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Rodriguez, Andrea; Fernandes, Fernando Lannes; Galella, Sabrina; Freeman, Ruth

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Call for Inputs: Housing discrimination and spatial segregation – May 2021

Andrea Rodriguez; School of Dentistry, University of Dundee, Scotland, UK

Fernando Fernandes; School of Education and Social Work, University of Dundee, Scotland, UK

Sabrina Galella, A Way Home Scotland, UK

Ruth Freeman; School of Dentistry, University of Dundee, Scotland, UK

Poverty and Homelessness in Scotland. How this legacy is impacting people's rights.

Poverty is linked with limited access to human rights. Living in poverty causes a wide range of health and social problems such as low levels of education, social isolation, domestic violence, mental health disorders, poor oral health, bad nutrition, and lack of participation in society. 19% of people in Scotland were living in poverty in 2018, representing 1.03 million [1]. Other consequences of poverty can be expressed through homelessness. In 2019/20 in Scotland, 31,333 households were assessed as experiencing homelessness which represented an increase of 4% compared with the previous year [2]. This means a total of 51,365 people (35,654 adults and 15,711 children) facing social exclusion, stigma, and health inequalities. The pandemic scenario has worsened even more this situation as due lockdown those who were sofa surfing or living in overcrowded and dangerous homes were forced to access help for the first time. New unemployed or those who have been furloughed due financial cuts during pandemic were led to homelessness as well.

Despite the Scottish Government commitment to tackle poverty and homelessness through a holistic approach [3,4] the coexistence of complex, diverse, and interconnected demands are still challenging to address. In Scotland, the health and social care integration policy, adopted in 2016 by the NHS Boards (National Health system), Third Sector and Local Authorities [4] highlighted the rights and needs of those facing housing issues, and required the development of a multi, accessible, person-centred, integrated, and equitable delivery of services [5].

The rights to health and housing

The rights to health and housing are widely recognized in international human rights instruments such as the Universal Declaration of Human Rights [5], the International Covenant on Economic, Social and Cultural Rights (Article 11) – ICESCR [6] and the Office of the United Nations High Commissioner for Human Rights – UN Habitat which clarified the characteristics on forced evictions and the right to adequate housing [7]. The right to health covers the right to the highest standards of physical and mental health, in a broader understanding of health as a concept not being restricted just to the right to be healthy. The underlying social and economic determinants of health would cover a wide range of factors and living conditions necessary to achieve a healthy life. Therefore, the right to health is linked to the obligations of States regarding complying with numerous other recommendations such as the issue of housing being permanent and safe, as a vital condition for the exercise of human rights.

Stigma linked to poverty and homelessness. The principal forms of discrimination and barriers towards equal enjoyment of the right to adequate housing and health.

Stigma and discrimination regarding living in poverty have been underlined as an important issue for the Scottish Government [8]. While there is evidence that people living in poverty and experiencing homelessness suffer stigma, there are gaps in the understanding of how public attitudes may be influencing this.

Negative attitudes towards people experiencing homelessness were confirmed in previous research and knowledge exchange programme in Scotland and Brazil [9; 10; 11]. People living near social houses or homeless accommodations usually express discomfort and prejudice. Similar attitudes come from practitioners from different services, which result in more barriers for those without a permanent address to accessing and engaging with services. Feelings of shame (in asking for help) and inadequacy, lack of trust, or the feeling of not being welcomed by services are commonly mentioned by these groups. Their consequent decision to not seek for help is often explained to avoid discrimination, but there are other elements to consider. The social stigma and the unequal spatial distribution of services across the most deprived areas in urban and rural locations add more complex challenges to guarantee the rights of people affected by homelessness. Difficulties to access services led to the worsening of people's health conditions (mental health issues, chronic diseases, alcohol, and drug abuse) and this can cause loss of tenancy. Cycles of poverty and homelessness are then repeated by generations.

The Reflexive Mapping Exercise (RME) as a framework to address integration and communication between services. Sharing good practices to inspire change.

The Reflective Mapping Exercise – RME [12] was a national framework created to encourage synergies and to map services collaboratively. The Scottish Oral Health and Psycho-social well-being preventive programme for people experiencing homelessness, Smile4life, identified a lack of integration and communication between the health and social care services. The RME aimed to maximize user's access by identifying what is available to support vulnerable and marginalised groups, the geographic distribution of services, the types of support that has been offered and how they are related to deprivation levels and stages of homelessness.

The RME is a national platform to mobilize an agenda of rights promotion that has been developed in four Scottish cities with the highest levels of homelessness and socio-economic deprivation. In Dundee, the RME is part of the five years strategic plan to prevent and tackle homelessness (2016–2021). It is informing the work carried out by the Dundee City Council's Joint Strategic Commissioning for Homelessness. The RME data in Dundee revealed a geographic unequal distribution of services (from housing, health, education/training, information and advice, food drop-in, etc) that was similar when we focussed on the type of support delivered. Not significant expression of services addressing prevention phases and sustainability outside homelessness were perceived.

This unequal distribution of services by location and type of support (before, during and after homelessness) alongside the stigma and discrimination against this population makes them distrust services and practitioners or walk for over one hour to have a meal in soup kitchen services and to meet health appointments. Considering this we believe priority should be given to the following aspects: 1. Equal spatial distribution of services; 2. Investment in services to address homelessness prevention and sustainability; 3. More opportunities for interprofessional

learning; 4. Training on communication and engagement with communities and marginalised groups; 5. Creation of channels to listen to people on issues that are affecting their right to adequate housing and health; 6. The involvement of people with lived experience on homelessness in the co-design of policies; and 7. Co-production of educational materials and training resources to reduce stigma against people experiencing homelessness.

The reduction of stigma that is embedded in institutional practices from housing, health, and social care sectors, needs to be faced with the inclusion of stigma-related indicators on the monitoring and evaluation of services.

The Reflexive Mapping Exercise in Scotland has been designed as a resource to inform local policies on homelessness and to support practitioners in their everyday practice, reflecting upon stigmatised practices and the possibilities for new connections and collaborative work that combine interconnected efforts towards health and housing for everyone. Moreover, we expect the mapping has increased awareness and knowledge of what is available combined with the needs of the users. The mapping identified areas for improvement through a practical framework that increased dialogue between services, informed local and national policies on homelessness, and it has contributed to articulate and design services, whilst meeting the main principle of social change that should be part of the academic universe. As such, the Reflexive Mapping Exercise needs to be taken as an attempt to mobilize key actors towards a more reflexive process to bring about change in which service providers can consider the limitations of their services, the barriers to better integration, as well the achievements when working together. The RME can be a relevant strategy to be adopted by any set of organizations or local government aiming to generate information that can support strategic planning for equal distribution of homelessness services with the promotion of mutual trust and dialogue across agencies, from both governmental and non-governmental nature.

It is only through meaningful collaboration and partnerships that we can identify and address the needs of people at risk or already experiencing homelessness, developing preventative interventions, while also safeguarding their rights to receive the support they need if they find themselves in a crisis. Academic programmes in partnership with housing, health and community organisations have been pivotal in elevating the voices of people with lived experience, a key element in ensuring their views and thoughts are reflected in policy and practice and in creating an empowering environment where people feel included, listened to and trusted.

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