Santé Mentale Exclusion Sociale
Mental Health Social Exclusion

EUROPEAN NETWORK

IN FAVOUR OF

The excluded & mentally ill people

Social Belonging and Inclusion Process
Prevention - Assistance – Reinsertion

2006 - 2007

INDEX

SMES – EUROPA
BROCHURE

"Everyone has a right to the best available mental health services within the health and social welfare systems."
UN Resolution 46/119,1.1

➢ CONTEXT

The problem of the "excluded & mentally ill people", abandoned on the streets, living in reception centres and in precarious housing conditions, is only the visible tip of a structural society problem which is more serious and widespread than at first appeared to be.
Loneliness, sickness, mental illness, drug abuse and/or alcoholism, may be the cause or the results of this state of alienation and exclusion from society, which in some cases may be irreversible and which could eventually lead to a complete break with society.

➢ EUROPEAN CHALLENGE

Despite national differences, in both the nature and severity of the problem, the social **exclusion** is a structural problem in European society and for this reason must be placed – as an absolute priority – at the centre of an urgent call for awareness and deeper consideration particularly with respect to the RIGHT and ACCES to the citizen services, developing an adequate political program at European level : ***the building of the European Community must take place within a framework of citizenship in respect of right and solidarity.***

➢ SMES-EUROPA

is a non-profit International Association (aisbl) operates at the interface, intersection of mental health and social exclusion. The European Network SMES began in 1992 in Rome as a result of the 1st European seminar on the appalling neglect and abandoned homeless people living in extremely poor health & social conditions and suffering from mental health problems.

➢ AIMS

SMES-EUROPA operates in order to improve mental, physical & social well-being, and to promote inclusion, citizenship and solidarity in European Countries for people living in extreme social and health precariousness.

➢ TARGET

are men and women **"home / belonging"- less** :

- mentally ill people without adequate assistance,
- young people at risk of losing viable contact with society,
- people addicted to alcohol and drugs,
- (ex) prisoners,
- elderly people who have been abandoned,
- refugees and immigrants without permission of residence**.**

➢ OBJECTIVES

The SMES network aims to develop for deprived and disadvantaged people:

1. **Information and heightening of awareness** : SMES promotes awareness in society as a whole, and more specifically among social and health workers, policy makers.

2. **Networking :** SMES is an European network improving opportunities of working together and promoting multi-disciplinary co-operation between :
   - workers in the fields of health care and social welfare
   - workers in public & private sectors
   - researchers and practitioners
   - professionals and voluntary people directly working with mentally ill and excluded people

3. **Education and training :** SMES works for the promotion and dissemination of effective projects and practices by means of study days, seminars and conferences. The intention is to offer an opportunity to workers, users, ex-users and their relatives of exchanging ideas, experiences and know-how.

4. **Research/action :** Not enough is known yet about needs and services in the European context to adapt a prescriptive approach. Rather we seek:
   - to identify innovative services
   - to develop and evaluate new interventions
   - to translate knowledge into practical action

➢ SMES INITIATIVES

1. SEMINARS

1.	Rome	1992	Homelessness & Mental illness
2.	Brussels	1993	Mental Health & Social Exclusion
3.	Paris	1995	From exclusion to participation
4.	Madrid	1997	Citizenship the first
5.	Copenhagen	1999	Dialogue & Exclusion
6.	Athens	2000	Health & Dignity
7.	Lisbon	2002	Exchanging for changing
8.	Prague	2004	Right - Access - Participation
9.	Berlin	2005	The voice of the exclusion

Next **10. ROME** **2007 November - 15 years after: from 1992 to 2007**

Exclusion & Mental illness impossible challenge ?

2. RESEARCHES/Action

1. "**Preliminary survey about needs of Homeless & mentally ill people**" 1996-98
2. "**To leave in health and dignity** : presentation and evaluation of good practices for disadvantaged people" 1998-2000

3. EXCHANGE PROGRAMS

1. **Exchange program D&H-5P : "Dignity and health 1 " 2003-2004**
2. **Exchange program D&H/II-5P : "Dignity and health 2 " 2004-2005**

➢ NEXT STEPS 2006- 2007

1. **Project " … what after 15th years 1992-2007**
2. **Publication resuming these 15 years**
3. **Exchanging *bilateral* programs developing 'Dignity and Health"**
4. **Training project : Application to LEONARDO 2006**
5. **Network project : Application for networks 2006-07**
6. **DIGNITY & HEALTH for immigrants**
7. **Preparing the CONGRESS in Roma 2007**

SMES-EUROPA INITIATIVES 1992-2005		year	coutry
SEMINARS			
• **1st Seminar:** ***Mentally ill and Homeless***	**10-13 December**	**1992**	**Rome**
• **2nd Seminar:** ***Mental health & social exclusion …***	**2-4 December**	**1993**	**Brussels**
• **3rd Seminar :** *From exclusion to participation: an impossible Challenge?"*	**18-20 Mai**	**1995**	**Paris**
• **4th Seminar :** *"Citizen First. Exclusion: a burning issue"*	**16-18 April**	**1997**	**Madrid**
• **5th Seminar :** *"Dialogue & Exclusion"*	**6-8 Mai**	**1999**	**Copenhagen**
• **6th Seminar :** *"To live in Health & Dignity"*	**28-30 September**	**2000**	**Athens**
• **7th Seminar :** *"Change through Exchange"*	**10-12 October**	**2002**	**Lisbon**
• **8th Seminar :** *"Dignity & Health "*	**17-19 June**	**2004**	**Prague**
• **9th Seminar :** *"Dignity & Health "*	**06-08 October**	**2005**	**Berlin**
RESEARCHES - ACTIONS			
• **Preliminary survey**		**1996-1998**	
• **Research/action H&D1 : "*To live in health and Dignity*"**		**1998-2000**	
EXCHANGE PROGRAMS			
• **Exchange program D&H-5P : "*Dignity and health 1 *"**		**2003-2004**	
• **Exchange program D&H/II-5P : "*Dignity and health 2 *"**		**2004-2005**	

CONCLUSIONS OF

9TH SEMINAR

BERLIN 6-8 OCTOBER 2005

Statements - Recommendations - Summary

9th Seminar: Berlin 6-8 October 2005

IN PLENUM	The majority of the participants – expressed in plenum and in work-shops at the SMES-conference in Berlin 6. – 8. October 2005 agreed to recommend the following viewpoints, on the basis of the presentations and from 5 double workshops

At Berlin Conference was present more than 160 participants, from the 11 partners countries (BG-CZ-LV-PL-RO and B-D-DK-E-F-I), as well as other participants from other European countries.

NAPincl is a useful instrument : In the two projects NAPincl has been helpful in understanding and working in exchanges and discussions and in developing new and better strategies for social work with severely excluded people in Europe.

More focus must be put on prevention : Absolute priority has to be given to prevention of all kinds of chronicity in exclusion and rough sleeping.

Treatment and re-socialization is important but not the only need : The general political situation, the culture, tradition and levels of equality and humanity in the community play an important role in determining who and how many are excluded. The way mainstream politics is handled is just as important as the policies aimed directly at minimizing exclusion. The professionals and users in eastern European countries need to participate in a mutual exchange of knowledge, discussions and learning with colleagues from all over Europe.

Vocational and skill training of social workers must be strengthened : Multidisciplinary and trans-national studies are important instruments in social work, at the local as well as the national level. Further development must focus on all forms of cooperation between different services and the network, street teams and mental health teams.
Social work training should pay particular attention to skills in listening to all citizens, no matter who they are and what kind of "language" they talk. There must be a real focus on how to invite excluded groups to participate in the debate and on the need to accept the fact that these people are experts on their own lives. This does not just happen but must be encouraged.
We have to realise that no support to excluded groups is simple and uses just one approach. To be excluded is the result of multiple factors and is a complex matter. Therefore services as well as evaluation must be based on a multi- dimensional approach.

More outreach work less institutionalization is needed : We have to realise that care facilities are increasingly inaccessible and impermeable for marginalised people because of their costs and the increasing number of barriers in place to exclude difficult costumers. For this reason it is important that some social workers work as "bridge-builders."

Throughout Europe it has repeatedly been expressed that co-working between health and social services does not work well. Ideology and "language" are different. The two systems don't understand each other and each has a tradition, a set of strategies and aims that are basically different. Evaluations and joint conferences are needed.
Street-work is an increasingly common part of social work all over Europe and new methods for this kind of work are being developed. As a new way of operating it is important that a lot of energy is put into developing methods but it is also important that this energy is not used by all involved to develop the same services. Training, evaluation, research and development could and should be done by co-working between European countries.
Proximity in outreach work is an example of a common method of working. It offers useful ways of entering into pragmatic relationships: shelter, food, personal care, syringes. Beginning from these forms of help, the links which are established allow, when needs are expressed, further intervention in the field of rights, shelter and care. Mobile teams and street work are the most effective ways of making progress, allowing the re-establishement of links and dealings with the person. In order to continue, this kind of work relies on progress in community awareness.

The role of the public system and the NGO's must be further discussed : It appears that public services and NGO's are focusing on the same problems, but in practice they are experiencing difficulties in their daily co-working. What is needed on both sides is knowledge of and respect for the differences while on the other hand a method of using the different approaches for a more comprehensive assistance.

Users must be more involved on all levels: It is important to develop models to involve users on all levels. There is general agreement about this by professionals from both NGO's and the public system.
Participation and empowerment are the driving forces in the development of new skills and abilities.
Users are naturally particularly sensitive to everything involving discrimination and stigmatisation which prevents them from really finding a place in society and which reduces attempts at participation in specialised services to a derisory level. The two ought to go hand in hand and lead to the question of citizenship.
Self-help experiences (development of resources which increase the capacity of people to manage their difficulties by themselves) are another consideration
On all levels it is important that professionals learn to co-work with users. This is important also in research and evaluation.

Ethical issues must be part of the quality discussion : For professionals, voluntary workers and others working with excluded people, the main points are respect, listening quality and targeted intervention. The way to establish rights and to make sure they are respected passes through the development of more open and tolerant attitudes on the part of society. Difficulties encountered in making progress in this direction means that some mentally ill people have begun to organise independently, to create their own services and pressure groups with a view to claiming their rights and improving their situation.

