Social

1. Introduction

Universal Declaration of Human Rights:

Article 2. Everyone is entitle to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 22. Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 25. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The fundament for any analysis and discussion of the general social right of homeless people must be aware of the 'Universal Declaration of Human Rights' and particularly the articles 2, 22 and 25.

"Social protection is commonly understood as "all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups" (Devereux & Sabates-Wheeler, 2004: i).

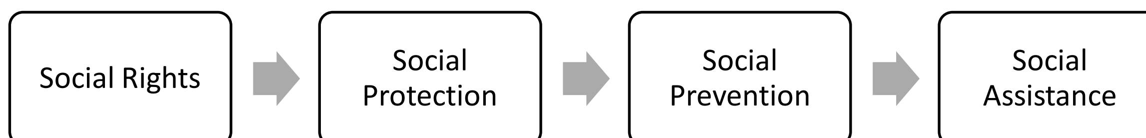
"This definition is in line with usage in international development and may be different from social policy definitions in high-income countries. Social protection is usually provided by the state; it is theoretically conceived as part of the 'state-citizen' contract, in which states and citizens have rights and responsibilities to each other" (Harvey et al., 2007).

Social assistance is a type of social protection, and it is a direct action with clear and immediate results. It is usually provided by the state and financed by national taxes. Support from donors is also important in lower income contexts. Transfers are non-contributory, i.e. the full amount is paid by the provider. Some are targeted based on categories of vulnerability, and some are targeted broadly as part of low-income groups. It seems more correct to speak about social protection than social assistance. Organising public services based on social protection creates automatically the conditions to deliver social assistance, labour market interventions and on the other hand facilitates the development of a social, informal protection net powered by donors, charity and community-based interventions.

Homelessness is a vulnerable condition related to many social factors, and social protection is at the same time part of the problem when lack of resources, safety net, legal status of permanence in the country become barriers and part of the solution for what concerns the positive actions that can help a person to find opportunities to break free form their condition and.

Social Rights have to be guaranteed by the Social Protection System. Thanks to the operating of the Social Protection System the conditions are created to prevent the social differences and the exclusion processes.

Prevention is the main aim of (must be part of) social protection. All the social protection systems in every country, are built to protect the most vulnerable against livelihood risks and enhance the social status and rights of the marginalised. In this specific field, social protection systems have the duty, as part of the prevention, to promote the end of the social drift by living as homeless in the streets and preventing returning to street homelessness after getting a place to live through the social assistance proces



Taking care of the last ones means taking care of one's community. Homeless people living in severe and chronic social, physical, psychical precariousness are a symptom of the malaise of a permanent injury to democracy and social cohesion. A community able to listen to the voice of its most vulnerable people is a community ready to take care of itself. The exclusion of homeless people with mental illness is a way to create two different typologies of the human being — the included ones, with rights, duty and relationships and the excluded ones without all these things. A right's based society should not accept to include someone if this means to exclude others. The community has to be the context in which everyone can be included and has the duty to take care, collectively, of those who are not productive and autonomous. This is not only for the well-being of the individuals but overall for the health of the whole community.

Because of a new reality in Europe, where also homeless people have the opportunity to move around between the member states social rights and social protection have come under a new challenge. , b These migrants are not indisputably covered by the national social legislation of the country in which they are resident as homeless.

2. Main Ideas

Social Professionals as mediators to the services

In delivering social services the main actor is the social professional in all his aspects and forms, changing from country to country. But generally "The social work practice to socially marginalised people can be divided into casework and into direct service delivery, which we might term social caretaking. Some employees will manage both" (Louise Christensen 2018). The professional meeting the homeless who is in the street assumes the role of first contact, mediator and link between the homeless people and the services. Very often in homeless people, we can see a total absence of connection with the world and very often the threshold to access to the specific services and facilities is too high for them. For these reasons the action of social professionals is fundamental, starting from the ones involved in the outreach work (see 'Outreach' chapter) ending to the institutional social workers. From this point of view, social professionals become a sort of translator for the homeless people, able to describe the way to work with the system and

able to facilitate the access to the opportunities that can be useful to break free from the condition of homelessness. Communication between the different type of social professionals and mutual recognition between formal and informal protection system seems to be necessary to build meaningful pathways.

