They are young, they are healthy, so why don't they go to work?!
Examining Society’s View on Youth Homelessness

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Abstract

The present article focuses on one of the marginalized social groups in our country – young homeless people – placing their social status within the context of the risk of permanent disintegration of a social group vulnerable to intergenerational poverty. In relation to this, the article includes the concept of the underclass and ponders its various connotations. It describes contemporary phenomena which pose an ever greater risk for young people, and focuses primarily on the transition into the world of employment and the inclusion into the health care system. For purposes of illustration it relies on two studies of homelessness conducted heretofore, “Homelessness in Ljubljana”/»Brezdomstvo v Ljubljani« (Dekleva and Razpotnik, 2007) and “Homelessness, health, and access to health care services”/»Brezdomstvo, zdravje in dostopnost zdravstvenih storitev« (Razpotnik and Dekleva, 2009). The results reveal a trend, whereby young homeless individuals have on average a lower level of education even when compared to the larger category of homeless people, and none of the young homeless individuals taking part in the study (2009) had
been permanently employed at the time the study was conducted. Another salient issue is also the high rate of expulsion from school – homeless youths are more than twice as likely to have been expelled from school as the entire sample group of homeless individuals. For these reasons homeless youths in Slovenia fit the concept of “status zer0 youth”.

**Key words:** young people, the homeless, post-modernity, employment, health, revolving door effect, underclass, status zer0 youth, intergenerational poverty, risk.

**Introduction and purpose**

Homelessness as a widespread and visible phenomenon afflicting a diverse group of people is relatively new in Slovenia. A growing number of disparate individuals, including an increasing number of young people, find themselves in conditions of extreme social exclusion. Thus far the subject of youth homelessness has not received much attention in Slovenia nor has there been a thorough analysis of the issue, the only exceptions being a few articles authored by Leskošek (2002) and Razpotnik (2007). In this article I will examine the issue of youth homelessness from two perspectives – the transition into the world of employment and the health care system. I will clarify and elucidate the relation of the two aspects of youth homelessness.

Judging by different public responses it seems that people find it difficult to understand how even young individuals can wind up homeless and at the mercy of the streets. While exploring this issue, I frequently encountered responses from members of various segments of the public expressing a lack of sympathy for the fact that there are young people living in the street. The intensity and frequency of such responses are also the main incentives for this article, which attempts to unveil the background of the issue of youth homelessness with a particular focus on the transition into the world of employment and the issues of health and inclusion into the health care system.
A lack of understanding of how young people can find themselves living in the street can also be discerned among experts in the professional community. This incomprehension and bewilderment are most frequently related to the assumption that young individuals should not depend on charity, for they are in good health because of their youth and could therefore participate actively and productively in society. Two suppositions held by the public underpin this notion. The first is the supposition that homeless people, who live in the streets and are visible and exposed to the public, should be viewed through the discourse of mercy. Whether or not they are deserving of charity from passers-by is assumed to be clearly discernible from their appearance. An individual’s appearance of strength and vitality should indicate whether that individual deserves charity. An obvious problem with such an argument is that the full extent of effects of social exclusion on an individual need not always be visible to an observer. Furthermore, the public’s judgement of who is deserving of charity is informed by unexamined discourses, which usually reflect traditional beliefs about the statuses of various social groups rather than the contemporary empirical reality. At this point we could also delve into a discussion on the meaning and merits of the discourse of mercy, however, we will leave that off for a more appropriate time.

The second assumption underlying an unsympathetic attitude towards youth homelessness is that young people cannot experience social exclusion presumably because of their youth, which affords them physical strength and vitality. Public responses reveal a suspicion that these young people are merely pretending to be helpless and are in fact impostors as opposed to those who are traditionally believed to be ‘deserving’ of charity (the old, the sick, the disabled or children). Furthermore, public discourse frequently portrays them as folk devils who, although faced with legitimate troubles, are assumed to deal with their problems in socially unacceptable ways (retreating into inertia or addiction, which leads to health problems and social ramifications). This attitude makes all the more pertinent Cohen’s assertion that: ‘More moral panics will be generated and other, as yet nameless, folk devils will be created. This is not because such developments have an inexorable inner logic, but because our society as presently structured will continue to generate problems for some of its members – like working class adolescents – and then condemn whatever solutions these groups find’ (Cohen, 1973).
Rather than only focusing on individuals, the public (and especially the professional field) should analyse and criticise social, youth, employment, housing, and health care policies in the country, all of which frame and delineate possibilities for young people to successfully enter adulthood. Indeed, a lack of sympathy for the fact that young people may plunged into homelessness because of their social exclusion permeates even the political climate, in which this issue is currently being overlooked.