In workshops The majority of the participants – expressed in work-shops at the SMES conference in Berlin agreed to recommend the following viewpoints, on the basis of the presentations and from 5 double workshops

EMPOWERMENT : regaining of dignity – rights – place in society

Statements

- Processes of exclusion and integration in society must be understood in a historical, political and community context.
- It is not only a question of treatment and services: the sense of community responsibility must be strengthened.
- Empowerment and the right to be a citizen must be based on a fight against inequality
- It is important to realise and overcome the history of political oppression in Eastern Europe.
- Users must be invited to active participation
- Excluded people must be regarded as individuals not as cases
- Users must be seen as human beings, with respect for their needs.
- There needs to be a change in the way health services work with users.
- Bridge the gap between psychiatry and social work!
- The need for new ideas and diffusion of information about alternatives to the official and traditional institutions
- Importance of active co-working between the public system and NGO's
- We suggest development of networking and common educational programmes for street-workers around Europe.
- Street-workers must network

Recommendation

The statements in the workshops concerning “regaining of dignity, rights and a place in society” seem to focus on five main themes:

1. The general political situation, the culture, tradition and levels of equality and humanity in the community play an important role in determining who and how many are excluded. The way mainstream politics is handled is just as important as the policies aimed directly at minimizing exclusion.
   The professionals and users in eastern European countries need to participate in a mutual exchange of knowledge, discussions and learning with colleagues from all over Europe .
2. It is important to develop models to involve users on all levels. There is general agreement about this by professionals from both NGO's and the public system.
3. Throughout Europe it has repeatedly been expressed that co-working between health and social services does not work well. Ideology and “language” are different. The two systems don’t understand each other and each has a tradition, a set of strategies and aims that are basically different. Evaluations and common conferences are needed.
4. It appears that public services and NGO's are focusing on the same problems, but in practice they are experiencing difficulties in their daily co-working. What is needed on both sides is knowledge of and respect for the differences while on the other hand a method of using the different approaches for a more comprehensive assistance.
5. Street-work is an increasingly common part of social work all over Europe and new methods for this kind of work are being developed. As a new way of operating it is important that a lot of energy is put into developing methods but it is also important that this energy is not used by all involved to develop the same services. Training, evaluation, research and development could and should be done by co-working between European countries.

DEINSTITUTIONALISATION :
alternatives to total institutions at social & health level

Statements:

- Care facilities are increasingly inaccessible and impermeable for marginalised people.

- Total institutions, those which claim to answer all the needs of the individual, produce only exclusion.

- The family-network and neighbourhood-network in which the mentally ill live, are not sufficient involved.

Recommendation

The statements in the workshops concerning “Deinstitutionalization†alternatives to total institutions at social & health level” seem to focus on three main themes:

1. Institutions working with the most excluded people must begin to involve all civil society
2. Put the person back at the centre in dealing with hospitals, places of specialised treatments
3. Promote community health with particular attention to those who are lacking in all social protection.

PARTICIPATION : evaluation, control, involvement

Statements

- Excluded people must be invited to participate in decision-making on political (state), administrative (state and local) and personal (local) levels
- Participation has to do with the right to democracy and promotion of involvement, empowerment and even citizenship
- To be heard and to be part of a dialogue should be the right of all citizens
- Peer research by people with experience of homelessness
- Professionals as well as users need to be trained in involvement
- Evaluation of services is needed
- We need structured threshold and crisis services

Recommendation

The statements in the workshops concerning “Participation, evaluation, control, involvement” have three main themes:

1. Particular attention should be paid to honest listening to all citizens, no matter who they are and what kind of “language” they talk. There must be a real focus on how to invite excluded groups to participate in the debate and on the need to accept the fact that these people are experts on their own lives. This does not just happen but must be encouraged.
2. On all levels it is important that professionals learn to co-work with users. The same with research and evaluation.
3. We have to realise that no support to excluded groups is simple and and uses just one approach. To be excluded is the result of multiple factors and is a complex matter. Therefore services as well as evaluation must be based on a multi -dimensional approach.

CHRONICITY and OUTREACH : on the street, in the institutions, at home

Statements

- Proximity and presence are the aptitudes characterising outreach
- Being able to have a say and being listened to are the most important aims of this work on the street.
- The contradiction between identity, respect for diversity and freedom of intervention in emergency situations can be overcome by caring for the person as a whole.

Recommedations

1. Develop research, both regarding real individual needs and the effective answers offered by the institutions.
2. Training – a specific training both for social workers and administrators
3. Prevention – absolute priority to be given to prevention of every kind of chronicity on the street
4. Multi-disciplinary and trans-national : develop all forms of co-operation between different services and the network, the street teams and mental health teams.
5. The basic aim is not to clear everyone off the streets, but to be present and care for these people.

DENIED IDENTITY - ILLEGAL MIGRANTS : dignity & health without borders

Statements

- Migration in itself is a cause and/or symptom of suffering, of deprivation
- Theoretical or practical rights – sometimes even the existence of migrants is denied
- This context of total deprivation of human rights and access to basic civil rights leads to vulnerability and exclusion.

Recommendations

1. The past history and present life of each excluded person must be studied, documented and made “public”
2. To define a real, official, secure, dignified place for migrants in our society.
3. It is important to investigate, discuss and bring changes to bear on ‘migration factors’…

DIGNITY & HEALTH

STUDY & EXCHANGE PROJECT

1ST & 2ND PHASE

2003 - 2005

FINALITY of PROJECT :

Using EU objectives to increase access to health and social services for the most deprived people and excluded people".

LOCATION

Brussels **(B)** and
Bucharest (**RO),** Warsaw (**PL**), Sophia (**BG**)**,** Riga (**LV**), Prague (**CZ**).

AIM

To promote the right and increase access to health and social services for homeless and socially excluded people in the 5 different accessing countries in EU

TARGET GROUPS

Professionals & non-professionals working directly with homeless and socially excluded people. This would, for example, include social workers, psychologist, G.P. doctors, nurses, and NGO staff.

DIGNITY and HEALTH – D&H/I-5P 2003-04

JUSTIFICATION

Is in the contacts were made with Eastern European organisations during previous pan European SMES seminars.
They requested assistance for increased contact between themselves and EU organisations Working with the homeless, particularly those with serious mental illness.

OBJECTVES

1. To present and discuss in each of the countries the daily practice and local dispositions that either interferes with or encourages access to social and healthcare services for homeless and vulnerable people
2. To present and discuss objectives of national action plans that might be effective in increasing access to health and social services
3. To increase local workers knowledge of EU objectives included in NAP, as it can be applied to
4. problems arising in their daily work
5. To increase awareness of EU action and initiatives with national and regional policy makers.
6. To produce local reports and materials which can both assist local practice and inform local policy and planning
7. To produce a final project report to enable wider dissemination of the local findings and to encourage international benchmarking.

DIGNITY and HEALTH – D&H/I-5P 2003-04

APPLICANT : **SMES-EUROPA**
Santé Mentale Exclusion Sociale Europa

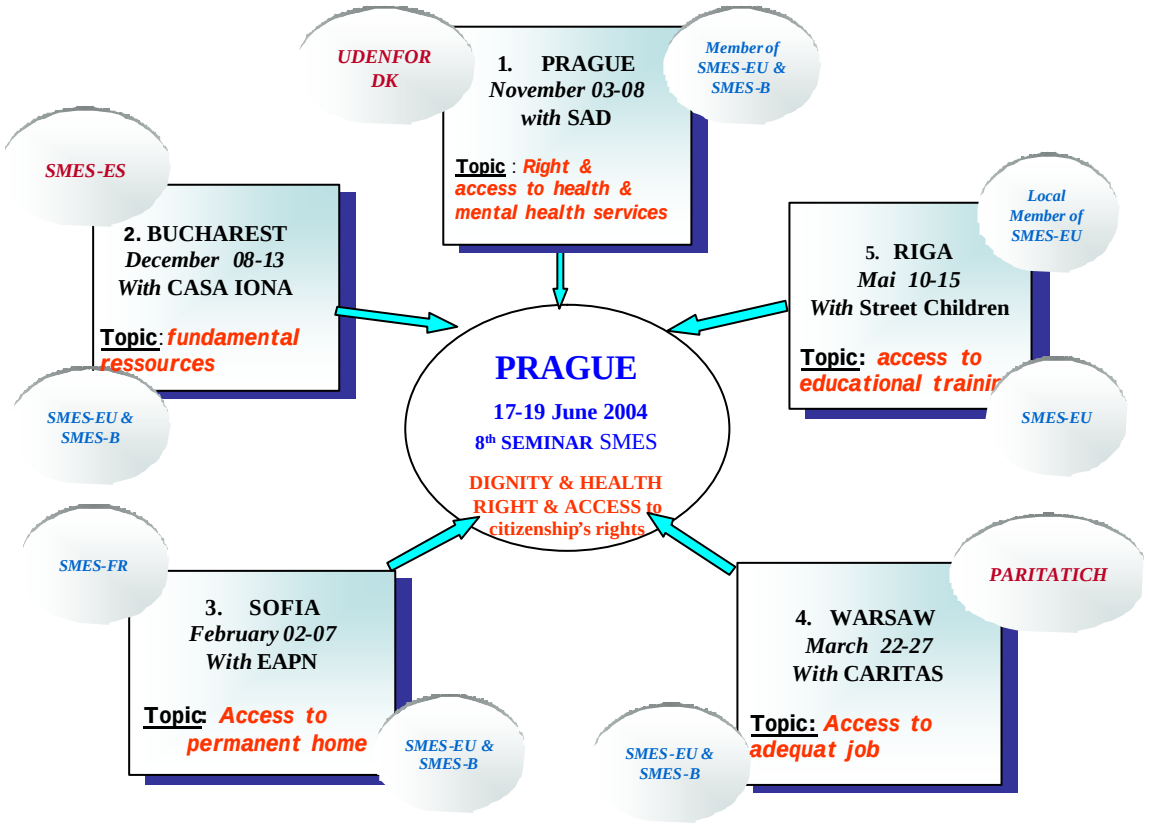
Responsible of D&H-5P : Luigi LEONORI, with supporter Team:
Preben Brandt, Philip Timms, Serge Zombek

Partners in EU countries: Udenfor, SMES-IT, Emmaus, SMES-B, Paritatische.

