

## Evaluation of the signalling and referral system for households at risk of eviction in Amsterdam

Igor van Laere MD<sup>1</sup>, Matty de Wit MSc, PhD<sup>1</sup> and Niek Klazinga MD, PhD<sup>1,2</sup>

<sup>1</sup>GGD Municipal Public Health Service, Amsterdam, the Netherlands and <sup>2</sup>University of Amsterdam, Department of Social Medicine, Amsterdam, the Netherlands

### Correspondence

Igor van Laere  
GGD Municipal Public Health Service –  
Community Mental Health Department  
Dr Valckenier Outreach Practice for the  
Homeless  
PO Box 2200  
Amsterdam 1000 CE, The Netherlands  
E-mail: ivlaere@ggd.amsterdam.nl

### Abstract

In Amsterdam, over 1400 households are evicted each year. We describe the results of an evaluation of the functioning of the signalling and referral system, set up for households at risk of eviction, through a qualitative and quantitative study. Interviews and questionnaires completed by employees of 12 housing associations (for rent arrears) and by employees of 13 nuisance control care networks (for nuisance), were used. Data on households with rent arrears, for which a court eviction order was requested, were collected prospectively in September and October 2003, and retrospectively on households causing nuisance and/or who were known to be evicted due to nuisance in 2001–2003. Functioning of signalling, of the ‘alarm’ of problems underlying rent arrears and/or nuisance, was evaluated by the extent of problems that were identified by the employees. Functioning of referral was evaluated by comparing the identified problems with the assistance contacts.

For 275 households with rent arrears, housing associations reported social problems in 196 (71%), of whom 94 (48%) were in contact with social assistance, and medical problems in 62 (23%) of whom 18 (29%) were in contact with medical assistance. House visits resulted in a much higher identification of problems, and were associated with a reduced eviction risk [relative risk 0.57 (95% confidence interval: 0.43–0.75)]. For 190 nuisance households, nuisance control care networks reported social problems in 103 (54%), of which 13 (13%) were in contact with social assistance, and medical problems in 155 (82%), of which 142 (92%) were in contact with medical assistance.

To prevent evictions in Amsterdam, housing associations should improve their signalling role by conducting more house visits, and they should refer more households to medical assistance. Nuisance control care networks should refer more households to social assistance. Only a systematic and integrated approach can keep more households at home.

**Keywords:** evictions, homeless, nuisance, preventing homelessness, public health strategy, rent arrears

**Accepted for publication** 20 March 2008

### Introduction

There are characteristics and risk factors that are specific to those households who have been evicted from their homes. Likewise, there are specific features to those local policy-makers and service providers

responsible for public assistance in the community to those households at risk of eviction (Nettleton & Burrows 1998, Crane & Warnes 2000, van Laere 2005, Allen 2006, Salize *et al.* 2006, Phinney *et al.* 2007). In order to prevent evictions and homelessness, it is essential that early signals of impending homelessness are recognised and

tailored assistance provided in response. Efforts should be aimed at protecting households at risk, to prevent the individual from becoming homeless and society against the burden of homelessness. This protection is embedded by recognizing the human right to adequate housing (Thiele 2002).

In Amsterdam, The Netherlands, between 2000 and 2006, the number of evictions increased from 3.9 up to 4.8 evicted households per 1000 rented houses annually, while the total number of rented houses decreased from 85.3% to 78.9% of the total housing supply (van Laere 2005, Amsterdam Bureau of Statistics 2006, Amsterdam Federation of Housing Associations 2006, Evictions in Amsterdam 2007). The main reasons for eviction were rent arrears (87%), housing-related nuisance (7%) and illegal use of the house (6%) (Aedes 2006).

The benefits of co-ordinating the efforts of housing, social work and medical professionals have been described (Crane & Warnes 2000, van Laere 2005, Allen 2006). However, there is little information available on the interventions used to help households at risk of eviction in the medical literature. We aim to describe how the existing assistance programmes for households at risk of eviction in Amsterdam function, in particular how they relate to situations where underlying problems have been identified or where there has been a referral for assistance. In this paper, the term *signalling* is used for households at risk to become evicted from their homes because of rent arrears and housing-related nuisance, as 'signals of alarm' to be actively picked up and acted upon by community services. In Amsterdam, for both rent arrears and nuisance, a variety of initiatives are taken to reduce the number of evictions.