Because the attitude towards youth homelessness is conditioned and informed by unfounded assumptions lacking any basis in empirical reality, this article attempts to discuss existing trends and discourses, and to present some illustrative data related to young people and their exclusion from the labour market and the health care system. Although these two areas are by no means the only critical ones – the issue of homelessness inevitably entails the question of housing policy – they are nevertheless crucial, and are in fact key elements of the abovementioned public charges against homeless young people. The purpose of this article is to present the changed social conditions and to shed light on how these conditions constitute a threat even to young people of extreme social exclusion and homelessness.

**Postmodern blurring, pluralized underemployment and the underclass**

In his *Risk Society: Towards a New Modernity* (1992) Beck asserts that a new modernity has emerged beyond its classical industrial design. If we take the industrial modernity as classical, then the period following it should be viewed as reflexive modernity. If during the last two decades we have considered the new modernity as a new phenomenon, at once auspicious and haunting, it has nowadays become a thoroughly vetted subject, which the humanities have examined from every possible angle, but one which has not lead to an end of history or to a liberation, but has regularly brought about new challenges stemming from uncertainty. The last two decades have also witnessed the emergence of new dividing lines and an oftentimes barely perceptible rise of new social groups based on the privilege of access to important resources, the level of social power they exert, and the capacity for confronting risks.
Regardless of the fact that the new modernity is nowadays no longer novel, we are still witnessing an ‘intermingling of continuity and discontinuity’ (Beck, 1992), whereby the industrial society carries within itself the causes for discontinuity – it destabilises itself through its establishment. Continuity thus becomes the cause of discontinuity. The concept of the industrial society rests upon the contradiction between the universal principles of modernity such as civil rights and equality on the one hand and, on the other hand, the exclusive structure of its institutions, in which these principles can only partially be realised.

In industrial society, social life was based on the nuclear family, which became normative and standardized. On the other hand, the nuclear family was based on what Beck refers to as ‘feudal’ sex roles, which began to break down as modernisation processes such as the inclusion of women in the work process, the increasing divorce rate, and so on, continued. This lead to a shift in the relation between production and reproduction, and a destabilisation of other processes which had relied on the ‘industrial ‘tradition of the nuclear family’: marriage, parenthood, sexuality, love,’ (Beck, 1992) intimacy (Giddens, 2000), as well as growing up and transitions between statuses.

In urban industrialised societies, which are characterized by a complex division of labour, the gap between the rich and the poor is steadily increasing. Those who are at the top of the social hierarchy can acquire privileges and power as well as a disproportionate share of social wealth. According to Bradley (2003), these new social hierarchies may be based on military conquest, property ownership, occupation, familial or ethnic background, religious affiliation, educational qualifications, gender, and age. She believes that in contemporary societies, hierarchies rest upon a complex mixture of many of these factors. Beck too asserts that the ‘system of coordinates in which life and thinking are fastened in industrial modernity – the axes of gender, family and occupation, the belief in science and progress – begins to shake, and a new twilight of opportunities and hazards comes into existence’ (Beck, 15). What exactly are these new opportunities and new hazards for the particular social group of young people, or, to put it another way, to whom do these new conditions represent an opportunity, and to whom do they represent a hazard?
We can say that young people comprise a social group which has gained a lot from the current welfare state. It has received improved and fairer forms of education, the possibility of permanent employment after schooling, social security and health insurance, a legal safety net, and numerous institutions devoted to dealing with the problems young people face (Mizen, 2004, as cited in Ule, 2008). However, during the last two decades, the situation for young people has changed dramatically in our society. For a small portion of the group the changes have opened the doors to professional success, career opportunities, and a standard of living which had heretofore been beyond conception. But for the majority of young people the changes described by Beck (1992) and Giddens (2000) have resulted in a prolonged dependence on parents, an increase in living expenses and a strong sense of uncertainty, even anxiousness about the future. A growing number of young individuals are faced with the uncertainty of fixed-term employment, a prolonged dependence on the immediate family, greater demands in the educational and work processes, the institutionalisation of lower income, diminishing state assistance and a drastic increase in expenses for maintaining at least some degree of independence, not to mention the difficulties they face in terms of housing and ensuring a safe and stable living environment. Ule (2008) interprets the growing number of young people in tertiary education as the result of fewer opportunities offered by the labour market, rather than greater opportunities for further education. On the other hand, young people from the middle and upper classes have profited the most from the rising demand for a qualified work force in the labour market. If in the past, unqualified workers were still able to find work, today’s restructured and market oriented economy demands mainly workers who posses higher qualifications. Thus in our society, two groups are emerging, the so called ‘winners’, i.e. young individuals who can take full advantage of the possibilities afforded by modern society and its technological advancements, and the ‘losers’, i.e. young individuals who become lost in these social processes because they lack the resources and support necessary for success in our competitive society.