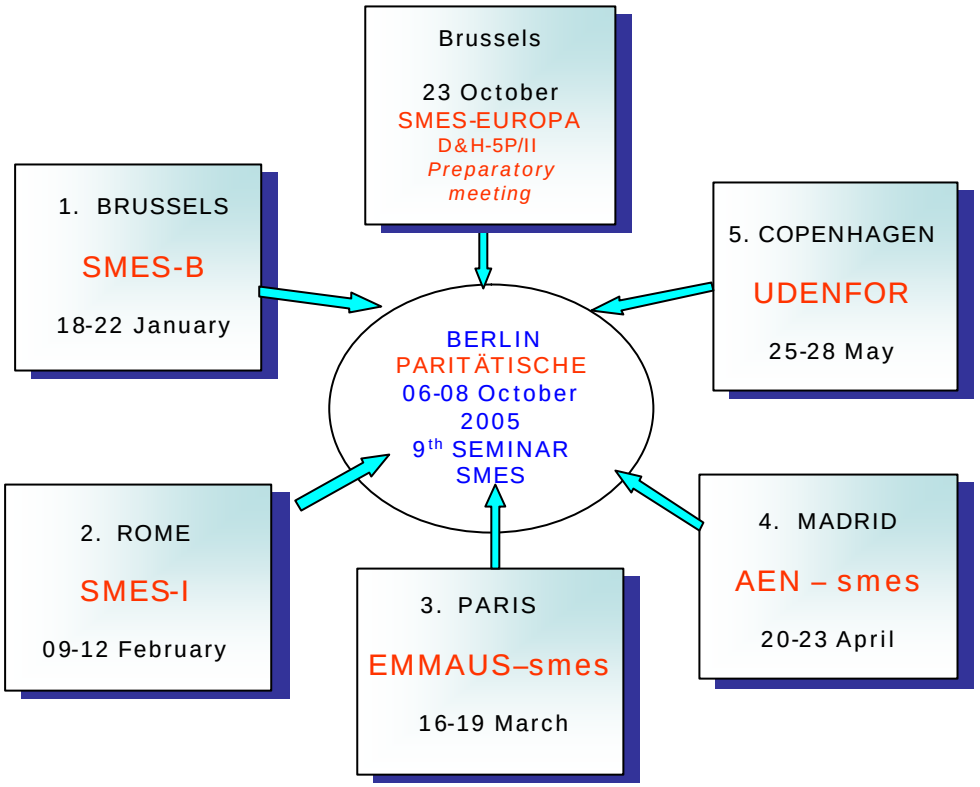
Partners of PHARE SPP:

Partner 1 Asociatia Casa Ioana - Bucharest, RO
Contact person: Marieta Radu
Partner 2 Assoc. for street children, Riga, LV
Contact person: Rita Erele
Partner 3 Caritas Polska, Warsawa, PL
Contact person: Andrew
Partner 4 Anti-Poverty Info Centre Sophia, BG
Contact person: Maria Jeliazkova
Partner 5 SAD – Prague CZ Republi
Contact person : Neil Davies

2004 DIGNITY & HEALTH 5 P phase 1



2005 DIGNITY & HEALTH 5 P phase 2



1. BRUSSELS SMES-B 18-22 January 2005

SMES-EUROPA : European Coord. Luigi Leonori

Local PARTNER : **SMES-B**
Serge ZOMBEK, psychiatrist

VISITORS

- **(BG) Todorova, Mariela** Coordinator NM "Women and Mothers against Violence"
- **(D)Patrizia Di Tolla** Psychologist, Der Paritätische Wohlfahrtsverband, LV Berlin e.V.
- **(D) Jochen Schroer,** Socialworker rowo e. V.
- **(D) Sabine Anneliese Dick,** student
- **(DK) Preben BRANDT,** Director of Udenfor
- **(DK) Ninna HOEG ,** Manager Projekt Udenfor
- **(F) Michelle DREYFUS,** social worker, CHS St Anne
- **(F) Jacques SIMONNET** délégué pour Sécours Cath
- **(I) Paolo REALACCI ,** sychiatrist,SMES-IT
- **(LV)Rita ERELE**, social worker, Association for Street Children
- **(LV) Janis Strazdins,** Program coordinator, Riga City Mission
- **(PL) Andrzej Czarnocki,,** Local Coordinator of the Project , Caritas Polska
- **(PL)Anna Kuczynska,** social worker, Coalition For Mental Health
- **(RO)Marieta Radu,** coordinator , The Casa Ioana Association

INITIATIVES

Exchange meetings : in CHS St Pierre

- **Mini-Seminar Social & Health System in B**
- **Poverty Observatory and NAP**

Exchange visits in daily practices :

1. **Centre de Santé mentale :** Antonin Artaud
2. **Cellule d'Appui Médico-psychologique** d'intersection entre la santé mentale et l'exclusion sociale
3. **Dispositif Hivernal (asbl Pierre d'Angle)**
4. **Espaces de Parole**
5. **Accès aux soins - MSF-B**
6. **Habitations Protégées Bruxelloises**
7. **Home Baudouin** (asbl Œuvre de l'Hospitalité)
8. **La Fontaine**
9. **Unité Mère – Enfant (C.H. Jean Titeca)**
10. **Parentalité – Addiction + Alizés** (CHU Saint-Pierre asbl)
11. **Service de Santé Mentale Rivage** – den Zaet
12. **Le SAS** (Service d'Accompagnement Social) (CPAS de Bruxelles)
13. **Maison d'Accueil** Socio -Sanitaire de Bruxelles

2. ROME SMES-It 9-12 February 2005

SMES-EUROPA : European Coord. Luigi Leonori

Local PARTNER SMES-IT
Paolo REALACCI , psychiatrist

VISITORS

- **(BG) Todorova, Mariela** Coordinator NM "Women and Mothers against Violence"
- **(CZ) Lucie RIPOVA** Psychologist, Der Paritätische Wohlfahrtsverband, LV Berlin e.V.
- **(D) Lage -Stede ,** Socialworker rowo e. V.
- **(DK) Ninna Hoêg,** Manager of Project , Udenfor
- **(DK) Preben BRANDT,** Psyciatrist, Udenfor
- **(F) Florence de Grammont, psychologist,** Emmaus
- **(F) Odile BOUDEAU (F) ,** social worker, Emmaus
- **(LV) Diana Vasilane ,** Christian Shelter for Street Children
- **(PL) Ewa Mochocka,** Local Coordinator of the Project , Caritas Polska
- **(PL) Danuta Mlynarczyk ,** social worker, Coalition For Mental Health
- **(RO)Marieta Radu,** coordinator , The Casa Ioana Association

INITIATIVES

Exchange meetings :

- **Mini Seminar Ministero del Lavoro e delle Politiche Sociali**; L. Battistoni
- **Dipartimento Salute Mentale Azienda Sanitaria "Roma C";** L. Attenasio
- **Medici Senza Frontiere** ; A. Oglino

Exchange visits in daily practices :

- **Medici Contro la Tortura,** E. Zerbino
- **Ex Ospedale Psichiatrico S. Maria della Pietà**; T. Losavio
- **Caritas clinic** ; S. Geraci
- **Ostello Termini** ; R. Molina
- **Dipartimento Salute Mentale Azienda Sanitaria "Roma C";** L. Attenasio
- **Cooperativava "Zingari"** – Giusi Gabriele
- **Centro Diurno e Comunità Terapeutico-Riabilitativa San Paolo T**onia di Cesare
- **Cooperativa il Grande Carro**; I. Volpi
- **Il Negozio "Fuori Serie"**; P. Lecce
- **Sant'Egidio Community**; T. Sammarone
- **Cooperativa Cotrad** ; L. Guerra
- **Zabaione** ; M. Zaccardi

3. PARIS EMMAUS Smes Paris 16-19 March 2005

SMES-EUROPA : European Coord. Luigi Leonori

Local PARTNER Association EMMAUS
Patrick ROUYER

VISITORS

- **(B) Serge Zombek,** Psychiatrist – SMES-B
- **(BG) Stoykova, Nadya** Social Worker ; SAPI
- **(CZ) Ilja Hradecky,** President ; NADEJE
- **(D)Patrizia Di Tolla** Psychologist, Der Paritätische Wohlfahrtsverband, LV Berlin e.V.
- **(D)Gisèle Borgol** Psychologist, Der Paritätische Wohlfahrtsverband, LV Berlin e.V.
- **(DK) Ninna Hoêg,** Manager of Project , Udenfor
- **(E) MariFe BRAVO,** Psychiatrist, AEN, Smes Madrid
- **(E) Paqui Mancebo Muñoz ,** Social Worker, RAIS FOUNDATION
- **(E) Pilar López Iglesias ,** Social Worker, RAIS FOUNDATION
- **(LV) Ieva Leimane-Valdmeijere ,** Program Director, Latvian centre for human rights and ethnic studies
- **(PL) Aneta Makowska** , Project Manager,; Caritas Wroclaw
- **(PL) Danuta Mlynarczyk** Project Manager,; Caritas Wroclaw
- **(RO) DRAGOI IRINA ,** Director , Saint Stelian" Association

INITIATIVES

Exchange meetings :

- **Mini Seminar in Municipality of Paris**
- **Final Evaluated Seminar in Emmaus Association**

Exchange visits in daily practices :

- **La Moquette** (Les Compagnons de la Nuit)
- **CHRS Pauline Roland,** du CASVP
- Advocacy
- **Association Emmaüs** divers projets
- **Aux Captifs, la Libération** «St Eustache»
- **Secours Catholique,** Accueils de jour; Voûte, 11 bis, antenne Sud Est
- **Centres d'Hébergement d'Urgence**
- **Maison Jean Rodhain** et Maison Helder Camara
- **Accueils de rue Gare du Nord** et Boulevard Edgar Quinet
- **Equipes mobiles** aux Apennins, à La Voûte, au 11 bis.
- **Equipes « SMES » des hôpitaux** psychiatriques
- **Equipe mobile Santé mentale** & Précarité MAISON-BLANCHE
- **Prévention Santé**: Equipe de rue,
- **Point Ecoute Jeunes** ; CHRS
- **Restos du Cœur** (Haxo)
- **La Halte Femmes** - La Halte Paris-Lyon
- **Le « 16/25 »** (Cœur des Haltes)

