unlike fixed-site locations which are based in buildings, mobile DCRs are normally vans or buses designed to move to sites. They are marketed as a safe place for an injection.
- Limited space and only function as a hygienic and so typically cater for smaller numbers.

11.1.9 Geographical scope

The Danish DCRs are established at the regional level, in the three most populous cities of Denmark: Copenhagen, Aarhus and Odense.

The first DCR was opened in Berne, Switzerland in June 1986; in subsequent years, further facilities were opened in a number of European countries including Germany, the Netherlands, Spain, Norway, Luxembourg and Greece. Outside of Europe, there are also two facilities located in Sydney, Australia and one in Canada.

11.1.10   Intersectoral dimension

The main policy focus is health, but also covers social care and crime / justice policy.

Social care: Whilst DCRs are a health–focused intervention, they are also low-threshold facilities, and so providing referrals to drug treatment is not the primary mission of the staff[143]. However, staff attempt to facilitate access to the wider health and social sector for those seeking drug treatment or help for other medical problems.

Some DCRs (e.g. the H17) will also have social workers as part of the staffing team, and they can help clients work through socio-economic problems such as bills, pensions and housing[144].

Crime, policing and justice: In addition to this, the scheme also has a policing and justice dimension as the DCRs shelter clients from the police so they are able to take drugs under calm and safe conditions. In Denmark, the police have proven to be working in cooperation with the DCRs to encourage clients to attend the facility. For example, there is a two-square mile "free zone" in the Vesterbro neighbourhood where

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[143] Kappel *et al.*, 2016, pg. 9
[144] Ibid., pg. 10

officers don't arrest adults for possession of drugs, although they can still be punished for dealing[145].

11.1.11   Duration

DCRs have been operating in Europe for the last three decades, but in Denmark, the first legal[146] DCR was only established after 2012, when the government passed legislation[147] to allow municipalities to establish the facilities. In Copenhagen, the most recent facility – and the world's largest DCR – was opened on 15th August 2016 in the Vesterbro district[148].

11.1.12   Lead organisation

In Denmark, the municipalities are responsible for the overall creation and implementation of local DCRs.

11.1.13   Partners

Local service providers, public health authorities and the police all work in collaboration with the DCR managers. All DCRs are staffed with health professionals with advanced first aide training in the effects and side-effects of drug taking. In most instances, the staff consist of registered nurses or nursing aides who work alongside social workers and educators.

11.1.14   Main sources of funding

The Danish DCRs are financed by the municipalities and managed by NGOs except for the mobile DCR, which is directly financed and run by the Municipality of Copenhagen.[149]

11.1.15   Evidence base for implementation

- There is an increasingly strong evidence base showing that DCRs are a cost-effective way to reduce overdose deaths, ambulance call-outs to overdose events, needle-sharing and public injecting[150]. There were two key reasons as to why the Danish government was persuaded to change the law and permit municipalities to run fixed-site DCRs in 2012. The first was the evidential success of DCRs in other countries, and the second was the accomplishment of the mobile facilities run by Danish NGOs since 2011.
- Firstly, during parliamentary debate on the issue, the government quoted peer-reviewed evidence from other countries (e.g. Dolan *et al*, 2000) showing DCRs contribution to reducing drug-related deaths[151]. The primary rationale for Denmark's DCRs is the contribution it can make towards improving the life situations of vulnerable groups, and evidence from other countries shows that DCRs can contribute to reducing the overall number of drug-related deaths, crimes and unsafe practices.

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[145] Ackerman, M. 2013: https://www.thefix.com/content/denmarks-fix-rooms-proven-success-first-year#.UrlK0GJQaKE.twitter

[146] Prior to this, in an 'act of civil disobedience', Danish NGOs bought two old ambulances and opened mobile DCRs with volunteer nurses and doctors (Kappel et al., 2016).

[147] The legislation, which was passed by 63 of 107 voting MPs, stipulated that police must not search or prosecute people in possession of "small quantities" of drugs in, or in the vicinity of, DCRs. (Tharoor, A., 2016)

[148] Tharoor, A., 2016: http://www.talkingdrugs.org/world-largest-drug-consumption-room-opens-in-copenhagen

[149] Kappel *et al.* 2016

[150] Hunt, N. & Lloyd, C. (2008)

[151] Stothard, B. (2014): http://www.drugwise.org.uk/wp-content/uploads/Dane-law.pdf

- Lowering the death rate: It is difficult to completely attribute any change in death rates on DCRs alone. However, there is indicative global evidence that the approach has an effect on lowering death rates. For example, In Vancouver, the Insite DCR reported a 35% drop in lethal overdoses in vicinity of project two years after it opened (against 9% in the rest of Vancouver in the same period)[152]. Additionally, in Sydney there was an 80% reduction in ambulance callouts to overdose incidents since their King's Cross DCR, MSIC, opened[153]. Research shows that the facilities reach their target population and provide immediate improvements through better hygiene and safety conditions for injectors[154].
- Decrease in crime rates: While there was no increase in crime or drug dealing in area around DCR (Vancouver and Sydney), in Europe, some public disorder and drug-dealing was reported around DCRs. However, this was successfully addressed through interagency working[155].
- Reducing unsafe practices: Frequent use of DCRs has also been linked with a 69% decrease in syringe sharing and regular use has been associated with increased requests for advice on safer injection practices[156]. There is consistent evidence that DCR use is associated with self-reported reductions in injecting risk behaviour such as syringe sharing, and in public drug use.

Secondly, unlike the Australian and Canadian DCRs – which started out as trials with legal exemptions - the DCRs in Denmark were only created as a result of a mobile unit which originally acted outside the law for several months. The evidence of this 'pilot' resulted in politicians legislating for DCRs[157].

11.1.16   Evaluation: Has the practice been evaluated?

As with most evaluations of public health interventions, large-scale research on DCRs faces a number of methodological challenges, such as: controlling for effects of broader local policy, ecological changes, and accessing clients[158]. Despite these limitations, peer-reviewed studies are available, and most studies have highlighted the local benefits of DCRs as a harm reduction strategy, particularly in addressing the various contextual risks associated with public injecting; facilitating access to healthcare and social resources; and delivering education regarding safer injection practices[159].

In Denmark too, evaluations have aimed to understand whether DCR facilities are fulfilling their objectives. In this instance:

- Kinnard *et al.* (2014) assessed the impact Copenhagen's first standalone supervised injecting facility had on drug injecting and disposing behaviours in the months after it opened. In particular, they hypothesised that since it's opening in October 2012, the Vesterbro neighbourhood would witness a decrease in risk behaviours such as syringe sharing and unsafe syringe disposal, as per the primary goal of the facility[160].
- In Denmark, the most comprehensive study of DCRs influence on health and wellbeing among drug clients was conducted by Kappel *et al*. (2016); their

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[152] Potier C, Laprévote V, Dubois-Arber F *et al.,* 2014
[153] Ibid.
[154] EMCDDA, 2016, pg.5
[155] Hunt, N. & Lloyd, C. (2008)
[156] Ibid.
[157] EMCDDA, 2016, pg.5
[158] Hedrich, D., Kerr T., and Dubois-Arber F. (2010) in Rhodes, T. and Hedrich, D (eds.)
[159] Kappel *et al.* 2016
[160] Kinnard *et al.*, 2014

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qualitative evaluation consisted of 250 hours of participant observation and in-depth interviews of 42 DCR clients and 25 staff members. Their study confirmed the findings of similar international studies, and also explored the access that clients have to drug rehabilitation treatment and primary and secondary healthcare facilities.

11.1.17 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and outcomes

Despite its relatively small population of 5.5 million people, Denmark has a relatively high number of drug related deaths; in 2005 and 2011, for example, there were 275 and 285 deaths respectively. While there is currently little hard evidence to show that there are fewer drug users as a result of DCRs, in their beginning phase of implementation (2012) there was a significant fall in the number of people dying from drug related deaths – only 210 people died[161]. It is unclear how much of this fall can be attributed to DCRs alone, not least because at the end of 2012, the two building based DCRs in Copenhagen had been open for just two or three months and the mobile consumption rooms for fifteen. Further to this, the numbers of deaths recorded in Copenhagen itself in 2012 rose slightly[162].

Nevertheless, DCR provision appears to be well-received by users, and they are fulfilling their primary aim of engaging hard-to-reach and high risk users. In 2014, it was reported that nurses witness up to 800 injections each day at The Skyen and Sundhedsrummet centres[163]. Additionally, the 2015 findings from the Ministry of Health evaluation of DCRs in Denmark showed that between 2012 and 2014 there were:

- 4372 unique users, with 3564 unique users in 2014 alone.
- 355,255 instances of drug consumption, with 199,075 instances in 2014 alone.
- 301 overdoses were treated, and no fatal overdoses
- Significant reduction of public drug use
- 70 - 80% reduction in drug related litter in Copenhagen.

Similarly, due to a lack of studies and methodological issues, there is no concrete evidence regarding whether the DCRs were effective in reducing HIV or HCV incidence. However, based on a study[164] of self-reported changes in drug use behaviours and syringe disposal, it is possible to infer that the Copenhagen DCR 'The Skyen' is associated with safer behaviours that reduce harm and promote health among people who inject drugs. In this instance, 75.6% of the 41 eligible participants reported reductions in injection risk behaviours including:

- 64.3% (26 individuals) reported less rushed or stressful injections
- 56.1% (23 individuals) reported fewer outdoor injections
- 53.7% (23 individuals) reported they were no longer syringe sharing
- 43.9% (22 individuals) reported cleaning their injecting sites more often

In addition, only 4.9% (2 individuals) reported an increase in injecting frequency; the remaining participants felt that their frequency of injection had not changed (65.9%, 27 individuals) or had decreased (12.2%, 5 individuals). When asked about disposal, over half of individuals reported changing their practices since the opening of The

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[161] Stothard, B., 2014, pg. 22
[162] Ibid.
[163] Ackerman, M. 2013
[164] Kinnard *et al.,* 2014 (all data collected between February and August, 2013)

Skyen, with 95.8% (23 individuals) reporting changing from not always disposing safely to always disposing safely.

Finally, the exact number of users who go on to receive treatment or medical care is not well documented in Denmark, but as the service is making contact with vulnerable and hard-to-reach groups who inject drugs, they are more likely to be referred on to relevant health service (as opposed to if the service did not exist). Indeed, DCR clients experience a sense of social acceptance while inside DCRs, as members of staff are welcoming and non-judgemental and clients felt comfortable knowing that in any case of health-related problems, they would be referred to local health clinics. Members of the staff also guided clients towards drug treatment programmes and services in the social and the health sectors, when it is appropriate; the staff's priority is to establish trust of the clients and only when this is achieved will they encourage clients to seek assistance beyond the DCR[165].

11.1.18 Success factors

The main success factors have been local cooperation and location:

- Local support from the public, police and voluntary agencies has enabled users to attend DCRs in Copenhagen without fearing shame or arrest.
- The location of the venues in Denmark has made an impact on the neighbouring area. In Copenhagen, the Vesterbro neighbourhood had a high concentration of drug users. The new DCR (H17) will considerably increase Copenhagen's capacity to host clients and contribute to the reduction in overdoses, public drug use and drug related litter.

11.1.19 Innovative features

There are two innovative features of Danish DCRs. The first is the experimental way in which DCRs were introduced in 2011; by being able to operate without police or government interference for ten months, the NGO 'Fixerum' managed to persuade the Danish parliament to adopt a new amendment to existing law.

The second innovative feature of the Copenhagen DCR in particular, is how they have developed a response to the use of crack cocaine in DCRs. As usage has increased, the DCRs have let clients make and smoke their own crack cocaine. This requires using ammonia or bicarbonate of soda to freebase cocaine. Initially, bottles of ammonia could be purchased in the shops surrounding the DCRs, but cases of ammonia being thrown in the faces of staff members (smoking crack produces aggressive and unpredictable behaviour) led to a change in the way ammonia was distributed. Initially the option of completely prohibiting the use of ammonia was considered, but as this would exclude many people from attending the DCR, staff instead created an ammonia station which dispenses 1ml of ammonia in the DCR, enough to produce a few pipes of cocaine. In parallel to this, staff also inform clients of the dangers of using ammonia, and encourage them to instead use bicarbonate of soda instead. Thus, the DCRs are flexible in offering options and appropriately giving harm reduction advice to motivate changes in behaviour[166].

11.1.20 Obstacles and lessons learnt

One of the biggest obstacles is the time-constraints as there are a continuous flow of clients entering and exiting the DCRs during the busy hours, which limits the time staff can spend establishing a rapport with clients. Yet, gaining acceptance and trust of DCR

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[165] Kappel *et al.* 2016, pgs. 5-7.
[166] Schäffer, D., Stöver, H., and Weichert, L. 2014, pgs. 15-16

clients is a time-consuming endeavour, and members of staff must be willing to 'give a great deal'[167].

Another obstacle, for some users, is the registration process. In this instance, under 18s are not allowed to use the centre and occasional or first-time users are also excluded. Denying entry is problematic as it can contribute to an increase in drug-related emergencies in the vicinity of the area[168].

11.1.21 Potential for transferability and sustainability

The project is fully transferable, and many other countries are debating introducing or piloting DCRs as a harm reduction policy. For example, in January 2016, French law approved a six year trial and it is expected that these will be opened in the second half of 2017. In Slovenia, a change in the penal code also created an enabling environment for drug consumption facilities, and the Ministry of Health has chosen a non-governmental organisation in Ljubljana to implement a pilot project in the coming months[169].

Whether or not this approach could be transferred to other countries would primarily depend upon the following three factors:

- **Support:** Local and political support is essential for the functioning of the DCRs. Without the support of government, the legal system cannot support the implementation of DCRs. Local support – particularly from the police and the public – is also essential, as the DCR is controversial in nature. Piloting projects on a smaller scale can help to encourage cooperation.
- **International evidence base:** Like Denmark, other countries are likely to be persuaded of the effectiveness of DCRs by learning from countries who have successful sustained the facilities over time. A number of regions and countries have stated their interest in opening DCRs. For example, Brighton and Hove City Council's proposals to consider opening a DCR, announced in April 2013, attracted much media attention. The Council had accepted the recommendations of a report it commissioned from an Independent Drugs Commission. One proposal was that Brighton Safe in the City Partnership undertake a feasibility study into how a DCR would assist in reducing drug-related deaths[170].
- **Funding:** The service is free for users and so DCRs did regional or local funding to enable the implementation, facilitation and development of the facilities.

This programme is fully sustainable, as illustrated by the continuing development of the facilities in Copenhagen. For example, the city's upcoming project is also to open permanent DCRs in Nørrebro, another area of Copenhagen with a high concentration of drug users[171].

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[167] Kappel *et al.* 2006, pg. 6
[168] Schäffer, D *et al.*, 2014, pg. 10
[169] EMCDDA, 2016, pg.2
[170] Stothard, B., 2014, pg. 23
[171] Rychla, L, 2016

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11.2 Case Study 21: Find and Treat

Name of practice: Find & Treat

Country: United Kingdom (UK)

11.2.1 Main objective and specific aims

The main objective of Find & Treat is to locate and ensure treatment of Tuberculosis (TB) in socially vulnerable people. The specific aims of the project are to:

- Identify TB cases among socially vulnerable groups at an early stage;
- Manage the treatment of complex and socially vulnerable patients found through the screening service or referred from other services in London. Complexities include non-compliance with, and non-completion of, treatment; not returning for follow up; and drug resistance.

11.2.2 Relevance for 3rd EU-Health Programme objectives

Find & Treat is relevant to objectives three and four of the 3rd EU-Health programme:

- Contribute to innovative, efficient and sustainable health systems, in that it is in an innovative programme;
- Facilitate access to better and safer healthcare for Union citizens- in that it facilitates access to healthcare for EU citizens who might otherwise not receive it in a timely manner.

11.2.3 Target groups

The main target groups of the programme are people with unstable housing situations (homeless), ex-prisoners and drug or alcohol users.

11.2.4 Thematic focus of intervention in relation to reducing health inequalities

Find & Treat provides direct access to healthcare to those who are socially disadvantaged. The Find & Treat service brings detection services to high risk individuals and spreads awareness of TB among these groups, so that people can identify their symptoms and access treatment more quickly.

A full course of TB treatment requires daily drug treatment for a minimum of six months. Find & Treat also supports patients with social problems such as homelessness or drug and alcohol dependency to complete their full course of treatment.

Patients at Find & Treat demonstrate social risk factors associated with TB and many also demonstrate multi-morbidity. This combination can mean that it is difficult for the individuals to navigate their way through the health care system and receive the support that they need. The multi-disciplinary approach at Find & Treat also targets the underlying causes of TB and assists the individual through the healthcare pathway.

11.2.5 Key activities

The main activities of the programme are as follows:

- Currently screens 10,000 high risk individuals for TB per year using a mobile digital x-ray unit. This works within every London borough and travels to support Public Health England (PHE) with national outbreaks using a van with diagnostic and information technologies and includes a private consultation / examination area with disabled access;
- Raises awareness among service users and healthcare professionals about TB – working with drug and alcohol services, homelessness services, criminal justice services etc.;

- Recruits and trains peer advocates (TB patients who have some experience of being homeless) to support individuals with their treatment and increase awareness in partnership with Groundswell, a homelessness charity;
- Manages the treatment of patients found through the screening service and complex and socially vulnerable patients referred from across London. Currently, around 300 patients a year are referred to the service;
- Locates individuals who have stopped treatment before it is finished and supports them with their continued treatment, through connections with third sector organisations and information gathered during regular screenings of the homeless population in London;
- Organises Directly Observed Treatment (DOT) in the community, tailored to the need of the individual. A patient participating in DOT will take their medicine with guidance and support from a professional. This helps patients to stay motivated and ensures that patients are taking the medicine correctly;
- Works with individuals to address the underlying causes of TB, including the provision of accommodation advice;
- Offers residential TB treatment for homeless and destitute patients through the St. John of God Hospitaller.

11.2.6 Geographical scope

This initiative covers London, with some use of the screening service elsewhere. London has the second highest incidence of TB of any city in Europe and the highest number of cases[172]. Around 40% of Tuberculosis cases in England occur in London and one in ten of TB patients in London is homeless or vulnerably housed[173].

11.2.7 Intersectoral dimension

Find & Treat cuts across two policy areas: health and housing. The programme includes social and outreach workers as well as peer mentors who provide guidance and support to help individuals out of homelessness. The service also works with St. John of God Hospitaller to provide residential places so that homeless individuals without other options have somewhere safe to live during treatment.

11.2.8 Duration

A mobile screening service was introduced in 2005 and Find & Treat was launched in 2007 and is ongoing.

11.2.9 Lead organisation

The lead organisation is University College London Hospital (UCLH). This is a hospital of the UK National Health Service (NHS).

11.2.10   Partners

The Find & Treat service works alongside over 200 NHS and third sector frontline services such as homeless hostels, community centres, prisons, community drug and alcohol support projects and street services. The service also works with Groundswell, a homelessness charity with a focus on helping homeless people to have more control of their own lives, to provide the peer mentor programme and St. John of God Hospitaller which provides residential places for individuals to complete their treatment.

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[172]Of Western European capitals, London has the second highest rate of TB behind Lisbon (see figure 4, p.8 of the Collaborative TB Strategy for England), but London has the highest number of cases

[173] London Assembly (2015) *Tackling TB in London*

11.2.11 Main sources of funding

Find & Treat started in 2005 with funding from the Department of Health to demonstrate the use of Mobile Digital X-ray (MXU) and value of active case finding[174]. In 2007 the Find & Treat service was commissioned by the Department of health along this model. In 2010 the funding switched to NHS London. Since the closure of the NHS strategic health authorities in 2013 the services is now funded by NHS England through the ULCH.

Find & Treat costs around £900,000 a year in London[175]. A new state-of-the-art van, funded by UCLH and unveiled in 2015, cost £450,000[176].

11.2.12 Evidence base for implementation

The project is based on research conducted into the social factors that affect prevalence of TB[177]. TB is usually curable and detecting cases can control outbreaks. It is most common among socially disadvantaged people who may face barriers to accessing healthcare and who may not identify that they need treatment[178].

The Find & Treat service was designed based on the findings of research conducted in 2003/4. This research identified that three target groups showed extremely high prevalence of TB: homeless people, people who have been in prison and problem alcohol and drug users. These factors are also highly correlated with complexities in treating TB, such as non-compliance with, and non-completion of, treatment; not returning for follow up; and drug resistance[179].

11.2.13 Evaluation: Has the practice been evaluated?

The practice was evaluated in 2011 by the Health Protection Agency on behalf of the Department of Health[180]. The practice was found to be cost-effective in fighting TB among hard to reach groups.

The evaluation recommended a more systematic approach to where the Find & Treat service travelled to to ensure coverage of all of London. The 2011 Model of Care for TB Services in London suggested that some of the geographic variability was due to varying levels of engagement with local TB services and recommended a detailed service specification as a method of addressing this issue.

11.2.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Find & Treat reaches high risk individuals

Find & Treat screens around 10,000 high risk individuals a year for TB and supports the TB treatment of 300 socially vulnerable and complex cases of TB.

Service data from between January 2008 and June 2013 showed that Find & Treat conducted 45,385 X-rays which led to 385 referrals, resulting in a total of 84 diagnoses of pulmonary Tuberculosis. Of these cases, 84% went on to fully complete

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[174] Hayward, A. The find & Treat Programme and TB control – *Staying Active*
[175] London Assembly (2015) *Tackling TB in London*
[176] UCLH (2015) New van unveiled for London infectious disease screening. UCLH Website
[177] Craig GM, et al (2008) Establishing a new service role in tuberculosis care: the tuberculosis link worker and Story A, et al (2007) London Tuberculosis Nurses Network. Tuberculosis in London: the importance of homelessness, problem drug use and prison.
[178] UCL (2014) Improving control of tuberculosis in hard-to-reach groups. *Research Excellence Framework 2014*
[179] Story A, et al (2007); London Tuberculosis Nurses Network. Tuberculosis in London: the importance of homelessness, problem drug use and prison.
[180] Full evaluation not published – for this case study, details of the evaluation have been taken from NHS London, 2011, Model of Care, *TB services in London*

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treatment within 12 months[181]. This is higher than the proportion who usually complete treatment nationally and demonstrates that Find & Treat is successful at helping patients through the treatment pathway. The 2011 HPA evaluation of Find & Treat found that 35% of active TB cases found through the service were asymptomatic meaning that they would not have not presented for treatment without the service[182].

As well as supporting individuals who have been identified with TB via the Mobile Digital X-ray (MXU) screening, Find & Treat also receives referrals of complex cases. Between January 2008 and June 2013, Find & Treat received 696 referrals of active cases. Of this total 780 cases, 33%[183] were drug resistant, 8% (n=59) were multi-drug resistant and .5% (n=4) were extensively drug resistant[184].

Find & Treat received 371 referrals from other agencies of patients who had begun their treatment or been diagnosed but had then had been lost during follow up and who had been categorised as uncontactable. Find & Treat were successful in contacting 74% (n=275) of these cases. Of these previously uncontactable cases, 73% (n=200) have completed or are well established and expected to complete treatment[185].

By engaging with the patient as a whole person rather than simply with the pathogen of TB, Find & Treat is able to influence the lifestyle factors which lead to TB and there is anecdotal evidence that patients found by Find & Treat have recovered from addiction and/or are no longer homeless[186].

Find & Treat is cost effective

An evaluation conducted by the Health Protection Agency (HPA) on behalf of the Department of Health have found Find & Treat to be cost effective or cost saving[187]. In 2011, at the time of the HPA evaluation, the Find & Treat service cost £816,000 per year. The evaluation found that if it were decommissioned the cost incurred to the NHS would be between £1.8 million to £3.3 million over five years. The evaluation also showed that 35% of the cases which were discovered at Find & Treat were asymptomatic and therefore patients would not have presented to services[188].

Additionally, in 2011 the Health Protection Agency used a decision analytical model to evaluate the cost-effectiveness of Find & Treat from September 2007 to July 2010. This study demonstrated that it was cost effective according to the NICE (National institute for Health and Clinical Excellence) cost threshold on Quality Adjusted Life Years (QALY).

The discrete, multiple age cohort, compartmental model utilised patient level data from the Find & Treat service and a control group. The control group was made up of aged matched patients displaying one or more risk factors (a history of homelessness or imprisonment, drug or alcohol abuse, or mental health problems) from London, found using passive case finding (as opposed to Find & Treat's active case finding model). It found both the mobile screening service and case management service to

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[181] UCL (2014) Improving control of tuberculosis in hard-to-reach groups. *Research Excellence Framework 2014*
[182] NHS London (2011) Model of Care, *TB services in London*
[183] n number not given, n=257 or 258
[184] ibid
[185] ibid
[186] London Assembly, 2015, *Tackling TB in London*
[187] Find & Treat website (2016)
[188] NHS London (2011) Model of Care, TB services in London

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be cost effective, based on the threshold set by NICE of £20,000 - £30,000 per QALY[189].

The study found the incremental cost effectiveness ratio of Find & Treat to be £6,400-£10,000 per QALY gained. This is based on an estimated cost of £1.4 million a year and a gain of 220 QALYs. According to this model, Find & Treat was more cost-effective than other TB interventions such as the BCG vaccine (£56,000 per QALY gained) and the tuberculin skin testing sand interferon gamma release assay testing (£29,955 per QALY gained).

Furthermore, a 2011 economic analysis by NICE (based on effectiveness evidence from the HPA and Department of Health evaluation from 2011) found that active TB screening is cost-effective in situations where the population has a higher incidence of TB (such as homeless populations) compared to standard approaches. It found that mobile MXU screening was cost-effective if the incidence of TB was above 100 cases in 100,000[190].

It stated that the benefits of active screening were threefold:

- People are generally unwell with active TB for a shorter period of time before they are found and treated with an active finding model;
- The proportion of those who successfully complete treatment increases with case management, thus fewer return to having active TB;
- There is a reduction in the prevalence of TB due to a reduction in transmission.

These evaluations and modelling studies demonstrate that Find & Treat, and more generally the active case finding model and case handling approach, is a cost-effective way of dealing with tuberculosis among hard-to-reach groups.

11.2.15 Success factors

Find & Treat recognises that TB is a socially complex disease, which disproportionately affects homeless people, people with drug or alcohol dependency, people who have been in prison and vulnerable migrants. The service therefore works with individuals to understand and combat the aspects of their life which lead to ill health in general and TB specifically, such as homelessness and alcohol and drug dependency[191]. The multidisciplinary approach gives complex cases the support to complete their treatment and remain healthy afterwards.

If screened patients are referred for a full test, Find & Treat can provide this service as well. Usually, a patient would need to make and attend a hospital appointment and receive results at a later time, increasing chances of the patient not attending or not receiving results. The Cepheid Xpert MTB/RIF test for TB – used by Find & Treat – allows for a result on site within two hours, allowing the medical staff to remain engaged with the patient and commence treatment quickly192.

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[189] Jit et. Al (2011) Dedicated outreach service for hard to reach patients with tuberculosis in London: observational study and economic evaluation. *BMJ*

[190] National Institute for Health and Clinical Excellence (2011) *Economic analysis of identifying and managing tuberculosis in hard to reach groups: homeless and prison populations*

[191] Health in Hackney Scrutiny Commission, (2016) Tuberculosis in Hackney
[192] HSJ (2014) Hard to reach groups: Making a call on the mobile

11.2.16   Innovative features

Find & Treat pioneered the use of the 'point of care' diagnostic tool they use. The Cepheid Xpert MTB/RIF is able to provide a diagnosis within two hours with an accuracy that is similar to lab testing[193].

The service also pioneered the use of digital technology to support TB patients with Directly Observed Treatment (DOT). In 2007 the service began DOT with a patient on an 18 month course of treatment via skype by providing a laptop connected to the internet via a dongle. Now the service provides patients with a smart phone and a data subscription. Patients are then trained to take their medicine during 1 or 2 visits with a nurse. The smartphone is fitted with an app developed for the purpose of VOT which does not store data. In 2015 there were 86 patients on VOT being managed by Find & Treat and none had become lost for follow up by the team[194].

In partnership with UCL and the Hep C Trust, the Find & Treat service supported the Department of Health funded study into the management of Hepatitis and Latent TB among hard-to-reach groups (HALT)[195]. HALT evaluated whether active case finding and peer support are effective and cost effective ways of fighting Hepatitis among hard-to-reach groups and trials were completed in 2015 and results are not yet published[196].

11.2.17   Obstacles and lessons learnt

* Find & Treat works closely with front-line services in all London boroughs. In 2015 the London Assembly report "Tackling TB in London" stated that the full potential for integration with rough-sleeping services has not yet been reached. It stated that Find & Treat had encountered difficulties in engaging some services. The report "recommended that existing rough sleeping services, such as No Second Night Out, expand their focus to explicitly require interaction with TB outreach services, alongside offering training for the staff to recognise the signs of TB[197].
* In 2011, the HPA evaluation of the service found that some areas of London were underserved by the service. It recommended a more strategic approach to the geographical positioning of the service to ensure equity across London. It also recommended more consistent information sharing between Find & Treat and the London TB register to ensure that patient records are updated[198].