### Assistance for rent arrears

In Amsterdam in 2002, housing associations signed an agreement with debt control agencies to cooperate on the reduction of rent arrears to prevent evictions (Amsterdam Federation of Housing Associations 2006). In case of rent arrears, employees of housing associations send households a letter to pay the bill. After 6–8 weeks, a second letter is sent in which households are informed of the possibility of seeking assistance from a debt control agency. It is the tenant's responsibility to contact the agency.

If bills remain unpaid, the bailiff is sent in after 10–12 weeks. If households do not cooperate, and the financial situation is not solved within 2–4 weeks, the household will be presented to the judge for a court order for eviction. With a court eviction, the owner of the house, represented by the bailiff, can go to the city hall to report the household. An eviction can thus be planned and executed by the community housing

effects management. The actual eviction is carried out by the housing effects management, the bailiff and carriers, as supervised by the police.

According to the Amsterdam Poverty Monitor, 3512 households were reported to debt control agencies in 2001, up to 8139 in 2005 (Poverty Monitor Amsterdam 2006). Despite an annual increase in contacts with debt control agencies, the number of evictions increased from 1296 in 1999 up to 1429 in 2006 (van Laere 2005, Evictions in Amsterdam 2007). The number of households with rent arrears that were eventually assisted and resulted in eviction is unknown.

Shelter organizations noticed evicted households visiting their shelters, and in response they introduced a social outreach team to conduct home visits at households with rent arrears, to make arrangements with social benefit providers, debt control agencies and bailiffs. The outreach team supported 546 households in 2003 and 609 in 2004, mostly single men between 30 and 50 years old, of whom in 90% of cases immediate eviction was prevented (Fransman 2005).

### Assistance for nuisance

In Amsterdam in 1993, the first *nuisance control care network* was started (in Dutch: Meldpunt Zorg en Overlast). Within the city of Amsterdam and in other cities in The Netherlands, these networks have been introduced. Today, households causing repetitive nuisance and/or households in need of assistance because of severe self-neglect, addiction, mental health problems and hygiene problems can be reported to 13 formalised and government-funded nuisance control care networks spread over the city of Amsterdam.

For each local network, a social mental health nurse of the Municipal Public Health Service (GGD) Safety Net department acts as a liaison between the households and employees of housing, social and medical services represented in the network, in close cooperation with the police. GGD Safety Net nurses, who are familiar with multi-problem households and pathways to find professional assistance, conduct home visits to identify underlying problems and introduce tailored assistance in response. The aim of this service is to improve the social and medical conditions of the households reported, to decrease nuisance and to prevent eviction.

In cases where the network fails to solve the problems, despite professional assistance, an *end of intervention statement* is issued. This statement signifies that the intervention has ceased and no further interventions will take place. An annulment of the rent contract from the judge can be requested by the owner of the house. After a court eviction, the process follows the same procedures as for rent arrears.

In Amsterdam, households causing nuisance and/or those who raise concern are increasingly reported. In 2003, according to the Amsterdam Police Safety Index, 5373 confused persons were reported to the police; housing-related nuisance, 11 920 times; and drug-related nuisance, 2617 times. In 2004, the numbers were 5227, 12 380 and 3337 times, respectively (Safety Index Amsterdam 2003 and 2004, 2005). The number of individuals assisted by the GGD Safety Net department increased from 3216 in 2001, up to 4751 in 2004. Dutch men between 20 and 50 years old with chronic addiction and/or mental health problems accounted for the majority of cases (van Brussel & Buster 2005). Because the overlap of reporting to different agencies is not known, the total number of households causing domestic/public nuisance cannot be determined.

Overall, services share little statistical information. The existing systems were developed for the delivery of service and not for information sharing. We were unable to identify the size and nature of households at risk of eviction or the underlying problems that needed attention because of the paucity of information available to us. The effects of public assistance remain obscure, when only using the available information. Therefore, we organised an additional data collection concerning households at risk of eviction.

### Objective of this study

We aimed to evaluate the functioning of the existing assistance programmes for households at risk of eviction because of rent arrears and nuisance, in terms of signalling and referral by the two systems first in line to become aware of households at risk of eviction: housing associations (evictions resulting from rent arrears) and nuisance control care networks (evictions resulting from nuisance). *Signalling* is defined as the identification of social and medical problems in households at risk of eviction. *Referral* is defined as the extent of contacts between households and relevant assistance institutions.