4. MADRID AEN – Smes Madrid 20-23 April 2005

SMES-EUROPA : European Coord. Luigi Leonori

Local PARTNER AEN, Smes Madrid
Maria Fe BRAVO, Psychiatrist

VISITORS

1. **(B) Chantal Van Oudenhove,** Psychologist, MSF-Belgique
2. **(BG) Angel Gyorev** Coordinator of Home care program ; Caritas Bulgaria
3. **(CZ) Pavla Klingerová ,** Street worker ; NADEJE
4. **(D)Patrizia Di Tolla** Psychologist, Der Paritätische Wohlfahrtsverband, LV Berlin e.V.
5. **(D) Birgit Angermann,** Social Therapeut , Die Reha & Wohnen Und Freizeit
6. **(D) Norbert Andreas Günter Prochnow**; assistant chairman Unionhiflswerk Sozialeinrichtungen gGmbH
7. **(D) Kerstin Döring,** Projektleiterin, Mittendrin in Hellersdorf – Verein zur Integration Behinderter"
8. **(D) Volker Schröder,** business manager, GINKO-Berlin gGmbH
9. **(D) Norbert Lassek**, MA Economist, Verein für Integrative Angebote VIA e. V. Berlin - BrandenburgDer Paritätische
10. **(DK) Preben BRANDT,** Psychiatrist, Director of Project , Udenfor
11. **(D) Jochen Schroer ,** Social Worker„ PROWO e. V
12. **(F) Jacques SIMONNET ,** Psychiatrist, Consultant of Emmaus & Secours Catholique
13. **(LV) Ilze Klauza ,** Psychologist, Project Coordinator, Riga City Mission
14. **(LV) Mareks Sirants ,** Lawyer, Volunteer, Riga City Mission
15. **(PL) Anna Dabrowska** , Director, Centrum Opieki Caritas Archidiecezji Wroclawskiej
16. **(PL) Renata CICHON** Akompaniator, Akompaniator Consultative Point Of Office
17. **(RO) Mariana ARMEAN ,** Project coordinator , Estuar Foundation, Bucharest

INITIATIVES

Exchange meetings :

- **Comunnity Mental Health Services**: SSM Fuencarral
  Mental Health System: Dr. Ferre
- **Seminar:** Agencia Laín Entralgo (Gran Via)
  Mental Social Services: Abelardo Rodriguez
  Local Social Services: Dario Perez
- **AEN** C. Villanueva 11

Exchange visits in daily practices :

- **Samur Social**
- **S. Vicente Paul** Intégral Project
- **CASI PRISEMI**
- RAIS "El Rincón del Encuentro"
- **RAIS Solidarios**
- **Mental Health Network** IP José Germain
- **Doctors without borders** MdM - Madrid
- **Mental Health Outreach Team**
- **"Centro Abierto"** Open Center
- **"Realidades"**

5. COPENHAGEN UDENFOR 25-28 May 2005

SMES-EUROPA : European Coord. Luigi Leonori

Local PARTNER UNENFOR Projeckt
Preben BRANDT, Ninna Hoêg

VISITORS

- **(BG) Todorova, Mariela** Coordinator NM "Women and Mothers against Violence"
- **(BG) Ekaterina Terzieva,** Volunteer Red Cross-Youth Section
- **(CZ) Jan Kadlec ,** Deputy Director ; NADEJE
- **(D) Rainer Deiters** Für alle Fälle e.V. In any case) Der Paritätische Wohlfahrtsverband, LV Berlin
- **(D) Annette K. Lorenz** BOP&P e.V. (Berlin Organisation of (ex-)users and survivors of psychiatry)
- **(D) Günter Geil,** Psychologist, Albatros e.V.
- **(E) Raquel Alonso Ruenes ,** Psychologist, Worker, RAIS FOUNDATION
- **(F) Jacques SIMONNET ,** Psychiatrist, Consultant of Emmaus & Secours Catholique
- **(LV) Sandra Alpa ,** Director of Integration Program, Oasis for children
- **(PL) Andrzej Czarnocki,,** Local Coordinator of the Project , Caritas Polska
- **(RO) Marieta Radu,** coordinator , The Casa Ioana Association

INITIATIVES

Exchange meetings :

- **Health – Mental health and Social health** for homeless, drug users and mentally ill people - By Preben Brandt
- **Denmarks N A P for Inclusion** By Mrs. Anne Worning, VFC Socialt Udsatte, (Danish Centre for Research on Social Vulnerability)
- **" Not in my back yard"** by Rune Gaustad, Project UDENFOR
- **Users of shelters' opinion of the NAPincl**. Including introduction to the national organisation of users of shelters S.A.N.D. by Ask Svejstrup

Exchange visits in daily practices :

- **Visit at "Mændenes Hjem"**(Mens Home) a drop in centre and shelter for homeless men; Mr. Robert Olsen
- **Visit at "Bisserne"**(toothy pegs)a dentist for homeless and excluded persons
  Kate Caroc and Peter Østergaard
- **Participation in the work of The Mobile Café** Brian Sørensen, Projekt UDENFOR,
- **Visit at E-huset- De Gamles** By (home for elderly with use of alcohol) Mrs. Mie Thomsen
- **Visit at Hotellet;** by Mrs. Janni Petersen
- **Ex-users as socialworkers**- by Mrs. Britt Nielsen
- **Visit at the Municipality of Ballerup :**
- **Visit at "drinking shelter":** Conni Hart and local politician Peter Falkenkrone
- **Visit at Christiania** : a) project "from here and furter on"– b) "House of Health" and tour

SMES – EUROPA
NEXT STEPS

Project " … what after 15th years 1992-2007

Publication resuming these 15 years

Exchanging *bilateral* programs developing 'Dignity and Health"

Preparing the CONGRESS in Roma 2007

Only any ideas

that would propose next new project

« Dignity & Health 1992 – 2007 : what after 15 years ?... »

PROJECT : « Dignité et Santé 1992-2007 : … et après 15 ans ? »

START POINT Point de depart

Also if from 1992 (date of our beginning) so many initiatives and programs, both at private and public (regional – national – European) level, today the poverty, discrimination and exclusion, touch more and more the people in EU.
From this *conclusion* of sociologist studies and politico-economic researches, SMES would like preparing, organising and realising for the 10th European Seminar, a large conference in Rome 2007, involving – as possible – all organiser Institutions and Participants, who created the other 9 seminars in Rome-92, Brussels-93, Paris-95, Madrid-97, Copenagen-99, Athens-00, Lisbon-02, Prague-04, Berlin-05: ***"what after 15 years ? what possible for the future ?"***

During : two years

A. PROPOSITION

Proposed project by SMES-EUROPA will be developped in 3 axes: evaluation – study/éxchange – dissemination of proposals.

a) **Comparative evaluation in longitudinal & transversal way:** at 15 years from the 1st seminar, (Rome dec. 92), in active way and together with che Organisations of 9 capital cities who organised the seminars Rome (92), Brussels (93), Paris (95) Madrid (97), Copenhagen (99), Athens (2000), Lisbon (02), Prague (04), Berlin (05), make reflection and evaluation on the past , but more try to bring out the priority and the perspectives for the future.
b) **Study/exchange:** to prepare a study (as our *'Preliminary Survey'*) on health and mental health condition of people welcome – supported and accompanied in drop-in centres, with especially attention in health and mental health needs of woman, elder people, immigrants undocumented.
Using for this adapted method and instruments of «P**reliminary Survey of SMES**», promoting also and facilitating any **exchange bilatelral prorgram** between professional people who working especially in this kind of centres, in relation with outreach teams, in order to bring out the criteria of "excellence" and the "efficiently" practices in both prevention and reinsertion levels.
c) **The report disseminated in and after conference "the present confronted with the past"** must feed the deepest reflection, the exchanges, the proposals in the 10th big Rome Conference in order to re-new the aims – projects – initiatives for the future.

B. CONCRETLY

In Paris, as in Rome, Brussels, Madrid, Copenhagen, Athens, Lisbon, Prague et Berlin

1) **To promote a deepest reflection** : using the usual and daily « espaces de parole et réflexion » of each Organisation,
   - **In relation to the past :** what kind of evolution (in + or /and in -), from 1992, concerning
     - The field (target people and workers - actors),
     - The politic & administration (political body and administrators),
     - The lows (lois, décrets, circulaires)
   - **In realtion to the présent** – study / exchange : more in the welcome centers - 'drop in' as Agora in Paris, where will be attentive observe the « needs & answers » in relationship with mental health and psychical suffering situation of more vulnerable and abandoned people : woman – elders – immigrants "clandestins".
   - **In relation to the future** - perspectives : at mi-time of this project and action will be possible beginning make attention in the priority where we would focus attention in the Conference / Congress.

2) **Description of the action**

   - **Préparation :** to program for the first quadrimestre (01-04 / 2006) any meetings :
     - With the more actif local coordinators in order to establish key words – subjects – topics that must offer inspiration for colecting information, data and method for the longitudinal (time) and transversal (field and national ….) evaluation.
     - With the redactor to prepare a frame bothe : for interviews with the coordinators and for the 'content' of book resuming this time and action.
   - **To collect documents :** in the two other quadrimestres (05-12 / 2006) to insure :
     - The collecte – by the coordinators - of documents concerning a) the field (target peope and workers), b) the politic action (political bodies and administrators), c) low field (low, decrets, circulaires)
     - The intreeviews and monitoring meetings between the European Coord. – redactor – Local Coordinators.
       - At May, if possible, to propose a monitoring meeting in Cyprus, take the opportunity of MHE conference (?)
       - At October, to have a meeting with all the 15 (?) in Finland, where will be the Round Table of Inclusion
   - **Elaboration and redaction : first** quadrimestre 2007 and complete the intrewiew and correction
   - **Printing (and translation) : from** May 2007

NB. : I propose as complement of collecting data and information to make DVD with interviews – film – photos 45 min. that will be useful for opening the conference in Rome . Each coord could develop a topic important for him.

A DISCUTER et ETUDIER ! - for discussion and study of DVD project

PROJECT FOUNDING

SMES – EUROPA

as **ASSOCIATION** a.i.s.b.l.

2000-2001

INTRODUCTION

"All people have the right to the best available mental health care,
which shall be part of the health and social care system".
(Resolution 46/119,1.1, Gen. Ass. UN, 17/12/1991)

The European Project "Santé Mentale et Exclusion Sociale" SMES-EUROPA "Mental Health and Social Exclusion" is a limited contribution to the actions and initiatives in several large European cities in favour (defence) of those frequently forsaken, i.e. **the severely mentally ill** who become homeless street-dwellers and also vice-versa.
Among the poor they are the most vulnerable, prone to further mental disorders and diseases.

A strong relationship exists between "**social problems - health problems",** "**extreme poverty - social exclusion"** and "**homelessness - mental illness"**.
The experience acquired working in this field[1], meetings with staff and agency representatives in major European cities, the nine European seminars on "***Mental Health and Social Exclusion"***, the conclusions of the *"Preliminary MHSE Survey"* and of "*Health and Dignity"* research/action, the direct contacts (visit and exchanges) with divers projects in many European metropolis realised with "Dignity and Health 5 Projects", amply demonstrate that successful actions and programmes of prevention, treatment, and rehabilitation have to be based on a double-sided approach where social aspects go alongside health considerations to achieve the overall well-being of an individual.

Aims and Objectives of MHSE Project

1. **Promote an awareness in society as a whole,** and more specifically among social and health workers, politicians and the public at large regarding the "*de facto***"** loss of access on the part of the homeless & mentally ill, (abandoned on the streets, in their own home, in psychiatric institutions), to basic health and social services which should be theirs by right.