If Ule (2008) sees the ‘winners’ as constituting a minority and those to whom risks pose a threat rather than a challenge as being in the majority, then we can add to this a small fraction of young individuals who succumb to the weight of risks and plummet to the margins where access is out of reach.
In order to better understand the shifting nature of the labour market and employment it must be pointed out that the mid-70s mark the onset of long-term trends of economic recession – the end of economic growth as well as the idea of infinite growth. This shift was accompanied by the arrival to the labour market of the off-spring of the *baby boom* generation, which triggered the rise of unemployment, particularly among young people. Bradley (2003) likewise establishes that in the last two decades young people have become particularly vulnerable to recession and long-term unemployment. They bear a disproportionate share of the weight of unemployment, and in many countries represent one third or even a larger share of all unemployed persons. Based on his study of unemployment and the risk of social exclusion among young people in six European countries, Keiselbach (2003) establishes that the rate of youth unemployment is considerably higher than the total unemployment rates in all countries except one. In recent years, the unemployment trend has coincided with the flexibilization of employment, which has generated new uncertainties and additional difficulties for young people entering the world of employment. Flexibilization of labour also entails a flexibilization of working hours and the workplace, which in turn leads to a blurring of the boundary between work and non-work. The previous legal and social premises of labour and the employment system are fading away, or, as Beck puts it, ‘are modernized away’. Mass unemployment has been integrated into the employment system in the form of ‘pluralized underemployment’, with all the hazards and opportunities such conditions entail.

According to the Statistical Office of the Republic of Slovenia, 41.7% of all unemployed persons, who make up 6.7% of the active population aged 15 and above, have only a primary school education or have not finished primary school. For young people, the transition into the world of employment is closely related to the acquisition of an education. Adolescents who drop out of the school system before obtaining an education have significantly more difficulties than their peers who have finished school when searching for employment which will provide them with economic security. Usually they occupy positions that require less skill and pay less. They commonly experience more difficulties when adapting to the work sphere and the social system (Ule, 2008). Ule also reports on
the youth unemployment rate, which peaked at the beginning of the 1990s with 24.2%. In the second half of the 1990s, the rate began to drop and the decline continued after the year 2000, however, the current economic crisis again threatens to efface the possibilities young people have and increases the risk of unemployment.

I will include into the following discussion the concept of the underclass. A growing number of researches from around the world assert that more and more young people are being systematically relegated to the edges of conventional and legitimate pathways into adulthood (Wilkinson, 1995; Williamson, 1993, as cited in Williamson, 2003). Although there is no evidence of a complete dissociation from societal opportunities, a large number of individuals have no access to many vital resources. The underclass may be defined as individuals who move between unemployment and uncertain part-time work and are trapped in a low-income cycle, from which they have few chances of escaping (Williamson, 2003).

The debate surrounding the underclass has a long history and is currently being inflamed in the English speaking world (Great Britain) by the “New Right”, a group of conservative authors, which seeks to expose individual characteristics of the so-called hopeless members of society in order to emphasize individual responsibility, i.e. blame these individuals for their marginalized status in society, thereby absolving the community and the state from the responsibility of having to find political solutions to these problems. Such rhetoric blames the poor for their poverty, the unemployed for their unemployment and the homeless for their homelessness, dismisses the need for social intervention and denies assistance to afflicted groups and individuals. Furthermore, it instigates moral panic and incites fear of the poor and excluded, while obfuscating the real causes of poverty and the plight of the poor (Ule, 2008).