11.2.18   Potential for transferability and sustainability

Find & Treat is a long-standing project, in effect since 2007. It began as a simple screening service and has evolved to include other aspects over time. Now, as well as providing TB screening and support for patients undergoing treatment, the service provides on-the-spot Hepatitis C testing, essential vaccinations[199] as well as advice from social worker, outreach worker, and peer advocates[200].

 It has changed its funding structure from being a pilot project funded by the Department of Health to being fully funded by NHS. The NHS continues to fund the

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[193] ibid
[194] Story, A (2015) Video Observed therapy for TB (UK) in: World health organisation (WHO) (2015) the role of e/m health in tuberculosis and tobacco control.
[195] Find & Treat Service (2016)
[196] ISRCTN (2015) The HALT Hepatitis study
[197] London Assembly (2015) *Tackling TB in London*
[198] NHS London (2011) Model of Care, TB services in London
[199] UCLH (2016) BMJ Awards – our team win praise for their outstanding work. UCLH Website
[200] Appleby, Yasmin et al (2015) Find and Treat TB - slideshare

service on the basis of evidence that it is effective at fighting TB among the homeless population and that it is cost-effective.

Public Health England is currently developing a mobile service, based on the Find & Treat model, to be used across England in area of high TB incidence[201]. Furthermore, a mobile testing unit for testing TB was introduced in Rotterdam in the Netherlands in 2002[202], showing that there is potential for this practice to work in various areas with a high prevalence of TB.

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[201] PHE and NHS England (2015) *Collaborative Tuberculosis Strategy for England 2015 to 2020*
[202] De Vreis, G et al (2007), Impact of mobile radiographic screening on tuberculosis among drug users and homeless persons

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Story A (2015) Video Observed therapy for TB (UK) in: World health organisation (WHO) (2015) the role of e/m health in tuberculosis and tobacco control. http://www.who.int/tb/features_archive/emHealthinTBandtobaccocontrol.pdf

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UCLH (2016) BMJ Awards – our team win praise for their outstanding work. UCLH Website. https://www.uclh.nhs.uk/News/Pages/BMJawardsfinalists.aspx

UCLH (2015) New van unveiled for London infectious disease screening. UCLH Website.
https://www.uclh.nhs.uk/News/Pages/UCLHunveilsnewvanforLondoninfectiousdiseasescreening.aspx

11.3 Case Study 22: Housing First

Name of practice: Housing First

Country: There are or have been programmes across Europe: Austria, Belgium, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Poland, Spain, Slovenia, Slovakia, Sweden, the UK.

11.3.1 Main objective and specific aims

Housing First is a practice bringing homeless people with high support needs into housing. The model provides access to permanent housing without any preconditions. This is in contrast to traditional homelessness services which operate a "staircase" approach where the individual is required to become "housing ready" before being offered their own home. In these models the individual makes their way through hostel accommodation with preconditions such as entering sobriety programmes or attending skills classes to increase employability. The main objective of the approach is therefore to enable an individual to live in their own home autonomously.

Housing First practices are not 'housing only', also providing support to help people improve their health and wellbeing, employability and social networks, once the individual is stably housed. This extra support is separate from the housing offer. A Housing First approach accepts that having a home allows the individual to deal with health and social problems more effectively.

11.3.2 Relevance for 3rd EU-Health Programme objectives

The Housing First approach supports the objective one of the EU Health Programme 2014-2020.

- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, in that it supports prisoners to make their lifestyles healthier.

11.3.3 Target groups

This programme targets homeless people, in particular the following sub-groups:

- Homeless people with high support needs;
- Homeless people with mental health issues;
- Homeless people with problematic drug and alcohol use; and
- People who are experiencing long-term or repeated homelessness.

11.3.4 Thematic focus of intervention in relation to reducing health inequalities

By providing a home and helping the individual to remain housed, Housing First removes the individual from the health risks of homelessness. People in adequate, secure housing and a social support network have better health status than those who do not[203]. Housing First tackles inequalities in health status as it provides a stable home and access to support to homeless individuals, many of whom have experienced chronic homelessness, mental health issues and/or substance abuse issues.

Housing First services may either directly provide or arrange access to primary health care. However, the focus of the approach is to put individuals in a position where they can seek treatment for health conditions, especially for mental health and substance misuse issues, if they choose to.

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[203] Berkman, L.F., Glass, T., Brissette, I. and Seeman, T.E. (2000) From Social integration to Health: Durkheim in the New Millennium, *Social Science and Medicine* 51, pp. 843-857; Pleace, N. and Quilgars, D. (1996) Health and Homelessness in London: A Review (London: The Kings Fund)

A secure and settled home provides "ontological security", a feeling of safety, predictability and security in life which provides the baseline for an improvement in mental health and wellbeing. This secure setting and potential for growing a social network allow the individual being in a position to combat mental and physical health problems[204].

Poor mental health and homelessness are interlinked for many individuals; mental health problems may be the cause of homelessness and is also likely that mental health conditions can arise or be exacerbated as a result of homelessness[205]. The French Un Chez-Soi d'abord Housing First trial programme and Housing First project, Lisbon were both designed specifically for homeless people with a mental health problem whereas other projects did not have this specific focus but include high proportions of individuals with mental health problems.

The Housing First approach is also designed to support individuals with substance misuse issues that are often linked in a mutually reinforcing relationship with homelessness[206]. Specifically, the Glasgow Housing First project was designed to work exclusively with people using hard drugs. As with mental health problems substance misuse is an issue seen across multiple Housing First projects.

11.3.5 Key activities

The primary activity of a Housing First project is to provide a suitable home for the individual to live in privacy without fear of being ejected and have control over their own life. Housing First approaches offer either "communal" housing, where previously homeless individuals are housed in blocks with other previously homeless individuals, or "scattered" housing, where individuals are placed in flats or areas within the general community.

In addition, Housing First services may offer opportunities to access treatment and support with social integration. Projects differ according to the local context. However, a Housing First approach shares eight basic principles[207]:

- Housing is a human right
- Harm reduction choice and control for service users
- Active engagement without coercion
- Separation of housing and treatment
- Person-centred planning
- Recovery orientation
- Flexible Support for as long as is required

Specific services offered in terms of mental health support differ by project. Projects may either directly provide mental health services, potentially through use of an assertive community treatment (ACT) team or other mental health professionals or

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[204] Pleace, N. & Quilgars, D. (2013) *Improving health and social integration through Housing First a review*. FEANTSA http://feantsaresearch.org/IMG/pdf/improving_health_and_social_integration_through_housing_first _a_review.pdf [Accessed 20 Sept. 2016]

[205] Cohen, C.I. and Thompson, K.S. (1992) 'Homeless mentally ill or mentally ill homeless?' *American Journal of Psychiatry* 149, 6, pp. 816-821

[206] Pleace, N. (2008) Effective services for substance misuse and homelessness in Scotland: Evidence from an international review. Centre For Housing Policy

[207] Pleace, N. (2016) *Housing First Guide, Europe Chapter 1*. FEANTSA Available at: http://www.housingfirstguide.eu/website/wp-content/uploads/2016/HFG/Chapter1.pdf [Accessed 20 Sept. 2016]

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offer intensive case management (ICM) which links the individual with mental health services or simply link the individual with services[208].

From a drugs and alcohol perspective Housing First follows a harm reduction approach entitled "recovery orientation" which provides individuals with support and enables them to seek help from services without requiring them to do so.

11.3.6 Geographical scope

Housing First projects operate across Europe. Projects operate within individual cities or local areas, either working individually or linked to each other in a national framework.

11.3.7 Intersectoral dimension

This programme cuts across two policy areas: Housing and health. Housing First is primarily a housing intervention which has clear positive outcomes for the health of the target population.

11.3.8 Duration

Projects have been operational in different locations for different amounts of time. Generally, in Europe an initial pilot project will last 2-3 years.

11.3.9 Lead organisation

Housing First projects are dispersed across European countries and form part of a national welfare strategy or are run by local NGOs. The European Federation of National Organisations working with the Homeless (FEANTSA) has recently brought together information as a guide to Housing First for providers and policy makers[209].

11.3.10 Partners

Housing First projects are led by various local and national organisations; either by the government department responsible for housing or NGOs and charities that support homeless people.

11.3.11 Main sources of funding

The level and source of funding differs widely from project to project. The table below summarises the way that Housing First is currently implemented across the EU.

Table 14. Status of Housing First projects [210]

Status of Housing First projects	Country
As important public policy intervention	FI, DK;
As large national experiments which are promoted and funded by the government and would normally be brought to scale and turned into public policy in due time (top-down)	BE, FR, LU
As scattered local experiments which are captured in/contribute to a common dynamic and mobilise serious political/government support	IT, ES, IE
As local experiments which exist independently from each other and which have not yet created a common dynamic or mobilised serious political support	HU, SE, UK, AT
As isolated projects which are often led by individuals on their own	PL, DE, HU, CZ, SI, SK

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[208] Pleace, N & Quilgars, D (2013)

[209] FEANTSA website (2016) Housing First Guide Europe [online] Available at: http://www.feantsa.org/spip.php?article3906&lang=en [Accessed 20 Sept. 216]

[210] Spinnewijn, F & Aldanas, MJ (2016) *Comments paper – FEANTSA Housing First Belgium 2016*. DG Employment, Social Affairs and Inclusion: Brussels

initiative in spite of little public support/interest available

11.3.12 Evidence base for implementation

Evidence from the first Housing First service in New York (Pathways) showed that the model was more successful than a traditional "staircase" approach at ending chronic homelessness.[211] Recently, further inspiration for Housing First projects in Europe has come from a Canadian Randomised Control trial involving 2,200 individuals showing successful results for Housing First[212].

In terms of health, those that are suitably housed tend to show better health outcomes than those who are not so an intervention based on keeping individuals in stable housing is likely to have a positive impact on their health.[213] Additionally, studies have shown that access to psychiatric and other mental health services for homeless individuals can be inadequate and the quality of care lower than that for housed people. Research also demonstrates that housing stability leads to an overall decrease in serious mental health difficulties[214].

11.3.13 Evaluation: Has the practice been evaluated?

In Europe, Housing First was initially evaluated as a research project involving five project locations across Europe called housing First Europe[215].This evaluation showed the housing retention was high in four out of five sites and that there was a generally positive impact on mental health and substance misuse. Additionally, a large scale randomised trial in France which tracked 297 people experiencing mental health difficulties, homelessness and having high support needs people over a 24 month period showed that participation in a communal Housing First programme was related to significant improvement severity of disability, psychological community integration, and recovery compared to treatment as usual[216]. The project has been running since 2011. Interim results in 2013 showed that the vast majority had remained in their house and other indicators were positive for the Housing First approach.[217]

There are also a number of descriptive studies from Belgium[218], Denmark[219], Finland[220], the Netherlands[221], Portugal[222], Spain[223] and the UK[224]. These have also

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[211] Tsemberis, S. (2010) 'Housing First: Ending Homelessness, Promoting Recovery and Reducing Costs' in I. Gould Ellen and B. O'Flaherty (eds) How to House the Homeless Russell Sage Foundation: New York

[212] Goering, P., Veldhuizen, S., Watson, A., Adair, C., Kopp, B., Latimer, E., Nelson, G., McNaughton. E., Streiner, D. and Aubry, T. (2014) National At Home/Chez Soi Final Report Calgary, AB: Mental Health Commission of Canada.

[213] Berkman, L.F.,et al (2000); Pleace, N. and Quilgars, D. (1996)

[214] Henry, J.M., Boyer, L., Belzeaux, R., Baumstarck-Barrau, K. and Samuelian, J.C. (2010) Mental Disorders Among Homeless People Admitted to a French Psychiatric Emergency Service, Psychiatric Services 61(3), pp. 264-271.; Rees, S. (2009) Mental Ill Health in the Adult Single Homeless Population: A Review of the Literature (London: Crisis).

[215] Busch-Geertsema, V. (2013) Housing First Europe: Final Report [pdf] Bremen: European Union programme for Employment and Social Security Available at: http://www.habitat.hu/files/FinalReportHousingFirstEurope.pdf

[216] Somers, J., Moniruzzaman, A., Patterson, M., Currie, L., Rezansoff, S., Palepu, A. and Fryer, K. (2017). A Randomized Trial Examining Housing First in Congregate and Scattered Site Formats. *PLOS*. http://dx.doi.org/10.1371/journal.pone.0168745

[217] Estecahandy, P (2013) A housing First trail in France

[218] Housing First Belgium (2016) *Housing First in Belgium: It Works! Results and invitations to fast track the exit from homelessness* [pdf] Brussels: Housing Frist Belgium Available at: http://www.housingfirstbelgium.be/medias/files/housing-first-belgium-results-en.pdf [Accessed 20 Sept. 216]

[219] Benjaminsen, L. (2013). Policy Review Up-date: Results from the Housing First-based Danish Homelessness Strategy. European Journal of Homelessness, 7(2), 109-131 Available at:

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reported generally positive results in relation to the initiative. These evaluations look at the Housing First process from the perspective of a programme which aims to take people out of homelessness. A 2013 review of evidence also exists which looked at how effective Housing First policies were in promoting health. It found that Housing First was at least as good as "staircase" services in improving mental health, substance abuse and physical health with the added feature of being better at keeping people in housing[225].

11.3.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Several evaluations show that Housing First is highly effective at keeping people housed. The evidence that it improves mental health, substance misuse or physical wellbeing is less strong but suggests that it does at least as well as other services.

The overall evidence of the effect on Housing First on health shows that it is mainly effective at preventing the deterioration in health status linked to homelessness by keeping people housed.

Housing First mental health

Evidence on Housing First programmes impact on mental health suggest either improvement or stabilisation. The 2013 evidence review of the Housing First project states that there is no evidence of deterioration and more recent evaluations also report stabilisation or improvement. The review cautions against expecting any housing approach to cure a mental health problem as treatment is complex and the individual may go through periods of recovery and deterioration during involvement in the programme.[226]

The 2013 Housing First Europe evaluation showed that in Amsterdam 70% of service users reported improvements in their mental health, over three quarters of individuals in the Lisbon project also reported improvement and that staff noted an improvement in mental health among service users in Glasgow. Furthermore, the 2015 evaluation of Housing First in England showed that 66% of service users showed a self-reported improvement in their mental health[227].

http://housingfirstguide.eu/website/wp-content/uploads/2016/03/Results-from-the-Housing-First-Based-Danish-Homeless-Strategy.pdf[Accessed 20 Sept. 216]

[220] Pleace, N., Culhane, D.P., Granfelt, R. and Knutagård, M. (2015) *The Finnish Homelessness Strategy: An International Review* Helsinki: Ministry of the Environment – Available at: https://helda.helsinki.fi/handle/10138/153258 [Accessed 20 Sept. 2016]

[221] Wewerinke, D., Al Shamma, S. and Wolf, J. (2013) *Housing First Europe. Local Evaluation Report Amsterdam* Amsterdam: European Union programme for Employment and Social Security Available at http://housingfirstguide.eu/website/housing-first-europe-local-evaluation-report-amsterdam [Accessed 20 Sept. 2016]

[222] Ornelas, J., Martins, P., Zilhão,M.T. and Duarte, T. (2014) Housing First: An Ecological Approach to Promoting Community Integration *European Journal of Homelessness* (8.1), 29-56

[223] RAISFundacion. *HABITAT – Housing Frist para personas sin hogar*. Available at: (https://www.raisfundacion.org/sites/default/files/rais/noticias/infografia_habitat_DEF_A3.pdf [Accessed 20 Sept. 2016]

[224] Bretherton, J. and Pleace, N. (2015) *Housing First in England: An Evaluation of Nine Services* [pdf] York: University of York Available at: https://www.york.ac.uk/media/chp/documents/2015/Housing%20First%20England%20Report%20February%202015.pdf [Accessed 20 Sept. 2016]

[225] Pleace, N & Quilgars, D (2013)

[226] ibid

[227] Bretherton, J. and Pleace, N. (2015)

However, the picture is not always clear. In the 2013 Danish review of their Housing First homelessness strategy ACT professionals found that the mental health status of 25% of their service users increased but that it decreased for 29%[228] of users.

The strongest indicators of positive outcomes are of self-reported wellbeing indicators. There is a suggestion in the evidence that feelings of 'choice' contribute to better mental wellbeing for individuals in Housing First projects[229].

Housing First drug and alcohol use

In general, Housing First is associated with stabilisation (rather than a significant reduction) in alcohol and substance misuse. The review of evidence found that there are cases where some limited improvements have been seen and no evidence of an increase in substance misuse whilst on the programme**[230]**.

The Housing First Europe project showed positive results in the area of substance misuse reduction. In Amsterdam 70% of individuals self-reported a reduction in use, there was a reduction or cessation among a minority of clients in Glasgow and stabilised in most cases, a reduction or cessation among half of clients in Lisbon. In Copenhagen most clients showed no change although staff reported some positive results in clients. The project in Budapest showed no change in client's substance use behaviour[231].

The 2013 evaluation of the Danish homelessness strategy showed that staff reported that 65% of clients showed no change in alcohol use, 17% showed a positive change and 18% showed a negative change[232].The evaluation of nine English projects showed some small reductions in alcohol and drug use[233].

Physical health

The 2013 evidence review of Housing First's health impact suggested that there was not enough evidence to draw clear conclusions on Housing First's impact on health although the available evidence suggested stabilisation of health status at least[234]. More recent evaluations have delivered clearer evidence that Housing First promotes an increase in overall health.

The evaluation of the English Housing First project reported that of the 60 service users who provided outcomes data most stated that their general health was better than it had been a year before they started working with Housing First. Overall, 63% service users reported better health since using Housing First (38 of the 60 service users)[235].

In the 2013 Housing First Europe evaluation of the Copenhagen project 28% of clients showed an increase in physical health, 46% remained unchanged and 26% had deteriorated.[236] Although in the overall review of the Danish projects also from 2013 this was a 19% improvement, 58% remaining the same and 23% deteriorating[237].

In the French Un Chez-Soi d'abord Housing First programme interim results showed a reduction of nights spent in hospital of 18.3 nights in the six months prior to joining

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[228] Benjaminsen, L. (2013).
[229] Pleace, N & Quilgars, D. (2013)
[230] ibid
[231] Busch-Geertsema, V. (2013)
[232] Benjaminsen, L. (2013).
[233] Bretherton, J. and Pleace, N. (2015)
[234] Pleace, N & Quilgars, D (2013)
[235] Bretherton, J. and Pleace, N. (2015)
[236] Busch-Geertsema, V. (2013)
[237] Benjaminsen, L. (2013)

Housing First compared to 8.8 nights in the previous six months after they had been on the programme for 12 months. Generally, contact with hospital and frequency of stays had reduced considerably[238].

In Housing First Belgium health had improved in 30% of cases and 60% of cases health had stabilised and fewer hospital visits were reported. The health of individual who had been homeless for some time before finding accommodation stabilised in 40% of cases, however, it declined in 30% of cases[239].

These results show that Housing First programmes can contribute to an increase in health. Those with long term ill health caused by long term homelessness will not automatically see an improvement in health status and for many will only experience a long term decline in health over time. Stabilisation of health status represents a removal of the negative effects on health of homelessness whereas improvements in health can take a long time, if they are possible.

Housing First is highly effective at keeping homeless individuals with high support needs in housing

Housing First programmes have shown a great deal of success in keeping clients housed and engaged with services. Levels of housing retention are detailed in the table below. An international evidence review showed that around 40% to 60% individuals with high support needs failed to graduate from "staircase" housing service to full housing. In this regard Housing First appears to be more effective at getting individuals into sustainable housing[240].

Table 15. Housing retention in Housing First projects

Project	Results
Amsterdam[241]	97% still housed 12 months into the service
Copenhagen [242]	94%still housed 12 months into the service
Glasgow [243]	92%s still housed 12 months into the service
Lisbon [244]	79% still housed 12 months into the service
France – Chez-Soi d'abord	Interim results – 80% retained for 13 months
Spain - HÁBITAT Housing First	100% retention after 6 months[245]
England[246]	74% retention over 12 months
Vienna[247]	98% retention over 2 years

[238] Tinland, A. and Psarra, C. (2015) Housing First: Lessons from France presentation at the IGH Homelessness in a Global Landscape conference, Chicago, June 2015 in: Pleace, N. (2016)

[239] European Commission Directorate-General for Employment, Social Affairs and Inclusion (2016) *Housing First Belgium, 16-17 March 2016.* Brussels*:* Peer Reviews in social protection and social inclusion

[240] Pleace, N. (2008)

[241] Busch-Geertsema, V. (2013)

[242] ibid

[243] ibid

[244] ibid

[245] Raisfundacion

[246] Bretherton, J. and Pleace, N; (2015)

[247] Neunerhaus (2015) Neunerhaus Available at : http://www.neunerhaus.at/wohnen/housing-first/ [Accessed 20 Sept 2016]

In Finland there has been a 25% reduction in the overall level of homelessness since Housing First was introduced to the homelessness policy between 2008 and late 2013[248].

Cost effectiveness

Housing First is not a low cost option though evaluations have cautiously indicated that it is likely to be cost effective. Three of the housing First Europe sites indicated that it would be more expensive to provide temporary accommodation over the Housing First project period[249].

The English evaluation stated that there was a clear potential for Housing First to reduce the financial cost of homelessness by reducing long term homelessness. Specifically, it found that Housing First was likely to be more cost effective than usual treatment for individuals who require high intensity support (the general target group of Housing First policies)[250].

Housing First Belgium showed that after two years, individual costs related to hospital stay decrease by 46%. The evaluation also reported that a housing First place cost €17.80 per night per person whereas a night shelter cost €55[251].

11.3.15 Success factors

In a Housing First model service users can exercise a high degree of choice and control. In the evaluation of the English Housing First practices service users reported that this, along with a sense of security and flexible support they were offered were the key strengths of the Housing First model[252].

The Housing First Europe evaluation suggested some key elements of Housing First project:

- Quick access to housing;
- Housing costs and the costs of living are covered long-term;
- Multidimensional support of high intensity available as long as it is needed; and
- Clear agreements on behaviour between landlords and tenants can ensure that any issues which arrived can be managed quickly[253].

11.3.16 Innovative features

Housing First is innovative in that it is different to traditional "staircase" models of housing for homeless individuals which begin with temporary accommodation. Under these services clients become "housing ready", and may be required to utilise support services for mental health or undertake programmes to end substance abuse. Under a Housing First model clients are given a high degree of choice and ownership over their own lives. In these cases they can choose to make use of available services, but these services are offered independently of the housing offer[254].

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[248] Pleace, N., et al (2015)
[249] Busch-Geertsema, V. (2013)
[250] Bretherton, J. and Pleace, N. (2015)
[251] Housing First Belgium (2016)
[252] Bretherton, J. and Pleace, N. (2015)
[253] Busch-Geertsema, V. (2013)

[254] Pleace, N. (2016) *Housing First Guide, Europe Chapter 1*. FEANTSA Available at: http://www.housingfirstguide.eu/website/wp-content/uploads/2016/HFG/Chapter1.pdf [Accessed 20 Sept. 2016]

11.3.17 Obstacles and lessons learnt

The major obstacle that a Housing First programme may have to address is lack of available affordable housing. Services may have to compromise on the type or location on offer to their clients, to guarantee a long term tenure[255]. The difficulty in securing housing can lead to long waiting times[256]. The evaluation of the English Housing First projects reported difficulties in finding appropriate housing in the private sector, noting that there were often difficulties with private landlords and the suitability (poor repair or safety issues) of the housing on offer[257].

An unexpected consequence discovered in the Housing First Europe project was that individuals may face difficulties with law enforcement once they have a permanent address or be contacted by creditors for old debts. The harm reduction approach to substance use may also cause difficulties with law enforcement for the organisation in countries with strict drug laws[258].

Another obstacle encountered is sustainable financing, as a Housing First initiative requires a strong funding commitment. Projects in Budapest and Lisbon experienced severe difficulties with funding. The model can be challenging to implement in countries without a well-developed welfare support provision, and as a result Housing First projects have therefore been more common in Western Europe[259].

11.3.18 Potential for transferability and sustainability

Based on the success of the original New York service and services developed across the USA the Housing First approach was brought to Europe. It was pioneered in Finland as part of the national strategy on homelessness in Finland and Denmark. Since then it has spread to several countries across Europe where individual organisations, or local governments have piloted the model.

Sustainability of such an initiative depends on two factors:

The political will and funding opportunities available. Housing First is a long term investment as the considerable difficulties of individuals are expected to be ongoing. Individual projects had differing rates of sustainability. For example, Housing First was trialed as a pilot project by Neuner Haus in Vienna is now an integral part of the Vienna Homelessness strategy as a result of the positive impact it demonstrated[260]. In contrast, the Lisbon project faced severe difficulties in accessing on-going funding and had to re-arrange support for some of the individuals it supported two years into the project[261].

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[255] Pleace, N & Quilgars, D (2013)
[256] Busch-Geertsema, V. (2013)
[257] Bretherton, J. and Pleace, N. (2015)
[258] Busch-Geertsema, V. (2013) Housing First Europe: Final Report
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[260] http://www.neunerhaus.at/wohnen/housing-first/
[261] Busch-Geertsema, V. (2013) Housing First Europe: Final Report

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http://www.housingfirst.fi/files/1242/Tsemberis_2011_-
_Observations_and_Recommendations.pdf.

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11.4 Case Study 23: Ombold, Homeless Football League

Name of practice: Ombold- Homeless Football League

Country: Denmark

11.4.1 Main objective and specific aims

The Ombolt project provides an opportunity to play football for homeless and socially vulnerable individuals, allowing them to enjoy sport and to exercise which they might not otherwise have and also to form social connections. The increase is self-esteem that comes from playing sport and establishing friendships can help homeless individuals to seek support from other support services.

11.4.2 Relevance for 3rd EU-Health Programme objectives

The Ombold programme supports the objective one of the EU health programme 2014-2020.

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle, in that it supports individuals experiencing homelessness to make their lifestyles healthier.

11.4.3 Target groups

This programme targets primarily those with unstable housing situations, however also has a broader outreach to those who are marginalised from mainstream society.

11.4.4 Thematic focus of intervention in relation to reducing health inequalities

Ombold reduces health inequalities by providing access to sport that homeless individuals would not otherwise have. Ombold's players do not have access to regular football clubs, either because of an inability to pay for football or because they would feel uncomfortable in a mainstream club. Half of Ombold's weekly players are staying in hostel accommodation for homeless people and most live on either welfare or no income[262]. Lack of access to opportunity to perform physical activity means that homeless people also miss the health benefits of exercising. By providing a space and time to exercise Ombold works to redress this inequality.

11.4.5 Key activities

Ombold creates opportunities for homeless and vulnerable people to play football. It does this through organising special events and ongoing trainings. The four main activities of that Ombold are to:

- Host tournaments throughout the year; at least eight tournaments a year including the annual two-day Danish championship. All tournaments have a men and women's division;
- Support local clubs which hold weekly training sessions in 12 locations across Denmark – 85% of participants are men though women do take part[263];
- Run the "asphalt league": A league which operates all year round for homeless and socially disadvantaged people (currently running in two locations[264] with plans to expand to six);

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[262] Ombold (2015). *Ombold- ÅRSRAPPORT 2014*. 1st ed. [pdf] Copenhagen. Available at: http://ombold.dk/wp-content/uploads/2015/12/%C3%85rsrapport-2014-low-res-til-web-1.pdf [Accessed 23 Sep. 2016].
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- Organise the Danish entry to the Homeless World Cup, by selecting eight individuals, who change every year, from the 1,200 who participate in Ombold activities across the year.

11.4.6 Geographical scope

Ombold is a national programme with weekly trainings taking place in eight cities across Denmark[265].

11.4.7 Intersectoral dimension

The practice cuts across health policy and culture. It is primarily a venture in culture, providing sport to an underserved portion of the population. Participating in this activity confers health benefits to the individuals taking part and is therefore also a case of preventative healthcare.

11.4.8 Duration

Ombolt has been running since 2003 and is still ongoing.

11.4.9 Lead organisation

Ombold is the lead organisation, an independent non-profit organisation that is focused solely on providing opportunities to play football for those who do not have access to normal sports clubs. Originally the organisation was set up to manage the football tournaments leading to the selection of the Danish national Homeless World Cup team and their activities have grown over time to include providing more regular opportunities for homeless people to play football.

11.4.10   Partners

Over 30 organisations, such as community centres, asylum centres, and substance abuse support services across Denmark sent teams to the Ombold rallies and tournaments across the year in 2015. The 12 local trainings are supported centrally but also have their own partners, funding and organisation structure.

In addition, the Danish Football Association (DFA) is involved and provides coaching for all trainers and the Danish national team.