- Professionalism
- First-hand meeting
- Casework
- Mediator
- Translator
- Networker
- Co-work between services

Rights and the individual will

Building meaningful pathways with, and not for or on, homeless people with mental illness is often a big challenge that can appear as impossible to win. In every moment the social professional has to take in mind that the main actor is the homeless people and that there is no external director or someone who knows better than him the solution of his problems. Dignity and respect of the choices of the users sometimes can bring social professionals into significant contradictions. Speaking about rights should include talking about the individual will, speaking about law should consist of speaking about justice. Many times good pathways are interrupted by legal barriers (i.e. documents), other times it is not possible to give a complete answer to the needs because of lack of resources.

On the other hand, nobody can force another person to enjoy his rights if this is not his will. Rights, individual will, law and justice are concepts that influence in every moment the work of social professionals. The only aim is to give back dignity to homeless people and to let them become the actors of their own life. Assistance has to be tailored to the specific needs of individuals.

Also, homeless people want to have the power to choose and have the right to have an influence on their own lives both on an individual level and on an associative level by going together in user-associations. This has led to a growing acceptance that homeless people should be listened to concerning what their opinions are about their own life, which kind of interventions they would accept and what they want for the future, in their contact with social workers and social institutions.

- Dignity and respect
- Right to choose

Reconnection to the individual's safety net

By its nature, the facilities delivered by the social protection system are an artificial context. They are useful to create opportunities to break free from the condition of homelessness, but they are artificial, system made. Another thing is the individual real life. Very often persons follow pathways in which shelters, day centres, soup kitchen are a sort of parallel world, that risks becoming the only world they access and that risks to bring them in a chronic condition of dependence from the protection system. More, relationships built in a context of help are influenced by the roles, professional vs users, that can be an obstacle to live a

real experience of friendship. The risk is that homeless people rebuild their life in something created expressly for them, increasing disempowerment and dependency, i.e. neverending vocational and rehabilitation programmes. Many homeless people with mental illness, at the same time, are not able to be included in society because of their lack of productivity, autonomy, health. Very important seems to be the opportunity to re-connect these persons to their safety net, as relatives, friends, job, etc. Giving them the chance to live a real life in a deinstitutionalised vision of the world in which the community supports the weak and the vulnerable.

- Risk of chronicity
- Relations
- Rebuilding relations
- Safety net

3. Difficulties

Poverty

It is the impression that poverty in European countries, in terms of housing prices for both rented and owner-occupied housing, plays an often overlooked role in understanding the homelessness and thus are often overlooked in the effort of both the prevention social intervention. Or maybe they are pushed in the background because poverty and housing prices are social conditions that are wrapped up in an irreversible set of political and traditional rules. There is some research concerning this.

- Relative poverty
- Research

> “Data demonstrate that, while that a range of health and support needs and behavioural issues, particularly in the teenage years, do significantly contribute to the risks of homelessness in young adulthood, their explanatory power is less than that of poverty.”
> And further: “However, again, it should be noted that the relationship between these ‘social support’ factors and homelessness is generally weaker than that with material poverty and economic status.”
> (Glen Bramley & Suzanne Fitzpatrick, 2018)

Pressure to intervene due to social alarm and lack of resources

A person lying in the street, in bad sanitary conditions, using the neighbourhood for his physiological needs and in some cases also with antisocial behaviour, creates social alarm. The conflict is between individual needs and society's needs. Where is the border between them? How long can a person live in front of the door of the house or the shop of another person? Also if he is ill, even if he is in a condition of need? Very often social professionals have to face the social alarm created by homeless people with mental illness and very often they are crushed between their professional attitude and the will of the stakeholders, the decision makers and the politics (funding the project they work in). The intervention has to keep in mind the two different forces that are playing the game, and it is not always possible. At first glance, it could be easy to side with the homeless people, more if we are speaking about social professionals, but this is not always the best way. The social alarm can push politics towards decisions against homeless people promoting intervention based on an ‘urban makeup’ vision instead of a person-centred intervention.