Underlying this ideology is the monetary logic of reducing spending and winning short-term political points, however, such policies increase financial costs and exacerbates social repercussions in the long term by relegating the ‘problematic’ elements of society to the margins, away from the ‘moral majority’, instead of tackling the structural causes of poverty. The underclass has in the past been referred to as a ‘residuum’ (Stedman, Jones, 1971; in Williamson, 2003), a culture of poverty (Lewis, 1966), or a “savage” class of people wholly or partly connected to criminal activities (Booth, Thompson, & Yeo, 1973, as
cited in Williamson, 2003). From a structural perspective, it is a class of people who are trapped in a cycle of impoverishment sustained from generation to generation, unstable employment and social disorder. Jones (2003), for instance, places the long-term unemployed, unskilled workers without permanent employment and single mothers in this category, while Baldwin, Coles and Mitchel (2003) also include the young disabled and young people leaving residential care institutions. However, there is no professional consensus that these groups really share enough similarities to justify systematic grouping into a category of ‘class’, given the fact that the discourse concerning the underclass is characterized by a lack, or even complete absence of ‘class consciousness’, which was a prominent feature of the working class. The underclass is in fact a diffuse category, with which no individual identifies, as is typical for the individualized and pluralized nature of modern societies. This fits in with the contemporary view on identity. Bradley (2003) speaks here of a fragmentation, meaning that categories such as the category of class nowadays intersect with other aspects of inequality, such as age, ethnicity, gender, and so on, thereby forming a multitude of overlapping groups.

There are considerable problems with considering the underclass to be a ‘solid’ category, since it does not consist of individuals sharing a common culture, but in fact includes a diverse population and various phenomena. A more appropriate concept is the notion of the underclass as a ‘fluid’ category, i.e. one with unfixed boundaries.

Williamson (2003) points out that young members of the underclass, who lose direction during the period of transition into adulthood and fall through the safety net on their path from education to occupation, are a relatively new phenomenon in British society. A slightly more consistent, yet still diffuse category within the concept of the underclass is what is referred to by Williamson (2003) as ‘status zero youth’. In Great Britain the term is used to refer to young people who are ‘not in education, training, or employment’ (Williamson, 70). It is a status which appears to foreshadow a future of economic disadvantage. We might say that status zero is an inauspicious designation for the underclass, since it is precisely the permanent exclusion from the labour market that is the central feature characterizing the members of the underclass.

Running along similar lines is also the definition of social exclusion penned by Kronauer (1998) and summed up and proposed
by Keiselbach (2003). The definition is related to the context of the current employment crisis, which severely affects unqualified workers in particular. According to the author, the growing unemployment rate eventually becomes permanent reality for certain individuals, which results in a growing number of people who are unable to live according to existing social standards of material and social prosperity. The new features of the cycle of unemployment and poverty call for a terminology which will expand the present focus on exclusively monetary aspects (associated with the term ‘poverty’) to include non-financial aspects as well. Keiselbach, therefore, introduces a definition of social exclusion which recognizes the phenomenon as a dynamic and multidimensional process which includes social and economic aspects of living as well as subjective experiences and objective situations, and depends on the access to personal and social resources.