11.4.11   Main sources of funding

Ombold is funded through state subsidies, charitable donations and applications to different funds for particular projects. It raises additional funds annually to send the Danish national homeless football team to the Homeless World Cup.

For three years leading to 2014, Ombold local weekly trainings were financed by the Nordea and Tryg Foundation but that funding came to an end. The annual report for 2015 notes that now the local trainings had become mostly self-sustaining through a combination of support from municipalities, other institutions and homeless hostels[266].

A three million funding grant from TrygFonden allowed Ombold to start the "Asphalt league" in mid-2015, a weekly league adapted for homeless and socially vulnerable people[267].

11.4.12   Evidence base for implementation

In 2003, the first year of the Homeless World Cup the founders of Ombold organised a tournament for sellers of a street paper to gauge interest and also to select the first

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[264] Liga Hovedstaden (Capital league) in Copenhagen and Liga Østjylland (East Jutland league) in Randers
[265] Aarhus, Bornholm, Hillerød, Esjerg, Copenhagen, Næstved, Randers, Svendborg
[266] ibid
[267] Ibid

team. Due to the success and popularity of this first venture other aspects of Ombold were introduced.

According to experience of the Homeless World Cup playing football impacts widely on the individual's life improving physical health and self-esteem as well as providing a social network. The organisation has also found that football is an effective method for engaging with individuals who have not engaged with other interventions[268].

A study conducted in 2014 by the University of Copenhagen Centre for Team Sport and Health in Denmark found that homeless men participating in street soccer in Copenhagen showed marked improvements in health and fitness indicators. After 12 weeks individuals participating in the training sessions 2-3 times a week gained on average 1.1 kg of muscle and improved their postural balance by 40% over the period[269]. The street soccer stimulated bone formation which is an important consideration in the homeless population who have a substantially higher risk of being hospitalised with sudden trauma than the general population[270]. Sudden traumas are often related to falls and fractures, studies in elderly people have shown that improved posture and muscle strength reduce falls and that stronger bones are more resistant to fractures[271]. The study also showed that the men showed decreases in fat mass and cholesterol, therefore reducing their risk of cardiovascular disease by 50%[272].

11.4.13   Evaluation: Has the practice been evaluated?

A full evaluation of the practice is not available. However, in 2012 a project looked at the Ombold practice and how it affected the individuals who took part by interviewing four individuals and observing the national team and six local teams in training[273]. The research concluded that the practice had an overall positive effect on the individuals.

11.4.14   Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Between 2003 and 2016 Ombold has hosted over 100 rallies and championships for homeless and socially vulnerable teams in Denmark and has participated in the Homeless World Cup 11 times. Ombold has engaged with 10,000 homeless and socially vulnerable people in this time[274].

In 2015 around 200 people per week participated in local trainings across the country. Ombold hosted eight tournaments and football rallies with participation from 120 teams relating to 30 different institutions across Denmark. In 2014 there were around 1,100 players in all of the tournaments and about 600 unique individuals took part. In

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[268] Homeless World Cup. (2016)

[269] Krustrup, P. and Kousgaard, B. (2016). *Street football boosts fitness and health in socially deprived men*. 1st ed. [pdf] Copenhagen: Copenhagen Centre for Team Sport and Health in Denmark. Available at: http://ombold.dk/wp-content/uploads/2015/12/Krustrup-Kousgaard-2014.-Street-football-boosts-fitness-and-health-in-socially-deprived-men.pdf [Accessed 23 Sep. 2016].

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[274] Ombold (2016a)

2014 a survey of individuals taking part in Ombold trainings said they took part weekly, and more than 80 % would like to train more if it were possible[275].

In 2014, a survey was conducted among players at the weekly Ombolt training. A total of 102 individuals participated in the survey. Of the respondents three out of four said they felt physically better since beginning the weekly training. Around two-thirds (65%) believed the training improved their mental wellbeing and half of the respondents reported that they smoke and drink less since joining Ombold[276].

The 2012 research project which examined the effects of Ombold on four players' lives through interviews found that participation in the national team led to a general reduction in substance abuse among the four interviewees. They also stated that they had made new friends and contacts, improved family relations and an improved sense of self-esteem. Their participation went alongside a general improvement in wellbeing. For example, one informant was able to find a place in a hostel to live as a result of a contact made through Ombold. Another said that they had reduced the amount of alcohol they drank by 70-80% whilst they were on the team. Participation in Ombold street football also had wider benefits; one individual had found a place at a hostel as a result of a connection made during football training and another had found employment this way[277].

11.4.15   Success factors

The social experience of Ombold encourages individuals to attend trainings regularly and the Danish Homeless World Cup team provides inspiration to those taking part. Ombold is open to anyone regardless of their standard of playing and people are encouraged to attend even if they feel they cannot play that day. Ombold players share common life experiences and being part of this peer group "as you are here and now" is a major draw of participating in Ombold[278].

11.4.16   Innovative features

Ombold was set-up as the organisation sending a national team to the Homeless World Cup and participated in the first ever Homeless World Cup; focusing on sport as a way to improve health and increase social integration. Going forward, Ombold has been innovative in introducing organised sport for homeless people across Denmark.

Within this programme, playing football provides not only the chance to exercise but also opportunities to socialise in a positive way which leads them out of isolation that many experience during homelessness. Participating in street football gives homeless individuals a sense of being part of something and empowerment which can lead to feeling able to make other changes in their life, including making healthier choices[279]. Ombold also includes players who have moved on from hostel accommodation to mainstream housing, providing continuity of social networks and peer support to others[280].

11.4.17   Obstacles and lessons learnt

The main obstacles were identified as related to funding of the activities. External funding for the women's Homeless World Cup team finished in 2015 and in 2016 Ombold decided to concentrate only on sending a men's team to the world cup as

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[275] ibid
[276] ibid
[277] Fritzen, M., Rosing, S. and Markhus, A. (2016).
[278] Ombold (2016a)
[279] Homeless World Cup. (2016). *Frequently Asked Questions - Homeless World Cup*. [online] Available at: https://www.homelessworldcup.org/about/faqs/ [Accessed 23 Sep. 2016].
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85% of Ombold participants are men[281]. Another example of funding difficulties was seen in 2014 where the team struggled to raise the funds required to take the homeless team to the Homeless World Cup. The problem was solved by a large donation from an individual[282].

11.4.18 Potential for transferability and sustainability

This practice is highly transferable. Currently, the Homeless World Cup includes representatives from 73 countries worldwide, including 23 Member States[283]. Each country represented at the world cup has a partner organisation working within that country to provide a national team. Ombold is one of the most well-established of such practices, able to offer extra tournaments and weekly coaching which are stated aims of other organisations; Ombold can therefore act as a practice example for other national organisations to expand their homeless football offer.

Ombold is reliant on time limited funds rather than central funding, the organisation continues to campaign to receive stable support for sport for vulnerable people. In 2015 sport for vulnerable people ceased to be an issue for the Ministry of Social affairs and came under the auspices of the ministry for Culture alongside mainstream sport. This was seen a positive step by Ombold as they were no longer required to prove that the practice helped individuals into work or housing, but that the project should be funded for the inherent benefit that sport has for all[284].

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[281] Ombold (2016b)

[282] Homeless World Cup News, (2014). Daniel Agger helps the Danish homeless team realise their dreams. [online] Available at: https://www.homelessworldcup.org/news/daniel-agger-helped-the-danish-homeless-team-realise-their-dreams/ [Accessed 23 Sep. 2016].

[283] Austria, Belgium, Bulgaria, Croatia, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Luxembourg, Netherlands, Poland, Portugal, Romania, Slovenia, Spain, Sweden, UK (England, Scotland, Wales and Northern Ireland are represented separately)

[284] Ombold (2016b)

Pedersen P, Christensen AI, Hess U, Curt T. (2007) *SUSY UDSAT – Sundhedsprofil for socialt udsatte i Danmark*. Copenhagen: Rådet for Socialt Udsatte, 2007.

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12   Prisoners

Four practices in the inventory target prisoners. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 16.   Practices targeting prisoners

	Title	Main aim and objective	Country	Coverage	Quality score
24	Danish model on food systems in correctional facilities	A programme allowing prisoners in all centres to be responsible for the preparation and management of food.	Denmark	National	24
25	Community-based Health and First Aid in Action	Groups of selected prisoners are trained as peer educators and do hands-on health promotion among fellow inmates to raise their awareness about community health, personal hygiene, first aid and well-being.	Ireland	National	23
26	Prison Inreach and Court Liaison Service (PICLS)	This project focuses on identifying prisoners with serious mental illness and referring them to appropriate mental health services as soon as possible.	Ireland	Local	22
27	Health education for social prosperity	The initiative aims to help reduce harm from drug use among prisoners in three prisons across Bulgaria, by increasing the capacity of prison staff to deal with drug issues. The main activities are: training modules for prison staff on treatment and prevention of drug use, brief interventions in case of drug use; harm reduction in case of drug use. Health training session are also organised with inmates.	Bulgaria	National	22

Two of these practices (Danish model; Community-based Health and First Aid in Action) aim to promote health awareness and healthy behaviours among prisoners, by empowering them to take control of aspects of life such as their nutrition and prison hygiene. The other two practices focus more on changing health services for prisoners, by increasing screening for mental health issues (PICLS) and by supporting harm reduction approaches to drug use.

The full case studies are given below.

12.1 Case Study 24: Danish model on food systems in correctional facilities

Name of practice: Danish model on food systems in correctional facilities

Country: Denmark (DK)

12.1.1 Main objective and specific aims

The model of catering in Danish prisons is one of self-catering. This is part of a broader prison strategy of 'normalising' prison conditions, to reduce the negative impacts of imprisonment on the prisoner and reduce re-offending once prisoners are released.

The specific aims of using the self-catering model are:

* 'Normalising' the preparation and consumption of meals, so that this aspect of prisoners' time in prison more closely matches life outside of prison.
* Helping prisoners acquire cooking skills that will enable them to eat more healthily.
* Helping cut re-offending, by teaching prisoners skills that will help them once they leave prison.

12.1.2 Relevance for 3rd EU Health Programme objectives

* This programme is relevant to objective one of the 3rd EU Health programme:

* Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, in that it supports prisoners to make their lifestyles healthier.

12.1.3 Target groups

The target group of this programme is prisoners. It is aimed at all prisoners within the Danish prison system, without a special focus on any particular sub-groups.

Self-cooking facilities are not generally available to prisoners being held in remand facilities[285]. Given Denmark has a total prison population of 3,481, 35.5% of whom are pre-trial/remand[286], this means approximately 2,245 prisoners (64.5%) are serving sentences in prisons that use this model of self-cooking.

12.1.4 Thematic focus of intervention in relation to reducing health inequalities

Through its focus on improving the food consumed by the prison population, this may help tackle health problems experienced by prisoners. Evidence of health outcomes for Danish prisoner specifically is not available, but there is global evidence that some aspects of prison diets present particular health risks for prisoners. A 2012 review of 60,000 prisoners worldwide[287] found that for prisoners in high-income countries:

* Overweight and obesity are a particular problem for female prisoners. One reason for this is that men make up the vast majority of the global prison population, and so prison systems tend to be designed with men's requirements in mind. This means that female prisoners are often given food containing too many calories.

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[285] Smoyer and Minke, 2015. Food systems in correctional settings: A literature review and case study.
[286] World Prison Brief, 2016. *Country profile: Denmark.*
[287] Herbert et al, 2012. Prevalence of risk factors for non-communicable diseases in prison populations worldwide: a systematic review.

- Prisoners of both sexes have diets containing too much salt and fat, compounded by the availability of extra (unhealthy) snacks that prisoners can purchase.

12.1.5 Key activities

There are no cafeterias or institutional kitchens in Danish prisons that hold sentence-serving prisoners. Instead, prisoners purchase ingredients from the prison grocery store, cook their own food and clean for themselves in communal kitchens. The main activities of the programme are as follows:

- Prisoners are given an allowance of EUR 67 per week for food and cleaning supplies.
- They also have to work, and are paid at least EUR 49 per week in wages.
- Prisoners can buy food from the prison grocery store. Most prison grocery stores are run by private companies and have to make a profit. They stock most regular grocery items.
- Prisoners are given a fridge in their cells in which to store the food they purchase.
- Each prisoner has access to a communal kitchen shared by around 20 prisoners, and meal preparation is supervised by prison staff.
- Keeping the kitchen clean is the responsibility of the prisoners who use it, with cleaning tasks allocated among the prisoners by prison staff to ensure the kitchen is maintained.
- Cookery training programmes are available in some prisons. By participating in these, prisoners can become certified chefs.

12.1.6 Geographical scope

National: this initiative covers all prisons for sentence-serving prisoners in Denmark.

12.1.7 Intersectoral dimension

This programme cuts across two policy areas: health and criminal justice. As well as addressing prisoner health, this initiative is run as part of a national strategy to reduce re-offending.

12.1.8 Duration

The model of prisoners cooking for themselves was first trialled in Denmark in 1976[288], before being expanded to all prisons during the 1970s and 1980s. The expansion of cooking lessons has only occurred in the past few years.

Self-catering is used as part of the Prisoner and Probation Service's principle of 'normalisation' of service delivery, and so is due to run indefinitely[289].

12.1.9 Lead organisation

The lead organisation is the Danish Prison and Probation Service, a department of the Ministry of Justice responsible for the national prison service. This is the government body that oversees all aspects of the prison and probationary services.

12.1.10   Partners

Self-catering in prisons is delivered entirely by the Prison and Probation service, although the prison grocery stores are operated by private companies. Delivery of the cookery courses is done with the assistance of catering company Meyers Foods, who provide staff to teach prisoners.

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[288] Smoyer and Minke, 2016.
[289] Prison and Probation Service, 2011.

12.1.11 Main sources of funding

Funding for the programme comes from the Danish Prison and Probation Service, as part of the overall budget allocated for running Danish prisons. The exact level of funding required to run self-catering is not publicly available.

12.1.12 Evidence base for implementation

The primary rationale for Denmark's programme of self-cooking in prisons is the contribution it can make towards improving prisoner behaviour and cutting re-offending rates, by helping to 'normalise' conditions in prison so that they more closely reflect conditions outside of prison. At 29%, re-offending rates in Denmark are among the lowest in Europe[290]. While hard evidence linking a 'normalisation' approach to imprisonment and lower re-offending rates is not available, there is indicative evidence that Denmark's approach has a positive impact upon prisoners' self-perception, and thereby their behaviour inside and outside of prison[291]. There is also considerable evidence that re-offending can be reduced through the provision of education and skills training in prisons, which help inmates find employment upon release[292].

While health effects are not the primary focus of the Danish approach to imprisonment, there is also evidence that dietary changes can have a significant positive impact on prisoners' physical and mental health, which Denmark's self-catering may indirectly facilitate by providing prisoners with fresher food than would usually be available through prison catering, and by educating them about cookery and healthy eating. Research from the United States and worldwide[293] has found that prisoners are more likely to be overweight than the general population, with prison diets high in processed foods, carbohydrates, fat and salt partly responsible[294]. Providing inmates with raw ingredients with which to make fresher food would help address this, and prisoner participation in cooking courses (a relatively new, but growing aspect of Denmark's model) can help improve prisoners' knowledge of nutrition and capacity to prepare healthier meals[295].

There is also some indicative evidence that improved diets might be beneficial for patients' mental health. Improved nutritional intake has been associated with reduced incidents of poor behaviour and violence in young incarcerated men296, as well as improved outcomes relating to aggression and psychopathology[297].

12.1.13 Evaluation: Has the practice been evaluated?

There are various reports on the self-catering model used in Danish prisons, as well as some qualitative outcomes assessments conducted by academics[298]. Given that the primary goal of self-catering and cookery lessons is to help reduce prisoner re-offending, this is the area that reports on the Danish model tend to focus on, although

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[290] Higher than only Iceland and Norway (Fazel and Wolf, 2015).

[291] Minke, 2014.

[292] HM Government, 2005; Social Exclusion Unit, 2002.

[293] WHO, 2014.

[294] Binswanger et al, 2009. Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population.

[295] Nikolas, 2000.

[296] Eves and Gesch, 2003. Food provision and the nutritional implications of food choices made by young adult males, in a young offenders' institution.

[297] Zaalberg et al, 2010. Effects of nutritional supplements on aggression, rule-breaking, & psychopathology among young adult prisoners.

[298] Minke, 2014. Cooking in prison – from crook to cook; Minke and Balvig, 2015. The Cookery School – evaluation of the experiences so far; Smoyer and Minke, 2015. Food systems in correctional settings: A literature review and case study.

qualitative evaluations have found preliminary evidence that self-catering and the provision of cookery lessons have a positive impact upon prisoners' ability to eat healthily and reduced likelihood of re-offending upon leaving prison.

12.1.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and outcomes

All sentenced prisoners in Denmark have self-catering facilities in their accommodation. The exact number of prisoners using prison facilities who self-cater varies year on year, as it depends on the number of prisoners incarcerated in any given year. It will generally be between 2,000 and 2,600 prisoners[299]. The number of prisoners participating in cookery or catering courses is not documented.

The system of self-catering and prisons' provision of cookery lessons have both been well-received by inmates[300], with prisoners who self-cook expressing much higher levels of satisfaction with the quality of their food than remand prisoners who have food cooked for them[301]. Prisoners appreciate the control they feel by being given control of their own diet.

Evaluations of cookery lesson programmes in Danish prisons have found these programmes to have:

- Helped some prisoners to find employment both inside and outside prison;
- Improved prisoner-staff relationships, through prisoners preparing meals for staff;
- Taught prisoners how to prepare health and inexpensive meals; and
- Helped spread knowledge of healthy eating to other prisoners, as programme participants pass on this knowledge to their peers[302].

While the full impact of this is yet to be evaluated, these findings do give some indication that access to healthier ingredients, as well as knowledge of how to prepare healthy food, have created the potential for Danish prisoners to improve their diets. This would likely have helped them improve their health as well. These evaluations highlight that these cookery courses' relatively recent introduction means it is currently still too early to assess their impact on re-offending rates.

12.1.15 Success factors

Qualitative evaluations of Denmark's system of self-catering have found that the main benefit of having prisoners cook for themselves is the freedom for prisoners to prepare their own food using healthy ingredients from prison grocery stores, as this enables prisoners to eat more healthily than centralised prison catering would allow.

Evidence on success factors for prison cookery classes is limited. Minke and Balvig's evaluation of a pilot cookery school project found that prisoners' successful completion of their courses was aided by using:

- A small number of teachers, to ensure continuity and cohesion of course delivery and the staff that prisoners come into contact with;
- Staff who are comfortable and competent teaching in the unusual teaching environment; and

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[299] Depending on the population of sentence-serving prisoners each year. Estimates above based on 2006-2015 total prison populations, and percentage of prisoners serving sentences in 2015 (WPB, 2016).
[300] Minke, 2014; Minke and Balvig, 2015.
[301] Smoyer and Minke, 2015.
[302] Minke and Balvig, 2015.

- A teaching space detached from regular prison activity, as this can improve prisoners' motivation for learning[303].

Their evaluation did not specifically examine the impact of the cookery courses on prisoners' diets or health, and they highlighted that it was conducted too early to be able to assess the impact of the course on participants' likelihood of re-offending.

12.1.16 Innovative features

A similar 'normalisation' approach is used at some prisons in Norway, including prisoner self-catering[304], although this is not a uniform approach. Self-catering has also been used at a small number of prisons in the UK, although as a reward for good behaviour rather than a universal system for all prisoners[305]. The provision of self-catering facilities for all prisoners is therefore in itself a highly innovative approach.

Other complementary elements of the scheme – such as prison food stores – are more commonly found in other countries, although the literature notes that grocery stores in Danish prisons offer a much wider range of foodstuffs than in most other countries.

12.1.17 Obstacles and lessons learnt

Minke and Balvig's evaluation of one prisoner cookery school project found that it had a dropout rate of 57%, with half of those who dropped out doing so due to either being released or to being transferred to another prison. The movement of prisoners within the prison system therefore presents a challenge to having prisoners successfully complete the cookery courses offered through this programme. The evaluation did not identify any means of addressing this issue, although some possible options would include: only allowing prisoners to enrol if they have enough time left on their sentence to complete it; and expanding the coverage of the programme to enable those transferring to continue their course at the location they are transferred to.

Another quarter of those who left the cookery project early were expelled for poor behaviour and/or lack of motivation. The evaluation also does not give an indication of measures that could be taken to reduce this or means of identifying potential problem students, although it is possible that some form of screening for prisoners who sign up for cookery projects would help reduce the rate of poor behaviour/motivation expulsions.

Some research has advised that prison staff should monitor the way in which prisoners' social organisation develops around their food practices. If food is used to construct group identities (delineating prisoners by cultural, religious or regional differences) then this could impact negatively upon prisoners' social networks[306]. However, current evidence does not demonstrate this being a particular problem in self-catering prison facilities, nor does it show whether such developments could have a detrimental impact on prisoner diet, health or chances of re-offending.

12.1.18 Potential for transferability and sustainability

Whether or not this approach could be transferred to other countries' prison systems would primarily depend upon two factors: political support for such an initiative, and the availability of the resources needed to provide cooking facilities and staff supervision:

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[303] Ibid.
[304] Stranberg, 2010. The Norway Prison System.
[305] HM Chief Inspector of Prisons, 2011. Report on an unannounced full follow-up inspection of HMP Full Sutton.
[306] Wilson, 2011; Earle and Phillips, 2012; Ugelvik, 2011; Smoyer, 2014; Vanhouche, 2014; Cate, 2008.

- **Funding:** Denmark currently spends EUR 188 per day on each prison inmate. This is higher than the European average[307]. While it appears that self-catering is a cost-effective method of feeding prisoners[308], detailed information on the cost of self-catering in prisons is not readily available and so it is difficult to fully assess the financial viability of self-catering for judicial systems with lower budgets.
- **Staff levels:** Denmark has a staff to prisoner ratio of 1.5 prisoners per custodian[309]. This puts it among the highest in Europe, with a European average of 3.6 prisoners per custodian. As with funding, there is little information available on the level of staff needed to supervise self-catering compared to a canteen system, but countries with lower levels of prison staff could potentially lack the staff to deliver self-catering.
- **Political Support:** Current evidence shows that Denmark's programme of self-catering for prisoners has broad support from both the public and from prisoners themselves[310]. For this programme to be adopted in other countries, it would need similar levels of support in those as well.
- **Regulatory environment.** Rollout of such a scheme across a national prison system would depend upon legislation allowing a central government to enact such reforms. For example, ongoing reforms to the UK's prison system will allow some prisons autonomy over much of their financial and operational decision-making[311]. In countries or localities where such a system is used, prisons might need to be persuaded to voluntarily adopt a self-catering model and could potentially resist.

Use of a similar model in other countries is limited. A similar 'normalisation' approach is in operation at some prisons in Norway[312], and self-catering has also been used at a small number of prisons in the UK[313], although no evidence of the impact of these programmes on prisoner's health or rehabilitation could be identified in the literature.

This programme is fully sustainable. Funding is guaranteed as part of the national budget for prison operations.

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[307] Including non-EU European countries.
[308] Justice Committee, 2015. Prisons: Planning and Policies – Ninth Report of Session 2014-2015.
[309] All statistics from Council of Europe, 2015.
[310] Smoyer & Minke, 2015.
[311] HM Government, 2016.
[312] Stranberg, 2010. The Norway Prison System.
[313] HM Chief Inspector of Prisons, 2011. Report on an unannounced full follow-up inspection of HMP Full Sutton.

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12.2 Case Study 25: Community-based Health and First Aid in Action

Name of practice: Community-based Health and First Aid in Action (CBHFA)

Country: Ireland (IE)

12.2.1 Main objective and specific aims

The main objective of the programme to raise prison inmates' awareness about community health, personal hygiene, first aid and well-being.

The specific aims of the programme are to:

- Limit spread of disease and infections by teaching prisoners good personal hygiene;
- Improve prisoners' dietary and exercise habits;
- Combat vermin and bad odours caused by litter;
- Reduce the costs to prisons of dealing with prisoner's ill-health; and
- Reduce the litigation costs incurred by prisons as a result of prisoner deaths.

12.2.2 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objective one of the 3rd EU-Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, in that it supports prisoners to make their lifestyles healthier.

12.2.3 Target groups

The target group of this programme is prisoners. It is aimed at all prisoners within the Irish prison system, with no special focus on any particular sub-groups. Ireland currently has a prison population of 3,812[314], who are all a target of the programme.

12.2.4 Thematic focus of intervention in relation to reducing health inequalities

Through its focus on tackling various health issues within the prison population, this may help tackle physical and mental health problems which are experienced at a disproportionately high rate by prison inmates.

Data on the spread of infectious diseases among Irish prisoners is not routinely published[315], although research from the US[316] and the WHO European Region[317] has found a number of infectious diseases to be more prevalent among prison populations than general populations. Mental health issues are also more prevalent in prisons[318]. For example, suicide rates are higher among the Irish prison population than among the general population[319] and, while no statistics on the relative prevalence of depression among Irish prisoners are available, current statistics for the UK show that rates of depression are 2-3 times higher among the prison population than the general population[320].

The difference in suicide rates between prisoners and non-prisoners is largely due to the prison population being disproportionately made up of young men and people with patterns of drug misuse, both of whom have higher suicide rates both inside and

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[314] Irish Penal Reform Trust, 2016.

[315] Ring, 2016. Call to track the spread of diseases in prison.

[316] Hammett, 2006. HIV/AIDS and Other Infectious Diseases Among Correctional Inmates; Bick, 2007. Infection Control in Jails and Prisons.

[317] Aerts et al, 2006. Tuberculosis and tuberculosis control in European prisons.

[318] WHO, 2014. Prisons and Health.

[319] Kennedy et al, 2004. Mental Illness in Irish Prisoners.

[320] Prison Reform Trust, 2016. Mental Health Care in Prisons.

outside of prison[321]. It is possible that similar factors explain the higher prevalence of depression in prison populations. However, this still means that the prison population disproportionately experiences these negative health outcomes.

12.2.5 Key activities

Groups of selected prisoners become special status Irish Red Cross Volunteer Inmates. They are trained as peer educators and organise hands-on health promotion among fellow inmates to raise inmates' awareness about community health, personal hygiene, first aid and well-being. Volunteer inmates have delivered various hygiene-related projects in different prisons, including:

Colour-coded mops

- A system of colour-coded mops is set up, to prevent the same mops being used to clean all areas of the prison. Different colour mops are used for cleaning various areas of the prison.
- Instruction on mop colour-coding was given to cleaning staff and inmates, and posters were put up to raise awareness for all inmates.

Anti-litter campaign

- To prevent inmates throwing litter from their cell windows, posters have been produced to encourage inmates to change behaviour.

Hand-washing techniques

- Prisoners are taught correct hand-washing techniques on an ongoing basis.

Health and fitness

- Volunteers in some prisons lead various health and fitness activities, in coordination with prison Gym Officers. Currently no further information on this is available.

Other health-related activities

- There have also been numerous other individual projects run under the initiative of inmates in different prisons, focusing on issues such as: consumption of sugar in soft drinks; dental hygiene; diseases such as TB and seasonal flu; and skin cancer awareness. The large number and relatively small scale of many of these projects means that the level of detail available on them is limited.
- Some Volunteer Inmates have also implemented projects aimed at reducing violence, such as weapons amnesties and participation in non-violence courses.
- During the strategic planning period 2015-2019, a new programme component is to be introduced. It will focus on supporting Volunteer Inmates move into suitable Irish Red Cross volunteer roles upon their release from prison, to continue using the skills they have learnt during the project within the outside community.
- There is also a plan in place for a mental health module to be delivered in partnership with the Irish Prison Service's Health and Rehabilitation Directorate, although this is still in the development stage and no fixed timeframe for finalising and launching this mental health module has been specified.

12.2.6 Geographical scope

National: this initiative covers the entire Irish prison system.

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[321] Kennedy et al, 2004. Mental Illness in Irish Prisoners.

12.2.7 Intersectoral dimension

This programme cuts across two policy areas: health and criminal justice. This programme aims to address the health of the prison population, while also addressing other issues such as prison violence.

12.2.8 Duration

This programme was first piloted in one prison in 2009, before being expanded to ten prisons in 2013 and then all 14 Irish prisons in 2014.

12.2.9 Lead organisation

The lead organisation is the Irish Red Cross. This is a national organisation which provides humanitarian support to vulnerable groups within the Irish population.

12.2.10 Partners

This programme is delivered in partnership with:

- The Irish Prison Service (IPS), an executive agency within the Department of Justice and Equality responsible for dealing with all prisoners nationally; and
- The Education and Training Boards Ireland (ETBI), a national statutory organisation responsible for representing Ireland's education and training boards.

ETBI teachers deliver training sessions to volunteer inmates, who are then supported by Irish Prison Service nurses and healthcare professionals to undertake peer-to-peer awareness raising and implement the component projects of the programme.