Another conflict in which social professionals are often involved is related to time. It is clear that to engage a homeless with mental illness it is a process that takes time, but on the other hand, the society asks the social professionals to do it as fast as possible and to ‘remove’ from the street, the person as soon as possible. In the same way, it is clear that to realise a meaningful pathway it is necessary a long term plan, but often resources, shelters’ rules, and other kinds of pressures force the social professional to work faster. How can a person living in the street for many years, change his life in a few months?

- Individual needs and society needs
- The process takes time

Difficulties in diagnosis

In the common way to think, the majority of people living in the street do it because of their own choice. Detecting if it is a real choice is another significant difficulty to face, and in the same way, it is difficult to identify if a homeless is ill or if his antisocial behaviour is the result of a bad character. Diagnosis is always difficult. Homelessness is probably the result of a multifactorial process composed by a combination of subjective and objective forces, and rarely it is possible to understand which are the real reasons that brought the person in the homelessness condition. Maybe diagnosis is not so necessary?

- Own choice
- Diagnosis
- Multifactorial

Lack of cooperation between health and social services

In an effort to obtain resources, homeless people are often confronted with a complex set of providers from a variety of systems that do not communicate with one another (Dennis, Cocozza, & Steadman, 1998), (John R. Belcher & Bruce R. DeForge 2012). The lack of cooperation between health and social services in delivering answers to needs composed of social and health aspects is one of the biggest difficulties. It is not a bad will of the professionals involved but the result of different training pathways, different languages, different objectives. Very often there exist no multidisciplinary team able to face the complexity brought by the homeless people with mental illness and the interventions are fragmented and 'unplugged'. The difficulties in mutual recognition between social and health professionals are the main reasons for this lack of cooperation. One way to bridge the gap between the two systems could be to include, in addition to the professional psychiatry, a social psychiatric thinking based on general humanistic principles such as care and understanding, performed by all types of psychiatric staff (Brandt, P., Proposal for a social psychiatry theory based on experiences from a programme for homeless mentally ill; 1996).

On the other hand, there are no specific training courses aimed to improve specific tools to face in a holistic way the social and health issues of people homeless with mental illness.

- a complex set of providers
- multidisciplinary team
- social psychiatry

Gender

It is estimated that around 80% of people who are roofless or houseless are men. Women are a minority and are often 'hidden homeless': they keep a roof over their heads (sofa surfing) through remaining in a relationship with a man; they may be physically and sexually abused but are unable to walk away due to lack of alternative housing options. Those women who are roofless most likely experience severe mental illnesses, have very complex needs and will, therefore, require very specific support. Homeless women consider themselves losers, bad mothers and the like.

- Minority
- Neglect of gender issues
- Special needs

Undocumented people

It has become more common to meet people who are homeless and sleep on the streets, but who are not citizens in the country where they are currently living. Undocumented people have no access to most of the social services and facilities because of the national legislation. This is a severe barrier for homeless people with mental illness migrating from one country to another. In these cases no action aimed to integrate or include the person is possible, and the interventions are designed only to answer to the fundamental needs (food, clothes and, often only during the winter time, emergency housing).

They can be EU-citizens or can be from outside the EU. Everyone recognises that those homeless people are difficult to help because the national social laws do not give these people all the rights.

The final case in this chapter shows the need to be able to collaborate between social workers across national borders. on services for homeless people Homelessness and mental illness without a regular status of permanence

- Fundamental needs
- Transeuropean network
- Transeuropean cowork

> The European Commission against Racism and Intolerance:
> "Recommends that the governments of the member States: […] Respect the fundamental human rights of irregularly present migrants, inter alia in the fields of education, health care, housing, social security and assistance, labour protection and justice…".