2. **Promote the "Human Right",** the most fundamental and indisputable rights which should guarantee all human beings access to all basic social and health services.

3. **Emphasising** the link between social precariousness (exclusion & extreme poverty) and disease (in general health and particularly in mental health).

4. **Facilitate meetings, seminars and exchange programs between** professional and voluntary people working in exclusion field, with the express aim of exchanging ideas and relating experiences and know-how on such topics as promoting the continuous learning and training of staff and sharing projects.

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[1] *The idea of the MHSE project is the result of our personal work experience as Director of the Ostello-Termini (sheltering homeless people in the central train station in Rome).*

5. **Promote collaboration by setting up a** European MHSE network which will act as the promoter of structured and coherent projects on the streets, in shelters for the homeless and in work rehabilitation centres.

6. **Promote analysis and evaluation,** based on research-actions and exchange programmes, of co-operation between social and health sectors both in the areas of identifying needs and in setting up prevention, rehabilitation and inclusion programs.

1. Starting point

The "mentally ill homeless" of any sex and age (increasingly young, though) may reach a state of total marginalisation and lose their rights as citizens. They do not benefit from solidarity or social security and are forced to live in a state of total neglect, as their presence in subway, train stations or in the street show.
Stripped of their dignity, they appeal to each and everyone of us: paid and unpaid staff, policy makers and the general public; we are all reminded of a fundamental *"human right"*, i.e. human dignity. These completely "useless" people are not the object of avant-garde psychiatric treatment, nor is their be rehabilitation considered through carefully studied training / rehabilitating programmes, for they are "mentally ill" rough sleepers frequently forsaken or undesired.

These outcasts are an epiphenomenon of an overall degradation process. The unbearable sight of these marginalised people point at the central core of society, they are an exaggerated projection of the latter's state. A line joining those on the **fringes** and those at the **centre** might easily be traced showing substantial continuity. Even if the role of pangs of conscience, pity or patronising attitudes cannot be denied, they are not the true cause for action. It is a question of "**rights"** and "**obligations"** and three considerations must be given priority:

- **Reaffirming personal dignity and human rights**
  The outrageous scenes in some highly industrialised countries in the world are urgent appeals to enforce the respect of basic human rights of the homeless and of those living in families or institutions. Their rights are often «tramp»led upon in the name of the much-acclaimed freedom of the individual or simply because of red tape.

- **Preferring innovative and alternative projects**
  The scale of the problem and the ineffectiveness of mere "assistance" in the long run call for medium/long term innovative and alternative projects. Individuals must be seen as people having rights, needs and living in a context where the social/health private and public sectors interact.

- **Promoting urgent prevention measures**
  Unless there is prompt intervention into the causes from which the process originates, the present crisis in the welfare system will inevitably deepen, with disastrous consequences for the young and all those in greatest need.

2. Relationship between : poverty - social exclusion homelessness - mental illness

Marginalizing and exclusion processes are **rarely deliberately "chosen", they are sometimes merely endured, and all too often imposed** in the name of certain social standards. Progressive marginalization has very serious consequences for the most vulnerable in society. Such consequences may manifest themselves as follows:

- Joblessness and homelessness;
- Family instability;
- Onset or deterioration of diseases;
- Failure in health and social security rights;
- Loss of points of reference and dissolution of social links;
- Definitive loss of identity and social status.

Not all may occur, still they pave the way to a process of marginalization resulting in final exclusion. Mental illness, if particularly severe and combined with social and economic uncertainty or outright poverty, is either the cause or an additional factor leading to marginalization. The poor mentally ill can be regarded as **those in greatest need amongst the "handicapped",** for their situation is a veritable psycho-social "handicap" preventing them from benefiting from the same rights as other citizens. Their state of neglect and exclusion is frequently doomed to worsening.

Several complex factors of a structural and personal nature accelerate exclusion processes in present-day European societies. They can be listed as follows:

❑ Socio-economic and cultural factors:

The family dissolution, long-term unemployment, "new" poverty added to the previous state of need, housing crisis, loss of primary and secondary social links, etc.

❑ Health system factors:

The disastrous consequences resulting from *reforms* in mental health legislation which do not create intermediate and alternative infrastructures following a decrease in the number of psychiatric wards or the closing down of mental hospitals.

Furthermore, the streamlining cuts in health expenditure are generally followed by greater administrative obstacles preventing the least favoured from getting care.

❑ Psychological and emotional factors:

The "discomfort" and "world weariness" experienced in a society where preference is given on the basis of competitiveness and productivity, thus causing failures, stress, emotional shocks, addiction to "substances", mental problems, psychiatric diseases, etc.

People receiving social assistance, individuals without a permanent lodging, rough sleepers, «tramps» and vagrants are not "new psychiatric categories". Utmost caution is needed to avoid offering a pretext to those who, all too easily, claim that "*poverty/homelessness equals mental illness*".
Mental weakness, mental illness, and a condition of poverty or social uncertainty do interact, and in the long run they may slide into a permanent state of extreme degradation.

- Individuals who previously suffered from psychiatric problems and had to put up (for there never is a deliberate "choice") with a "facile, passive, calculated" discharge from an institution risk becoming rough sleepers or «tramps» because they fail to get alternative follow-up treatment.
- Individuals with poor or no accommodation very often begin to suffer or suffer more acutely from mental disorders and psychiatric diseases (depression, suicidal behaviour, alcoholism, addiction to substances, etc.).

Poverty and disease become strictly intertwined in a vicious circle of marginalization leading to a total loss of social links.
Experience shows that adequate housing, and appropriate regular care enable those who suffered or are still chronically suffering from psychiatric disorders to lead an independent and satisfactorily autonomous life.

3. European problem European response

In the European Union these people live in a state of uncertainty for their immediate future. Their "world weariness" deepens because of the economic crisis and especially because of the crisis in values: the respect of an individual's dignity (who cannot be seen as a mere means of production), the recognition of diversity, and the value of solidarity in a society ruled by competitiveness and productivity for the unproductive and uncompetitive. Thus, sliding from a situation of *marginalization* (still "within" society, even if on its fringes) into *exclusion* ("outside" society) is merely a matter of time.
Marginalization and exclusion affect an increasing number of people in different areas. Anxiety for the future even spreads among those who have not yet been affected by unemployment or poverty.

The extreme situation of the *mentally ill homeless people* living in subway or train stations or on the street is a common feature of large European cities. It is intolerable because of:

- the scale of the problem, even though precise figures are not available;
- the serious state of degradation and exclusion experienced;
- the high degree of physical and mental suffering despite apparent "apathy and aloofness" which might give the opposite impression.

If persisting for some time and coinciding with physical and mental stress, the social and economic uncertainty of long term unemployed or socially assisted individuals, of those without a permanent lodging or with poor or no accommodation, of vagrants and «tramps» can reinforce and accelerate the process of de-socialisation and marginalization resulting in irreversible "vagrancy" and social exclusion.
Indifference towards someone else's suffering may result from being used to outrageous sights, and from a feeling of helplessness when faced with such complex problems.
This is a European problem which is becoming more serious every day.
Beyond national differences, this is a European problem: the problem of marginalization and exclusion is becoming more and more serious in Europe, hence the need for European responses.

4. The need for integrated multidimensional programmes

The state of exclusion and neglect of some people among the mentally ill is certainly not a priority for policy makers in the social or health sectors. Sometimes they are not even a priority for the social or health staff. People suffering from extreme precariousness do not have the possibility of making themselves heard to denounce this *blatant non respect of fundamental human rights, social misery and lack of medical care* which is not their fault or choice.

What does being a man or a woman mean to these mentally ill homeless people ?
Piecemeal action in favour of this group is a stopgap in extreme cases of need, when aid is urgently needed, but in the long run it is ineffective unless supported by political action allocating resources or active participation of users. Overall responses to the needs of an individual call for medium/long term programmes which are:

- specific and consistent vis-à-vis the right of each and everyone of us to physical, mental and social health/well-being, particularly for the most vulnerable in society;
- linked and complementary with health/social, public/private aspects of policy makers and staff;
- integrated and with a community nature so that they refer to their territory (sector) to achieve rehabilitation within society and within families through a type of solidarity that recognises diversity as well as the autonomy of individuals.

There cannot be a sectionalised approach to fight marginalization and exclusion: marginalization results from various complex and interlocked factors, and experience has shown that overall, integrated responses are urgently needed. These responses cannot be offered by "charity" associations. Public/private organisations working in the health and social sectors must definitely be involved. Despite these self-evident truths, initiatives, both at the national and European levels, tend to adopt a piecemeal approach deprived of any context. Problems are tackled in isolation (e.g. physical or mental handicaps, addiction to drugs or alcohol, unemployment, housing, etc.) ignoring the links and the complexity of all the factors behind them. Their solution, however, precisely requires multidisciplinary, integrated programmes.

5. INTERACTION – COMPLEMENTARY - PARTNERSHIP

The missing interrelationship and complementary between social and health policies are best seen through the many inconsistencies in everyday social and health practice, which reflects the missing link between European, national and regional policies. For instance:

- Social services point out: "*the mentally ill are not our responsibility*"
- Health services react stating: "*these are genuine social cases well outside our remit*"
- Rehabilitation services remark: "*they are unfit for work and we cannot help them*"
- Housing agencies observe: "*they do not have the means to get an accommodation, let alone keep it*".

Local authorities often wash their hands of these people, placing a heavy burden on charity organisations and associations who have to *assist* those in greatest need. Various agencies act with charity associations and volunteers to respond to urgent needs. Constant financial uncertainty, due to the difficulties in getting grants and subsidies, prevents medium/long term programmes, differentiated strategies, innovative initiatives, training courses, etc.

These services can be viewed as *humanitarian assistance*. They respond to *urgent needs,* do not fitting into social or health programmes with integrated projects caring for the overall needs of an individual in a specific environment. The risk is that of making these people totally dependent on charity assistance.
It goes without saying that the specific initiatives of private organisations offering solidarity are totally inadequate without the involvement of policy makers.

6. RESEARCH – ACTION FORWARD STUDIES

There are no fixed criteria or statistical data to assess the number of marginalised and excluded people. Experience, though, shows that their numbers are larger than their presence in the street or in subway stations might lead us one believe to think. Furthermore, the scale of the problem is bound to increase as immigrants, especially from Eastern Europe, will come to our society searching for "well-being".
In the absence of prevention programmes and consistent planning, the number of marginalised and excluded mentally ill homeless people is bound to increase.
Consistent planning to avoid long term ineffectiveness of fragmented assistance needs a comprehensive, multidisciplinary study on the problem's scale and on the factors behind the exclusion process.