The Irish Red Cross has also worked with the British Red Cross and Honduras Red Cross to help launch CBHFA pilots in the UK and Honduras.

12.2.11 Main sources of funding

Information on funding allocations for CBHFA is not published, but each of the organisations supplying staff for the programme (the Irish Red Cross, IPS and ETBI) appears to cover its own staffing costs.

The Irish Red Cross has recently joined a consortium led by the Italian Red Cross in application for EU funding for improving knowledge around drug-related issues in justice systems, which would provide the programme with additional funding for 2017 and 2018 if the application is successful.

12.2.12 Evidence base for implementation

CBHFA aims to improve prisoners' health outcomes relating to infectious diseases, non-infectious diet-related diseases, and mental health (particularly depression and suicide). CBHFA projects cover a range of health areas using a wide variety of methods but the central premise of all of them is prisoner education, and there is significant evidence that hygiene and health education can play an important role in reducing negative health outcomes.

A 2003 Irish Prison Service survey of Ireland's prisoner population[322] tested prisoners' literacy and compared the findings to International Adult Literacy Survey results for Ireland's general population. It found that prisoners were significantly more likely to possess low levels of literacy than the general population. On the IALS scale of Level 1 to Level 5 (5 being the highest level of literacy), 53% of prisoners tested were assessed as either Level 1 or Pre-Level 1, compared to 23% of the general population.

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[322] Irish Prison Service, 2003. The Prison Adult Literacy Survey: Results and Implications.

This is important given that low levels of literacy will mean low levels of health literacy[323]. Research conducted in England by the King's Fund has found that long-term health conditions are more prevalent among people with poor health literacy[324], while improved health literacy has been found to increase people's motivation and ability to self-manage their own health[325]. Evidence from other health literacy education programmes has shown that they can have a significant impact upon population health. For example, a Pan American Health Organisation programme to educate communities about mosquito control measures led to a 63% reduction in malaria cases in its target areas between 2004 and 2007[326]. Measures to tackle prisoner health literacy, such as CBHFA, therefore have significant potential for improving the health outcomes of prisoners.

12.2.13 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The Irish Red Cross conducted a three year evaluation in 2012, once the programme had been extended to cover six of Ireland's 14 prisons, examining the programme from 2009 to 2012[327]. The findings of this evaluation were primarily based on the results of a workshop attended by staff and Volunteer Inmates from the six prisons, a survey of inmate volunteers, as some smaller surveys conducted before and after particular CBHFA projects. It also draws on findings from an evaluation of the pilot[328].

All information presented in this section is from the three year evaluation, unless indicated otherwise.

Outputs and outcomes

About 800 prisoners have been recruited as volunteer inmates since the start of the programme, with roughly half completing the full training course[329]. Data is not available on how many of these volunteers are still prisoners within the Irish prison system, but this equates to 110-115 inmates recruited each year, with 55-60 per year completing their training course and becoming Volunteer Inmates. The Irish Red Cross estimates that during the period 2009-2012 volunteer inmates worked to provide information to over 2,000 inmates, roughly equivalent to 500 a year.

Programme-wide outcomes reported qualitatively by prisoners and/or prison staff were:

- A slight positive change in relationships between prisoners and staff in the prisons running CBHFA projects;
- Volunteer inmates reported feeling more confident, more positive and having a higher self-esteem; and
- Volunteer inmates also reported helping raise awareness and feeling they can make a difference.

Outcomes from specific projects included:

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[323] Health literacy is 'the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (WHO, 2016).
[324] King's Fund, 2013. Delivering better services for people with long-term conditions.
[325] Edwards et al, 2012. The development of health literacy in patients with a long-term health condition: the health literacy pathway model.
[326] Pan American Health Organization, 2008. Regional Program of Action and Demonstration of Sustainable Alternative to DDT for Malaria Vector Control in Mexico and Central America.
[327] Irish Red Cross, 2012. Community Based Health and First Aid in Action in Irish Prisons: 3 Year Evaluation.
[328] Not published separately.
[329] Irish Red Cross, 2016. Community Based Health & First Aid Prison Programme Overview.

- HIV/AIDS projects in two prisons led to the proportion of inmates who were aware of their viral status increasing from 2% to 50%, through participation in voluntary HIV testing;
- 100% of volunteers involved in the pilot reported enjoying it, with 90% saying it created a sense of community and 90% enjoying passing on things they had learnt to their local community; and
- 'Excellent' success rates in persuading prisoners to give up or significantly reduce their smoking habits, through a smoking cessation programme run in several prisons.

12.2.14   Success factors

Prisoners participating in projects run in open or semi-open prisons were more enthusiastic about participation when the primary focus of training was on preparing to leave prison and re-enter society, rather than creating change within the prison. This was because prisoners in these prisons were due to leave prison relatively soon, and were therefore generally less motivated to try and enact change within the prison. When the emphasis of inmate training was changed to focus more on inmates' futures outside of prison, volunteers became more motivated and ran a higher number of projects than before.

Active support from prison staff had a significant impact upon CBHFA's performance in one prison. In the prison where CBHFA projects were judged to have had the greatest impact during the first few years of the programme, much of this was attributed to a governor, chief officers and assistant chief officers being dedicated to helping ensure projects remained active and were productive. Ensuring strong buy-in and dedicated support from a wider range of prison staff therefore appears to be one factor which can help ensure stronger overall programme performance.

12.2.15   Innovative features

The CBHFA model of peer-to-peer awareness raising for improving health outcomes is already used in a wide variety of community settings globally, but Ireland was the first country to run a CBHFA programme in a prison[330]. While there exist various projects and programmes for improving prisoner health in various countries, these are usually delivered by non-prisoners, such as:

- Health screening, immunisation and other health checks or treatments administered by healthcare professionals; or
- Changes made to the prison environment by prison staff, such as modifying food provided by the prison[331].

The novel nature of prisoner peer-to-peer training and mentoring as a means of improving prisoner health is further evidenced by the international interest which has been shown in piloting the CBHFA model in prisons other countries. This piloting is explored in more detail in the section on transferability and sustainability.

12.2.16   Obstacles and lessons learnt

Projects run at one prison experienced difficulties related to that particular prison being a remand centre. Only prisoners awaiting trial were held there, meaning that there was quick and sometimes unanticipated turnover of prisoners. This was a key reason for prisoners dropping out of volunteer training within this particular prison. Since expansion of CBHFA to a greater number of prisons, it has become easier to ensure prisoners transferred out of the remand centre during their volunteer training

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[330] IFRC, 2012.
[331] WHO, 2014. Prisons and Health.

can be placed onto a training course in another prison (if they are transferred to another prison).

12.2.17 Potential for transferability and sustainability

In 2015, pilot programmes using the CBHFA in prisons model were launched in one Northern Irish and one Welsh prison, and the British Red Cross is currently working with Public Health England to develop a similar pilot for an English prison as well. Outside of Europe, CBHFA is currently being piloted in two prisons in Honduras, and the development of pilots is also being explored in America and Australia[332].

Whether or not this approach could be transferred to more countries' prison systems would primarily depend upon two factors: the availability of the resources needed to provide training to inmates and the materials needed to run CBHFA projects, and institutional support for such an initiative:

- **Resources:** CBHFA in Irish prisons has been run using resources of the Irish Red Cross, Irish Prison Service, and the Education and Training Boards Ireland association. For the scheme to be run in another country, similar amounts of funding and suitably-skilled staff would need to be available.
- **Institutional support:** For a similar scheme to be run in other countries, health organisations access to prisoners would need to be supported by the relevant government agencies, and potentially also by the individual prisons themselves. For example, ongoing reforms to the UK's prison system will allow some prisons autonomy over much of their financial and operational decision-making[333]. In countries or localities where such a system is used, prisons might need to be approached individually for discussions on initiating a CBHFA programme.
- The Irish Red Cross plans to continue with the programme for at least several more years, and has the funding to do so. Nonetheless, the Irish Red Cross has highlighted a number of options for ensuring greater programme sustainability:

  - **Training inmate trainers**. Training inmates to a level where they are capable of training new inmate volunteers would help ensure programme sustainability, by reducing the need for the Irish Red Cross or ETBI to continually provide staff for inmate training.
  - **Transferral of responsibility to government**. Meetings have been held between the Irish Prison Service and the Health Service Executive (HSE)[334] to explore the possibility of the HSE allocating resources to support the activities of CBHFA Volunteer Inmates. This could help transfer some of the financial responsibility to the government, which would in theory provide greater funding security for the programme.

12.2.18 List of references

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[334] The provider of all Ireland's public health services, hospitals and communities.

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12.3 Case study 26: Prison In-reach and Court Liaison Service (PICLS)

Name of practice: Prison Inreach and Court Liaison Service (PICLS)

Country: Ireland (IE)

12.3.1 Main objective and specific aims

PICLS is a diversion policy to transfer mentally ill people away from the criminal justice system and into psychiatric care.

The main objective of PICLS is to improve the identification of mentally ill people when they are remanded to prison. The scheme aims to assist patients, the criminal justice system and local psychiatric services by ensuring a rapid response and by systematically identifying prisoners with a primary diagnosis of psychotic illness[335].

The specific aims of the service are:

- **Prison in-reach:** The service immediately identify prisoners with serious mental health issues and appropriately refers them to, or puts in place practical solutions for accessing, mental health services[336].
- **Court liaison:** The service operates a "liaison" model; this means that there is an assertive focus on diverting patients to their local psychiatric service when this is feasible and safe[337].

12.3.2 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objective four of the 3rd EU Health programme:
- Facilitate access to **better and safer healthcare** for Union citizens; the programme supports prisoners to access appropriate mental healthcare.

12.3.3 Target groups

The target group is prisoners – specifically prisoners who have mental illnesses. As the project took place at Cloverhill Prison, only male prisoners have benefited from the scheme so far[338].

12.3.4 Thematic focus of intervention in relation to reducing health inequalities

People with mental illnesses are overrepresented in prison populations. In Ireland, a 2002 cross-sectional study found 7.6% of male remand prisoners have psychotic illness, which is 10 times more than the community rate. 3.8% of newly-remanded prisoners were actively psychotic on committal to prison[339]. As the prison population in Ireland continues to grow[340], so does the number of prisoners with mental illnesses. This disproportionately high rate of mental illnesses in Irish remand settings calls for a formal, legal mechanism for court diversions; mental health courts; and, investment in community psychiatric services[341]. This is because prisoners who are and remain mentally ill are a risk, both to themselves and others in the prison setting.

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[335] O'Neill, 2011, pg. 9: http://www.mhcirl.ie/File/NOFMHS_report11.pdf
[336] McInery *et al.* 2013
[337] Ibid.
[338] Cloverhill Prison is the committal prison for male adults remanded in custody from the courts in the Dublin and Leinster.
[339] McInery *et al.* 2013
[340] The mean daily prison population in Ireland increased by 39% from 3,165 in 2002 to 4,390 in 2011. Total committals increased by 46% from 11,860 in 2002 to 17,318 in 2011 (McInery *et al.* 2013)
[341] McInery and O'Neill, 2008, pg. 148

12.3.5 Key activities

There are a four main steps[342] to identifying and referring prisoners to the appropriate metal healthcare services. An overview is shown in Figure 5.

Firstly, prisoners with severe mental illnesses need to be **identified**. To achieve this:

- Daily screening is carried out by mental health staff; they look for committals who have a history of, for example, using psychiatric medication, deliberate self-harm, who have a history of homelessness or observed unusual behaviour, or a history of previous psychiatric contact.
- Standard committal interviews are carried out by the Irish Prison Service nursing staff
- Any referrals, made from the judiciary, legal representatives, prison or correctional staff etc. are also accepted and considered.

Secondly, **appropriate treatment** options are identified – a number of options exist when someone requires psychiatric treatment:

- A patient with severe illness who is thought to pose a high risk to others can be transferred to the Central Mental Hospital, Ireland's only forensic inpatient hospital.
- A patient who has a severe mental illness, poses a low or negligible risk to others and was only charged with a minor offence may be treated at a local psychiatric hospital (approved centre). In this case, bail or a suspended sentence may be awarded to enable treatment to take place in inpatient or outpatient settings.
- In-reach treatment in the prison setting can also be provided for those with less severe mental illnesses facing serious charges.

The third stage involves **gathering information and liaising** with all relevant interest groups to ensure appropriate care is provided. This can include speaking to relatives, the police and the referral service. The history of violence committed by the patient is considered to assess risk, and to make recommendations to the court.

Finally, the last stage is **provision of advice to the court**: it is usual practice to provide a psychiatric report to the court (e.g. when an offender is entitled to bail) and to inform the court of any custodial and non-custodial treatment options. In cases of admission to a local hospital, defendants are usually accompanied to court by a member of the PICLS nursing staff to facilitate communication and assist in transfer. Any relevant paperwork is prepared and signed in advance of the court appearance.

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[342] McInery *et al.* 2013

Figure 2.   The Prison Inreach and Court Liaison Service model (based on McInerney et al., 2013)
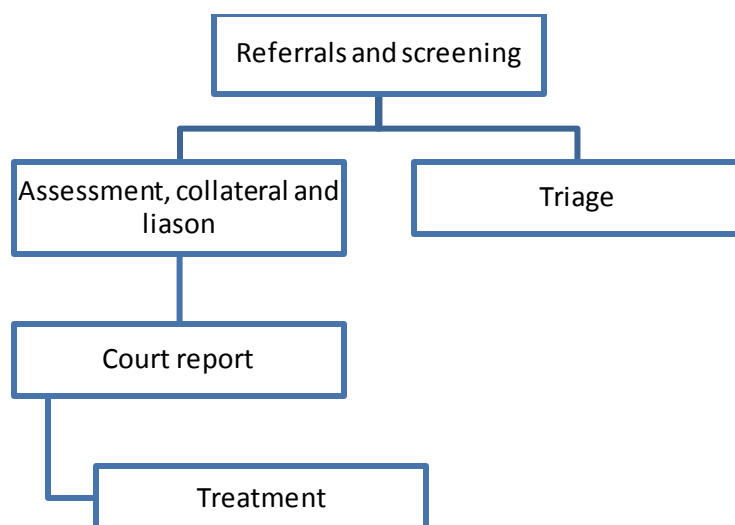
12.3.6 Geographical scope

The project was local, and took place at Cloverhill Prison in Dublin, Ireland. This is a committal facility for remand prisoners who come mainly from the Dublin and Leinster area.

12.3.7 Intersectoral dimension

The project is run with a dual aim: to improve the healthcare of prisoners, and to improve the way the prison system handles mental health cases.

12.3.8 Duration

This service commenced in Cloverhill Prison in 2006 and is ongoing.

12.3.9 Lead organisation

The lead organisation is the Irish Prison Service, under the political responsibility for the Department for Justice and Equality.

12.3.10   Partners

There are two main delivery partners: the healthcare service and the prison staff[343].

Although the mental health service was administered in prison and court settings, the PICLS staff was employed by the Health Service Executive (the national health body in Ireland).

The mental health team comprises of psychiatric specialists e.g. a consultant psychiatrist, psychiatric registrars and forensic psychiatric nurses. Other healthcare specialists e.g. consultants or counsellors specialising in addition, also attend the prison regularly.

Referrals are made from a wide range of sources, including the medical team, prison officers, the Governor and chaplain.

12.3.11   Main sources of funding

The funding is secured through the Irish Prison Service.

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[343] See: http://www.mhcirl.ie/File/IRs/CloverhillPrisonServiceIR_2009.pdf for more information

12.3.12 Evidence base for implementation

Inadequate pathways to care for the mentally ill have led to individuals with major mental illness increasingly presenting to courts for of minor offences rather than to psychiatric services. Research into the Irish Prison System has confirmed that there is a disproportionate number of mental disorders among both male and female prisoners compared to the general population. Internationally, diversion schemes have developed to identify people with mental health needs and improve the access (remand) they have to mental healthcare[344]. Political authorities in Ireland too have recognised the need for a service that improved the rights of prisoners. In *A Vision for Change*[345], a government document providing a blueprint for future mental health service provision in Ireland, it was stated that anyone with serious mental health problems who comes into contact with the forensic system should be afforded non-forensic mental healthcare, unless cogent and legal reasons prevent this.

In 2006, recommendations were made for services that could integrate community and forensic mental health services together, and fall under the remit of both health and justice. In response to the high rates of psychiatric illness among remand prisoners, the forensic mental health service established the PICLS project in Dublin. This prison was selected as it has a high turnover of prisoners; for example, in 2008 there were 3,685 committals to Cloverhill, and because it is the main remand prison in Ireland.

The PICLS project was driven by two needs: to implement a standardised system of identification of persons with or mental illnesses remanded to Cloverhill and to implement systems to enable diversion to appropriate health care settings.

12.3.13 Evaluation: Has the practice been evaluated?

A study published in the International Journal of Mental Health Systems in 2013 (McIrney *et al.*) describes the implementation of the PICLS model over the first six years (2006–2011). Using the method of participatory action research, the authors aim to understand the effects on Ireland's major remand prison. In addition, the prison annual reports and inspection reports also produce a number of summary outputs and outcomes[346].

At an earlier stage of the project, information was also gathered on psychiatric activity at Cloverhill Prison from 2005, 2006 and 2007, representing the year before the introduction of the service, the period of transition while the service was set up, and the period of full functioning of the service respectively[347].

12.3.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Outputs and outcomes

The mental health Prison in-reach and Court Liaison Service, based in Cloverhill prison, has been a success with: improved identification of mental illness; increased appropriate mental health diversions; and a reduction in the waiting time of the provision of treatment after identification of need.[348]

During the first few years of the service (2006/07), there were already clear signs of the effectiveness of the service[349]. As per its main goal, PICLS has led to an increased

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[344] O'Neill, 2006
[345] Department of Health and Children, 2006.
[346] As shown here: http://www.mhcirl.ie/File/IRs/CloverhillPrisonServiceIR_2009.pdf
[347] McInery and O'Neill, 2008
[348] O'Neill, 2006
[349] McInery and O'Neill, 2008: pg. 154

detection of serious mental illness in Cloverhill Prison, and appropriately assessed and referred them on to treatment. In this case:

- The introduction of the service in January 2007 led to an overall increase in the number of prisoners being assessed, from 326 in 2006, to 388 in 2007.
- Reflecting on the aim of the service, to transfer mentally ill patients away from the criminal justice system and into psychiatric care, the number of people identified with active psychotic symptoms increased from 74 in 2006 to 95 in 2007, approaching the expected rate in the prison.

Furthermore, during the same study period, there was also a clear increase in appropriate mental health diversions[350]. In this instance:

- The number of individuals afforded treatment in non-forensic mental health settings grew considerably from 19 in 2005, to 44 in 2006 and 72 in 2008. Linked to this was a reduction in time individuals who went on to receive treatment in local psychiatric services spent in custody.
- The main impact of the service was the reduction in non-essential admissions to the Central Mental Hospital as individuals, who did not require conditions of special security, were given alternative forms of care. In 2005, 77% of all patients transferred from Cloverhill Prison to the Central Mental Hospital were not actually identified as needing high secure or medium secure psychiatric treatment, but this reduced to 28% by 2007.

The time between identifying an individual with a psychiatric illness and getting them the treatment they required decreased in the first two years of the project[351]. For example:

- The median time from referral to assessment by the PICLS team was two days, with 80% of prisoners assessed within seven days in 2008.

Evidence from a later study, covering six years of the project (2006 – 2011), highlights that since its inception in Cloverhill prison in 2006, PICLS has grown in size and experience[352].

- A total of 572 prisoners with severe mental illness were diverted from prison to mental health services over the six year period observed.
- These were delivered to varying levels of care: 89 to a secure forensic hospital; 164 to community mental health hospitals; 319 to other community mental health services, which demonstrates the improved assessment of risk and need.
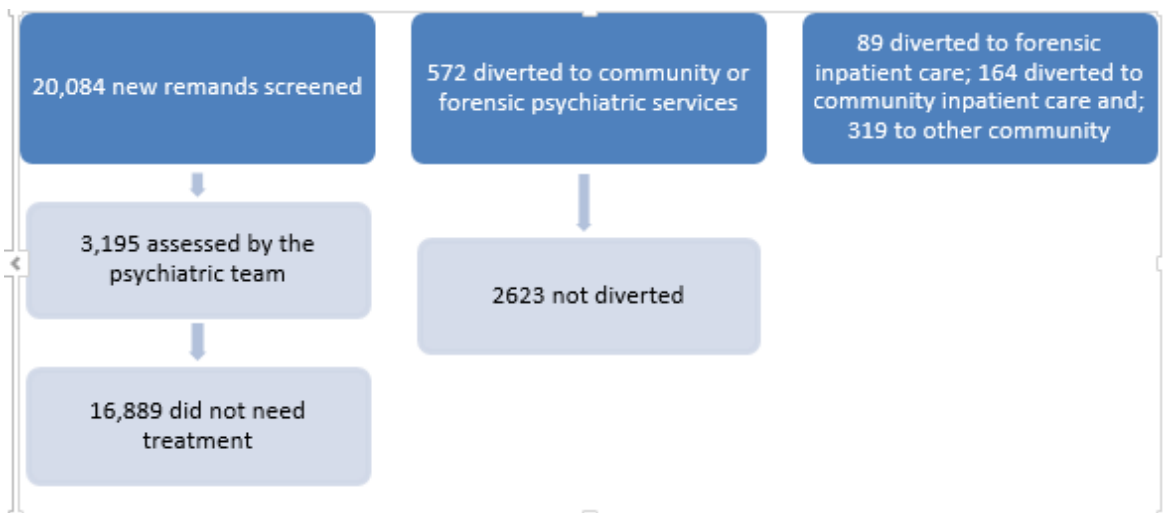
Additional outcomes from this period are shown in Figure 6.

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[350] Ibid.
[351] Report of the Inspector of Mental Health Services, 2009: pg. 2
[352] McInery *et al.,* 2013

Figure 3. Outcomes of the diversion process at Cloverhill Prison (adapted from McInerney et al. 2013)

12.3.15   Success factors

The following success factors were identified:

- **Interagency working:** The PICLS model is reliant on clear and open communication as the service team needs to liaise daily with prison staff; have weekly meetings with prison medical and police staff; review care planning for vulnerable prisoners with other keyworkers; receive and manage referrals from a wide range of services; and, inform the drug court of any risks or issues.
- **Preparation:** One of the key roles of the in-reach team is to prepare a report on each prisoner under their care for their next remand court hearing. Each member of the team was involved in the preparation of the reports, under the supervision of the consultant. These reports were of vital importance to the courts in making their decision regarding the placement of the prisoners[353].

12.3.16   Innovative features

One of the key initiatives of the in-reach team had been to make provision for the diversion of appropriate remand prisoners to their community mental health team (CMHT) in instances where the offence was judged to be of a minor category. In 2015, the diversion system resulted in only 11 admissions to the Central Mental Hospital, and up to 150 persons diverted from custody in prison to other mental health services[354].

12.3.17   Obstacles and lessons learnt

There are two obstacles associated with this project, detailed below.

The first is to do with the location of the scheme. The necessity of locating the service in Cloverhill Prison, which means that an opportunity to divert individuals to hospital is missed before they enter prison. Further, individuals remanded to other prisons nationally can be assessed on request, but the specialised screening is only carried out in Cloverhill prison, and so they must be transferred for this.

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[353] Ibid.

[354]

http://oireachtasdebates.oireachtas.ie/debates%20authoring/debateswebpack.nsf/takes/dail2016053100054

Secondly, another obstacle is to do with the handling of individuals requiring treatment, as many will lack insight into their illness, have a history of poor compliance with treatment or fail to cooperate with PICLS staff. This can have serious consequences as non-adherence to treatment is a significant factor in recidivism risk for people with psychotic disorders. Legal leverage may help with resolving this issue.

12.3.18 Potential for transferability and sustainability

The success of Cloverhill implies that the model is transferable to other prisons, if funding and resources are available to deliver the services. Indeed, PICLS has been sustained at Cloverhill prison[355], and provision has continued to be led by the Central Mental Hospital Dundrum. The team attends Cloverhill 5 days a week, provide a comprehensive service dealing with day to day referrals and committals and diversions and transfer to outpatient services. In 2015[356], inmates were even transferred from other prisons for review and assessment by the in reach team.

It is unclear whether a similar service is planned in other Irish prisons. Extra psychiatric staff have now been hired for other prisons but it is clear that as a referral system exists from other remand centres, there is a need to expand this service to cover remands nationally[357]. This would enable the widest possible use of diversion to community and/or non-forensic mental health service, and would therefore be the most effective system.

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[356] Ibid.
[357] McInery *et al.*, 2013

http://www.mhcirl.ie/File/IRs/CloverhillPrisonServiceIR_2009.pdf   [Accessed   26 September 2016]

12.4 Case study 27: Health Education for Social Prosperity

Name of practice: Health Education for Social Prosperity

Country: Bulgaria

12.4.1 Main objective and specific aims

The main objective of the project is to reduce drug-related harm in prisons and prevent drug use. It has three specific objectives:

- To build the professional capacity of prison and NGO staff working with inmates who are at risk of drug use;
- To reduce the vulnerability to health risks of prison inmates using drugs;
- Improve co-operation between the prison service and civil society in working with inmates at risk of drug use.

12.4.2 Relevance for 3rd EU-Health Programme objectives

- This programme is relevant to objective one of the 3rd EU Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, in that it supports prisoners to make their lifestyles healthier.

12.4.3 Target groups

The target group of this programme was prisoners. The activities were targeted at three of the most vulnerable groups of prisoners in Bulgaria; drug users, underage inmates and Roma inmates.

12.4.4 Thematic focus of intervention in relation to reducing health inequalities

Prison inmates tend to have lower educational status, lack of a supportive social environment, low awareness of health issues. These factors are also associated with low health literacy and increase the likelihood that the individual will take health risks[358].The project was designed to redress the lack of knowledge of health risks among prisoners and teach them harm reduction techniques related to drug use.

The project also trains prison staff to help bring inmates away from drugs and teaches them harm reduction techniques to share with the prisoners. This works to improve the health of prisoners by helping more of the prison population to avoid or cease using drugs and by improving the prison staff's overall knowledge of health prison health issues.

12.4.5 Key activities

The project took place in three prisons in Bulgaria and consists of two stages:

- Prison staff and NGO teams participated in four training modules over four days:

  - Motivational interviewing (a method of counselling to help individuals find motivation to seek treatment);
  - Treatment and prevention of drug use in prisons;
  - Brief interventions in cases of drug use or suspected drug use; and
  - Reduction of the harms of drug use.

- The trained prison staff and NGO members deliver health training to groups of inmates in their prison. The trainings take place in small groups of around 10

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[358] Здравно обучение за социален просперитет "health Education for Social Prosperity" (2015) *Project Summary: English* [Online] Available at: http://www.healthyprisons.info/en/ [Accessed 21 Sept. 2016]

inmates over a period of eight months, with each group receiving at least three sessions. Training workshops with prisoners were centred on harm reduction themes: "Drugs, safer use and overdose", "TB and sexually transmitted infections" and "HIV and hepatitis". The prison staff also implement the techniques of brief intervention and motivational interviewing in the daily work with inmates. A brief intervention helps the individual to identify current issues with substance misuse and motivational interviewing is a non-combative counselling technique which seeks to help the individual find motivation to change their behaviour.

The intervention was performed in prisons by the trained staff from each locality and they were supported by the expert team made up of representatives of the Bulgarian Initiative for Health Foundation and the Norwegian Tyrili Foundation. This support was provided in the form of follow up visits and remotely via email and phone.

12.4.6 Geographical scope

The project takes place in three prisons across Bulgaria: the prison in the town of Pleven, the Prison in the town of Plovdiv and the Correctional Facility in the town of Boychinovtsi.

12.4.7 Intersectoral dimension

This programme cuts across two policy areas: health and criminal justice. The harm reduction techniques are specific to the health risks faced by prisoners, especially vulnerable prisoners at risk of using drugs. The programme has a preventative element which is a criminal justice issue as keeping inmates away from drugs or helping them to stop using them means they are more likely to leave prison rehabilitated and not addicted to drugs.

12.4.8 Duration

The project was a single intervention which ran for 14 months ending in April 2016.

12.4.9 Lead organisation

The project was led by Initiative for Health[359] – a Bulgarian NGO foundation which promotes harm reduction approaches for drug users in Bulgaria and prevention of HIV among intravenous drug users.

12.4.10 Partners

Initiative for Health was supported by the Norwegian organisation Tyrili[360] who were represented on the expert team that provided training to the prison staff and NGOs. Tyril has extensive experience of working with drug users in closed communities.

The project worked with prison staff and local NGOS in each of three localities.

12.4.11 Main sources of funding

The project was mostly funded by the Norwegian Financial Mechanism 2009-2014. It was a project in the "Correctional services including non-custodial sanctions" programme under the Justice and Home Affairs priority sector. The total costs of the project was € 97,166 and Norway grants provided €74,332, with the remainder co-funded by other sources.