Williamson (2003) relates young members of the underclass with commitment to short-term goals and a preference for short-term planning, a constant preoccupation with financial matters, and a shifting dependency on financial assistance, occasional employment and – particularly when they receive no financial aid from parents or the state – occasional petty crime, with some individuals continuing on that path to more calculated and organized criminal acts. A common characteristic among the youth is also a stark disillusion and a dismissive attitude towards educational and training schemes available to unskilled young people. Frequently they face uncertainty with regard to housing and accommodation for a number of reasons (leaving a residential care institution, unstable relations with the family, inadequate resources, a lack of vision and goals, etc.). Focusing on this group of young people, Roberts (1981, as cited in Williamson, 2003) speaks of the so called revolving door effect, defining it as unsuccessful transitions from one form of assistance to another, i.e. from unemployment and professional training schemes to short-term occupation and attempts to obtain resources by other, oftentimes illicit means. Young people spin around in these vicious circles, trying to find alternative means to support themselves, however, such continuous shifting from one state to the other clearly points to an inefficacy of state-run forms of assistance and training, which in effect do not provide any means for progress. The concept of the revolving door effect should draw the attention of experts and policy makers to the inadequacy of social and civil systems instated to tackle issues related to a marginalized group of people.
For young unemployed persons facing the threat of social exclusion, the main obstacle is their low level of qualification (Keiselbach, 2003). Unemployment is the central risk factor for young people, which can jeopardize the whole process of social integration in the long term. In Slovenia, as well as in other countries, more and more young people from disadvantaged families and poor environments perform badly in school when compared with those from well situated families (Ule, 2008). Considering the reasons for this discrepancy, it should be pointed out that there is no conclusive evidence of a relation between poverty and diminished capacities for learning or a low level of intelligence. The term status zero is not as entrenched in our country as it is elsewhere, however, we do speak of drop-outs, i.e. those who drop out of the educational system. Ule defines members of this group as young people who drop out of school before completing it and fail to enrol in a different school or some other educational institution. In Slovenia, drop-outs comprise approximately 15% of students, which is similar to Italy and Germany (Eurostat, 2005), although it is difficult to make comparisons due to the differences between the respective educational systems (Walther, 2006). Ule recognizes that dropping out of school has dire consequences for the individual as well as society, and groups the consequences into individual, social, health-related, educational and economic repercussions. Exclusion from the educational system, which is frequently accompanied by an exclusion from other spheres, may in certain cases also lead to homelessness. Denying this issue and dismissing social responsibility and rejecting serious efforts to combat the problem (implementing preventive and remedial measures) can result in homelessness and social exclusion becoming chronic and can increase the risk of long-term intergenerational perpetuation of extreme exclusion.

Keiselbach (2003) relates youth unemployment with health issues. His comparative analysis of six European countries reveals that health risks are much higher for young unemployed persons as opposed to their employed counterparts. These risks pertain in particular to deteriorating mental health and psycho-social issues, increased vulnerability, a sense of inferiority, depression and a diminished confidence, as well as a general dissatisfaction with one’s life. Rapuš Pavel (2005) has researched similar issues in Slovenia. The group is also characterized by an increased risk of suicidal behaviour (Keiselbach, 2003). Compounding the situation even further is the lack of supportive
social ties, which usually stem from the working environment and can ameliorate the experience of long-term unemployment. The issue of health is discussed more thoroughly in the following chapter.

**Homelessness, health, dual diagnoses and access to services**

In recent decades, the issue of homelessness has changed on a worldwide scale. The image of a homeless adult man no longer holds true, for the issue has spread to include previously unaffected segments of the population with more complex needs in terms of health and other areas (Turnbull, Muckle & Masters, 2007). Researchers predict that the issue will continue to spread and include an ever more heterogeneous group of individuals, especially in light of the current financial crisis and the (un)successful measures proposed to grapple with it, which obviously acknowledge the primacy of economic imperatives over the social wellbeing and health of citizens.

Homelessness is also the result of social and demographic changes taking place in the last two decades, increasing risks and the process of individualization, which may be viewed as the result of weak and dissolving social networks, which might compensate for a lack of other resources and would represent an adequate level of social security against exclusion. A key role in the rise and heterogeneity of the issue of homelessness is played by the changing function and image of the family, the rise of single-parent families and the changing patterns of child emancipation. Crucial to this issue is also the interaction between cultural and demographic changes on the one hand, and the housing market on the other. Running parallel to rising numbers of nuclear and single-parent families as well as single adults is the increasing demand for smaller residences; however, the housing market cannot accommodate this trend. The result is a shortage of residences and a rise in rent costs. In Europe, the economic crunch is accompanied by long-term trends of diminishing state assistance, which intensify precisely during critical times. This

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1 A segment of this chapter has been published in a study report entitled »Brezdomstvo, zdravje in dostopnost zdravstvenih storitev« (Homelessness, Health and Access to Health Care Services) by Razpotnik and Dekleva (2009).
issue is at the centre of attention in Slovenia as well. In this regard, the people most affected are certainly young people, who do not belong to social groups considered to be a priority by social policies. Related to this is the current ideology, which places more and more responsibilities squarely on the family. This becomes problematic when it applies to vulnerable families with few resources and little social power, which are unable to guarantee sufficient support and security for each member. Therefore, such policies implemented during crises turn out to be detrimental and counterproductive, for they result in intergenerational perpetuation of extreme social exclusion (see discussion of the underclass in the previous chapter).