Such a study would overcome the present stage of a *policy based on need,* which risks perpetuating a state of dependence on assistance by responding to urgent necessities.
In order to achieve these goals, i.e. drawing up specific programmes with clear targets and creating a network of integrated structures and services, the study should analyse:

- the scale and nature of the problem,
- social factors and mechanisms leading to marginalization and exclusion,
- existing needs and responses in order to identify missing services.

7. CRUCIAL PRIORITIES

Urgent problems should never avert attention from basic ones.
The first priority consists in establishing basic conditions for a decent life safeguarding the dignity and the fundamental rights of a person.
A specific medium/long term programme will promote:
A comprehensive study with preliminary multidisciplinary research.
Before drawing up a programme, a study has to be carried out on causes, needs of individuals, services provided and those needed.

Prevention measures which avoid risk groups and individuals, made more vulnerable by the economic crisis (e.g. un-integrated youths, women facing family difficulties, the elderly suffering from isolation, "new" immigrants, etc.), from slipping towards a state of chronic vagrancy which is more difficult to overcome at a later stage.
Time combined with a failure in regular and appropriate *continuous treatment and social assistance* are crucial factors for a temporary condition to become chronic.

The creation of a network linking integrated and complementary bodies and service centres (i.e. communities, medical and rehabilitation services, psychiatric wards in hospitals) adapting them to needs. More specifically :

- on the street: (namely in subway and train stations or on the pavement) this is the first and most difficult approach which has to be carried out by specialised staff who know how to "listen" and establish confidence;
- in first aid centres which are open 24 hours a day to respond to crisis situations;
- in “intermediate structures”: those centres between “indoors” and “outdoors”, e.g. shelters and care or treatment centres;
- in "life spaces" adapted to the needs of individuals that are to be rehabilitated in society.

Rehabilitation and work: in these “life spaces” different job opportunities have to be offered and supported by observation, guidance, and training structures facilitating social rehabilitation.
Many previous operative programmes supported innovative actions and model initiatives intended to "*improve the access to work and the competitiveness of the handicapped [...] by means of vocational training and [...] economic and social integration*".

The logic here seems to be the same as the one that is the basis of the job market, namely:

TRAINING ➔ COMPETITIVENESS ➔ PRODUCTION

.

This “strategy” cannot be applied to people suffering from mental disorders, it does not take into account the situation of degradation they experience.
Social integration cannot be achieved without a job. A job, however, does not guarantee automatic rehabilitation. It is not for the individual to adjust to a job, but for a job to be the expression of an individual's "participation" and "production" within society.
An individual may be said to live in a social context as long as he/she produces services through her/his personal abilities by participating in the social development of a community.
The mentally ill have long been condemned to a passive role leading to the inevitable loss of human potential and at high social costs.
If only new opportunities could be offered !

8. THE NEW CHALLENGE

The shocking scenes of mentally ill homeless people on the streets or in the subway and train stations of large cities are not merely a reminder of their own status as people on the fringes of society, but they are also an indication of the situation in the centre of society, where the medical and social challenges lie, that is:
Treatment is not a synonym for *cure* and impoverishment/de socialisation lead to *world weariness* causing or worsening diseases.. Alternative and innovative social and health initiatives have to be devised on the basis of new theories, which refer to the individual as a whole.

De stabilisation and severance of social links result in the individual leaving primary and secondary places of socialisation because *of unemployment and homelessness.* New social rehabilitation and solidarity policies have to be implemented.
The loss of social identity and citizenship is worsened by various administrative obstacles which marginalise and exclude individuals who are deprived of their civil rights and social status.

Services have to be conceived in order to promote a new approach to citizenship.
Marginalised individuals do not merely expect a response in terms of their basic needs (housing, food and clothing), they are entitled to an overall response that requires:

- drawing up new strategies in the fight against marginalization (unemployment, mental illness, housing, poverty, etc.) within society,
- promoting a new approach to solidarity,
- moving from tolerance/acceptance of diversity to recognition/integration,
- reaffirming the inalienable rights to health treatment, social security and housing for all individuals regardless of their social status.

An overall response will be possible only if there is a *change in attitude* with new values guiding theory and practice. For instance: staff and volunteers must go beyond the principles of "cure - treatment" and "reintegration", policy makers must go beyond "immediate economic considerations" thus rising to the new challenge and facing their responsibilities, vis-à-vis those who have long been *on the fringes* of social and health policies.

Luigi LEONORI

Place A. Leemans 3
B-1050 Brussels
e-mail : smeseu@compuserve.com
tel. & fax + 32.2.5385887

STATUTES

SMES – EUROPA

Association International

Non Profit - a.i.s.b.l.

2001

STATUTES

The signed people agree to establish an international non-profit organisation, registered by the Belgian law of 25 October 1919, modified by the laws of 6 December 1954 and of 30 June 2000, of which they decree the statutes as follows :

I. NAME – HEADQUARTERS - OBJECTIVE - TERM

Art. 1 : The association with philanthropic, scientific and pedagogic objectives, shall be called "Santé Mentale Exclusion Sociale - Europa", abbreviated as SMES-EUROPA. This association is registered by the Belgian law of 25 October 1919, modified by the law of 6 December 1954.
Art. 2: The association has its headquarters in Place de Ninove 10, 1000 Brussels. The headquarters may be transferred to any other Belgian address by a simple decision of the Board of Directors published the month of the transfer in the "Annexes du Moniteur belge"
Art. 3: The main objective of the association is to promote mental health and social rehabilitation/inclusion in European Countries in the first place.

SMES-EUROPA aims at promoting the rights of persons who are socially excluded and discriminated against:

- the homeless, mentally ill without assistance,
- (ex)users of psychiatric services,
- people addicted to alcohol and drugs,
- (ex)prisoners,
- elderly people,
- refugees and illegal immigrants.

In order to achieve its objectives, the association recurs to the following methods:

- The study and analysis of political, ethical, and legal realities
- Research activity in order to evaluate existing practices and to promote innovative, suitable and efficient practices
- Multidisciplinary and permanent educational training
- Awareness-raising in society.

Art. 4 : The association has been established for an indefinite period of time.

II. MEMBERS

Art. 5 : The Association is composed of physical or legal persons constituted according to the laws and habits of their countries of origin. The Association is constituted of different categories of members, originating from any country without exception, who - depending on their respective investment in the Association - can be: founder members, effective members, supporting members and honorary members. **The founder members,** who are also effective members by right, offer to the Association their active contribution of their experience, competence and involvement.

The admission of members is subject to the following conditions:

1. Effective members are those who dedicate part of of their professional activity to SMES with the aim of contributing experience and competence. Every person, physical or legal, moral who wishes to become an effective member, must

present written request to the Administration Council – board – supported by two effective members Board of Directors. The admission of new effective members is decided in a soveriegn way, by the General Assembly on prior proposal by the Board of Directors.

2. Supporting members: are persons who share and promote the aims of SMES- EUROPA and support its initiatives. Each physical or legal person who wants to become a supporting member of the association has to address a written request to the Board of Directors. The Board of Directors decides, in a soveregn way, the admission of new passive members.

3. Honorary members: the title of honorary member is conferred as a tribute and distinction to persons who have contributed to the progress of the cause of SMES-EUROPA.

The election of honorary members is carried out by the General Assembly on prior proposal by the Board of Directors.

The status of member may be lost by:

1. - Resignation: members are free to resign from the association at any time by addressing a written notification of their intention to resign to the Board of Directors.
2. - Death

3. - Expulsion: the exclusion of members of the association may be proposed by the Board of Directors, after having heard the defence of the party concerned; the exclusion has to be decided by the General Assembly by a majority vote of two thirds of the members present or represented. The Board of Directors may suspend the party concerned until decision by the General Assembly.

The resigning associate, whether suspended or excluded, their heirs, or those who have claim to the estate of the deceased associate are without claim on the social funds of the association. They may under no circumstances reclaim bank statements, nor inventory, nor membership fees that have been paid.

Art. 6 : Effective members have to pay a fee, according to their category, the amount of which is reviewed on an annual basis by the General Assembly on prior proposal by the Board of Directors.

III. GENERAL ASSEMBLY

Art. 7. The General Assembly is the governing body of the association and disposes of the powers needed to realise the objective of the association. The General Assembly is composed of all effective members. The supporting members and the honorary members may attend with consultative status. Only effective members having paid their membership fee have the right to vote. The General Assembly shall have the following responsibilities:

a)To approve the budget and accounts

b)To elect and dismiss Directors;

c)To modify the statutes;

d)To dissolve the association,

e)To exclude associates.

Art. 8. The General Assembly - presided by the President, or, in his absence, the Vice-President – shall meet at least once in a year. The session shall be held at the headquarters or at the location indicated on the invitation. The General Assembly is convoked by the Board of Directors by letter, fax, e-mail or any other means of communication at least 15 days prior to the General Assembly and contains the agenda signed by a member of the Board of Directors. An extraordinary session of the General Assembly can be held at any time by decision of the Board of Directors or on request of at least one fifth of the associate membership. Each meeting will be held on the day, time and place mentioned in the invitation. All active members must be invited.

Art. 9. Effective members may be represented at the General Assembly by another effectiveb member bearing written permission to represent the aforesaid member by proxy. No active member may attend by proxy for more than two other active members. The exact voting modalities are described in detail in the Rule of Internal Order. All active members have an equal right to vote in the General Assembly, each member having one vote. In case of a draw, the vote of the President or Director who replaces him takes precedence.

Art. 10. The resolutions are taken by simple majority vote of those active members present or represented and are made known to all members. The general assembly cannot deliberate in a valid way if two thirds of those members of the associat(ion having voting rights are not present or represented. Deliberation on a matter not presented in the agenda is not per,itted Apart from the cases foreseen in Art. 8, 12 and 20 of the law of 27 June 1921, the Assembly may validly deliberate on points not covered in the agenda. The decisions of the General Assembly are registered in the minutes and signed by the President and a Director. These minutes are to be kept at the Headquarters and have to be accessible to all members.

Art. 11. In respect of Art. 5 of the law of 25 October 1919, all proposals concerning the modification of the statutes or the dissolution of the association must emanate from the Board of Directors or from at least two thirds of all active members of the association. The Board of Directors must inform the members of the association at least three months in advance about the date of the General Assembly that will decide about the aforementioned proposal.