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[359] Initiative for health (2016) "*Инициатива за здраве" намалява рисковете за здравето на най-уязвимите членове на общество*т [Online] Available at: http://www.initiativeforhealth.org/ [Accessed 21 Sept. 2016]
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12.4.12 Evidence base for implementation

The lead organisation, Initiative for Health, began conducting health training for inmates in prisons in Sofia, Bulgaria in 2005. These sessions focused on reducing the risks of drug use and how to take more care of the prisoner's general health. This strand of activity grew over five years and is to be one of the major activities of the organisation. In the years between 2005 and 2010 they trained around 400 prisoners. The Health Education for Prosperity project was designed to replicate Initiative for Health's action in Sofia across the country. The interest from other prisons came as a result of the positive reputation of the Sofia project[361].

Roma prisoners were particularly targeted for the intervention as the Initiative for Health outreach work in Sofia found that 70% of drug users were Roma[362].

12.4.13 Evaluation: Has the practice been evaluated?

The project was evaluated in 2016 using Kirkpatrick's Four-Level Training Evaluation Model. The evaluation looked at the training of the prison staff, and the prison staff's application of what they learnt in the trainings.

12.4.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness[363]

The staff training was attended by 27 members of the penitentiary system and 9 experts from NGOs. Over a period of eight months the professionals conducted 35 educational groups with prison inmates: 15 groups in Pleven, 15 groups in Plovdiv and 5 groups in Boychinovtsi. The groups each did three sessions covering: "Drugs, safer use and overdose", "TB and sexually transmitted infections" and "HIV and hepatitis". The overall number of educated inmates was 352.

Generally, the evaluation of the project was positive, finding that the trainings were a successful way to transfer knowledge to prison staff. It also showed some early findings of changes in attitudes of inmates and some evidence of behaviour change. Additionally, the project had a positive effect on establishing a stronger relationship between NGOs and prison staff.

12.4.15 Effectiveness of training on prison inmates[364]

The evaluation of the effectiveness of the training for prison inmates is based on entry and outcome information level tests and in-depth interviews with inmates and staff which assessed the usefulness of the information provided in the trainings. Interviews were conducted with prisoners to evaluate the trainings; 14 in Pleven, 14 in Plovdiv and 5 in Boychinovtsi. A professional was also interviewed from each location.

Positive results were found in each location during the inmate interviews. In Pleven respondents reported that they were previously unaware of the risk of contracting a blood disease via tattooing but were now going to end this practice as a result of the training. In Plovdiv six of the 14 respondents stated that the training changed their attitudes and five had discussed the training with others. One inmate had even

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[361] Здравно обучение за социален просперитет "health Education for Social Prosperity" (2015)

[362] EEA Grants (2015) *Health Education for Social Prosperity* http://eeagrants.org/project-portal/project/BG15-0016

[363] All data from Rusev, A., Genchev, E., Nesheva, E., Rainov, I. and Georgieva, Y. (2016). *Evaluation report on the results of the project "Health Education for Social Prosperity"*. [pdf] Iniitative for Health. Available at: http://www.initiativeforhealth.org/wp-content/uploads/2016/04/Evaluation-report-en.pdf [Accessed 21 Sep. 2016]

[364] All data from Rusev, A., Genchev, E., Nesheva, E., Rainov, I. and Georgieva, Y. (2016)

organised his own hepatitis C training, demonstrating the capacity for knowledge to spread through the prison.

In Boychinovtsi juvenile prison the piece of information which stuck with the inmates the most was the need to use condoms during sex with many saying they had never used a condom before. During the interviews the respondents stated that they had discussed the trainings further with other inmates.

The head of the unit "Social work and educational activities" at Pleven stated that he found a change in behaviour and attitudes among a part of the inmates after the training. They now wanted to pass a screening for blood test. In Plovdiv this counterpart reported that interest in the trainings had been high among the inmates and that after the first training information "was flying over the corridors"[365]. A staff member at Boychinovtsi reported that the trainings were playing a positive role in changing the attitudes of the inmates who were now thinking more about the topics and asking further questions. He also believed that the trainings had made the inmates consider their drug use more carefully.

Some of the prisoners stated that they were motivated to attend the trainings by the opportunity to meet people outside the prison whereas others stated that they went because they were obliged to and had taken nothing of the training in. The prisoners stressed that the trainings should be better targeted at prisoners who were illiterate by using more visual materials.

Between the entry and outcome tests there was an overall percentage point increase of 8 percentage points. This corresponds to a total of 1163 right answers out of a possible 2100 at the entry tests stage and 1334 at the outcome test stage. The test was completed by all 349 participants and the analysis is based on a sample of 30% of the completed entry and outcome tests completed by the prisoners.

Levels of knowledge at the entry stages were reflected in how interesting the participants found the topics when they rated them. This seen in that "Drug use and overdoses" had the highest information scores on entry followed by "Sexually transmitted infections" and then "HIV and Hepatitis".

The "HIV and Hepatitis" training showed the greatest level of information increase in the prisoners, who were particularly interested to learn about the dangers of contracting HIV in tattooing and by sharing shaving equipment. The next highest increase was in the "Sexually transmitted infections" training of 9 percentage points.

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[365] Rusev, A., Genchev, E., Nesheva, E., Rainov, I. and Georgieva, Y. (2016) pg.16

Figure 4.   Information levels of prisoners before and after trainings
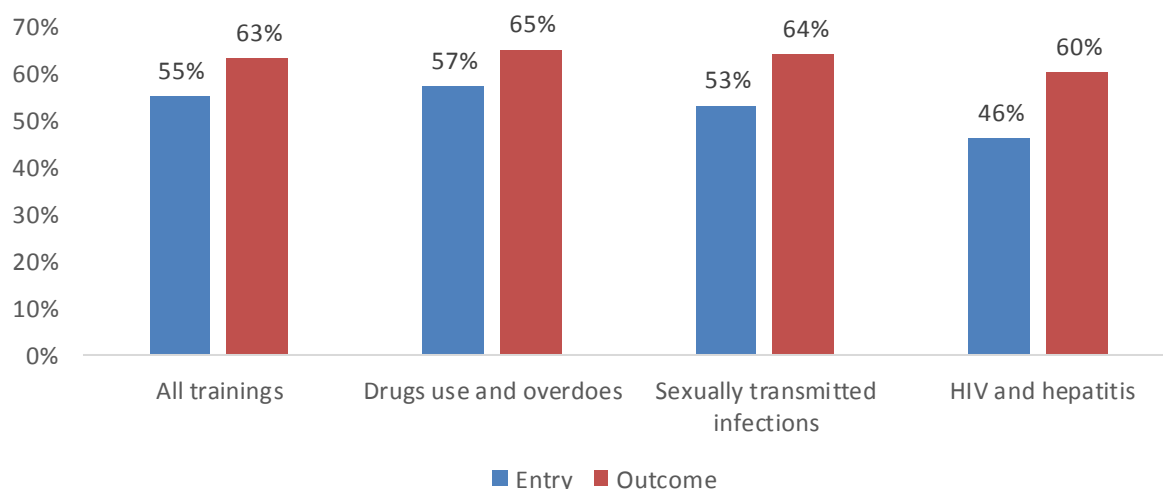
These three trainings successfully demonstrated an increase in information levels among the inmates afterwards. However, the section on Tuberculosis that was also run showed no improvement in the information levels of inmates. The evaluation suggests that this was because the training was provided in a manner that was complicated and confusing. The information levels of participants before and after the Tuberculosis training was not provided in the evaluation.

12.4.16   Evaluation of the staff training[366]

Overall, the evaluation of the training found that those who attended found it useful, satisfactory and that majority were able to apply what they had learnt into their practice. The training of the prison staff was evaluated by a satisfaction inquiry and a questionnaire which assed the practical knowledge gained from the trainings as well as providing additional space for comments. Of the 36 participants in the training, 30 provided completed evaluation surveys.

Two training participants from the Plovdiv prison stated that the training had radically changed their attitude to treating inmates with drug abuse issues and that this had made them more effective in their role. In the Correctional facility of Boychinovtsi the training participants found that the training helped them to be more effective in their work with juveniles. Participants from the Pleven institute reported that they would continue to do group work on harm reduction after the project period had ended.

There was a high level of satisfaction with the trainings. From a scale of 5 the overall satisfaction with the training modules was between 3.7 and 4.3. The training modules received the highest satisfaction scores in Boychinvtsi, followed by Pleven then Plovdiv. Participants gave the highest satisfaction score to module four which looked at harm reduction for drug users, then module two which covered brief interventions, module two covering treatment. The lowest satisfaction scores were for the first module which covered motivational interviewing.

The questionnaire also examined the extent to which participants had applied what they had learnt in the trainings. Two fifths of survey respondents (41%) found that they used over half of what they were taught in the training module in their everyday work lives that day with only 3% stating that they had not used any of the material covered in the trainings that day as shown in Figure 2.

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[366] All data from Rusev, A., Genchev, E., Nesheva, E., Rainov, I. and Georgieva, Y. (2016)

Figure 5. If you consider the overall training, what percentage of the discussed topics, methods and instruments do you use in your work today?

0%   1%-25%   26%-50%   51%-75%   76%-100%
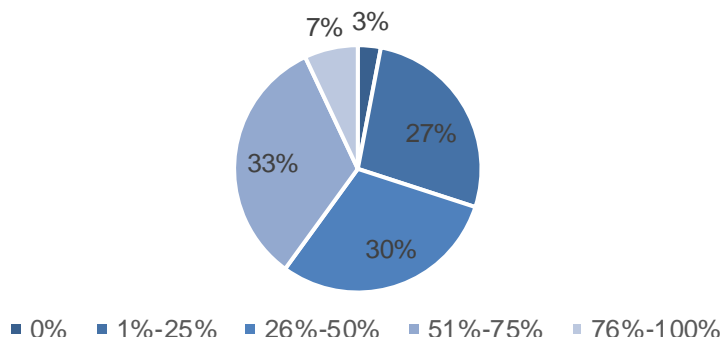
Source: Initiative for Health survey of prison staff training attendees; n=30

Nearly half (47%) of the prison staff stated that they found out something new in the training which they had used in practice with valuable results. However, over a quarter (27%) reported that whilst they had learnt something new and put it into practice it had not yielded valuable results and a further quarter (23%) stated that they had not yet had a chance to put what they had learnt into practice.

Figure 6. Which of the five statements below corresponds most precisely to your experience after the participation in the training?
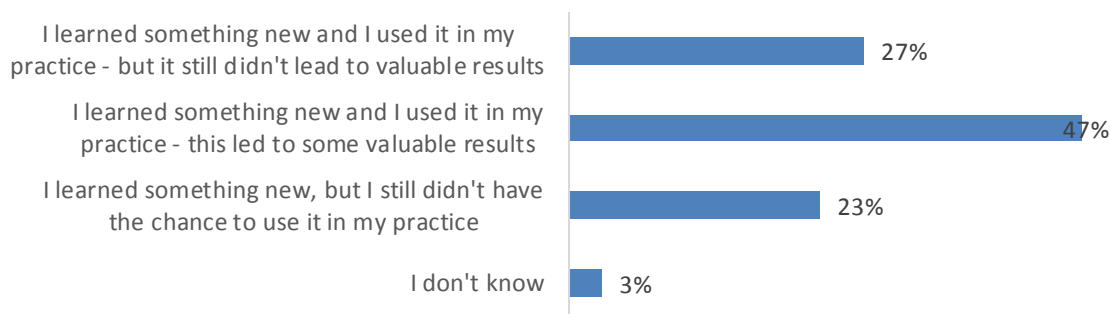
Source: Initiative for Health survey of prison staff training attendees; n=30

Just under two thirds (62%) of staff attending the trainings felt that it improved their results and performance whilst over half (54%) found that the trainings provided inspiration and energy for future development. Less training attendees found that they acquired new/better instruments and methods so this would be the area to focus on, still, 18% of attendees did feel the training had this effect.

Figure 7. Which specific effect/s had the greatest significance for you in regard to the training?

Source: Initiative for Health survey of prison staff training attendees; n=30

Overall, the results suggest that the majority of the training attendees were able to utilise the information which they learnt in the trainings and that in most of these cases it had yielded positive results.

12.4.17 Success factors

The evaluation of the prison staff training showed that the participants felt the trainings were successful for five key reasons: "*1) Professionalism of trainers in all four modules; 2) Information transferred in accessible way; 3) Gaining new working methods, making them more effective; 4) Complex and systematised working approach; 5) Acquiring new information, relevant for their everyday work*".[367]

For the inmate trainings element of success were the high motivation of the NGO representatives which in turn motivated the inmates and interactive teaching methods. Additionally, in Plovdiv the trainers were known to the inmates already through outreach work which helped the training to run well.

The head of unit "Social work and educational activities" at Plovdiv also thought that the trainings succeeded because of the opportunity for inmates to communicate and was also facilitated by the coffee breaks, a gesture which the prisoners highly appreciated as usually providing such drinks is not possible due to budget constraints.

12.4.18 Innovative features

This programme was innovative given that it was aimed at providing inmates with health information for them to make their own decision rather than enforcing a stricter drugs policy. It was also innovative in that it demonstrates a positive example of work between the prison service and NGOs.

These sessions targeted at prisoners were the most extensive training on health issues that had yet been completed in the three settings. This was the first time such an extensive training had been provided at Plovdiv, and the only training that staff at Boychinovtsi had received on the topic. At Pleven they had some experience of a 12-step programme and sessions run by "mothers against drugs".

An objective of the project was to build better relationships between the prison and NGO's. Some prison staff were initially sceptical of working with NGOs having had bad experiences in the past. However, the results of the project were generally positive demonstrating an effective example of NGO and prison staff working together in

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[367] Rusev, A et al (2016) pg. 10

Bulgaria and good working relationships were built. This demonstrates a well-built partnership which helped support the programme's success.

12.4.19 Obstacles and lessons learnt

One obstacle identified during the programme was financial stability. A number of the skills learnt in the trainings may be lost due to budget constraints with the Bulgarian penitentiary system. Two individuals who had passed all of the training modules lost their positons over the course of the project due to funding cuts. Overall, there was a feeling of unease within the system and staff were not sure how they could continue the work given the overall climate of uncertainty. Prison staff were experiencing an overload of duties and responsibilities which can make them unreceptive to new programmes.

Some prison staff are still not convinced of harm reduction in terms of drug use despite viewing the programme as a success. They were concerned that information about psychoactive substances or needle exchange programmes may actually promote more drug use. This attitude may hinder the expansion of such programmes in Bulgaria.

The evaluation found that some of the training courses provided for inmates were not appropriate for the audience because they were difficult to understand and did not make use of enough visual material. Most of the inmates are illiterate with little experience of learning, this is especially likely to be true of inmates in more vulnerable groups such as Roma. Presentations that made greater use of clips, games and simple presentations would have a better impact on the inmate's health as they would engage with the training more.

12.4.20 Potential for transferability and sustainability

The prisons professionals were highly engaged in the project and wished to carry it on. In Plovdiv, Pleven and Boychinovtsi professionals have continued to provide education to inmates in co-ordination with the NGO since the project finished.

However, the evaluation found that the project based approach was inappropriate as the prison professionals would need ongoing training to maintain their skills and also to train further inmates. Additionally, staff turnover in the section was/is high. Two prison staff who had been trained by the programme have subsequently lost their job due to budget cuts. Prison staff feel that without long term commitment it is impossible to achieve a lasting and significant change in the prisoners' behaviour.

This model of training could be transferred to other prison systems in Bulgaria or other European countries; bearing in mind the different structure and funding of prison systems. Nevertheless the concept of training prisoners (and certain vulnerable sub-groups) on specific aspects of health can improve, on the one hand, health literacy, and on the other their health itself, as demonstrated by this programme.

12.4.21 List of references

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13 Survivors of domestic violence and intimate partner violence

There are four practices that aim to improve the health of victims of domestic violence, including intimate partner violence. A summary table of these practices is given below, which outlines the title, main aim and objective, country and geographical coverage of each.

Table 17. Practices targeting victims of domestic violence, including intimate partner violence

	Title	Main aim and objective	Country	Coverage	Quality score
28	Multi-agency risk assessment conferences (MARACs), United Kingdom 2003–14	Meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse to identify and risk assess cases of domestic abuse.	UK	National	22
29	Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen - MIGG), Germany 2008–11	The programme aims at developing unified standards for the treatment of women victims of violence and improving the ambulatory health treatment of women suffering violence. This was done by carrying out intense exchange with universities and healthcare units; offering doctors support in documenting injuries for use in a court of law; giving specialist advice and information to patients.	Germany	Regional	20
30	Care for Maternity At Risk Programme	The programme aims to promote good maternal and reproductive health among vulnerable women and young people, by offering care and guidance for victims of intimate partner violence. Also helps to detect intimate partner violence among women attending the centres other programmes.	Spain	Local	20
31	Training Curriculum: 'Violence against women and children' - Victim protection in Vienna's hospitals Austria, 2001–14	The programme aims at enhancing the sensitivity of health professionals in dealing with victims of domestic violence, by ensuring adequate support to victims and creating awareness and effective responses among providers in the main hospitals in Vienna.	Austria	Regional	19

The two practices from Austria and Germany aim to sensitise healthcare professionals to identify and support victims of domestic/intimate partner violence more effectively. A related practice (MARACs) aims to take a more holistic approach to supporting victims, by bringing together professionals from healthcare, social care and the third sector to identify and risk assess cases of domestic abuse. The final practice from Spain supports two target groups – victims of domestic/intimate partner violence primarily, but also at-risk children and families. Specifically, the lead organisation, the Health and Family Association, offers care and guidance to victims of intimate partner violence, as well as helping to detect intimate partner violence among women attending its centres for other programmes, such as the Maternity Risk programme.

The full case studies are given below.

13.1 Case study 28: Multi-agency risk assessment conferences (MARACs), United Kingdom 2003-14

Name of practice: Multi-agency risk assessment conferences (MARACs)

Country: United Kingdom (UK)

13.1.1 Main objective and specific aims

The main objective of this intervention is to organise meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse to identify and risk assess cases of domestic abuse. The purpose of such meetings is to:

- Share information to increase the safety, health and well-being of victims and their children
- Determine whether the perpetrator poses a significant risk to any particular individual or the general community
- Construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve the accountability of agencies involved with domestic abuse
- Improve support for staff involved in high risk domestic violence cases.

13.1.2 Relevance for 3rd EU Health Programme objectives

The intervention contributes to objective three and four of the EU health programme 2014-2020:

- Contribute to innovative, efficient and sustainable health systems.
- Facilitate access to better and safer healthcare for Union citizens.

13.1.3 Target groups

The target groups for the intervention are victims of domestic violence and intimate partner violence and their children.

13.1.4 Thematic focus of intervention in relation to reducing health inequalities

The intervention focuses on both improving access to healthcare services for victims of domestic violence and tackling inequalities in health status. It removes victims from dangerous situations and ensures they are able to access the treatment that they need and which they may not have otherwise been able to receive. This is an approach to supporting victims of domestic abuse in an integrated way as it recognises that dealing with the health care issues of this group requires a broad understanding of all aspects of domestic violence.

13.1.5 Key activities

MARACs adopt a partnership approach, bringing statutory and voluntary agencies concerned with domestic abuse together around the same table, to discuss the cases of individual high-risk victims, and formulate co-ordinated action plans for each of them. They operate as one element of a wider infrastructure which includes Specialist Domestic Violence Courts (SDVCs) and Independent Domestic Violence Advisers (IDVAs). The agencies that attend MARACs vary but include the police, probation service, IDVAs, children's, health and housing services as well as a range of other adult and child-focused services. Any agency may refer a case to a MARAC, based on its assessment of risk.

Referrals to a MARAC are made in the following cases:

- Those that reach a threshold level of risk, determined through the use of a standard risk assessment tool.

- Those where there is serious concern about the victim's situation based on the professional judgement of the referrer.
- Those where there is evidence of escalation of abuse (i.e. a specified number of police call-outs in a certain time period).
- Those where there are repeat incidents within 12 months of the first referral.

A typical MARAC meeting lasts half a day and discusses 15 to 20 cases using a very brief and focused information-sharing process. Meetings are followed by a simple multi-agency action plan to support the victim and to make links with other public protection procedures, in particular safeguarding children, vulnerable adults, and managing perpetrators.

By working together, agencies are able to get a better picture of the risks victims face, including the frequency and severity of abuse. This enables them to develop an action plan to increase the safety of each victim and their children. It also gives victims the confidence that a number of different agencies are aware of the abuse and will offer support and protection, whilst at the same time providing access to a wide range of health and social services in a coherent and integrated manner.

13.1.6 Geographical scope

This programme operates at national level across the UK. In total there are over 280 MARACs spread across localities in the UK, mainly operating independently of one another.

13.1.7 Intersectoral dimension

The intervention is primarily concerned with the health and wellbeing of victims of domestic violence. However, because the intervention seeks to involve multiple agencies involved with several different aspects of domestic abuse, the scheme overlaps with other policy areas including criminal prosecution, children services and the housing situation of domestic violence victims and their families.

13.1.8 Duration

The first MARAC was held in April 2003 in Cardiff, South Wales. The intervention has since expanded across the UK and continues to operate today.

13.1.9 Lead organisation

The intervention comes under the jurisdiction of the Home Office, the UK's government department responsible for immigration, counter-terrorism, police, drugs policy and related science and research. However, the lead organisation responsible for the intervention is national charity SafeLives (previously CAADA) who are dedicated to ending domestic abuse and supporting victims of domestic abuse. At the local level, each MARAC is independently lead, usually by local police services and other local bodies involved with issues related to domestic violence.

13.1.10 Partners

The intervention is dependent upon a 'partnership approach' between numerous different bodies and agencies, which vary across the UK. Typical partners include the police, probation service, IDVAs, children's services, housing services and health services, as well as a range of relevant adult and child-focused services and organisations.

13.1.11 Main sources of funding

Since 2008, the Home Office has provided MARACs with funding for administrator/co-ordinator posts, training and quality assurance. In the financial year 2014/15, it

provided funding of £3.3 million[368]. SafeLives, the organisation that runs the intervention, is a state supported charitable organisation.

13.1.12   Evaluation: Has the practice been evaluated?

The practice has been evaluated three times. The first and second evaluations are from 2004[369] and 2005[370] respectively, and evaluate the scheme in Wales after its initial introduction in 2003. The third evaluation is from 2011, and was completed on behalf of the Home Office. It provides a broad review of MARACs across England and Wales, looking at cost effectiveness, how the MARAC model operates, variation in practice and potential areas for future development[371].

13.1.13   Evidence base for implementation

In December 2002 the South Wales Police piloted a Victim Initial Risk Indicator Form (VIRIF) for responding officers to complete at the scene of domestic violence incidents. The risk instrument, developed jointly with the Domestic Violence Prevention Service of the NSPCC, emerged from an evidence based review of 47 domestic homicides, relevant research, and communication with other community and criminal justice agencies, that indicated the potential benefits of a more joined up and systematic response by agencies involved with various aspects of domestic abuse. The aim of the risk indicator form is to identify serious cases of domestic violence that can be addressed through Multi-Agency Risk Assessment Conferences (MARAC)[372]. The MARAC model was subsequently developed in Cardiff in 2003, in response to the lack of systematic risk assessment among agencies responding to domestic violence and the need for a forum for local agencies to share information about victims experiencing extremely serious levels of abuse (Robinson & Tredigda, 2005)[373].

13.1.14   Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Evaluations of the Cardiff MARACs published in 2004[374] and 2005[375] generally showed positive results. Similar multi-agency models of intervention for very high-risk victims have proliferated since, and can now be found throughout the UK. The Robinson studies indicate that MARACs can improve victim safety by enabling agencies to assist victims more efficiently, primarily through enhanced information sharing. An examination of rates of re-victimisation for cases heard at the Cardiff MARAC, found that approximately six in ten victims reported a complete cessation of abuse in the six months following a MARAC, and approximately four in ten victims remained abuse free after 12 months, thereby leading to a reduction in the number of injuries and medical issues sustained as a result of abuse. In addition, the agencies involved in the MARAC perceived the process as helping to improve awareness and to strengthen the links

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[370] Robinson, A., Tregidga, J. (2005) Domestic Violence MARACs for Very High-Risk Victims in Cardiff, Wales: Views from the Victims, Cardiff University.

[371] Steel, N., Blakeborough, L., and Nicholas, S. (2011) Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). Home Office

[372] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

[373] Robinson, A., Tregidga, J. (2005) Domestic Violence MARACs for Very High-Risk Victims in Cardiff, Wales: Views from the Victims, Cardiff University.

[374] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

[375] Robinson, A., Tregidga, J. (2005) Domestic Violence MARACs for Very High-Risk Victims in Cardiff, Wales: Views from the Victims, Cardiff University.

between key agencies, particularly with regard to more joined up responses to dealing with psychological and physiological health issues and making sure victims have access to the medical support that they need (Robinson, 2004; Robinson & Tregidga, 2005)[376][377]. Whilst these two studies were subject to limitations, the findings suggest that MARACs may have a positive impact and an analysis of administrative data from MARACs carried out by CAADA lends support to these findings. CAADA's analysis suggested that mature MARACs – and an IDVA – can achieve up to a 60 per cent reduction in violence, even to 43 per cent if adjusted to account for serial perpetrators and cases where the abuse would have stopped regardless of the MARAC intervention (CAADA, 2010)[378]. The findings from practitioners and interest groups surveyed/interviewed as part of the Steel et al. (2011)[379] review also show that MARACs are perceived to be effective – the vast majority of respondents to the national survey (97%) reported that, in their opinion, the MARAC they attend is either 'very effective' or 'fairly effective' at improving the safety, health and wellbeing for victims of domestic violence in their area. Whilst the survey was targeted at IDVAs, MARAC Chairs and DV/MARAC coordinators, and therefore cannot be considered representative of all agencies involved in MARAC, similar responses were found among NMSG members and case study interviewees, which incorporated representatives from a wider range of agencies.

Whilst the current evidence base for MARACs highlights the potential for positive safety, health and wellbeing outcomes, it is limited due to the lack of an existing evaluation including a control group. Estimations of the cost-effectiveness of MARACs are therefore weakened by the lack of availability of strong evidence particularly in relation to:

- The level of abuse experienced by individual's pre-intervention (pre-MARAC).
- The degree to which the abuse experienced would change over time regardless of any intervention (the counterfactual).
- The reduction in abuse caused by the intervention itself.

In addition, stronger evidence in relation to the potential for any displacement effect (i.e. perpetrators who go on to abuse a different victim) would be needed for a fully valid estimate of cost-effectiveness to be made. However, despite the evidence in these areas being limited, some estimations of the cost effectiveness of MARACs have been completed based on the research available. For example, CAADA (2010)[380] carried out an analysis which suggests that for every one pound spent on MARACs, at least six pounds of public money could be saved annually on direct costs of domestic abuse to agencies such as the police and health services. Acknowledging the uncertainty of the evidence base, the analysis applies a reasonably conservative estimate of the reduction in re-victimisation and includes cashable benefits only. It also assumes that MARACs' impact lasts for three years. Home Office analysts, using the CAADA analysis as a base, carried out additional analysis to see how sensitive the overall result is to changes in these estimates and assumptions. This similarly revealed that, even using the most negative assumptions, MARACs are still likely to be

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[376] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation
[377] Robinson, A., Tregidga, J. (2005) Domestic Violence MARACs for Very High-Risk Victims in Cardiff, Wales: Views from the Victims, Cardiff University.
[378] CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.
[379] Steel, N., Blakeborough, L., and Nicholas, S. (2011) Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). Home Office
[380] CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.

cost-effective and, under most scenarios, the return on investment is likely to be at least as big as that suggested by CAADA[381].

13.1.15   Success factors

Analysis by Steel et al. (2011)[382] suggests three main features of the MARAC process that are seen as contributing to its success – enhanced information sharing, appropriate representation of relevant agencies, and the role of the IDVA- discussed below.

Agencies often have access to different information related to a case and sharing this information in a co-ordinated way can create a fuller account of the facts and circumstances of each client's situation. This enables more comprehensive risk identification and better informed decision-making regarding a victim's domestic situation, individual health and their wellbeing, which in turn can help authorities to be more effective in their decision making, leading to improved health and safety of domestic abuse victims.

MARACs provide a forum for information sharing and the evaluation of the first MARAC in Cardiff indicated that this enhanced information sharing process was a key contributing factor to the observed reduction in repeat victimisation (Robinson, 2004)[383]. Complementing these findings, 84 per cent of respondents to the national survey reported that, in their opinion, their MARAC was very effective at enhancing information sharing.

Appropriate representation of the relevant statutory agencies, specialist domestic violence services, health services and voluntary and community organisations is another important feature of an effective MARAC as each agency will typically bring specific information which contributes to an effective information sharing process. In addition, each agency will be able to offer different types of support/intervention for a case as well as different knowledge and expertise around the options that may be available to victims and their families supporting the action/safety planning and healthcare provision processes. Best practice guidance (CAADA, 2010)[384] suggests that, as a minimum, there are six core agencies which should consistently attend MARACs, namely; police, probation, IDVAs, housing, children services and health services.