### Methods

Qualitative and quantitative data were collected. Interviews were conducted with and questionnaires applied to employees of all 12 housing associations available and employees handling nuisance through all 13 nuisance control care networks in Amsterdam. In the summer of 2003, interviews were held to learn how employees handle households at risk of eviction, how these households are approached, what problems are encountered and what actions are being taken.

We decided not to apply questionnaires directly to households concerned, for logistic, financial and

confidentiality reasons. The study design did not need a process of ethical approval according to the Dutch Act on Medical Research. In consultation with employees of housing associations and nuisance control care networks, we designed questionnaires to collect data, from their own records, on households at risk of eviction or already evicted. We designed a one-page questionnaire in order to ensure employees would complete questionnaires (anonymously) during their daily routine.

For the *rent arrears group*, employees prospectively completed a questionnaire for every household for which a court eviction order was requested, in September or October 2003. An estimated 330 court orders were expected in a period of 2 months. This was based on an extrapolation of around 2000 court orders reported by 86% of the housing associations annually (Amsterdam Federation of Housing Associations 2006).

For the *nuisance group*, employees retrospectively completed a questionnaire for every household that had received an 'end of intervention statement' or was known to be evicted in 2001 to 2003. Nuisance households can be evicted because of rent arrears, without an end of intervention statement. As a central monitor to report (reasons for) evictions did not exist, we anticipated a small overlap of nuisance and rent arrears. Analysis of 10 out of 13 separate annual reports available in 2001 and 2002 produced 775 cases of housing-related nuisance, 30 end of intervention statements and 35 households evicted per year. After extrapolation to a 3-year period, we estimated a study population of approximately 225 nuisance households.

### Collected data

Employees of housing associations contacted households with rent arrears by letter, telephone or home visit. Nuisance control care networks conducted a home visit for all cases. All employees reported if an eviction took place or not.

To reflect daily practice, underlying problems were assessed by employees themselves, and were divided into social and medical problems, so as to identify which problems should be referred to social and/or medical workers. Social problems included: antisocial behaviour (in the nuisance group), reduced income and financial difficulties. Medical problems included: addiction or misuse of alcohol, drugs and gambling, mental health problems and physical health problems.

Social assistance could be provided by the police (in case of nuisance), social workers and debt control agencies. Medical assistance could be provided by a general practitioner, addiction services, mental health services and the GGD Public Health Service (van Brussel

& Buster 2005). We studied the extent of total contacts with the overall assistance.

Statistical analyses were performed using SPSS 14.0 (SPSS Inc., Chicago, IL, USA), and were mainly descriptive. Association between categorical variables was assessed using chi-square test and the chi-square test for trend where appropriate.

## Results

### Qualitative information rent arrears group

During interviews, employees of seven housing associations provided the following information. Besides sending letters to households with rent arrears, they tried to contact the households by telephone and three out of 12 housing associations had hired social workers to conduct home visits. In regard to home visits, it was not always possible to reach certain households, in particular single households, where individuals were absent for various reasons including being in a clinic, in prison or abroad. In general, housing association employees reported little support for households who do not actively seek help themselves. During eviction, no help was offered to find another house or shelter.

Housing association employees who had contact with households found the most common scenarios where an eviction took place included a combination of financial difficulties, alcohol/drug addiction and mental health problems among mainly single (male) households. Efforts to introduce assistance were mainly based on financial arrangements. In some cases with evident health issues, and in case of nuisance, employees would alert the GGD Safety Net department for assistance.

Regarding prevention of eviction because of rent arrears, the effect of the agreement between housing associations and debt control agencies, to invite a tenant by letter to report to a debt control agency, could not be evaluated. Housing associations could not provide data reflecting the number of letters sent, nor the number of tenants that consequently reported to debt control agencies. We could not determine if those households at most risk of eviction are reached by means of letters. Contacts by telephone or home visits were reported only for this study.

### Questionnaires rent arrears group

The 275 questionnaires completed for all households at risk of eviction by the housing associations employees showed that in the rent arrears group, nearly half became evicted ( $n = 132$ ; 48%), ranging from 22% to 100% per housing association. Beside rent arrears, other reasons for eviction reported were housing-related

nuisance in 7% and illegal use of the house in 8%. Evicted households were more often single ( $P = 0.003$ ) and of Dutch origin ( $P = 0.007$ ), than households that were not evicted. The mean age of the main tenant was 39 years, the majority (87%) were between 25 years and 55 years; see Table 1.