Stigmatisation

People who become homeless are often referred to by their label, ''homeless,'' taking on a less-than-human quality that also has other connotations that they are perceived as threatening/dangerous, nonproductive, and personally culpable. Breaking this stigma is not easy, but at the same time, it is fundamental to build integration pathways. Recognising homeless people like human being with equal opportunities, skills, wills of the others is at the same time one of the most significant barriers and one of the biggest challenge.

- Homeless people are human beings.

Aggressive behaviour

To be close, in proximity, to the people, also means to be close to their emotions, their joys and their pains. Sometimes social professionals are subject to aggressive behaviours by homeless people. When it is possible the training of the professionals should allow them to prevent aggressions but sometimes the “acting outs” are sudden and unpredictable. Handling the aggressive and violent behaviours, it is one of the most difficulties for social professionals. Often they feel not adequate to give the right answers, and this is one of the first cause of the burnout and the turn over of the professionals.

- Preventing aggressions
- Handling aggression and violence

4. Good practices

Improving services for socially excluded people requires strategies to reduce and eliminate these barriers of poverty, isolation, service fragmentation and hostility. As social and health care professionals we must root out prejudice; to ensure that our services are non-discriminatory and facilitate access to care. We must ensure that we assist people in helping themselves and in our efforts to help we do not end up increasing disempowerment and dependency.

Curiosity

- Curiosity is the basic attitude to face the complexity of homelessness and mental illness.

- Every human being is the result of a long process made by choices, experiences, success and failures and every individual has his richness worth of respect despite the social and health condition. Very often the social professional is moved or pushed to intervene to respond to the emergency but sometimes it is better to take time to listen, to know and to appreciate with a curiosity attitude.

- Nobody has the right answer except the person herself, so, sometimes, instead of an attitude of interventism seems to be better to listen with curiosity what the other one has to say.

Choosing a method, measuring quality and documentation of results

- It is essential to be aware that there is a need for consistency between the method selected for an organisation’s social work and the group of socially disadvantaged and homeless people for whom the activities are aimed.

- A pragmatically built-up method in the organisation can be used, but there must still be an awareness of what it is has been doing and why. It can also be chosen to use the prefered method, for example, 'Housing First' as the basis for the work. In any case, it is important to agree on the choice of method.

- We are doing social work with human beings, and we owe them that the work is continually based on quality goals.

- Finally, documentation of the results of the actions performed, based on goals set for the job, must be submitted continuously.

Proactive attitude and anticipation

- A proactive stance is a result-oriented behaviour, instead of one that waits for things to happen and then tries to adjust (react) to them. Proactive behaviour aims at identification and exploration of opportunities and in taking preemptive action against potential problems and threats, whereas reactive behaviour focuses on fighting a fire or solving a problem after it occurs. Proactive people are continually moving forward, looking to the future, and making things happen. They’re actively engaged, not passively observing. Being proactive is a way of thinking and acting.

- The proactive individual has a vision and has an image of what could be done, and sets goals in line with this vision. With a proactive attitude, it is possible to anticipate the events and to settle all the resources that could be useful before then they are. For instance, it could be helpful to arrange the hosting in a shelter and the following discharge to another service even if the homeless person is not ready yet to accept it. Waiting in our own office for things to happen has like the unique result the necessity to work in emergency and to patch an old jacket with a roll of tape.

Communication and visibility

- Social work is often invisible and collects results that could be not appreciable. To fight against the pressure of social alarm, it seems a good practice to give visibility to our job. Good communication with the political level establishment share goals and strategies to fight the social exclusion of people homeless with mental illness. At the same time organising events, opened conferences and seminaries could be useful to share with the communities the values and the meanings of our job. On the other hand, having the opportunity to listen to the voice and the needs of the community, the politics, the stakeholders, through good mutual communication, enables the building of new strategies. Very often the expected results are the same, f.i. do not have people rough sleepers inside the train station, but the motivations are different (giving a respectable look to the station for the passengers is the motivation of the politics, finding a better, more dignified and healthy place for homeless people is the motivation of the social professional). If there is a common and shared will on the expected result, it could be possible to enlarge the resources available for the common goal, instead of using different resources one against the other. Advocacy, lobbying, community empowerment, sensitisation and awareness on the homelessness issues through a good communication should be a fundamental frame of social work.