Findings from the national survey and both the NMSG and case study interviews suggest that there is broad agreement that these are the core agencies whose representation is needed for an effective MARAC that will have positive safety, health and wellbeing outcomes. Whilst having the right mix of agencies around the table was seen as key, it was also emphasised that for MARACs to work effectively agency representatives must do more than just attend the meetings but ensure that they bring the relevant information on cases to the meeting and actively participate in both the development and delivery of action plans. To facilitate this, the most effective MARACs were perceived as those which had an inclusive atmosphere that really encouraged multi-agency working across all the agencies participating.

Having a dedicated specialist domestic abuse support service was seen as crucial to the success of MARACs. This support is usually provided by an IDVA service. IDVAs

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[381] Steel, N., Blakeborough, L., and Nicholas, S. (2011) Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). Home Office

[382] Steel, N., Blakeborough, L., and Nicholas, S. (2011) Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). Home Office

[383] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

[384] CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.

both make referrals to and receive referrals from the MARAC. They act as the representative for the victim at MARAC meetings and are usually the victims' primary point of contact. It is also often the IDVA who is responsible for the ongoing case-management of MARAC cases and communication over potential health and safety issues (CAADA, 2010)[385]. The pivotal role in the MARAC process played by such specialist domestic abuse support services was highlighted in the evaluation of the first Cardiff MARAC (Robinson, 2004)[386]. Interviews with both NMSG members and the case study sites for this review similarly highlighted how important a role IDVAs are perceived to play in the MARAC process. IDVAs were seen as key in gaining the engagement of victims in the MARAC process which interviewees from both the NMSG and case study sites reported to be crucial in effectively supporting victims' health and wellbeing needs.

Whilst enhanced information sharing, agency representation and involvement of IDVAs were seen as core to the effectiveness of MARACs, a range of other features were also described by NMSG and case study interviewees as important to delivering a successful MARAC:

- Having strong leadership of the MARAC helped to ensure all agencies attended with the right information and that meetings are used for action planning and not just 'talking shops'.
- A good co-ordinator was also seen as important for ensuring that the agenda goes out before the meeting in sufficient time so that agencies could be prepared at meetings; to follow up on actions agreed at the meeting; and to ensure that bureaucracy is minimised.

13.1.16 Innovative features

The key innovation of this intervention is the sharing of information across different agencies, to help provide a more coordinated response to domestic violence. Having a strong partnership approach to tackling domestic violence more widely was seen as highly beneficial to MARACs and the key innovation to their success due to the increased ability of authorities to provide more coordinated responses to domestic abuse. This included a willingness to work together and a commitment from agencies to tackle domestic violence upstream, with interviewees reporting that a lot of work outside meetings was required to ensure that procedures and policies were in place to allow actions to be taken[387]. Increased integration of working practices locally was seen as having the potential to facilitate more effective healthcare provision, particularly with regard to dealing with mental health issues which benefited from a more rounded understanding of a victim's individual circumstances that the intervention provided.

13.1.17 Obstacles and lessons learnt

In spite of significant success, there are still limits to what can be accomplished particularly if victims do not want assistance or do not admit there is a problem. As highlighted by Robinson (2004)[388], respondents were very clear that they felt that the MARAC-process is effectively 'stopped in its tracks' by the victims themselves if they

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[385]   CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.
[386] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation
[387] CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'. Bristol: CAADA.
[388] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

do not want to cooperate with the intervention[389]. More therefore needs to be done to integrate those who do not wish to cooperate into the process.

Another issue highlighted by Robinson is the significant administrative burden that the intervention places on those involved with MARAC meetings, in some cases potentially reducing the ability of police to provide services for victims themselves. It has therefore been identified that the administrative burden should not be shouldered by the same people who need to carry out actions for and on behalf of victims and their children.

13.1.18   Potential for transferability and sustainability

Originally only operating in England and Wales when it was set up in 2003, the scheme has now been transferred across the whole of the UK. The intervention is still operating 13 years after its introduction, and continues to be centrally funded by the UK government. Transferability of the scheme to other countries would depend upon:

- The availability of secure funding, either from governmental or charitable sources.
- The willingness and availability of multiple different agents involved with domestic abuse to commit to regular meetings and adopt a more integrated approach for dealing with domestic abuse.

13.1.19   List of references

- CAADA (2010) 'Saving lives, Saving money: MARACs and high risk domestic abuse'.   Bristol: CAADA; http://www.safelives.org.uk/sites/default/files/resources/Saving_lives_saving_ money_FINAL_REFERENCED_VERSION.pdf
- Home   Office.   (2010)   Grant   Funding   for   IDVAs   and   MARAC coordinators/administrators 2011/12 – 2014/15: guidance and eligibility criteria.
- Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation
- Robinson, A., Tregidga, J. (2005) Domestic Violence MARACs for Very High-Risk Victims in Cardiff, Wales: Views from the Victims, Cardiff University.
- Steel, N., Blakeborough, L., and Nicholas, S. (2011) Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). Home Office

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[389] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

13.2 Case study 29: Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen – MIGG), Germany 2008-11

Name of practice: Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen - MIGG), Germany 2008–11

Country: Germany

13.2.1 Main objective and specific aims

The intervention developed and piloted a standard for treating victims of violence in hospitals. This includes how to identify and approach women who they believe to have been victims of domestic violence.

The main aims and objectives are to raise awareness of doctors and to develop unified standards for the treatment of women victims of violence. The aim was also to improve the ambulatory health treatment of women suffering violence.

GESINE, the lead organisation, serves all women but made special efforts to reach vulnerable sub-groups such as migrant women, women with disabilities, children, through:

- Networking with doctors from diverse ethnical backgrounds and specialised disciplines
- Providing material/web information in different languages
- Co-operation with specialised local and national organisations and networks
- Becoming a partner of a specialised website for children
- Developing specific training modules
- Organising conferences.

13.2.2 Relevance for 3rd EU Health Programme objectives

This project is relevant to objectives one, three and four of the 3rd EU-Health programme:

- Promote health, prevent diseases and foster supportive environments for healthy lifestyles taking into account the 'health in all policies' principle.
- Contribute to innovative, efficient and sustainable health systems.
- Facilitate access to better and safer healthcare for Union citizens.

13.2.3 Target groups

The primary target group are female victims of domestic violence and intimate partner violence.

13.2.4 Thematic focus of intervention in relation to reducing health inequalities

This practice ensures that victims of domestic violence are receiving access to not just the immediate primary healthcare services but also continuing support that can help remove themselves from the dangerous situation.

13.2.5 Key activities

The Medizinische Intervention gegen Gewalt (Medical Intervention against Violence – MIGG) project developed unified standards for the treatment of women victims of violence in emergency rooms and specialist outpatient departments, and identified the

main warning signs – known as red flags – that may indicate domestic violence and merit attention from health personnel. It also considered the needs of specific victim groups such as migrant women and women with a disability.

The main aim of the three-year project (2008-2011), which was piloted in five locations, was to introduce and test an intervention programme that improves the healthcare treatment of women victims of domestic violence by physicians and increases healthcare professionals' awareness of the issue. It also tested the cooperation and networking between out-patient departments and regional emergency violence support centres.

The project helped doctors to identify and address the signs of violence, and to document evidence for use in court. It did this through conducting an intense exchange with universities and healthcare units, offering doctors support in documenting injuries for use in a court of law, giving specialist advice, distributing posters and information for patients to support health education, training and information events, and setting up an internet platform providing detailed information and advice regarding evidencing violence in a court of law.

13.2.6 Geographical scope

The project was implemented at the regional level in Germany. The pilot project was implemented and tested in five regions in Germany (Berlin, Ennepe-Ruhr County, Dusseldorf, Munich and Kiel), each with 20 to 25 medical practices, consisting mainly of general practitioners (GPs) and gynaecological surgeries.

13.2.7 Intersectoral dimension

The intervention is primarily a healthcare initiative for women experiencing violence in Germany.

13.2.8 Duration

The intervention ran for three years, between 2008 and 2011.

13.2.9 Lead organisation

The intervention was led by GESINE, a government funded organisation that helps to improve the healthcare of women affected by violence and their children across Germany.

13.2.10 Partners

The project was carried out by the Society for Social Scientific Women and Gender Research. (GSF e.V.), the charity Signal e.V. (Berlin), GESINE-Netzwerk (Ennepe-Ruhr-Kreis) and the Institute of Legal Medicine, University of Düsseldorf (for Kiel and Munich) in cooperation with the local Institutes of forensic medicine at the university hospitals.

The project also involved organisations and authorities working with women victims of violence, to improve networking and enable them to integrate healthcare in their overall intervention.

13.2.11 Main sources of funding

The intervention was centrally funded by the German Ministry of Family, Senior Citizens, Women and Youth (BMFSFJ) for the pilot period of 2008 to 2011.

13.2.12   Evaluation: Has the practice been evaluated?

The pilot project was evaluated by GSF e.V and summarised by EIGE[390]. The evaluation interviewed trainers and trainees during the project. Other methods of evaluation were questionnaires for trainers and trainees, participatory monitoring of the training sessions, interviews with board members and continuous counselling of the project managers. The evaluators included social scientists, medical doctors and self-employed practitioners. An additional result of the evaluation was the development of an implementation guide, including practical examples and recommendations, for those who want to implement the model.

13.2.13   Evidence base for implementation

Gender-specific violence received increased public attention over the latter half of the 20th century in Germany, following the emergence of the women's movement and the subsequent creation of women's refuges, help lines and programmes to protect and support women, as well as sexual abuse being systematically defined as a crime in the 1980s. To combat gender-specific violence, since 1999 the government has developed National Action Plans (NAPs). The core of the first NAP was legislation (such as the Protection against Violence Act (Gesetz zur Verbesserung des zivilrechtlichen Schutzes bei Gewalttaten und Nachstellungen, Gewaltschutzgesetz – GwschG) to ramp up the criminal prosecution of violence – especially domestic violence. Federal programmes are interconnected with initiatives at state (Land) level and with projects by non-governmental organisations. Several initiatives at Land level aim to raise the awareness of the public in general and of experts in this field in particular.

In September 2007, the federal government launched the Second Action Plan of the Federal Government to Combat Violence against Women to respond to the current challenges regarding the protection of women affected by violence and their children. A key focus of the plan is the healthcare sector. As part of this action plan, and following positive experience in the clinical area, the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth launched a pilot project to ensure that women victims are given the right assistance[391].

The intervention model was based on international standards for health units in different medical sectors, and was tested with several self-employed medical practitioners in five regions of Germany, including both rural and urban areas in Berlin, Düsseldorf, Kiel, Munich and Ennepe-Ruhr-Kreis.

13.2.14   Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

The project trained 136 doctors (77 female and 60 male with various qualifications, including internists and gynaecologists in outpatient departments) in how to approach women victims of violence, and in where to find information and support for dealing with issues of gender based violence. It provided information and training materials on documentation, communication, the law and regional networks working with women victims of violence (both NGOs and the judiciary system). The project also presented and implemented standards for practice: an evidence-based plan of action for the medical care of women victims of domestic violence. During implementation, doctors

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[390] http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence
[391] http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

were supported by the pilot project partners. The training was seen as very successful, as testified by interviews with both trainers and trainees[392].

The project also involved organisations and authorities working with women victims of violence, to improve networking and enable them to integrate healthcare in their overall intervention. The best outcome in this regard was in Berlin, where networking has continued since the end of the pilot project with additional financing from the Berlin government.

13.2.15   Success factors

The project's success resulted from the partners' great experience and competence in the field. The GESINE Network is the WAVE (Women Against Violence Europe) focal point on health in Germany, and since 2004 has been working on intervention models for improving the treatment of women victims of violence, and helping health professionals to better recognise violence and treat it adequately, including considering psychological aspects. It also benefited from a multiagency approach with strong and committed networking involving anti-violence associations, medical organisations and associations of general practitioners[393].

Furthermore, the project identified a systematic routine screening procedure to detect domestic violence victims in emergency rooms and other health departments, supported by comprehensive tailored information and support. Its federal government financing allowed the partners to dedicate to it the time and resources needed to obtain good results.

13.2.16   Obstacles and lessons learnt

The GSF e.V. evaluation[394] found that doctors are a complex target group to work with, given the varying standards and procedures that they adhere to, so at the outset it was quite hard to shift perceptions and approaches with regard to treating female victims of violence in a certain way. To overcome this obstacle and successfully introduce new standards and procedures, it was important to make sure that doctors were involved with the intervention from the outset. Ensuring that medical associations were committed was an important tool in promoting the new intervention.

13.2.17   Potential for transferability and sustainability

At the moment, the model is still operational in Berlin and Ennepe-Ruhr-Kreis, financially supported by the governments of Berlin and Nordrhein-Westfalen. The project has been further transferred and in Munich, Kiel and Düsseldorf the outpatient services at the university institutes of legal medicine are working with women victims of domestic violence, also financed by the respective Land governments. Further transferability would depend upon:

- The availability of funding from the federal state.
- Developing a partnership approach within the given region between the lead organisation, doctors and other local services.

13.2.18   List of references

EIGE (2016) Setting standards for the medical care of victims of gender violence. Online. Available at: http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

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[392] http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

[393] http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

[394] http://eige.europa.eu/gender-based-violence/good-practices/germany/setting-standards-medical-care-victims-gender-violence

13.3 Case study 30: Care for Maternity At Risk Programme

Name of practice: Care for Maternity at Risk Programme of the Health and Family Association (Asociación Salud y Familia, ASF)

Country: Spain

13.3.1 Main objective and specific aims

The Programme aims to promote good maternal and reproductive health among vulnerable women and young people across Catalonia. It does so through offering a range of contraceptive and counselling services, as well as acting to prevent repeat abortions[395]. For women who are particularly vulnerable, the Programme will also co-fund voluntary abortion.

As part of all its Programmes (including this one), the Health and Family Association (ASF) also aims to prevent and detect partner violence against women at an early stage[396].

13.3.2 Relevance for 3rd EU Health Programme objectives

This practice relates to objective four of the 3rd EU Health Programme to facilitate access to better and safer healthcare for Union citizens.

13.3.3 Target groups

Victims of domestic and intimate partner violence are the primary target group, with children and families at risk of poor health also identified. Among adult beneficiaries, the Programme targets women exclusively.

13.3.4 Thematic focus of intervention in relation to reducing health inequalities

This practice aims to promote good health among women with unwanted pregnancies through directly providing healthcare services and offering family planning services.

13.3.5 Key activities

The Care for Maternity at Risk Programme offers family planning services and long-term forms of contraception to women with unwanted pregnancies who are vulnerable or at risk of social exclusion.

Specifically, it offers these services for free:

- Information and individual support for all women with unwanted pregnancies, taking a pro-choice perspective;
- Forms of long-term contraception, such as the intrauterine device (five years) or the subdermal implant, Implanon (three years).
- Pregnancy tests;
- Maternity support groups for all women;
- Services to tackle child poverty and deprivation, such as support for infant nutrition;
- Support and counselling for women and couples undergoing abortion due to risk to the baby or mother's health.

In addition, all beneficiaries of the Association's programmes are screened to detect the presence or absence of intimate partner violence in their lives. In cases when

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[395] However, the Programme is pro-choice and does not advocate restricted access to abortion. Rather, it aims to provide long-term contraception that makes repeat abortions unnecessary.
[396] This is a cross-cutting aim of all of the Association's programmes.

individuals have experienced such violence, the Association offers immediate legal and psychological support[397], as part of its Brussels Programme.

13.3.6 Geographical scope

Regional (Catalonia)

13.3.7 Intersectoral dimension

This practice is relevant to health, but also violence prevention (among the beneficiaries) and reduction of child poverty.

13.3.8 Duration

Ongoing since 1992.

13.3.9 Lead organisation

Saludyfamilia (Health and Family Association) – non-profit NGO.

13.3.10 Partners

The main partner is the Vall d'Hebron University Hospital. More generally, the ASF collaborates with a range of private and public healthcare providers, as well as social centres and third sector organisations.

13.3.11 Main sources of funding

Spanish Ministry of Health, Social Services and Equality; Catalan Health Service.

13.3.12 Evidence base for implementation

Family planning services are a highly cost-effective public health intervention, and the costs of unwanted births are far greater than the costs of preventing them. Family planning services can also bring about reductions to the mortality and morbidity of mothers and children[398]. Contraceptive methods specifically are linked to many health benefits beyond preventing pregnancy, such as lower risk of particular reproductive cancers and easier treatment of menstrual-related disorders[399].

A recent European multi-country study has also demonstrated that women with an experience of lifetime abuse have less control over their fertility and are much more likely to become pregnant unintentionally. This is particularly the case for those who have faced recent abuse, who are twice as likely to be in this position[400].

13.3.13 Evaluation: Has the practice been evaluated?

There is no in-depth, independent evaluation that assesses the impact of the Programme. However, the Associations releases annual reports [in Castilian and Catalan] that include monitoring data on the beneficiaries' profile, use of health services, reproductive choices, and the prevalence of intimate partner violence. These are available on the Association's website[401].

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[397] http://www.saludyfamilia.es/en/maternitat-risc/atencio-maternitat-risc ; Health and Family Association (2014), *Report 2014: Care for Maternity at Risk Programme* [Catalan].
[398] Mwaikambo et al. 2011.
[399] Kavanaugh and Anderson, 2013.
[400] Nearly one-fifth (19.2%) of all pregnant women in the study had an unintended pregnancy; this figure was 24.5% for those who had experienced abuse in their lifetime, and 38.5% for those who had faced recent abuse. See Lukasse et al., 2015.
[401] http://www.saludyfamilia.es/en/publicacions-per-programa/programa-atencio-a-la-maternitat-a-risc

13.3.14 Effectiveness: evidence of outputs and outcomes

In 2015, the Programme supported 3647 women and 4040 cases[402].

During this year (2016), the Programme had the following additional outputs[403]:

- 983 cases of support and counselling for those with unwanted pregnancies;
- 45 cases of facilitated access to the health system for pregnant women at risk of social exclusion;
- 2,619 cases of administering long-term contraception;
- 393 cases of familiar counselling.

Programme beneficiaries were screened for partner violence in the vast majority of cases (97.5%) and partner violence was prevalent in 8.4% of cases[404].

Of the women who benefited, 41.4% had not consulted a health service for family planning purposes in the last two years and 43.4% reported not using any form of contraception, versus 26.7% who were using condoms and 18.6% who were using oral contraception[405].

In terms of outreach, in 2015, the ASF's website received 44,934 visits, and of these 1,763 were directed to the Programme's page[406].

13.3.15 Success factors

Not identified in the public reports. .

13.3.16 Innovative features

The systematic screening for partner violence is innovative, and represents a promising 'mainstreaming' approach to supporting victims. Multi-language versions of the screening tools are also available to support immigrant women.

13.3.17 Obstacles and lessons learnt

Not identified in the public reports. .

13.3.18 Potential for transferability and sustainability

This Programme is a long-term initiative financed by the central government and Catalan Health Service, which suggests that it is sustainable.

13.3.19 List of references

Health and Family Association (2014), *2014 Report of the Care for Maternity at Risk Programme* [Catalan]: www.saludyfamilia.es/sites/default/files/Programa%20Atenci%C3%B3%20a%20la%20Maternitat%20a%20Risc.2014.pdf

Health and Family Association (2015), *2015 Report of the Care for Maternity at Risk Programme* [Castilian Spanish]: http://www.saludyfamilia.es/en/content/memoria-2015-programa-atenci%C3%B3n-la-maternidad-riesgo

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[402] Health and Family Association (2015), Activities Report.
[403] Health and Family Association (2015), *2015 Report of the Care for Maternity at Risk Programme* [Castilian Spanish].
[404] Ibid.
[405] Ibid.
[406] Ibid.

Health and Family Association (2015), *Report of Association's activities* [Catalan]: www.saludyfamilia.es/sites/default/files/CATMem%C3%B2ria%20ASSOCIACI%C3%93 %20SALUT%20I%20FAM%C3%8DLIA%202015%20CATAL%C3%80%20BAIXA.pdf

Kavanaugh, M., and Anderson, R. (2013), Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centres, Guttmacher Institute.

Lukasse et al., 'Pregnancy intendedness and the association with physical, sexual and emotional abuse – a European multi-country cross-sectional study', *BMC Pregnancy and Childbirth.* 2015, 15:120.

Mwaikambo L, Speizer IS, Schurmann A, Morgan G, Fikree F., What works in family planning interventions: A systematic review of the evidence'. *Studies in family planning*. 2011;42(2):67-82.

Presentation of Elvira Méndez, MD, General Director Asociación Salud y Familia, 'Buffering the long-term impact of the crisis on Spanish women: Mosaic of Services from Asociación Salud y Familia'. Delivered at European Conference on *Families in the Crisis: Finding work-life balance in a difficult economic context*, 28-29 April 2014, Athens.

13.4 Case study 31: Training Curriculum: Violence against women and children – victim protection in Vienna's hospitals

Name of practice: Training Curriculum: Violence against women and children – victim protection in Vienna's hospital

Country: Austria (AT)

13.4.1 Main objective and specific aims

In light of the high level of contact that health providers have with victims of domestic violence, the programme's main objective is to enhance the sensitivity of health professionals in dealing with victims of domestic violence, ensuring adequate support to victims and creating awareness and effective responses among providers in the main hospitals in Vienna. The programme aims to do this through the following:

- Improving response to domestic violence through early detection;
- Establishing treatment standards;
- Streamlining internal communication processes;
- Defining emergency treatment plans;
- Communicating know-how on support available outside the healthcare system; and,
- Establishing a victim protection group within hospitals.

The programme also aims to support health professionals to better recognise the signs of domestic violence and to prevent future incidents.

13.4.2 Relevance for 3rd EU Health Programme objectives

- This programme is relevant to objectives one, three and four of the 3rd EU Health programme:
- Promote health, prevent diseases and foster supportive environments for **healthy lifestyles** taking into account the 'health in all policies' principle, because it aims to prevent incidents of domestic violence which may lead to poor health and supports women and children to lead healthier lifestyles.
- Contribute to innovative, efficient and sustainable **health systems**, through improving the knowledge and skills of health professionals through education and training.
- Facilitate access to **better and safer healthcare** for union citizens, in that the programme trains health professionals to provide better care and support to victims of domestic violence.

13.4.3 Target groups

The target group of this programme are victims of domestic violence and intimate partner violence, but it also covers at risk children and families. More specifically, the programme is aimed at women and children living in Austria, who are most likely to be affected by domestic violence.

13.4.4 Thematic focus of intervention in relation to reducing health inequalities

Through its focus on improving support to victims of domestic violence, particularly women, the programme focuses on improving access to healthcare and may also help tackle gender specific health problems experienced by women and inequalities in health.

13.4.5 Key activities

The key activities of the programme focused on planning and implementation, and include the following:

- Establishment of the programme steering group, development of the education and training concept, staff survey and preparation of information material. This involved a multi-agency group of hospitals and local governmental women's support agencies developing a training curriculum for health professionals on how to support victims of domestic violence. The curriculum was comprised of five modules and included the following topics:

  - Forms and effects of sexual and physical violence against women;
  - Forms and effects of sexual and physical violence against children;
  - Securing evidence and DNA analysis;
  - Legal information; and,
  - Implementation of victim protection groups at local hospitals.

- Implementation of the training programme at two model hospitals, including the municipal hospital SMZ Ost and the Danube Hospital, over a four year period;
- Revision of the education and training concepts, based on feedback on the training programme; and,
- Implementation of the training courses in four of Vienna's municipal hospitals.

13.4.6 Geographical scope

Regional: this initiative was implemented across the City of Vienna, Austria.

13.4.7 Intersectoral dimension

This programme primarily focuses on the area of health policy through its aim of improving skills of health professionals and addressing the issue of domestic violence. It also covers some aspects of criminal justice policy and welfare policy through its collaboration with the police and welfare services.

13.4.8 Duration

The policy agenda of domestic violence was first introduced into legislation in Austria through the Federal Act on Protection Against Domestic Violence in May 1997[407]. Since then, Austrian policymakers have made several amendments to the legislation implementing a comprehensive second violence protection law package and the programme is still ongoing.

Acknowledging that violence against women and children is a public concern, the healthcare sector has increasingly become involved in the development of new interventions and strategies to address the issue. This programme fits in with the policy developments and was initially introduced in 2001.[408]

13.4.9 Lead organisation

The programme is led by a consortium which included the Vienna women's health programme, the 24-hour women's emergency hotline of the Vienna Municipal Department of Women's Affairs, the Youth and Family Offices of Vienna, Vienna Hospital Association and Vienna Municipal Hospitals.

13.4.10   Partners

The programme is supported by partners, including the Vienna Federal Police and the University Institute of Forensic Medicine, which helped prepared a trace preservation kit that ensures uniform procedures in the preservation of evidence.

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[407] Logar, R. (2005) The Austrian model of intervention in domestic violence cases. Vienna: UN Division for the Advancement of Women.
[408] The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

13.4.11 Main sources of funding

Information on funding allocations for the programme is not published, but each of the organisations supplying staff for the programme appears to cover its own costs.

13.4.12 Evidence base for implementation

Violence against women and children can have a number of negative health consequences for victims, ranging from physical injuries, mental health and longer term physical ailments. It is estimated that one in five women in Austria experience domestic violence in current or past relationships and abuses against children is also common.[409] Within this context the primary rationale for the programme is based on a number of considerations. Health services are often the first port of call for many victims of domestic violence and, thus, health professionals are in frequent contact with this group. However, because victims of domestic violence often feel ashamed of their experience or in fear of others finding out, health professionals are often unaware of the situation of victims and address the immediate medical issues in the short-term. In addition, victims are more likely to seek the anonymity of outpatient services and avoid doctors' surgeries.

In light of these considerations, health professionals play a key role in identifying the early signs of violence and providing an opportunity for abused women and children to access support. To gain a better insight into the knowledge and understanding of health professionals in Vienna on issues of domestic violence, a survey was conducted as part of the preliminary stage of the programme to establish how physical and psychological violence against women and children is perceived and dealt with within two Viennese hospitals. The outcome of the survey indicated that one in four respondents felt well-informed about dealing with issues of domestic violence, and 80% of respondents said they would like more information about domestic violence and to improve their knowledge on services to support victims.[410]

13.4.13 Evaluation: Has the practice been evaluated?

There are a number of published documents which provide quantitative and qualitative information on the monitoring of the programme. Given that one of the main aims of the programme is to improve the capability of health professionals to address the specific needs of victims of domestic violence through training, these documents predominantly focus on the immediate outputs and outcomes of the training aspect of the programme for health professionals that participated in the programme. However, evidence on the outcomes for victims is limited.

13.4.14 Effectiveness: evidence of outputs, outcomes, results and cost-effectiveness

Information has been collected by the Vienna Hospital Association from the participating hospitals, detailing some of the outputs and outcomes. For example, during the first period of implementation (2001-2005), the programme trained around 560 health professionals including those working in the emergency department, internal medicine, ophthalmology, dermatology, surgery, gynaecology and psychiatry. By the end of the programme a total of 880 health professionals across the four hospitals had been trained. The Vienna Hospital Association also agreed to offer

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[409] Municipal Department 57 (2006) Violence against women and children: Curriculum. Victim protection at hospitals in Vienna.
[410] Municipal Department 57 (2006) Violence against women and children: Curriculum. Victim protection at hospitals in Vienna.

internal training events on victim protection for their staff at regular intervals, based on the curriculum. However, the number of staff trained was not documented.[411]

A survey was also conducted by the Vienna Hospital Association among trainees at two of the participating hospitals after delivery of training. The findings from the survey suggest that the programme has improved the know-how of health professionals to better support victims of domestic violence through the information and guidance materials delivered as part of the training. The programme also resulted in the establishment of victim protection groups being setup in each participating hospital and improved the coordination among agencies that support victims.[412]

13.4.15   Success factors

Qualitative research conducted as part of the programme found that the main benefit of the training curriculum was meeting the needs of health professionals who had demonstrated a clear information deficit in the area of domestic violence and felt they lacked appropriate education and training. The programme was effective in increasing the number of trained professionals, thus increasing the potential for early detection of signs of domestic violence among victims and ensuring that appropriate and specialised support is provided to those in need.[413]

These successes were achieved through close multiagency cooperation among healthcare services, abuse intervention agencies, women's shelters, the police and welfare services, as well as having an appropriate timeframe for implementation.