Let us now look at the issue of homeless in terms of health. Homelessness is most commonly associated with mental health issues, with some researches contending that those suffering from mental health problems make up 80-95% of the homeless population. Others believe this share to be between 10 and 60% (counting prior hospitalisations and treatments in psychiatric institutions), with up to 70% of the population suffering from substance abuse (Scott, 1993; Savage et al., 2006). It is widely believed that the reason for the high instance of mental health problems among the homeless is the collapse of institutions which provided long-term accommodation for people with mental problems only a few decades ago. Craig and Timms (1992) believe that the root of the problem is too complex to be reduced simply to the deinstitutionalization or breakdown of asylums. According to them, the widening extent of mental health problems among the homeless can also be attributed to ever shorter and more intensive forms of treatment, even in cases of severe and complex mental problems – in other words, to diminishing expenditures on matters of public health. The need for long-term treatment and subsequent social rehabilitation thus remains unfulfilled, while homeless patients suffering from mental problems and requiring long-term treatment and constant social care are perceived as taking up space in the already overcrowded health care system, an issue as topical in Slovenia as it is elsewhere. Craig and Timms (1992) also expose the lack of efficient services in the field as another reason for the difficulties homeless individuals with mental health issues face with regard to access to medical services. Melvin (2004) likewise determines that effective services in the field are viewed by many experts as the most successful way to engage and include this commonly secluded segment of service users.
Studies frequently connect homelessness to risk factors such as child-abuse (Mounier & Andujo, 2003) or dysfunctional (vulnerable, marginalized, facing several problems) families (Tyler, Cauce, & Whitbeck, 2004). In Scotland, for instance, a third of homeless young people had been placed in foster homes or care institutions (Jones, 2003). Among the homeless young people, the high rate of substance abuse and addiction also increases the risk of unprotected sex, which in turn increases the risk of HIV infections (Bell et al., 2003). Related to this is also the issue of prostitution (Gwadz et al., 2004), which frequently becomes a last resort for endangered homeless addicts to acquire money. Whitbeck et al. (2004) relate the issue of homelessness to affiliation with subcultures (based on ethnicity, culture, sexual orientation, and so on). The differences stem from unequal statuses of different social groups in different societies and are related to obstacles in accessing vital social resources as well as to the discrimination different subcultures face within the system. The consequences of these systemic obstacles and unequal opportunities for access commonly appear as psychological peculiarities of an individual, which prevent him/her from establishing long-term, satisfactory social relationships, and indirectly in one’s lifestyle, which increases social and health risks and exacerbates access to services, employment and other resources.

Turnbull, Muckle and Masters (2007) have found that in spite of a higher rate of various health issues homeless individuals rarely avail themselves of medical services or believe there to be a lack of available effective services. The perceived lack of suitable services is reflected by the fact that homeless people rarely visit medical institutions, therefore, their health problems accumulate and remain untreated and subsequently become harder to cure. A lack of accessible medical treatment is also reflected in the fact that emergency services are commonly the only form of medical attention homeless people receive (Savage et al. 2006). This means that for various reasons homeless people receive medical treatment only when their health deteriorates to the point where they are either brought in by others or seek urgent care themselves. Specialized literature worldwide calls for a reform of the health care system in order to adjust it to the needs of the most vulnerable and excluded segments of the population with little or no access to health care services. In certain parts of the world, this requirement is met by proactive community services available
to the homeless and the excluded, whereby professionals take to the field and approach the afflicted in their environment, instead of waiting for them to make the first step. These services must be based on individualized, integrated and indiscriminating practices.