In Table 2, the benefit of personal contact is demonstrated. For every two out of five households, 'no contact' was reported. Sixty-one per cent of these 'no contact' households became evicted. Degree of home visit was significantly associated with eviction ( $\chi^2 = 17.1$ , d.f. = 2,  $P < 0.001$ ;  $\chi^2_{\text{trend}} = 17.0$ , d.f. = 1,  $P < 0.001$ ). A home visit was associated with a reduced risk of becoming evicted [relative risk 0.57 (95% confidence interval: 0.43–0.75)]. We note that more than 80% of the home visits were performed by two housing associations.

As shown in Table 3, social problems were three times more often reported than medical problems (71% versus 23%). Problems such as financial difficulties, addiction and mental health problems were most often reported.

The 86 households who received a home visit were more likely than the 189 who received no visit to be identified with social problems; 91% versus 63%, respectively ( $\chi^2 = 21.5$ , d.f. = 1,  $P < 0.001$ ). For medical problems, the rates were 37% and 15%, respectively ( $\chi^2 = 15.6$ , d.f. = 1,  $P < 0.001$ ). Among the medical problems, mental health problems were more often identified among households that were visited than those without a home visit; 21% versus 7% ( $\chi^2 = 11.2$ , d.f. = 1,  $P < 0.001$ ).

Within the 196 households in which social problems were identified, 94 (48%) were in contact with social assistance. Almost three quarters of the households with reduced income were in contact with social assistance. Within 62 households in which medical problems were identified, 18 (29%) were in contact with medical assistance. Out of 30 households in which individuals were identified with addiction problems, 10 were in contact with medical assistance; out of 33 households in which individuals were identified with mental health problems, one was in contact with medical assistance.

### Quantitative information nuisance group

During interviews, employees of nuisance control care networks provided the following views on the problems. About one-third of the nuisance households were reported to the network by the police, one in five by neighbours and others by several assistance services. In about three quarters, the house owner would be a housing association and nearly one in five private rent. Most of the reported nuisance household consisted of single men or women with antisocial behaviour, financial

**Table 1** Demographics of households at risk of eviction and evicted households in Amsterdam\*

	Housing associations				Nuisance control care networks			
	Total ( <i>n</i> = 275)		Evicted ( <i>n</i> = 132)		Total ( <i>n</i> = 190)		Evicted ( <i>n</i> = 136)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Households composition								
Single men	128	49	68†	56	113	61	83	62
Single women	42	16	21	17	24	13	17	13
Adults without children	36	14	13	11	21	11	15	11
Single parent	31	12	12	10	19	10	11	8
Parents with children	24	9	7	6	9	5	8	6
Country of origin					na		na	
The Netherlands	105	41	58**	49				
Surinam and Antilles	48	19	16	14				
Morocco	19	8	5	4				
Turkey	19	8	5	4				
Other	64	25	34	30				
Age main tenant (years)								
15–24	11	5	6	5	6	3	6	5
25–34	83	34	36	30	41	23	32	25
35–44	77	31	40	34	72	41	51	40
45–54	55	22	28	24	40	23	29	23
55–64	17	7	6	5	13	7	7	6
> 65	4	2	3	3	3	2	3	2

\* Known to all 12 housing associations (September–October 2003), and 13 nuisance control care networks (January 2001–December 2003) in Amsterdam.

† Single versus non-single ( $P = 0.003$ ); \*\* Dutch versus non-Dutch ( $P = 0.007$ ).

na, not available (nuisance control care networks did not register ethnic background for privacy reasons).

**Table 2** Housing associations and reported contact with households with rent arrears at risk of eviction and evicted households\*

Housing associations' contact with households	Households at risk of eviction ( <i>n</i> = 275)		Evicted households ( <i>n</i> = 132)	
	<i>n</i>	%	<i>n</i>	%
No contact	99	36	60	61
Contact by telephone	76	28	35	46
Contact by house visit	86	31	26	30
Missing	14		11	

\* Known to all 12 housing associations (September–October 2003) in Amsterdam, The Netherlands.

difficulties, addiction and/or mental health problems. Interventions often included the introduction of assistance by addiction and/or mental health services. For only a few households, coercive treatment in a mental health clinic would be applied.

After intervention of the network, in the majority of households, nuisance would decrease and eviction could be prevented. For about one in 20 households, an end of intervention statement would be issued and/or

an eviction would follow. During eviction, and if contact was possible, assistance for alternative housing in a shelter would mostly be offered.