13.4.16   Obstacles and lessons learnt

There is limited evidence on the obstacles and lessons learnt from the programme as a whole. However, there is some information on the obstacles and lessons learnt from the implementation of the training. The main obstacle identified during the implementation of the training was the constraints placed on the time of health professionals, as it took a lot of effort to incorporate the training agenda into the working hours of health professionals. The key lessons learnt from the programme are:

- The development of the programme was important in building capacity and improving the ability of health services to respond to victims of domestic violence.
- The multi-agency collaboration generated through the programme provides a good basis for strengthening prevention as well as providing assistance and care to victims of violence.
- Despite having support from hospital directors, the sustainability of the programme depends on the commitment of individual staff members.[414]

13.4.17   Potential for transferability and sustainability

Whether this approach could be transferred to other countries would primarily depend upon three factors:

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[411] The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

[412] The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

[413] The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

[414] The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

- The level of training and education needs among health professionals in a given country/region: this programme may be useful within health systems where knowledge about domestic violence is poor among health professionals;
- There is political support for such an initiative: this programme received support from the health department within local government which was considered one of the key factors in ensuring the programme's sustainability, backed up by legislative changes; and,
- The availability of resources and capacity within the health system to develop and deliver curriculum: the programme relied on a range of internal resources within the health system and local partners to support the development and implementation of the curriculum.

There is evidence that the programme is sustainable. The programme is relatively low cost, using existing staff as activated trainers to continue improving the knowledge of health professionals in supporting victims of domestic violence, and has been supported by the Vienna Women's Health Programme and the City of Councillors for Health, Women and Children from the beginning of the programme. Legislative changes have also supported the sustainability of the programme, whereby, as of 2012, it became federal law that all hospitals within Austria were required to setup children and victim protection groups.[415]

13.4.18   List of references

The European Institute for Gender Equality (EIGE) (2015) Preventing domestic violence – Good practices. Vilnius: EIGE.

Logar, R. (2005) The Austrian model of intervention in domestic violence cases. Vienna: UN Division for the Advancement of Women.

Municipal Department 57 (2006) Violence against women and children: Curriculum. Victim protection at hospitals in Vienna.

69th Federal Law: Change of the Federal Law on Hospitals and Convalescent Homes, § 8e, Children's and Victims' Protection Groups

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[415] 69th Federal Law: Change of the Federal Law on Hospitals and Convalescent Homes, § 8e, Children's and Victims' Protection Groups

14 Overall findings from the inventory on approaches to addressing vulnerability in health

All 31 case studies aim to improve access to health care for one of the nine target groups of the project, to address inequalities in health status, or both. Specific approaches include:

- Setting up mobile health and outreach services to reach out to vulnerable groups;
- Reforming the delivery of healthcare to make it more appropriate to the needs of vulnerable groups (for example, by sensitising professionals);
- Tackling the lifestyle factors that contribute to poor health;
- Addressing the root cause[s] of poor health[416] for a particular group;
- Raising awareness, engaging communities and empowering individuals to take greater control over their health;
- Improving general understanding of the needs of particular groups (through research and engagement)

These approaches were seen in various contexts and similarities and differences in approaches are explored below.

14.1.1 Differences between national contexts

Each Member State has its own social care model and complexities, which leaves different groups at risk of vulnerability and affects the approaches that are being tested. For example, in some Member States, such as Germany, access to public healthcare is linked to an individual's employment or dependent status. Thus, *OpenMed Munich* seeks to address the issue of an individual who is not entitled to national insurance. However, in other countries (such as the UK), healthcare may be free at the point of access, and barriers to access may be of a different nature. It is worth bearing in mind these contextual differences when considering the approaches identified in the inventory.

14.2 Transferability through advocacy

Within the good practice inventory, there are several practices that have been championed at various points for transferability. Two examples of projects that are currently the subject of campaigns for transference are the *Sure Start* model and the *Housing First* Model.

Sure Start in Hungary was adapted from the original UK *Sure Start* programme, showing the possibility for transferability. In both the UK and Hungary, the *Sure Start* programme aims to reach families from diverse backgrounds to promote mutual learning and support, as well as the integration of children and parents facing multiple disadvantages into the community. In the UK, *Sure Start* centres offer a range of practical support and guidance to families with young children, including health advice, skills training and (in some cases) day-care options. The programme was adapted for use in Hungary and now the programme operates 'Children Houses' in the 36 most deprived sub-regions in Hungary. The programme was specifically considered for Hungary due to very limited day-care opportunities for young children before they enter the compulsory educational system at the age of five[417]. Recently, the Tulip Foundation[418], a Bulgarian charity encouraging social responsibility, set up a new

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[416] For example, a lack of housing and employment, the experience of domestic abuse, etc.
[417] http://health-gradient.eu/wp-content/uploads/2015/02/DRIVERS_Case_Studies_
Synthesis_Report_Early_Child_Development.pdf
[418] http://www.tulipfoundation.net/en/news/oak-2-study-trip-to-hungary-
449/#sthash.dwoa1XMf.dpbs

programme that aims to introduce the Hungarian Sure Start to civil organisations from Central and Eastern Europe in order to identify opportunities for introducing the programme in other counties in the region.

The *Housing First* model of care is promoted by the European Federation of National Organisations (FEANTSA) as an effective practice to tackle holistically the issues faced by those experiencing homelessness. The *Housing First* model involves providing an offer of secure permanent housing to an individual without any pre-conditions on their behaviour, such as drug abstinence or participation in a wider programme of support. However, on entering housing, further support is then made available to these individuals. FEANTSA have produced a toolkit for policy makers on implementing a housing first model[419]. This supports its continued growth throughout Europe and the opportunity for learning from others' experience. The implementation of the model in Europe was based on the success of the original New York service developed across the USA and then brought to Europe. It was pioneered in Finland as part of the national strategy on homelessness in Finland and Denmark. Since then it has spread to several countries across Europe where individual organisations or local governments have piloted the model.

Other practices in the case study inventory have been transferred between contexts. For example*, Let's live healthily project Mura* in Slovenia started as a regional health plan and the successful approach was replicated across Slovenia. Similarly, family centres, which began in Sweden in the 1970s, have since been transferred to most Nordic countries. Practices have also travelled further.

One issue to consider in terms of transferability is the way in which practices may be specifically adapted for member states, due to the particular infrastructure and cultural environment. One example of a project that utilises existing infrastructure is the *Let's Live Healthily* part of *Project Mura*. It ran in Slovenia and made use of pre-existing village halls that were available in most villages in the country. This sort of infrastructure may not be available in all member states, demonstrating the importance of carrying out close contextual analysis when considering transferability.

14.3 Practice funding

Most of the practices in the inventory are financed by short-term project-related funding, often EU structural funding or EEA grants. These grants cover the cost of all project activities but are time bound and if the practice does not become supported by local or central government funding it does not always continue, especially given the economic climate post-2008. There were fewer projects that had begun centrally and more that were associated with local government. Many were a result of a project consortium involving a research institution and a partner NGO or healthcare provider. Others were run entirely by NGOs, leading to an on-going cycle of securing funding. Some are able to do this sustainably and successfully and others may need to change their approach based on funding from year to year.

14.4 Approaches to targeting

Most of the practices within the case study inventory are deliberately targeted at a particular group experiencing health inequalities, rather than adapting a system for all (a universalist approach). The practice inventory does contain one example of a universalist change that was targeted at a whole geographic region, the *POAT Salute* project. This practice addressed the general population in four 'Convergence' regions

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[419] http://housingfirstguide.eu/website/

(those with a GDP/capita of less than 75% of the average of the average GDP/capita of EU-25)[420].

Another approach is to target both the areas experiencing health inequalities and then specific target populations within them as various arms of that programme. This approach was seen in Ireland with the *Building Healthy Communities* programme, which carried out health impact assessments and interventions for key vulnerable sub-groups. Similarly, *Let's live healthily!* in Slovenia identified specific vulnerable populations in the region who were not receiving adequate health support from universal policies. These included pregnant women, children, the elderly, Roma, members of the Hungarian national minority group and school dropouts. These were target groups of specific health promotion actions that are being implemented in parallel to the general *Let's live Healthily!* Programme.

Many of the smaller practices discussed in the inventory are also targeted geographically. That is, practices are established in areas where there is judged to be the greatest need. Still, within this, the services are generally targeted at a specific sub-population (E.G. vulnerable children and families). For example, in Hungary *Sure Start* centres were established in the 36 most deprived sub-regions in Hungary. Following the same logic on a smaller scale, in Greece a free school meals programme, *DIATROFI*, distributes free schools meals to all of the children in the schools they work, not just those who are economically disadvantaged. However, the schools are selected according to the proportion of children with this need[421]. The evaluation of *DIATROFI* demonstrated that there were calls for more schools included on the *DIATROFI* programme than there was capacity to accommodate, with the logical conclusion that some disadvantaged children are not receiving free meals whilst some who are not economically disadvantaged are. However, the benefits of running the system for a whole school is that it avoids the issue of stigmatization for children receiving the free meals.

Another approach to delivering practices is to target them very specifically at an individual level. For example, *Action nutritionnelle dans une épicerie solidaire (Nutritional action in a solidarity store)* – which provides inexpensive food for those who are experiencing economic hardship – is based on socioeconomic and family criteria, and is established by each individual shop, depending on the socio-economic context it is operating in.

Avoiding stigmatization is a key issue when targeting policies. The research has suggested multiple times that individuals may not always access support services out of a feeling of shame or embarrassment. There are various ways to combat this issue; one, as described above in the DIATROFI project, is to provide the service without conditions on socioeconomic status. Another is to create a relaxed and social environment using professionals who are highly sensitised to the needs of the target group, perhaps individuals who have experience of the issue themselves.

Practices may also be targeted at professionals who are already working with vulnerable groups. This approach is either targeted at health professionals to increase their understanding of vulnerable groups and how to provide healthcare for them or

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[420]   http://fundsforhealth.eu/sf-in-your-country-and-region/sf-per-member-state/?aid=906&sa=1

[421] Petralias et al, The impact of school food aid program on household food insecurity, , European Journal of Public Health,216: 26(2), 290-296;

for other professionals, such as prison guards, working with vulnerable groups to increase their capacity to support the health of those they work with.

14.5 Multiagency Approaches that combine health and social care

Across the practices, there is a distinct focus on inter-agency working across policy areas. The difficulties that lead to health inequalities are for the most part social in nature and therefore their solutions will generally involve multifaceted support. The degree of interdependency is generally along a continuum where practices which are primarily social also provide support with preventive health care. For instance the various children centre practices presented in the inventory and the practices which tackle the problem of healthcare access act more as signposting agencies. An example of this is *Find and Treat* that provides TB testing and treatment for London's homeless population.

Another example of of multi-agency working is *Family Centers*, which are seen in Sweden and across the Nordic countries. *Family Centres* provide access to healthcare and other relevant services, targeting families and children in one place, thus promoting universal and simplified access. Family Centres bring together several sectors into a single initiative, cutting across health (through maternity and child health care services), social care (through social welfare preventive activities and operations) and education (through nursery and kindergarten facilities available for the families involved in the initiative). The 2009 evaluation of the *Family Centres* activities in the Swedish Vastra Gotaland region showed that bringing together different services under one roof has contributed to an increase in health promotion and the decreasing of health inequalities between families with children[422].

Another example of this multifaceted support is *Sortir de soi sortir de chez soi* (Wallon Province, Belgium).The programme cuts across health, social inclusion and employment policies, given the population group targeted. Also, the training programme includes information sessions on public services and employment services available in the Province.

One way that multiagency working can be very beneficial to individual experiencing healthcare inequalities is through effective referrals. *Shutzengel (guardian Angel-*Germany) supports pregnant mothers and those with children aged 0-3 with healthcare. Due to the project's strong networking with governmental and non-governmental institutions, families in need of support can be quickly and efficiently referred to the appropriate services. Another example of the importance of referrals being made efficiently is the *Prison Inreach and Court Liaison Service (PICLS)*. *PICLS* is a diversion policy, as it aims to transfer mentally ill people away from the criminal justice system and into psychiatric care. This is done via multiagency working where prisoners are identified through various methods by all agencies involved.

Some of the practices included in the inventory in fact have health as a secondary outcome, focusing on another area as their key aim. For example, *Housing First* is a practice bringing homeless people with high support needs into housing. The model provides access to permanent housing without any preconditions. These services also provide support to help people improve their health and wellbeing, employability and social networks, once the individual is stably housed. A *Housing First* approach accepts that having a home allows the individual to deal with health and social problems more effectively. Several evaluations show that Housing First is highly effective at keeping

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[422] Abrahamsson A, Bing V, Lofstrom M (2009) *An Evaluation of Family Centres in Region Vastra Gotaland, Sweden – Summary of the Report*. Vastra Gotaland
http://www.vgregion.se/upload/Folkh%C3%A4lsa/rapporter/Family%20centre.pdf

people housed. The evidence that it improves mental health, substance misuse or physical wellbeing is less strong but suggests that it does at least as well as other services.

A further approach for providing for the needs of vulnerable groups via interagency co-operation is case-review committees designed to ensure that vulnerable individuals are identified and offered support. *Multi-agency risk assessment conferences (MARACS)* are an example of this from the UK where they are used to identify victims of intimate partner violence from across services. *MARACs* adopt a partnership approach, bringing statutory and voluntary agencies concerned with domestic abuse together around the same table, to discuss the cases of individual high-risk victims, and formulate co-ordinated action plans for each of them. They operate as one element of a wider infrastructure, which includes Specialist Domestic Violence Courts (SDVCs) and Independent Domestic Violence Advisers (IDVAs). The agencies that attend *MARACs* vary but include the police, probation service, IDVAs, children's, health and housing services as well as a range of other adult and child-focused services. Any agency may refer a case to a *MARACs*, based on its assessment of risk. This method has been evaluated and found to work well, although one issue to avoid is the significant administrative burden placed on individuals involved with *MARACs* meetings, which could potentially reduce the ability of police to provide services to the victims. [423].

14.6 E-health

A second cross-cutting theme from the good practice inventory is the increased use of technology in providing healthcare in innovative ways. For example, the programme *Healthy Aging Supported by the Internet and the Community (HASIC)* involved the development and testing of an online programme supporting elder people's lifestyles, as well as a multilingual website for the promotion of healthy lifestyle for older citizens.[424]

Another example of this is seen in *Find & Treat*, which pioneered the use of digital technology to support TB patients with Directly Observed Treatment (DOT). In 2007, the service began DOT with a patient on an 18-month course of treatment via skype by providing a laptop connected to the internet via a dongle. Now the service provides patients with a smart phone and a data subscription. Patients are then trained to take their medicine during one or two visits with a nurse. The smartphone is fitted with an app developed for the purpose of Video Observed Τreatment (VOT) which allows for observing treatment remotely. The app does not store data, making it confidential. In 2015, there were 86 patients on VOT being managed by *Find & Treat* and none had become lost for follow up by the team[425].

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[423] Robinson, A. (2004) Domestic Violence MARACs (Multi-Agency Risk Assessment Conferences) for Very High-Risk Victims in Cardiff, Wales: A Process and Outcome Evaluation

[424] HASIC http://www.hasicplus.eu/

[425] Story, A (2015) Video Observed therapy for TB (UK) in: World health organisation (WHO) (2015) the role of e/m health in tuberculosis and tobacco control.

Annexes

Annex 1 Longlist- overview of good practices (111)

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Project intergénérationnel au sein d'une ferme	Intergenerational friendship between children and elderly home residents. This project aims to reduce isolation of elderly people.	Tackling inequalities in health status	Older people	Belgium	Local
Recharge Yourself (Steunpunt Vakantieparticipatie)	Subsidised holidays for people with a low income.	Tackling inequalities in health status	In-work poor	Belgium	National
Sortir de soi sortir de chez soi	3 month programme for unemployed women to prepare them to re-enter the workforce	Tackling inequalities in health status	Long-term unemployed and Inactive	Belgium	Regional
Relais-Santé (RS).	Help individuals who are homeless or in 'great difficulty' (the poorest) access health. This is both through health assessments for the individual and training for health practitioners on these individual's needs.	Access to healthcare	People with unstable housing situations (homeless)	Belgium	Regional
KTA Jette	Project provided opportunities for students at technical college to speak to a health advisor about any health issues they currently had.	Access to healthcare	Children and families (at risk group: lone parents)	Belgium	Local
CRISIS Centre in the territory of ruse municipality for victims of domestic and gender-based violence and the provision of services	Crisis centre in Ruse. Project supports victims of gender based violence. Providing protection, individual support, meeting the persons' daily needs, providing legal counselling and assistance for reintegration of the users into society, as well as providing socio-psychological support	Access to healthcare	Victims of domestic violence and intimate partner violence	Bulgaria	Local
Prisons without risk – pilot initiative to prevent STI and blood	Pilot project in three prisons in Bulgaria of socialising activities which include service and information to promote a healthy culture, project has a specific focus on providing information	Both	Prisoners	Bulgaria	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
transmitted infections in three selected prisons in Bulgaria 2015 - 2016	around preventing infection from blood borne diseases.				
Affordable health services in Sofia	Improving access to healthcare for mothers and children in vulnerable groups and increase awareness among the target group of their health insurance rights. This includes outreach work to provide information and health consultancy services for pregnant women and new mothers in vulnerable groups.	Both	Children and families (at risk group: lone parents)	Bulgaria	Local
Health education for social prosperity	A model which reduces harm from drug use among prisoners in three prisoners across Bulgaria by increasing the capacity of prison staff to deal with drug issues.	Both	Prisoners	Bulgaria	National
Semitam	Offers work for people in disadvantaged situations, helping them to develop skills and confidence	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Czech Republic	Local
Focus Labe	Fokus Labe provides services to help those with mental health or learning difficulties join in with work and society. It operates in the Usti region and provides counselling and careers advice, help with financial matters and a social support network	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Czech Republic	Regional
Café Bistro with Two Friends	Provides young adults with mild mental health issues with a support network and employment opportunities	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Czech Republic	Local
Psychological individual counselling for victims of domestic violence	The project provides counselling for victims of domestic violence to help them overcome the negative physiological impact of the violence. The project also aims to raise awareness of domestic violence among the general population and increase the professional capacity of those working with victims of domestic violence.	Access to healthcare	Victims of domestic violence and intimate partner violence	Czech Republic	Regional
Increasing awareness about sexual abuse and violence among women	Project produces easily understandable information for women with mental disabilities about sex and the female body to support them to make informed choices about sex,	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor	Czech Republic	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
with mental disabilities	relationships, and their health.		mental health		
Lighed i sundhed - equity in health	Equity in health is a cross cutting theme in the Danish 'health agreement'. This includes access to differentiated healthcare for vulnerable people. There are specific projects under this scheme targeting disadvantaged pregnant women, combatting drug use among those with mental illness, and ensuring equal access to health care for all (including homeless people).	Both	All	Denmark	Local
Ombolt	A football league for homeless youth	Tackling inequalities in health status	People with unstable housing situations (homeless)	Denmark	National
Drug consumption rooms (DCRs)	Drug consumption rooms (DCRs) in Copenhagen are dedicated centres where homeless people can take drugs, under the supervision of a nurse. While a nurse does not inject the client they are available on site to respond to overdoses and act quickly. Similar services are now available in other EU Member States. The centres also build relationships with the service users and there is promising evidence to show successful transitions from the injection centres to rehabilitation and detox programs.	Access to healthcare	People with unstable housing situations (homeless)	Denmark	Regional
Danish model on food systems in correctional facilities	In Denmark, prisoners are responsible for their own food. There are kitchens in all wings and often prisoners join cooking groups, share food / resources and receive training from special prison staff. They also have to clean their cells and wash their own clothes. This can increase prisoner satisfaction about the quality of food. Key benefits: prisoners have a day which is comparable to life outside prison; they receive training and their own money, which helps them when they leave prison and can reduce re-offending. In other countries there tends to be a centralised kitchen and prisoners have limited involvement.	Tackling inequalities in health status	Prisoners	Denmark	National
Roots to Freedom	A nature based rehabilitation programme for prisoners in Kevara prison including after care once a prisoner is released	Tackling inequalities in	Prisoners	Finland	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
		health status			
Klubitalolta tuetusti töihin	The clubhouse is for people with mental illness, the Clubhouse offers its own Transitional Employment programme (TE) which provides opportunities for members to work on job placements in the labour market. They offer courses and groups with themes such as job applications, skill analyses, IT and hygiene and the project worker seeks for external work placements.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Finland	Local
Time out!	'Time out!' is a support advisory service for young men who have been called for military service to prevent social exclusion.	Tackling inequalities in health status	Long-term unemployed and Inactive	Finland	Regional
CIDFF	Organisations run support groups for victims of domestic violence. It provides information and support for victims as they deal with police and judicial proceedings.	Tackling inequalities in health status	Victims of domestic violence and intimate partner violence	France	National
Medical intervention against violence (Model project MIGG), Germany 2008– 11	Developed and piloted a standard for treating victims of violence in hospitals. This includes how to identify and approach women who they believe to have been victims of domestic violence.	Both	Victims of domestic violence and intimate partner violence	Germany	Regional
Neúplná rodina a stres	Model project offering support for families with small children in disadvantaged neighbourhoods through a family midwife, social worker and parent´s café	Access to healthcare	Children and families (at risk group: lone parents)	Germany	Local
MedMobil Stuttggart	Offers people with social difficulties primary care and health information on the spot in a mobile van.	Access to healthcare	People with unstable housing situations (homeless)	Germany	Local
opened Munich	Offers medical treatment to people without medical insurance.	Access to healthcare	In-work poor	Germany	Local
multigenerational house	This is a day centre for both young and old people, it supports social integration by allowing different generations to spend time	Tackling inequalities in	Older people	Germany	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	together	health status			
Food aid and healthy nutrition programme: DIATROFI	A programme delivering free school meals for children in deprived areas of Greece.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Greece	National
Mobile mental health unit	Mobile mental health unit provides mental health services to people living in rural areas of the Trikala prefecture. This includes counselling, psychosocial care education on mental health, combating discrimination, the "stigma" and prejudices. It also supports victims of domestic violence in these areas.	Access to healthcare	Living in rural / isolated areas	Greece	Regional
help at home	Support services for older people in Greece allowing them to care for themselves rather than going in to an institution.	Tackling inequalities in health status	Older people	Greece	National
Sure Start (Biztos Kezdet)	The Sure Start program is provided to families with children 0-5. Sure Start premises, called "houses" in Hungary provide mothers - or other caregivers - and their children planned activities delivered by trained staff.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Hungary	National
Universal Medical Visitor	Health visits delivered at home for expecting mothers and children. The programme has universal coverage and its aims are to give advice on infant care and children, prevent unwanted pregnancies, and detect child abuse and maternal depression.	Access to healthcare	Children and families (at risk group: lone parents)	Hungary	National
Primary Care Development Pilot	Pilot project in Hungary in 2012 being implemented in four disadvantaged micro-regions in Hungary with a high proportion of Roma people and where residents have a lower than average health status than the average Hungarian. The overall objective is to expand the preventative services of primary care through the establishment of so called 'GP clusters'. Each cluster comprises of 6 general practitioners which work within a 50km radius of one another, as well as two public health specialists, a health psychologist, a dietician and a physiotherapist. All professionals in the cluster share information through a modern,	Both	All	Hungary	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	cloud-based IT system.				
"With a Detour in Life"	Project for Out-of-School Education and Employment of Disadvantaged Young People in District III of Budapest. Project focused on employability skills for 24 individuals and offered psycho-social support to help them into a school / work environment.	Tackling inequalities in health status	Long-term unemployed and Inactive	Hungary	Local
A project on complex services to facilitate entry and re-entry to the labour market for disabled people and for those with compromised health	Supporting those with disabilities and long-term health issues into employment for 200 participants.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Hungary	Local
"Notice me!"	A day care centre and employment programme for those with mental health issues	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Hungary	Local
Integration of young people with disabilities to the streetball recreational sports events	Offering a chance for young people with disabilities to participate in streetball events.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Hungary	National
Neither this should be an obstacle	This project aims to increase understanding of and support for disabled people with drug addictions, through group therapy.	Access to healthcare	Having physical, mental and learning disabilities or poor mental health	Hungary	Local
Prison Inreach and Court Liaison Service (PICLS)	Identifying prisoners with serious mental illness and referring them to appropriate mental health services as soon as possible.	Access to healthcare	Prisoners	Ireland	Local
Northside Community Health Initiative	NICHE aims to improve community and individual health and wellbeing using a community development approach, using	Tackling inequalities in	In-work poor	Ireland	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	community health workers. It is located in one of the most deprived areas of Cork	health status			
CanCom' project	Health literacy project relating to cancer in women and working with different groups of women in the community. It involved medical professionals around gynaecology and oncology in working with the women, so that there was a common medical basis for the work. The women were involved in designing the information and went on a roadshow afterwards, working with local authorities and going around the country to try to get women to use the information for their information days. In the evaluation of the project, they found that women valued the information and were more likely to make healthy choices as a result of having been involved in developing it. This was funded by DG SANTE (then SANCO).	Tackling inequalities in health status	All	Ireland	Europe wide
Community-based Health and First Aid in Action	"Groups of selected prisoners are trained as peer educators and do hands-on health promotion among fellow inmates to raise their awareness about community health, personal hygiene, first aid and well-being. This "whole of prison approach" involves staff, the health care system and the prisoners themselves." Health promotion activities included educating prisoners about hand-washing techniques, an anti-litter campaign and colour-coded mops. The Programme also involved a weapons amnesty, without sanctions, to reduce assaults with weapons.	Tackling inequalities in health status	Prisoners	Ireland	National
Ireland: Building Healthy Communities Programme	Collection of several community run projects which aim to tackle health inequalities. Included research into support for one-parent families and Integrated support for rural communities in the region of Offaly.	Both	Living in rural / isolated areas	Ireland	National
CHANGE	A programme which aims to change the way lone parents think about food. It aims to help lone parents improve their nutrition and the nutrition of their children by educating them about healthy eating in an affordable manner.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Ireland	Local
Ballybeg Family Growing Project	Locally managed project that provides a community garden for targeted families to improve health and community connection.	Tackling inequalities in	Children and families (at risk	Ireland	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
		health status	group: lone parents)		
Italy: Volunteering as a practical response to rural isolation in Liguria	Volunteers set up centres which offer support for people who live in rural areas, including supporting elderly people, making sure medicines reach those who are isolated, setting up medical clinics	Both	Living in rural / isolated areas	Italy	Regional
POAT Salute	Strengthening the capacity of the public administration to address health inequalities by targeting deficits in knowledge and skills among the health care worker sector.	Access to healthcare	All	Italy	Regional
A.T.S.E.SI project	Intervention based in Sicily aimed at implementing a pilot programme to increase the capacity of the health authority to measure and take action on health inequalities.	Access to healthcare	All	Italy	Regional
Area Socio Sanitaria - Naga	A van equipped with medical equipment travels to shanty towns to offer basic medical assistance.	Access to healthcare	People with unstable housing situations (homeless)	Italy	Local
Integration of homeless and long-term unemployed: Bezpajumtnieku un ilgstošo bezdarbnieku integrācija	Project runs in Liepaja city most deprived area. Main objective: To facilitate the integration of marginalised groups into society by providing social support, training, employment and democratic participation possibilities, provide primary healthcare.	Both	People with unstable housing situations (homeless)	Latvia	Local
Social welfare development, representing the rights of disabled people	Map of places that are accessible for disabled people to help them leave the house more often and be more confident about going into public places.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Lithuania	National
Child Poverty and Health: Developing an advocacy strategy to promote a child health intervention for disadvantaged families	Child health intervention for disadvantaged families at the regional level by engaging local government with the issue.	Access to healthcare	Children and families (at risk group: lone parents)	Netherlands	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
De Stadsbrug	A collection of small social firms to provide work and community for people struggling with housing, mental health or other issues.	Tackling inequalities in health status	Long-term unemployed and Inactive	Netherlands	Local
Health promotion and prevention of risk – action for seniors (Pro-Health 65+)	Project to prepare a manual for health workers, to advise them on the most effective health promotion strategies among older people. The research will be disseminated among healthcare professionals to help them improve their care of older people	Access to healthcare	Older people	Poland	Europe wide
The Theotokos Centre	A service that provides young (14-25) single mothers and families in difficult situations with childcare support and programmed activities such as parenting advice in Romania	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Romania	Local
Mobile health care fund	Mobile health programme travels to remote places and provides family planning, social support, health education essential drug supply for emergencies and the very poor, pharmacies, transport for vaccination programmes and training for health care professionals	Access to healthcare	Living in rural / isolated areas	Romania	Regional
«Let's Live Healthily» part of Project mura	Project that piloted in Slovenia's Pomurje region which is deprived compared to the rest of Slovenia and has a lower life expectancy, developed to promote healthy lifestyles among adults in rural communities through health promotion workshops.	Tackling inequalities in health status	Living in rural / isolated areas	Slovenia	Regional
Harm reduction measures - methadone maintenance treatment (MMT) with needle exchange programmes	Since 1999, methadone maintenance treatment (MMT) has been available in most Spanish prisons. In the last 10-15 years, Spain has applied a 'harm reduction' policy to reduce the transmission of infectious diseases in prisons, through opioid agonist maintenance treatment (OAMT) (such as methadone maintenance treatment), the supply of condoms and sterile needles.	Access to healthcare	Prisoners	Spain	National
Care for Maternity At Risk Programme	Offers care and guidance for victims of intimate partner violence. Also helps to detect intimate partner violence among women attending the centres other programmes.	Tackling inequalities in health status	Victims of domestic violence and intimate partner violence	Spain	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Family centres	In 'family centres', universal access is provided to low-threshold information and support, but vulnerable and isolated groups can also access more specialised services. "The term family centre is defined by the Swedish National Board of Health and Welfare as a fully integrated family centre with maternity healthcare centre, child health centre, open pre-school and social welfare activities and operations".	Both	Children and families (at risk group: lone parents)	Sweden	National
Kvinnofridslinjen - National Helpline	The national helpline provides 24 hour support to victims of domestic violence. The phone service means that women are able to seek help at any time and without leaving the house and putting themselves at risk from a controlling partner.	Access to healthcare	Victims of domestic violence and intimate partner violence	Sweden	National
Mental health first aid programme:	A training programme to increase detection and treatment of mental health problems in the workplace in Wales	Access to healthcare	Having physical, mental and learning disabilities or poor mental health	UK	Regional
SeedS	A mobile space that can be moved around prisons to allow inmates to access mental and physical healthcare in a private, safe environment.	Access to healthcare	Prisoners	UK	Local
Sure Start	Engage with parents, pregnant mothers, infants and pre-school age children to reduce the rates of low birth weight, cognitive delay and promote child development, as well as work with parents and families to improve relationships, child attachment and reduce social disadvantage.	Both	Children and families (at risk group: lone parents)	UK	National
Think Family	A programme for families with complex needs at the local level (Blackburn, UK) which focuses on early help to tackle emerging problems for children and young people to prevent impairment of the children's health and wellbeing.	Both	Children and families (at risk group: lone parents)	UK	Local
Ruchazie Family Centre	A wide range of support, advice and information services for local families in East Glasgow	Tackling inequalities in health status	Children and families (at risk group: lone parents)	UK	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
The Upstream Healthy Living Centre	UPSTREAM reaches out into local communities to help people who are mentally, physically or socially isolated to improve their health, well-being, quality of life, and to prolong their independence.	Tackling inequalities in health status	Living in rural / isolated areas	UK	National
Time for Life	Provides support for isolated older people and helps them connect to a community	Tackling inequalities in health status	Older people	UK	Regional
Older people for older people	Engaging older people in providing health services in rural regions of Scotland by helping them to set up 'social enterprises'. The aim was to discover what older people living in rural communities could do for their own community.	Tackling inequalities in health status	Living in rural / isolated areas	UK	Regional
Yorkshire and Humber: Collaborative working between NHS England and PHE to improve the delivery of integrated dental services in PPDs	The Yorkshire and Humber PHE centre health and justice public health specialist and dental public health lead worked with NHS England to support the procurement of healthcare provision, including dental services in the Humber cluster (3 prisons) between February and November 2014.	Access to healthcare	Prisoners	UK	Local
Multi-agency risk assessment conferences (MARACs), United Kingdom 2003–14	Meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse to identify and risk assess cases of domestic abuse.	Both	Victims of domestic violence and intimate partner violence	UK	National
Scotland: Supporting people affected by cancer in rural UK	The Macmillan connected project offers emotional support to cancer patients via skype when they live in isolated areas. This project has concluded.	Tackling inequalities in health status	Living in rural / isolated areas	UK	Regional
SLAM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach	Offers culturally sensitive peer support training to staff and service users within psychiatric units. 'Tree of Life' workshops promote recovery and improve relationships between service users and staff in the adult acute wards and psychiatric intensive care units (PICU).	Access to healthcare	Having physical, mental and learning disabilities or poor mental health	UK	Regional
Pathways in London	Project led by GPs specializing in homelessness which target	Both	People with	UK	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	homeless patients, bringing together medical specialists and housing agencies to ensure that a patient is not discharged to the street or a shelter. These patients are usually the most complex clients that present to homeless services and require intense case management. The service also involves follow-ups and the team keeps in contact to remind service users of appointments and in some instances bring them to appointments and ensure they stick to treatments.		unstable housing situations (homeless)		
Find & Treat, London	In London a mobile health unit has been funded which travels across the London boroughs and screens homeless people for TB. Using x-rays on board the unit can diagnose TB in 30 seconds. The service, both the identification and treatment of TB in addition to the case management for the service user has proven to be cost-effective and cost-saving. There are now plans to purchase a similar unit to cover the North of England as due to demand the unit is often requested outside of London, it has also been used in Dublin (Ireland) and owing to the success of the project the Netherlands are keen to introduce a similar project. The service creates a medical file for the homeless person which is stored with the unit for whenever they next present to the service.	Access to healthcare	People with unstable housing situations (homeless)	UK	Regional
Evergreen 50+	Provides advocacy and support to older prisoners to help improve their health outcomes.	Tackling inequalities in health status	Prisoners	UK	Local
Family Network	A targeted referral service aimed at families in need, with children aged 0-2 in Voralberg	Access to healthcare	Children and families (at risk group: lone parents)	Austria	Regional
Curriculum 'Violence against women and children' — victim protection in Vienna's hospitals	Given the high level of contact of healthcare providers with victims of domestic violence, "multi-agency group of hospitals and local governmental women's support agencies created a curriculum on how to deal with victims of domestic violence. It comprises five modules covering the forms and effects of	Both	Victims of domestic violence and intimate partner violence	Austria	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Austria, 2001–14	violence against women and children, securing evidence, legal issues and victim protection groups"				
neunerHAUSARZT	Project based in Vienna which ensures that homeless people have access to healthcare. It is based out of several homeless shelters across Vienna.	Access to healthcare	People with unstable housing situations (homeless)	Austria	Local
Corner for happier aging	Project which provides information for older people about their health rights including rights in the social welfare system and health and security.	Tackling inequalities in health status	Older people	Croatia	Local
Health promotion with inactive men in Guldborgsund, Denmark	Public / private partnership to improve the health of obese men with low education levels working in two private companies by providing information and support to make healthier lifestyle choices	Tackling inequalities in health status	In-work poor	Denmark	Regional
Developing services for victims of domestic violence, strengthening co-operation between different institutions and raising awareness among victims and the general public	Project aims to increase awareness of domestic violence in Estonia and improve support services especially by training relevant professionals.	Tackling inequalities in health status	Victims of domestic violence and intimate partner violence	Estonia	National
eHealth solutions across the Northern Periphery	Piloting e-health solutions for use in rural areas in Finland, Sweden, Norway and Scotland	Access to healthcare	Living in rural / isolated areas	Europe Wide	Europe wide
Our life as elderly	Preventative home care visits with older people who do not have support from social services	Access to healthcare	Older people	Europe Wide	Europe wide
Healthy Ageing Supported by Internet and Community	Project to empower older people in Europe to take care of their own health both virtually and in peer groups.	Tackling inequalities in health status	Older people	Europe Wide	Europe wide
Special Olympics Europe Eurasia Foundation	Provides health services for children and adults with intellectual and physical disabilities. Helps them to participate in sport and live active lifestyles contributing to health and well-being.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor	Europe Wide	Europe wide