Choose, enlarge choices

- In the day to day routine, there is the risk to use prepacked solutions to answer to homeless people needs offering them pathways already built. During the exchanges we had, it seemed clear how important it is giving to the persons the opportunity to choose what it is better for them. Of course, the first goal has to be to "preserve" human life, but after that, all the other choices have to be in the hands of the homeless people. Having a house, paying the bill and so on is not for everyone the best way. We should be able to leave the choice to the person we meet. Making available to them all the resources and the solutions we can but leave them the dignity to choose without forcing them towards something instead of something other.

- On the other hand, it is true that sometimes persons are not able to see all the opportunities they have. For this reason, it is equally essential trying to enlarge the possibilities of choice of the person, showing him/her other and new solutions. Like the majority of the actions of the social professional also, in this case, the challenge is to find the right equilibrium between the two different attitudes.

Tailored services

- Before tailing the service, it is important to meet with respect and using the time for really knowing the other.

- Services and facilities have to be tailored to the person's needs and have to be flexible to answer in the most tailored way are possible. Rules, lack of resources, lack of time make the services' system strict and rigid. Because of that very often people have to be tailored to the services instead of the opposite. Trying to modify the services and the facilities measuring them on the effective needs brought by the individual allows building pathways believable and achievable.

- People in homeless conditions with mental illness rarely can follow the demands of the services and often this is one of the reasons for the revolving doors phenomenon.

- If the homeless person is from abroad, it must be included in the considerations for social efforts about and when in the process one should help the homeless return to the country where he is a citizen.

Relationship

Social professionals have the big opportunity to spend time with people they are engaged with. In the opposite of health professional, they can enjoy continuity in the relationship with homeless people with mental illness. They have time to build a relationship based on mutual trust but time also to know in a deepened way the people, to listen and to collect better their needs, to give them dignity in their approach to life. This is maybe one of the most important tools a social professional can have: day by day relationship shared moments and mutual recognition in the ever closer ties.

5. Case

- Told by the social worker involved in the case:

I found Claire a late evening during my outreach work in the streets of Copenhagen. She was sitting on a bench in a square in Vesterbro, called Vesterbro Torv. She was wearing ragged clothes, and she looked very exposed and vulnerable. She didn’t wear any shoes, and she was so dirty, that it was plain to see, that she hadn't showered for a long time.

She was cursing and yelling out loud at people passing by, and it seemed that she saw something, the rest of us didn't see. She spoke with a deep, rusty and monotone voice, chanting the same three or four lines over and over again. Her behaviour was so conspicuous, that she drew a lot of attention, leaving her even more vulnerable and exposed in the streets of Copenhagen.

I approached her on the bench, offered her a cigarette and contact were established. Claire wasn't dismissive by my contact attempt, and I was a little surprised with her reaction. She spoke French, so we had some troubles communicating, but we managed to understand each other with gestures and with a little help from Google translate. She seemed very happy with my presence, and she was eager to talk.

In the following days, I visited Claire on the bench and helped her out with the most basic things. For instance, I gave her a pair of shoes and a good sleeping bag. I also got our Mobile Cafe to come by with some food in the evenings.

After a little while, we managed to get her into a night cafe for women. You usually need Danish social rights to stay there, but the night cafe agreed to let Claire stay if we tried to find a more permanent and sustainable solution. During her stay we had a meeting with an interpreter, so Claire had the opportunity to explain to us why she was here in Copenhagen, what her plans were and how we could help her the most. During this conversation, we realised that Claire was very tormented by her thoughts and how she perceived the world. She told us she was stalked by French-Arabic men in the streets and that they wouldn't leave her alone.