### Questionnaires nuisance group

The 190 questionnaires completed by the nuisance control care networks for households at risk of eviction in 2001 to 2003 showed that for 140 households, an end of intervention statement was issued, and nearly three quarters were evicted ( $n = 136$ ; 71%). Besides nuisance, rent arrears were reported in 24% ( $n = 44$ ) and illegal use of the house 5%. In the total nuisance group, one in five households had children, whereas among the evicted nuisance households the corresponding figure was 15%. The mean age of the head of household was 41 years (range 17–71 years); the majority (88%) were between 25 and 55 years (see Table 1).

In Table 4, the social and medical problems and extent of contacts and referrals to assistance are shown. Social problems were reported in more than half (54%), although only a small proportion (13%) reported having received assistance from social work departments or debt control agencies, possibly leaving rent arrears as the reason for eviction. Evicted or not, more than half of

**Table 3** Housing associations and signalled problems in households at risk of eviction and evicted households, and referral to/contacts with assistance in Amsterdam\*

	At risk households ( <i>n</i> = 275)				Evicted households ( <i>n</i> = 132)			
	Signalled problems		Referral/ Assistance		Signalled problems		Referral/ Assistance	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Social problems total†	196	71	94	48	75	57	29	39
Reduced income	48	18	35	73	12	9	7	58
Financial difficulties	157	57	78	50	59	45	27	46
Medical problems total‡	62	23	18	29	32	24	10	31
Addiction total	30	11	10	33	20	15	5	25
Alcohol	11	4	5	46	7	5	3	43
Drugs	20	7	7	35	16	12	4	25
Gambling	6	2	2	33	4	3	2	50
Mental	33	12	1	3	15	11	1	7
Physical	11	4	0	0	2	2	0	0

\* Households known to all 12 housing associations (September–October 2003) in Amsterdam, The Netherlands.

† Social assistance = social work and debt control agency.

‡ Medical assistance = general practitioner, addiction health service, mental health service and municipal public health service (GGD).

**Table 4** Nuisance control care networks and signalled problems in households at risk of eviction and evicted households, and referral to/contacts with assistance in Amsterdam\*

	At risk households ( <i>n</i> = 190)				Evicted households ( <i>n</i> = 136)			
	Signalled problems		Referral/ Assistance		Signalled problems		Referral/ Assistance	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Social problems total†	103	54	13	13	77	57	12	16
Antisocial behaviour	88	46	8	9	63	46	7	11
Reduced income	1	1		1	1			
Financial difficulties	29	15	9	31	26	19	9	35
Medical problems total‡	155	82	142	92	111	82	105	95
Addiction total	115	61	69	60	83	61	49	59
Alcohol	42	22	34	81	26	19	22	85
Drugs	85	45	44	52	66	49	35	53
Gambling	0	0	0	0	0	0	0	0
Mental	72	38	51	71	54	40	41	76
Physical	2	1	0	0	0	0	0	0

\* Households known to all 13 nuisance control care networks (January 2001–December 2003) in Amsterdam, The Netherlands.

† Social assistance = social work and debt control agency.

‡ Medical assistance = general practitioner, addiction health service, mental health service and municipal public health service (GGD).

the households with addiction problems and almost three quarters of the households with mental health problems were in contact with medical assistance. Of 155 nuisance households with medical problems, only 12% had contact with a general practitioner.

## Discussion

The city of Amsterdam had two separate assistance networks that worked to prevent evictions by addressing

underlying problems associated with the two major reasons for evictions to be signalled: rent arrears as a 'silent signal' and housing-related nuisance as a 'loud signal' (van Brussel & Buster 2005, van Laere 2005). Comparable with assistance networks abroad (Crane & Warnes 2000, Allen 2006), the Amsterdam networks had a different approach to providing and reporting their activities. Because of the fact that agencies only recorded information that was pertinent to the provision of their service information, we had to put the pieces of

the evictions puzzle together ourselves. This was not an easy task, considering the multitude of problems among households at risk and different services available. Questionnaires were used to obtain data on characteristics and risk factors that related to situations where problems were identified or where there had been a referral for assistance.

Regarding rent arrears, most housing associations had a bureaucratic and administrative relationship with their tenants. For those households who were unable to solve their problems to keep their house and/or who refrained from asking for help (the silent group), little or no assistance was introduced.