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
			mental health		
Boys and Girls	Project produced a web-series about healthy living for young people who are not in education or employment. It ran 2012-2013.	Tackling inequalities in health status	Long-term unemployed and Inactive	Europe Wide	National
Mallu does the rounds	The Mallu bus was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas. This was delivered through its new integrated mobile facility, a converted mobile caravan.	Access to healthcare	Living in rural / isolated areas	Finland	Regional
Active 55+	Counsellors to support older people through the healthcare system.	Tackling inequalities in health status	Older people	Germany	National
Public health: prevention-testing-support	Project aims to increase early diagnosis of HIV and HEP C and provide counselling and support for those infected. This will be done in mobile testing units and targeted at those with higher rates of infection.	Access to healthcare	All	Greece	National
Advocacy For Multiple Sclerosis in Western Greece	This project aims to treat and prevent Multiple Sclerosis (MS) with a special emphasis on youth in rural areas in Western Greece by creating an office for advocacy staffed by two mental health professionals with experience helping those with MS.	Access to healthcare	Living in rural / isolated areas	Greece	Regional
Support for single parent families - resources for parents, opportunities for children	Support group and classes for single parents to discuss parenting issues and how to make time to take care of their own welfare.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Latvia	Local
Grip & glow (grip & glans)	Class for vulnerable older women on improving own wellbeing and taking care of their own lives, it also works to decrease loneliness.	Tackling inequalities in health status	Older people	Netherlands	Local
Lone mothers adopt a grandmother	This project matches lone mothers with an elderly grandmother to decrease the social isolation and increase the wellbeing of both groups. The lone mothers visit the older women regularly.	Tackling inequalities in health status	Older people	Poland	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Malnutrition screening among the elderly population	Screening elderly patients to determine their nutritional status to facilitate early detection of malnutrition	Tackling inequalities in health status	Older people	Portugal	Local
empregosaudavel	A mental health network to promote good mental health among the unemployed and temporary workers. This will work to develop indicators and good practice among these populations.	Tackling inequalities in health status	Long-term unemployed and Inactive	Portugal	National
Ariadna Project	Project to design innovative strategies for dealing with gender violence, including an information system which connects all professionals who come into contact with victims of gender based violence, a 'reference person' and a training plan.	Tackling inequalities in health status	Victims of domestic violence and intimate partner violence	Spain	Regional
Rehab' project	"REHAB aims to launch an innovative training program to improve health and hygienic conditions and a psychological and communicational strategy within the detention environment. Through the trainers' training approach, prison staff will be trained to manage communication, medical and hygienic measures, social support in custody addressed at both inmates and prison staff." http://www.rehabproject.eu/sections/3	Both	Prisoners	Spain and Italy	National
CareOnLine	Help for vulnerable adults in the community to use computers and the Internet and therefore increase their capacity to look after themselves and their overall well being	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	UK	Regional
Housing First	Housing First is a practice model to support homeless people with high support needs. The project provides access to permanent housing without any preconditions. The model has been trailed in Belgium, France and Spain and there is interest in scaling up the practice and disseminating it across Europe. A guide has been produced and launched by Feantsa (European Federation of National Organisations Working with the Homeless) to help organisations follow the model.	Tackling inequalities in health status	People with unstable housing situations (homeless)	Europe Wide	Europe wide
Healthy Communities	The aim of activities of "Healthy Communities" within the Roma community is to bring about changes in attitudes and to support Roma interest and motivation with respect to finding solutions to	Both	Disadvantaged Roma people living in segregated and	Slovakia	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	their own situations. The project supports the development of human resources directly in the Roma settlements through educational interventions which aim to increase health / healthcare awareness. Healthy Communities project is a tool for integration of marginalized Roma communities to the society.		separated settlements)		
Migrant Health Liaison Office	Liaising with government departments, agencies and other entities to address issues pertaining to migrant health. Provision of health education sessions to migrants in open centres and assisting migrants in accessing health care through the right channels.	Both	Migrants	Malta	National
MAMMA +	The project aims to (1) promote the health of HIV-positive women during pregnancy and in the first year of life of their children to prevent vertical transmission of the infection. (2) to provide a support in the development of the role of parents in situations of social, cultural and economic vulnerability and aims to initiate a process of social and economic independence.	Both	HIV-positive pregnant women and their children	Italy	Local
PRESIDIO Project	The aim of the project is to support the seasonal worker close to their workplace through the intervention of health and social professionals. They provide legal and healthcare assistance as well as support in the response to basic material needs.	Both	In-work poor	Italy	Local / Regional
Progetto Prostituzione e Tratta	The project helps women to leave prostitution by helping women to women to obtain qualifications or employment and social autonomy. The project provides support by finding an accommodation, taking care of basic financial matters; looking for a study program or a job; providing legal support and healthcare assistance. The project contributes to the protection of migrants' and minors' rights, supports in the healthcare services utilization, contributes to the prevention of STD.	Both	Prostitutes	Italy	Local
Psychosocial support for women with disabilities in the reproductive age	The overall objective of this project is to improve reproductive health of women with disabilities. The specific objectives are training of volunteers and health workers to support pregnant women and mothers with disabilities, psychosocial support and advising of pregnant women and mothers with disabilities,	Both	Having physical, mental and learning disabilities or poor mental health	Croatia	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	distribution of educational materials (brochures) for women with disabilities.				
Research into Motherhood and women with disabilities	Study to determinate the factors and circumstances of the health care of pregnant women and mothers with disabilities and the need to support mothers with disabilities. The outcome of the research will be to make recommendations to all interested parties to improve the status of pregnant women, new mothers and mothers with disabilities. The study consists of in-depth interviews, questionnaires and focus groups.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Croatia	National
Troubled Families	Supporting disadvantaged families with significant social problems to improve their lives. The Troubled Families programme for 120,000 began in 2012 and ran to 2015. It sought to improve outcomes for families with multiple problems relating to worklessness, crime and antisocial behaviour, engagement with the education system and other factors that lead to social exclusion and high public expenditure. Local authorities were tasked with ensuring that families were directed to relevant sources of support and that their problems are considered as a whole, rather than independently of each other. This first wave of the programme initially targeted families with issues relating to crime and antisocial behaviour, worklessness and truancy. The second wave from 2015 was extended to support families with a broader range of problems. The programme runs until 2020.	Both	Children and families (at risk group: lone parents)	UK	Regional
Health Promoting Offices	Health Promoting Offices (HPOs) are a novel element of the Hungarian primary health care system and provide a direct and effective link between health development activities and curative medicine. The main aim of HPOs is to improve individuals' health thorough disease prevention and promotion of healthy lifestyles and to avoid early and preventable mortality by targeting chronic and non-communicable diseases such as cardio-vascular diseases and malignancies.	Both	All		National
Coventry: A Marmot	The aim of the project is reducing persistent health inequalities	Tackling	All	UK	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
City	among Coventry residents. Coventry is one of seven Marmot Cities in the UK. The initiative is locally funded and receives expert support from the national Marmot team at the UCL Institute of Health Equity to build local partnership approaches to tackling health inequalities. Following the initial success of Coventry's 2013-2015 Marmot programme, a new strategy for 2016-2019 is being implemented. This brings together partners from a number of sectors, including health, social care, criminal justice, emergency services and local employers, to deliver innovative projects and initiatives for health improvement in local communities. The new strategy places more of an emphasis on evaluating outcomes, working with Public Health England to develop a robust set of indicators to demonstrate effectiveness.	inequalities in health status			
Inspiring Change Manchester	Addressing barriers that stop people with multiple needs from leading fulfilling lives and being engaged with relevant services. Inspiring Change Manchester is an eight-year programme funded through Big Lottery Fund's £112m Fulfilling Lives project. It has been designed and developed with service users to meet the diverse requirements of people with a variety of complex needs. The project aims to break down barriers that can prevent these people from leading fulfilling lives by delivering the right range of services at the right time, via a key worker bringing services to the individual.	Tackling inequalities in health status and improving access to health care	Having physical, mental and learning disabilities or poor mental health	UK	Local

Annex 2 Shortlist-overview of good practices (47)

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Relais-Santé (RS).	Help individuals who are homeless or in 'great difficulty' (the poorest) access health. This is both through health assessments for the individual and training for health practitioners on these individual's needs.	Access to healthcare	People with unstable housing situations (homeless)	Belgium	Regional
empregosaudavel	A mental health network to promote good mental health among the unemployed and temporary workers. This will work to develop indicators and good practice among these populations.	Tackling inequalities in health status	Long-term unemployed and Inactive	Portugal	National
PRESIDIO Project	The aim of the project is to support the seasonal worker close to their workplace through the intervention of health and social professionals. They provide legal and healthcare assistance as well as support in the response to basic material needs.	Both	In-work poor	Italy	Local / Regional
Care for Maternity At Risk Programme	Offers care and guidance for victims of intimate partner violence. Also helps to detect intimate partner violence among women attending the centres other programmes. They run relevant programmes on maternity risk and offering support to women and families.	Tackling inequalities in health status	Victims of domestic violence and intimate partner violence	Spain	Local
Prison Inreach and Court Liaison Service (PICLS)	Identifying prisoners with serious mental illness and referring them to appropriate mental health services as soon as possible.	Access to healthcare	Prisoners	Ireland	Local
Northside Community Health Initiative	NICHE aims to improve community and individual health and wellbeing using a community development approach, using community health workers. It is located in one of the most deprived areas of Cork. Programmes include: Health Information and Services, Community Cancer Screening Programme, and Family Health	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Ireland	Local
Community-based Health and First Aid in Action	"Groups of selected prisoners are trained as peer educators and do hands-on health promotion among fellow inmates to raise their awareness about community health, personal hygiene, first aid and well-being. This "whole of prison approach" involves staff, the	Tackling inequalities in health status	Prisoners	Ireland	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	health care system and the prisoners themselves." Health promotion activities included educating prisoners about hand-washing techniques, an anti-litter campaign and colour-coded mops The Programme also involved a weapons amnesty, without sanctions, to reduce assaults with weapons.				
Ireland: Building Healthy Communities Programme	Collection of several community run projects which aim to tackle health inequalities. Included research into support for one-parent families and Integrated support for rural communities in the region of Offaly.	Both	Living in rural / isolated areas	Ireland	National
Prisons without risk – pilot initiative to prevent STI and blood transmitted infections in three selected prisons in Bulgaria 2015 - 2016	Pilot project in three prisons in Bulgaria of re-socialising activities which include service and information to promote a healthy culture, project has a specific focus on providing information around preventing infection from blood borne diseases.	Both	Prisoners	Bulgaria	National
Health education for social prosperity	A model which reduces harm from drug use among prisoners in three prisoners across Bulgaria by increasing the capacity of prison staff to deal with drug issues.	Both	Prisoners	Bulgaria	National
I know! Comprehensibly of soul and body for women with mental disabilities (Czech: Už vím! Srozumitelně o duši a těle pro ženy s mentálním postižením)	Project produces easily understandable information for women with intellectual disabilities about sex and the female body to support them to make informed choices about sex, relationships, and their health.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Czech Republic	National
Ombolt	A football league for homeless youth	Both	People with unstable housing situations (homeless)	Denmark	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
Drug consumption rooms (DCRs)	Drug consumption rooms (DCRs) in Copenhagen are dedicated centres where homeless people can take drugs, under the supervision of a nurse. While a nurse does not inject the client they are available on site to respond to overdoses and act quickly. Similar services are now available in other EU Member States. The centres also build relationships with the service users and there is promising evidence to show successful transitions from the injection centres to rehabilitation and detox programs.	Access to healthcare	People with unstable housing situations (homeless)	Denmark	Regional
Danish model on food systems in correctional facilities	In Denmark, prisoners are responsible for their own food. There are kitchens in all wings and often prisoners join cooking groups, share food / resources and receive training from special prison staff. They also have to clean their cells and wash their own clothes. This can increase prisoner satisfaction about the quality of food. Key benefits: prisoners have a day which is comparable to life outside prison; they receive training and their own money, which helps them when they leave prison and can reduce re-offending. In other countries there tends to be a centralised kitchen and prisoners have limited involvement.	Tackling inequalities in health status	Prisoners	Denmark	National
Medical intervention against violence (Model project Medizinische Intervention gegen Gewalt an Frauen - MIGG), Germany 2008–11	Developed and piloted a standard for treating victims of violence in hospitals. This includes how to identify and approach women who they believe to have been victims of domestic violence.	Both	Victims of domestic violence and intimate partner violence	Germany	Regional
Schutzengel	Model project offering support for families with small children in disadvantaged neighbourhoods through a family midwife, social worker and parent´s café	Access to healthcare	Children and families (at risk group: lone parents)	Germany	Local
Mobile mental health unit	Mobile mental health unit provides mental health services to people living in rural areas of the Trikala prefecture. This includes	Access to healthcare	Living in rural / isolated areas	Greece	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	counselling, psychosocial care education on mental health, combating discrimination, the "stigma" and prejudices. It also supports victims of domestic violence in these areas.				
Sure Start (Biztos Kezdet)	The Sure Start program is provided to families with children 0-5. Sure Start premises, called "houses" in Hungary provide mothers - or other caregivers - and their children planned activities delivered by trained staff.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Hungary	National
Integration of young people with disabilities to the streetball recreational sports events	Offering a chance for young people with disabilities to participate in streetball events.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Hungary	National
Neither this should be an obstacle	This project aims to increase understanding of and support for disabled people with drug addictions, through group therapy.	Access to healthcare	Having physical, mental and learning disabilities or poor mental health	Hungary	Local
CRISIS Centre in the territory of ruse municipality for victims of domestic and gender-based violence and the provision of services	Crisis centre in Ruse. Project supports victims of gender based violence.	Access to healthcare	Victims of domestic violence and intimate partner violence	Bulgaria	Local
CHANGE	A programme which aims to change the way lone parents think about food. It aims to help lone parents improve their nutrition and the nutrition of their children by educating them about healthy eating in an affordable manner.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Ireland	Local
Health promotion and prevention of risk – action for seniors (Pro-Health 65+)	Project to prepare a manual for health workers, to advise them on the most effective health promotion strategies among older people. The research will be disseminated among healthcare professionals to help them improve their care of older people	Access to healthcare	Older people	Poland	Europe wide
Mobile health care fund	Mobile health programme travels to remote places and provides	Access to	Living in rural /	Romania	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	family planning, social support, health education essential drug supply for emergencies and the very poor, pharmacies, transport for vaccination programmes, and training for health care professionals.	healthcare	isolated areas		
«Let's Live Healthily» part of Project mura	Project that piloted in Slovenia's Pomurje region which is deprived compared to the rest of Slovenia and has a lower life expectancy, developed to promote healthy lifestyles among adults in rural communities through health promotion workshops.	Tackling inequalities in health status	Living in rural / isolated areas	Slovenia	Regional
Family centres	In 'family centres', universal access is provided to low-threshold information and support, but vulnerable and isolated groups can also access more specialised services. "The term family centre is defined by the Swedish National Board of Health and Welfare as a fully integrated family centre with maternity healthcare centre, child health centre, open pre-school and social welfare activities and operations"	Both	Children and families (at risk group: lone parents)	Sweden	National
seedS	A mobile space that can be moved around prisons to allow inmates to access mental and physical healthcare in a private, safe environment.	Access to healthcare	Prisoners	UK	Local
Multi-agency risk assessment conferences (MARACs), United Kingdom 2003–14	Meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse to identify and risk assess cases of domestic abuse.	Both	Victims of domestic violence and intimate partner violence	UK	National
SLAM (South London and Maudsley NHS Foundation Trust) 'Tree of Life' approach	Offers culturally sensitive peer support training to staff and service users within psychiatric units. 'Tree of Life' workshops promote recovery and improve relationships between service users and staff in the adult acute wards and psychiatric intensive care units (PICU).	Access to healthcare	Having physical, mental and learning disabilities or poor mental health	UK	Regional
Pathways in London	Project led by GPs specializing in homelessness which target homeless patients, bringing together medical specialists and housing agencies to ensure that a patient is not discharged to the street or a shelter. These patients are usually the most complex	Both	People with unstable housing situations (homeless)	UK	Regional

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	clients that present to homeless services and require intense case management. The service also involves follow-ups and the team keeps in contact to remind service users of appointments and in some instances bring them to appointments and ensure they stick to treatments.				
Find & Treat, London	In London a mobile health unit has been funded which travels across the London boroughs and screens homeless people for TB. Using x-rays on board the unit can diagnose TB in 30 seconds. The service, both the identification and treatment of TB in addition to the case management for the service user has proven to be cost-effective and cost-saving. There are now plans to purchase a similar unit to cover the North of England as due to demand the unit is often requested outside of London, it has also been used in Dublin (Ireland) and owing to the success of the project the Netherlands are keen to introduce a similar project. The service creates a medical file for the homeless person which is stored with the unit for whenever they next present to the service.	Access to healthcare	People with unstable housing situations (homeless)	UK	Regional
Evergreen 50+	Provides advocacy and support to older prisoners to help improve their health outcomes.	Tackling inequalities in health status	Prisoners	UK	Local
Curriculum 'Violence against women and children' — victim protection in Vienna's hospitals Austria, 2001–14	Given the high level of contact of healthcare providers with victims of domestic violence, "multi-agency group of hospitals and local governmental women's support agencies created a curriculum on how to deal with victims of domestic violence. It comprises five modules covering the forms and effects of violence against women and children, securing evidence, legal issues and victim protection groups"	Both	Victims of domestic violence and intimate partner violence	Austria	Regional
neunerHAUSARZT	Project based in Vienna which ensures that homeless people have access to healthcare. It is based out of several homeless shelters across Vienna.	Access to healthcare	People with unstable housing situations (homeless)	Austria	Local
Our life as elderly	Preventative home care visits with older people who do not have	Access to	Older people	Europe	Europe

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	support from social services	healthcare		Wide	wide
Healthy Ageing Supported by Internet and Community	Project to empower older people in Europe to take care of their own health both virtually and in peer groups.	Tackling inequalities in health status	Older people	Europe Wide	Europe wide
Special Olympics Europe Eurasia Foundation	Provides health services for children and adults with intellectual and physical disabilities. Helps them to participate in sport and live active lifestyles contributing to health and well-being.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Europe Wide	Europe wide
Mallu does the rounds	The Mallu bus was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas. This was delivered through its new integrated mobile facility, a converted mobile caravan.	Access to healthcare	Living in rural / isolated areas	Finland	Regional
Advocacy For Multiple Sclerosis in Western Greece	This project aims to treat and prevent Multiple Sclerosis (MS) with a special emphasis on youth in rural areas in Western Greece by creating an office for advocacy staffed by two mental health professionals with experience helping those with MS.	Access to healthcare	Living in rural / isolated areas	Greece	Regional
Housing First	Housing First is a practice model to support homeless people with high support needs. The project provides access to permanent housing without any preconditions. The model has been trailed in Belgium, France and Spain and there is interest in scaling up the practice and disseminating it across Europe. A guide has been produced and launched by Feantsa (European Federation of National Organisations Working with the Homeless) to help organisations follow the model.	Tackling inequalities in health status	People with unstable housing situations (homeless)	Europe Wide	Europe wide
Coventry: A Marmot City	The aim of the project is reducing persistent health inequalities among Coventry residents. Coventry is one of seven Marmot Cities in the UK. The initiative is locally funded and receives expert support from the national Marmot team at the UCL Institute of Health Equity to build local partnership approaches to tackling health inequalities. Following the initial success of Coventry's 2013-2015 Marmot programme, a new strategy for 2016-2019 is being implemented. This brings together partners	Tackling inequalities in health status	All	UK	Local

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	from a number of sectors, including health, social care, criminal justice, emergency services and local employers, to deliver innovative projects and initiatives for health improvement in local communities. The new strategy places more of an emphasis on evaluating outcomes, working with Public Health England to develop a robust set of indicators to demonstrate effectiveness.				
Food aid and healthy nutrition programme: DIATROFI	A programme delivering free school meals for children in deprived areas of Greece.	Tackling inequalities in health status	Children and families (at risk group: lone parents)	Greece	National
Sortir de soi sortir de chez soi	3 month programme for unemployed women to prepare them to re-enter the workforce	Tackling inequalities in health status	Long-term unemployed and Inactive	Belgium	Regional
Action nutritionnelle dans une épicerie solidaire	Project based in shops where products are 10-20% of normal price for people who need support but would be reluctant to benefit from 'charity', the shops encouraged the beneficiaries to eat more fruit and vegetables. The project also employs people who have difficulty finding employment for short placements to sort vegetables left over from wholesale markets at the end of the day for produce which could be sold at the shops.	Tackling inequalities in health status	Long-term unemployed and Inactive	France	National
Health Promoting Offices	Health Promoting Offices (HPOs) are a novel element of the Hungarian primary health care system and provide a direct and effective link between health development activities and curative medicine. The main aim of HPOs is to improve individuals' health thorough disease prevention and promotion of healthy lifestyles and to avoid early and preventable mortality by targeting chronic and non-communicable diseases such as cardio-vascular diseases and malignancies.	Both	All	Hungary	National
Psychosocial support for women with disabilities in the reproductive age	The overall objective of this project is to improve reproductive health of women with disabilities. The specific objectives are training of volunteers and health workers to support pregnant women and mothers with disabilities, psychosocial support and advising of pregnant women and mothers with disabilities,	Both	Having physical, mental and learning disabilities or poor mental health	Croatia	National

Title	Main aim and objective	Thematic focus of intervention	Target Group - Primary	Country	Coverage
	distribution of educational materials (brochures) for women with disabilities.				
Research into Motherhood and women with disabilities	Study to determinate the factors and circumstances of the health care of pregnant women and mothers with disabilities and the need to support mothers with disabilities. The outcome of the research will be to make recommendations to all interested parties to improve the status of pregnant women, new mothers and mothers with disabilities. The study consists of in-depth interviews, questionnaires and focus groups.	Tackling inequalities in health status	Having physical, mental and learning disabilities or poor mental health	Croatia	National