The General Assembly may only validly deliberate on the dissolution of the association or the amendment of the statutes if it respects the Arts. 8 and 20 of the law of 17 June 1921. The General Assembly can only take a valid decision if at least two thirds of the members having the right to vote are present or represented. No decision can be taken unless it is voted by a majority of two thirds of the votes. However, if two thirds of the active members are not present at this General Assembly, a new General Assembly mu st be convoked with the same conditions applying as above. This new General Assembly will then take a final and valid decision on the proposal in question with the same majority of two thirds whatever the number of members present or represented. The modifications of the statutes will not take effect until after approbation by royal decree and will be published in accordance with Art. 3 of the law of 25 October 1919. The General Assembly will determine the method of dissolution and the liquidation of the association.

IV. ADMINISTRATION

Art. 12. The association is administered by a Board of Directors composed of at least three members.

The Directors are appointed by the General Assembly under the following conditions:

- **Their mandate expires** every three years, either by death, resignation or revocation of membership;

- **Every member** of the Board of Directors who loses their status of member of the General Assembly relinquishes all rights and functions and privileges of practise within the association.

If for any reason there is a vacancy of a Director's position, a temporary Director may be appointed by the Board of Directors.

This temporary Director will then finish the term of the Director he is replacing.

The Directors may be recalled by the General Assembly by a majority of two thirds of the active members present or represented.

Art. 13. The Board must designate from among its members, a President, a Vice-President, a Secretary and a Treasurer. Should the President be unable to attend to his duties, they may be assumed by the Vice-President.

Art. 14. The Board shall meet at least once a year or by special request of the President. The invitation may be sent by letter, fax, e-mail or any other means of communication. A Director may be represented by another Director who may not represent more than one member by written proxy. The Board may not take decisions unless the majority of its members are present or represented. Decisions are taken by simple majority vote. Each member of the Board of Directors has one vote. In case of parity, the vote of the President or his replacement takes precedence.

Art. 15. The Board of Directors has comprehensive powers concerning the administration and management, apart from specific attributes reseerved for the Ge neral Asse,bly;subject to the appropriate attributions by the General Assembly.

The Board may delegate the day to day management of the association, with the possibillity of signing, to a Director who has to be chosen among the members by common accord. The Board shall determine the powers of this person. The Board can also confer under its responsibility special powers to one or several persons. The personnel of the Association are recruited and dismissed by the Board of Directors, who organises their work and fixes their remuneration.

Art. 16. The decisions of the Board of Directors are recorded in a register signed by the President or a Director. The register is accessible to the members of the association.

Art. 17. Acts that commit the association to something, other than those of daily management and except for special proxies of the Council, have to be signed by the President and the delegate Director. The decisions to entrust powers to this end do not have to be justified towards other people.

Art. 18. The legal actions and legal defence are followed by the Board of Directors, represented by the President or a Director who has been appointed to this task by the former.

In case of emergency, the President or the delegate Director may take legally binding decisions, yet subject to ratification of actions by the Board of Directors.

The Directors do not have to assume - due to their function - any personal obligation; they are responsible only for the exertion of their mandate.

An Office of the Board of Directors has been established, which is composed of the President, Vice-President, secretary, treasurer and Director (?). The Office shall carry out responsibilities that are assigned to it by the Board of Directors.

V. Budgets and accounts

Art. 19. The fiscal year ends on 31st December each year .The Board must submit to approval of the General Assembly the bookkeeping of the past year's budget as well as the budget of the forthcoming year. Ensuring transparency of the budget is considered a basic and honourable task of the association.

VI. VARIOUS DISPOSITIONS

Art. 20. The Board of Directors will present a rule of internal order to the General Assembly. Modifications to these rules may be made by the Board of Directors; they have to be submitted to approval to the General Assembly which has to decide by a vote of simple majority of the members present or represented.

Art. 21. In exceptional cases which have to be duly justified by their urgent character and the common interest, the decisions of the General Assembly and the Board of Directors may be taken by unanimity of the members and Directors. They have to be stated in a form addressed to each member and Director, accompanied by an explanatory note concerning the motivation and the modalities of the decision to be taken. This form has to contain the following elements: name and surname of the member or Director, their home address, the agenda, the sense of vote or of the abstention regarding each point of the agenda and probably the term of mandate. It has to be signed. The first General Assembly and/or the Board of Directors which will be held after the written decision will ratify it.

VII. general Measures

Art. 22. The General Assembly must designate a commissary, associate or non-associate, responsible for verifying the accounts of the association and for presenting an annual report. The Assembly will determine the term of his mandate. Should the association be dissolved, the General Assembly will designate liquidators, determine their powers and indicate the allocation of the net assets of the group holdings. In any case of voluntary or legal dissolution, no matter when and why this may occur, the net assets of the association dissolved will be allocated to social initiatives which shall be selected by the General Assembly.

Transitory Disposition

The commitments taken by the association in state of composition will be adopted by the association once its legal personality is established by royal decree. Anything not explicitly foreseen in the present statutes and notably the publications to be made to the "Annexes du Moniteur belge" (?), will be regulated conforming to the dispositions of the law of October 25, 1919 regarding international non-profit organisations.

(Signatures

SYNTHESIS of SMES-EUROPA aisbl

SMES : ASSOCIATION

STARTING of the Project and Network :	**Rome: December 1991 with the 1st Seminar**
PROMOTOR of the project and network :	**Luigi LEONORI**
STARTING of Association A.I.S.B.L. :	**10 August 2001 - A.R. : 7/CDLF/14.638/S – 10/08/01**

SMES STATUTE : cf. www.moniteur.be ; http://www.ejustice.just.fgov.be/vzw/vzwf.htm

Publication Moniteur Belge : 2002-01-15 N. 000620 Numéro de l'association : 6202002
No TVA ou no entreprise : 476429158f. - "Arretée Royale" 10 August 2001

FOUNDER MEMBERS

Leonori Luigi, Psychologist	**SMES-IT**	smeseu@smes-europa.org	**I**
Brandt Preben, Psychiatrist	**UDENFOR**	preben.brandt@udenfor.dk	**DK**
Horenbeek Bernard, Psychologist	**SMES-B B**	bernard.horenbeek@gov.wallonie.be	**B**
Timms Philip, Psychiatrist		philip.timms@virgin.net	**UK**
Zombek Serge, Psychiatrist		serge_zombek@stpierre-bru.be	**B**
Fernando Silva, Psychologist	**A.R.I.A.**	aria@aria-ajuda.pt	**P**
Bento Antonio José Gomes, Psychiatrist		ajgbento@clix.pt	**P**
Bravo Maria Fe, Psychiatrist		mfbravo@telefonica.net	**SP**
Craig Thomas, Psychaitarist		thomas.craig@kcl.ac.uk	**UK**
Di Tolla Patrizia, Psychologist	**PARITÄTISCHE**	ditolla@paritaet-berlin.de	**D**
Frangouli Athena, Psychologist		ekpsath@otenet.gr	**GR**
Mannu Giuseppe, Psychiatrist		jomannu@hotmail.com	**I**
Muñoz Manuel, Psychologist		mmunoz@psi.ucm.es	**SP**

MEMBERS of SMES BORD

Leonori Luigi, Psychologist	**President**		smeseu@smes-europa.org	**I**
Zombek Serge, Psychiatrist	**Vice President**	**SMES-B**	serge_zombek@stpierre-bru.be	**B**
Bravo MariFe, Psychiatrist	**Vice President**	**SMES-Madrid**	marife.bravo@uam.es	**E**
Di Tolla Patrizia, Psychologist	**Treasurer**	**Der PARITÄTISCHE**	ditolla@paritaet-berlin.de	**D**
Hoegh Ninna,	**Secretary**	**UDENFOR**	ninna.hoegh@udenfor.dk	**DK**
Erele Rita,	**Administrator**	**Street Children Project**		**LV**
Dreyfus Michelle , Psychologist	**Administrator**	**CHS St ANNE**		**F**
Realacci Paolo , Psychiatrist	**Administrator**	**SMES-IT**		**I**

ANNEXE

SOCIAL EMERGENCY AND POLITICAL EMERGENCY
HOMELESS PEOPLE ARE STILL DYING IN THE STREET TODAY

PAR LUIGI LEONORI

SMES-EUROPA

Social Emergency and Political Emergency
Homeless people are still dying in the street today

Par **Luigi Leonori**, *SMES-Europa*

The death of a homeless person abandoned in the street has always provoked, and continues to provoke, a public scandal: how is it possible that nowadays, in civilised, rich and modern European countries, people can still die in the street, from heat, cold or hunger?

And yet these *winter victims* seem to be taken by surprise every year in the period leading up to Christmas. The rituals that follow are well-established: journalists record the information (which indeed sells rather well during the holiday season) and the finger is pointed at politicians, whose policies fail to take account of the most vulnerable. They feel obliged to urgently put in place emergency plans and structures. On the basis of this political decision, service-providers set up a winter emergency plan (stations, underground stops, gymnasiums etc, which are open all night). The service-providers find that their task increases all the time, in the face of growing needs and in light of the policy gaps that they must seek to fill, without, however, becoming complicit with inadequate social policies - a problem which is simply not taken seriously by political decision-makers.

And thus a familiar scenario takes place when the winter emergency is declared: one which is far removed however from the reality of the social emergency that is experienced by rough sleepers.

In my opinion, the social emergency that is street homelessness necessitates an urgent recognition by the whole of society of the unquestionable and unacceptable seriousness of the consequences of social exclusion for the weakest and most vulnerable among the population. This social emergency must be translated in to an imperative and urgent issue for all: whether politicians, administrative decision-makers, service providers and citizens. Everyone must be involved in prioritising this issue with all the necessary and adequate resources and in attacking the structural root causes, which exclude and kill the must vulnerable citizens.

The response to street homelessness cannot be reduced to an unvarying packet of emergency measures. These add up to nothing more than easing society's conscience and do nothing more than reduce the damages caused by a society, that, as it has undergone its transformation into a market-driven economy, has become a source of exclusion and marginalisation and which is no longer social. It is a society that can no longer ensure the protection and the respect of the rights of all of its citizens and especially of the weakest.

We should no longer speak of a social emergency, but rather of a political emergency and a need to target the real causes, which are well-known to the politicians and policy-makers responsible for the well-being of citizens. It is necessary to develop coherent action plans in relation to the situation of street homeless people, to apply adequate and sustainable strategies, making all of the professional and financial services necessary available. In total contrast to such an approach, what we are presently witnessing is the "rationalisation" (which really means "making savings") of the health and social protection budgets. And it is the weakest and most vulnerable who face the gravest consequences.

The winter cold or the summer heat are just a pretext and a context that serve as alibis for the true causes of these scandalous deaths: the reality of biological death (from hypothermia or dehydration…) is just the final stage in a long process of exclusion and the "death of the citizen," through being cut off from society, had taken place long before and led to the loss of life of these rough sleepers.