After signalling persistent rent arrears, personal contact with the households could be beneficial for the household to receive help and for the house owner to make payment arrangements to collect the rent. Housing associations who conducted house visits reported half as many evictions as housing associations without contact with their tenants. House visits resulted in a higher reporting of problems, most likely as a result of personal contact. In addition, referrals seemed to prevent households from becoming evicted. The fact that 80% of all house visits were performed by two housing associations shows that whether or not a house visit is performed is mainly determined by the policy of the housing association and not by the characteristics of the household.

Housing associations reported social problems in two-thirds, of whom nearly half had contact with social assistance, and medical problems in one quarter, of whom less than one-third was in contact with medical assistance. Despite contacts with services, households that became evicted did not receive adequate help. A provision-driven and fragmented approach of assistance led the households in highest need, who were unable, or refrained from asking for assistance, on a pathway towards eviction and/or homelessness (van Laere 2005).

Through the approach of local nuisance control care networks, with integrated social and medical assistance and personal contact with the nuisance households (the loud group), tailored assistance could be introduced. The reported nuisance households in this study, those with an end of intervention statement or those known to be evicted, can be considered as households in highest need of assistance and/or the most difficult to serve households.

Among 190 nuisance households, the networks identified social problems in 54% and medical problems in 82%. These numbers might be underreported because of retrospective data collection and limited record keeping within the nuisance control care networks.

Although financial problems were identified in 26 nuisance households, only nine of them were in contact

with debt control agencies. Nuisance households in financial chaos (and with addiction and/or mental health problems) might not be inclined to contact social work and or debt control agencies on their own initiative, and even if they do make contact, they might not be able to meet the criteria or follow rules to complete a financial assistance programme (Ombudsman Amsterdam 2007)

Remarkably, gambling problems, as antecedents for rent arrears and becoming homeless (Crane & Warnes 2000, Crane *et al.* 2005), were not reported. For house owners, rent arrears in nuisance households are an easier and more practical route to obtaining an end of intervention statement by the nuisance control care networks. Without debt control assistance, nuisance households might end up becoming evicted and homeless (Crane & Warnes 2000, van Laere 2005).

Because of the design and functioning of the nuisance control care networks, in cooperation with the GGD social mental health nurses, the focus on medical problems resulted in a high proportion (92%) of households receiving assistance for addiction and mental health problems, and less debt control assistance for 'financial health'. The general practitioner, as a gatekeeper for addiction, mental and physical health problems, played a marginal role in providing assistance for the nuisance households.

### Policy implications

The presence of an increasing subgroup of the housed population at risk of losing their home demands an adequate approach to assist these households and so prevent evictions. A combined 'rent arrears and nuisance control care network' to report the alarm for silent and loud households in need for assistance, with provision of integrated assistance by housing, social and medical professionals, could be an effective strategy to reach households at an early stage (Nettleton & Burrows 1998, Crane & Warnes 2000, van Laere 2005, Allen 2006, Salize *et al.* 2006, Phinney *et al.* 2007).

In cases where households are 2 months in rent arrears or in cases where households cause repetitive nuisance and/or for whom concern is raised, the network can make personal contact to systematically explore underlying social and medical problems. Consequently, problem-oriented assistance can be introduced, actively followed and monitored to evaluate the effect of policies and interventions (Stronks & Mackenbach 2006).

For the situation in Amsterdam, to reach households most at risk, assistance should be aimed at single Dutch men between 25 years and 55 years old. These men need guidance for financial, addiction and mental

health problems. Unguided, and not being able to live independently, they might end up becoming evicted and follow a pathway into homelessness. Carrying a growing burden of financial, addiction and mental health problems, single homeless men footstep through multiple streets, shelters, clinics and prisons in Amsterdam (Slegers 2000, van Brussel & Buster 2005, van Laere 2005).

### Central monitor

In order to get an insight into the size and nature of households at risk of eviction, and the effect of interventions, all organizations involved should collect defined, analyzable data. We recommend a *central monitor* – [a bureau of social medical statistics] – to collect a simple and clear set of data on characteristics and underlying social and medical problems of households in rent arrears, households causing nuisance, households who become evicted and households who become homeless, and also at what stage social and/or medical assistance is introduced.