Furthermore, she told us that her family was living in Norway and she was on her way up there, but she got stuck in Copenhagen. She also told us that she previously had been admitted to a hospital in Oslo. Claire

desired to go to Norway and live with her family and going back to her home country, France, was not an option.

As a result of this meeting I decided, in cooperation with the employee from the night cafe, to involve a psychiatric street team. The team had the opportunity to contact the psychiatric hospital in Norway and ask them if they had been in contact with Claire before. They told us that she had previously been admitted and that she had an entry ban in Norway. They also said that she had no family in Oslo, but the illusion of having relatives in Norway was a part of her psychosis and mental illness.

After the nurses from the psychiatric team met Claire a couple of times, we resolved to set up a meeting with Claire, the two nurses and a psychiatrist also from the psychiatric street team, an employee from the night cafe, an interpreter and me. The outcome of this meeting was that Claire voluntarily agreed to be admitted to a psychiatric hospital in Copenhagen. So, after the meeting was finished, Claire and I went to the psychiatric ward. We had an interview with a doctor, and hereafter Claire was admitted.

When Claire had been admitted for about a week, I was contacted by a social worker from the hospital. We arranged a meeting with Claire, the psychiatric street team, a psychiatrist from the hospital, a nurse and a social worker also from the hospital and me. The hospital said that they were ready to discharge her but wanted to know what plans were made for Claire. The psychiatric street team and I advocated that Claire should have a long admission and when she started to benefit from the medical treatment, we would then talk to her about going back to France, as this was her only real option.

Claire stayed at the hospital for about two and a half months, and I came and visited at least once a week. She got better and better for every time I visited her, and after two months, she agreed to go back to France. While Claire was hospitalised the psychiatric street team and the hospital, found out that she had family and a place to live in the eastern part of France with help from the French consulate in Copenhagen.

After that, we arranged that I should fly to Geneva with Claire, where we would be met by two representatives from the psychiatric hospital in France. Claire already knew the two staff members from the past, so it was apparent, that she felt that she was in safe hands. They took her back to the hospital in the Alps and admitted her there, and when she had finished her treatment, they would help her back to her apartment.

Questions:

- What strengths and risk factors do you identify in the intervention described?
- What could be the critical moments in the process?
- Starting from your experience can you imagine a different intervention? If yes can you describe it?

6. References

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7. Glossary

Homelessness: In Europe is mostly used the ETHOS definition. ETHOS categories cover all living situations which amount to forms of homelessness, as 1) rooflessness (without a shelter of any kind, sleeping rough),2) houselessness (with a place to sleep but temporary in institutions or shelter)

3) living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence), 4) living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

In this text, we are only focusing on homeless people sleeping rough.

Social service: The social service offered by the public system or by Non-Government Organizations to people in social need.

Casework: Social work that is case processing

Mental illness: Also called mental disorder or psychiatric disorder, is a behavioural or mental pattern that causes significant distress or impairment of personal functioning.

Humanism: That man should show respect to man, irrespective of class, race or creed is fundamental to the humanist attitude to life. Among the fundamental moral principles, he would count those of freedom, justice, tolerance and happiness…the attitude that people can live an honest, meaningful life without following a formal religious creed. (Pears Cyclopaedia, 87th edition, 1978)

Social Psychiatry: The field of interest for social psychiatry is the life of the mentally ill person as it comes out in the dialogue and contact between individual persons and between the individual and the surrounding society. Social psychiatry must deal with the question of "what is the good life", and must be an analysing, critical and active partner in the public debate. It is a supplement to the biological-medical and the psychotherapeutic psychiatry

Poverty: "Poverty is hunger. Poverty is a lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time.

Poverty has many faces, changing from place to place and across time, and has been described in many ways. Most often, poverty is a situation people want to escape. So poverty is a call to action -- for the poor and the wealthy alike -- a call to change the world so that many more may have enough to eat, adequate shelter, access to education and health, protection from violence, and a voice in what happens in their communities." (The World Bank Organization)

Multidisciplinary team: Refers to social activities that involve the efforts of individuals from several relevant disciplines.