Who are these citizens who die on a winter's night, abandoned in the street? They are the deaths "of no importance"![1] Often they are the same people we are used to seeing, rather than meeting, who wander around or lie on the ground in the streets and the railway stations, delirious or silent, searching in dustbins or next to an empty bottle. These are homeless and mentally ill people, abandoned to the street, where they survive as a reminder of the profound malaise of "civilised society". They are the leftovers, those that don't count, those that have plumbed the greatest depths of rupture, of rejection of non-existence. Their situation of abandonment and their mental suffering is an indicator of deep-seated social insecurity. The term "mental suffering" designates the articulation between a person's mental state, somatic state and social state – that is to say, the way in which social inequalities stigmatise excluded people right down to their very bodies.

It is these *'poorest of the poor'*, whether abandoned on the street or living in shelters or insecure and inadequate housing, who are the visible part of what is a far more serious and widespread structural and societal phenomenon than one might think at first glance.

It is a stereotype to declare that in today's society 'the rich get richer and the poor get poorer" (yet this is a fact borne out by European statistics, and confirmed for example, in Italy by the 2005 report of Censis).[2] All the factors at play in poverty and exclusion (loss or lack of housing, of work, of training, of minimum income etc.) have an impact on health and on mental health. Inversely, incidences of mental suffering and mental illness, which are not treated by competent services, impoverish the person. We have always sought to sort and to label the population of homeless people suffering from mental illness into categories like "schizophrenic, "borderline", alcoholic, drug addict and so on…But we must face up to the reality: despite many tests, it is not really possible to categorise this part of the population of our cities. What they do have in common, however, is that they are unfortunate enough to be chronic rough sleepers, that is, without a "home" and in a situation of rupture, of disgust, of indifference, of *social anorexia.*

Their situation of social exclusion is further complicated by their mental health condition, which further accentuates all of the factors contributing to exclusion: breakdown, of social networks, loss of social rights, of housing, of family, of work, of health…

We try to mark them, to scan them, to count them with all the statistical artifices at our disposal – almost to reassure ourselves that really, there aren't that many of them. Among chronic street homeless people, at least some 30-40% are both homeless and suffering from mental illness – this is something that is borne out by all professional studies and estimates. A further estimate emerging from the work done in this area is that some ten percent of this group have lost – in a more or less irreversible way – all contact with society in general, and often even with workers and service providers and live in a state of total degradation, both in relation to their dignity as a human person, and in relation to their state of mental, physical and social health and wellbeing.

These street homeless are those that no longer ask for anything at all: despite the very high levels of mental and physical suffering experienced by these socially excluded people, they are unlikely to have recourse to medical or mental health services. There are obstacles and barriers that raise themselves for subjective, structural and institutional reasons, because of poverty, because of lack of support and because of the fragmentation of and bad coordination of basic services. And when these people do, in fact, try to access services, or are accompanied to them, it is generally in a crisis situation and they are treated by emergency services, but with little or no follow-up.

Mental health and medical services very often exclude users that have a psychiatric "career" and a life on the street: they are passed around in an endless game of table tennis between different services and units, because it is rare that any will engage with them and take responsibility for all of their complex needs in the areas of mental and physical health and social wellbeing. This is the reason, among other things, that traditional mental health services often neglect this problem, or indeed simply do not have the competencies or the attitude necessary to reach out to these homeless people in the streets of cities, to engage with them, and to support and treat them.

Today's consumer society produces tonnes of waste, some of which, at least, can thankfully be recycled. Today's market society produces many excluded people, who are not always or easily reintegrated.

There is a growing gap between this *exterior world* of the street, the railway stations, the shelters etc. and the *interior world* of medical and social institutions. And so these people who are homeless remain isolated, in the street, asking for nothing and living in an ever worsening state of degradation: there is no *dignity* without health and *no health without mental health.* We often forget the definition of health coming from the World Health Organisation: *health is a state* (a dynamic and indivisible whole, therefore) *of mental, physical and social wellbeing;* as well the UN resolution that states that all people have the right *'to enjoy the highest attainable standard of health.'* [3]

The mental health situation of excluded people sometimes deteriorates very rapidly, mainly due to the lack of any work in the area of prevention and access to information. Information on healthcare and hospital services, and in particular on how to access them, is very difficult, even impossible, to come by. Health promotion and primary and secondary preventative measures often do not reach the most vulnerable groups. There is a lack of specific training for general practitioners, as well as for specialists, on how to work with homeless and marginalised people. And finally, it must also be added that networking and working in a joined-up fashion remains very difficult.

Going out to meet people: Outreach Services

For several years already in the various capital cities of Europe, different organisations offer services to rough sleepers, through the work of volunteers in many cases, who regularly visit the places where homeless people tend to stay. The common denominator among these initiatives is mainly the fact that they are centred around contact with those people who ask for nothing and expect nothing from society and its institutions. Motivated by solidarity, as well sometimes as a desire to rise to a professional and humanist challenge, these volunteers and professionals comb the streets during the night and visit the train stations, in order to make contact with "those people", with no other goal than simply to be present, to establish or re-establish contact, to understand their lives and value them according to criteria that differ greatly from those values and beliefs espoused by traditional socio-medical bodies.

Over the past few years, there has been a growing consciousness among public authorities of the seriousness of the situation of exclusion and abandonment of rough sleepers. They have begun, therefore, to directly organise certain social emergency services, without however giving much consideration to existing services; to building them up or to working in partnership with them. There is, however, one happy result of this approach, which is that there has seldom been so much outreach work taking place in the streets and stations, thanks to the very numerous workers and volunteers from the public and NGO sector who are attached to mobile units and teams of street workers.

Certainly the diversity of identities, of aims and of resources (both at the level of personnel and of services) would be very positive, if only working in a joined-up, inter-disciplinary and inter-institutional network were the reality, rather than simply an objective. What is needed is a high-level system of coordination, whose methodogy is based on concertation, with strategies that involve policy-makers and decision-makers in their development. Networking and cooperation should be seen as essential by all street services and teams. There is a need to tighten the network, even at the informal level. The tasks and objectives should be clearly defined in order for them to be shared out within a flexible and adaptable network.

Thus, outreach work could move from being a space of competition, whether real or ideological, to being a real instance of "de-institutionalisation": that is; a move from the inside, from the institution and from all-knowingness; to the outside: towards the person. More than simply a way of working that uses mobile tools; outreach is above all an unconditional ability to reach out and to listen to those people who no longer ask for anything from anyone. It is an aptitude for openness - towards homeless people living in the street - but also towards other actors and service providers: partnership working, where the diversity of actions becomes a synergy and richness of response is undoubtedly the most effective way to meet the complex needs of homeless people within an overall framework of reintegration.

IN CONCLUSION:

Street homelessness is above all a political issue: if it is what we really want, then we can build a social Europe – we must simply launch a political attack on the real structural causes of poverty, arming ourselves with medium and long-term plans, by developing coherent, priority projects and by allocating adequate budgetary resources. Extreme poverty and exclusion have very serious consequences for mental, physical and social health and wellbeing – especially for those people who have been born into such difficult circumstances. Mental suffering, arising from all forms of poverty and deprivation – and often further complicated by mental illness – reinforces the condition of poverty, hardening it into extreme exclusion. The situation of street homeless people suffering from mental health problems is getting more and more serious and means that the current modus operandi of mental health services must be called into question. We cannot simply wait for people, and especially people who are homeless, to come and access care. They ask for nothing and yet sometimes they have extremely pressing needs. The interaction of social exclusion and mental illness gives rise to complex needs that require holistic and sustainable responses, both in terms of prevention programmes, but also in terms of adapted care.

Street homelessness is not an isolated phenomenon: rights issues and health issues are also connected to the social sphere, making a partnership approach and working within a interdisciplinary network (with all relevant actors, public and non-governmental) absolutely essential in order to propose, but not impose, coherent, sustainable and integrated solutions, that look beyond monopolistic competition and see further than an emergency approach as an end in itself.

Outreach – reaching out to people: this is first and foremost an aptitude for proximity, a presence that brings together the ability to be available and to listen, with a partnership working approach, that uses all the tools and resources available. Reaching out requires time and attention to the person as an individual: it requires a quality-based, rather than quantity-based approach. The primary aim is not to reduce the number of homeless people in the streets and not to force immediate solutions (except in cases of emergency), but rather the idea is to make contact, to offer, to suggest, to support, while respecting the person. Outreach can play a mediating role between the inside and the outside, both at the institutional level and the individual, personal level.

To conclude: there will probably be more *victims of the cold*. But it is at least to be hoped that these deaths will raise awareness in society about the need for programmes and strategies to eradicate the underlying causes of street homelessness, which still kills - all too often in a climate of indifference. ●

[1] Des morts sans importance ? (Deaths of No Importance?) Twenty organisations working with rough sleepers tell of the numerous deaths among these homeless and denounce the terrible conditions that they have endured.
(Aux Captifs, la Libération – Paris 2005)

[2] Rome, 2nd December 2005 – The rich get richer and the poor get poorer – luckily there are organisations which fill the gaps left by the absent welfare states. This is the message coming from the 39th Report by Censis on the social situation in Italy in 2005. The rich have not only increased in number, but they are spending more and more – the richest 10 percent own almost half of the net riches of the country.

[3] Resolution. 46/119,1.1, UN General Assembly 17/12/199).

MENTAL HEALTH, SOCIAL EXCLUSION - SMES-EUROPA

The SMES Network was launched in 1992 in Rome, following a first conference on the "indecent" condition of abandonment and social and medical exclusion experienced by rough sleepers in European capitals. Up to now, at least, it is hard to claim that there has been an improvement in the situation. The movement developed into the European SMES network, made up of professionals from the health and social sector, who have come together in an international NGO. The aim of SMES-Europa is the positive promotion of the dignity of the human person, as well as of mental health, for all those living in extreme poverty and hardship. Through study and analysis of policies, ethics and laws in the area of social inclusion and mental health, SMES-Europa aims to raise awareness in society, to denounce the inadequacies of policies and to place pressure on decision-makers.

SMES-Europa focuses particularly on those people in a situation of extreme marginalisation, exclusion and discrimination, who have a range of complex needs and mental health needs: homeless people suffering from mental illness; exploited children and young people who have lost their social networks; (former) prisoners; alcoholics and drug addicts; isolated old people; refugees and migrants, who are sometimes undocumented, with an illegal status, and who are not accepted or integrated into society.
Contact SMES-EUROPA: www.smes-europa.org - smeseu@smes-europa.org