In conclusion, the functioning of the signalling and referral systems in Amsterdam, for households at risk of eviction because of rent arrears and/or nuisance, as signals of alarm to act upon, can be improved. To prevent evictions (mostly among single men, between 25 years and 55 years, in financial difficulties, with addiction and or mental health problems), housing associations should improve their service by conducting more house visits. In addition, more medical assistance should be introduced. The approach of nuisance control care networks is functioning adequately, although more social assistance should be provided. Outreach assistance is needed for households at risk of eviction. Only a systematic and an integrated approach will keep more people at home.

### Acknowledgements

Employees of housing associations and nuisance control care networks in Amsterdam contributed to this study with the design of the questionnaires and collection of data. Professor A. Verhoeff, PhD; G.H.A. van Brussel, MD; T.S. Sluijs, MPH; and R. Zegerius, all with the GGD Municipal Public Health Service Amsterdam, contributed to the study during the preparation phase and commented on previous versions of the paper. We also thank Dr Austin O'Carroll, general practitioner at Mountjoy Street Practice, Dublin, Ireland, for comments and editing of the paper.

### References

- Aedes. (2006) *Dutch Federation of Housing Associations* [WWW document]. URL <http://www.aedes.nl>
- Allen T. (2006) Improving housing, improving health: the need for collaborative working. *British Journal of Community Nursing* **11** (4), 157–161.
- Amsterdam Bureau of Statistics (2006) *Amsterdam*. [WWW document]. URL <http://www.os.amsterdam.nl>
- Amsterdam Federation of Housing Associations (2006) *Amsterdam*. [WWW document]. URL <http://www.afwc.nl>
- van Brussel G.H. & Buster M.C. (2005) *Public Mental Health Care Monitor 2002, 2003 and 2004*. GGD Municipal Public Health Service, Amsterdam.
- Crane M. & Warnes A.M. (2000) Evictions and prolonged homelessness. *Journal of Housing Studies* **15** (5), 757–773.
- Crane M., Byrne K., Fu R., *et al.* (2005) The causes of homelessness in later life: findings from a 3-nation study. *Journals of Gerontology, Series B, Psychological Sciences and Social Sciences* **60** (3), S152–S159.
- Evictions in Amsterdam (2007) *Amsterdam: uitzettingen vanaf 2000*. Dienst Boedelbeheer, Amsterdam.
- Fransman J. (2005) *Kleurrijk Leven. [Annual report HVO-Querido Shelters and Hostels in Amsterdam 2004]*. HVO-Querido, Amsterdam. [WWW document]. URL <http://www.hvo-querido.nl> (In Dutch).
- van Laere I.R.A.L. (2005) *Outreach Medical Care for the Homeless in Amsterdam. Ambulatory Medical Team: The Years 1997–2004*. GGD Municipal Public Health Service, Amsterdam.
- Nettleton S. & Burrows R. (1998) Mortgage debt, insecure home ownership and health: an exploratory analysis. *Sociology of Health & Illness* **20** (5), 731–753.
- Ombudsman Amsterdam (2007) *Schuldhulpverlening. Gemeente Amsterdam, Dienst Werk en Inkomen, Gemeentelijke Kredietbank, Doras, Madi*. Gemeente, Amsterdam. (In Dutch).
- Phinney R., Danziger S., Pollack H.A. & Seefeldt K. (2007) Housing instability among current and former welfare recipients. *American Journal of Public Health* **97** (5), 832–837.
- Poverty Monitor Amsterdam (2006) *Amsterdam: Armoedemonitor Gemeentelijke Sociale Dienst*, no. 9. Gemeente, Amsterdam. (In Dutch).
- Safety Index Amsterdam 2003 and 2004 (2005) *Amsterdam: Directie Openbare Orde en Veiligheid*. [WWW document]. URL <http://www.eenveiligamsterdam.nl> (In Dutch).
- Salize H.J., Dillmann-Lange C., Kentner-Figura B. & Reinhard I. (2006) [Threatened homelessness and mental disorders. Prevalence and influencing factors in populations at risk.] *Nervenarzt* **77** (11), 1345–1354.
- Slegers J. (2000) Similarities and differences in homelessness in Amsterdam and New York City. *Psychiatric Services* **51** (1), 100–104.
- Stronks K. & Mackenbach J.P. (2006) Evaluating the effect of policies and interventions to address inequalities in health: lessons from a Dutch programme. *European Journal of Public Health* **16** (4), 346–353.
- Thiele B. (2002) The human right to adequate housing: a tool for promoting and protecting individual and community health. *American Journal of Public Health* **92** (5), 712–715.