Changing social conditions effect changes in the structure of the homeless population, which also alter the characteristics and needs of the group. In this respect, it is important to take into account the age structure of the homeless population, because the needs of the young are completely different from the needs of the elderly, the discrepancy resulting from different levels of physical health as well as from different sociological features of each generation. Surveys (conducted in the USA) based on the comparison of health statuses and unfulfilled medical needs between a group of young and a group of old homeless people (Garibaldi, Conde-Martel and O’Toole, 2005) found that the elderly place the need for medical attention much higher on the scale of priorities than young people: the elderly were 3,6 times more likely to report chronic illness; they were 2,8 times more likely to have medical insurance; heroin addiction was 2,4 times more common among the elderly than among the young (this contrasts with the situation in Slovenia where heroin addiction is more common among young homeless people (Razpotnik & Dekleva, 2007); the difference might be related to a longer history of heroin abuse in the USA when compared with Slovenia); the elderly were more likely to take advantage of medical services intended for the homeless, such as shelters, clinics and field services. In spite of a higher rate of substance abuse, however, the elderly expressed the need for treatment of drug addiction less frequently than the young. Such surveys confirm the logical assumption that medical problems progress and accumulate with advanced age and that inclusion into the health care system and favourable experiences of individuals with medical services are of crucial importance already at an early age. The key word in this area is ‘preventive’; once the medical problems become chronic their treatment becomes much more expensive and less likely to be successful. This pertains to our country as well.

Studies reveal the paramount significance of post-treatment programs for homeless addicts, who are the most vulnerable and endangered among the homeless population. It has been found that relapses into addiction as well as into homelessness are much more common in cases where there is no availability of programs after
the initial treatment of addiction or detoxification. Such follow-up programs can slow down the aforementioned revolving door effect and the spiralling cycle, in which homeless people move from one assistance program or scheme into another without making any visible progress. Slowing down the revolving door effect opens up possibilities for suitable intervention and the establishment of behavioural patterns unrelated to the addict lifestyle. A number of studies (Ulfrstad, 1999; Ytrehus, 2002; Taksdal et al. 2006, as cited in Hansen, 2006) have also shown that services available primarily to addicts and the mentally ill have great potential for interrupting an individual’s cycle of wandering from one institution, shelter or asylum to the next, provided they treat the person as an individual (instead of a symptom or a deviant) and offer treatment suited to individual needs, which requires mutual cooperation and the patients active involvement. It also requires cooperation and coordination between different institutions available to the homeless, for if such coordination between programs is lacking it can further aggravate the difficulties related to homelessness (Hansen, 2006).

A study carried out by Crane and Warnes (2001) confirmed that individuals suffering from a combination of afflictions, i.e. struggling with mental health difficulties, alcohol abuse as well as substance abuse, are particularly problematic in terms of access to health care and other services. The study revealed a lack or inadequacy of social services which would offer comprehensive assistance and assume responsibility for such individuals. Offering comprehensive treatment in one place would be of crucial importance for individuals struggling with several issues, since their lifestyle is marked by a refusal to seek and enter such social services.

Empirical findings

In the following paragraphs, I will focus on the situation in Slovenia in order to illuminate the abovementioned findings. The results of the survey conducted in Ljubljana (Dekleva and Razpotnik, 2007) show that 20% of homeless people in Ljubljana admit to having an alcohol addiction, at least 20% of them are addicted to illicit substances (a majority of them have consumed the substances intravenously) and 23% have already undergone treatment because of their addiction.
 Approximately 40% believe that their homelessness is related to their mental problems, 24% reported being committed to a psychiatric hospital, and we can assume that the percentage is even higher among the hidden population. To this, we can also add the share of individuals who have not undergone treatment for mental health issues and whose problems remain unexamined. In 2008, a study was conducted on the availability and obstacles in accessing assistance schemes for users of illicit drugs in Slovenia (Nolimal, Leskovšek and Pokrajac, 2008). The study revealed a strong vulnerability of this group in terms of accessing assistance programs in health care and other areas.

Having the fewest opportunities for accessing medical services are those who do not have even basic medical insurance. The number of these individuals, who have been excluded from the system, has been growing in Slovenia since 1992 when the health care system was reformed. Because basic medical insurance and access to services are typically tied to various formal statuses such as citizenship, employment, permanent residence, and so on, the rise in the number of unemployed persons (in the last two decades) and the increasing uncertainty regarding employment and housing are also connected to the problem of hindered access to health care services for socially excluded individuals. In response to this shortcoming of the system, two clinics were opened in Ljubljana and Maribor, which provide consultations and medical treatment to individuals without insurance. However, the mere fact that the clinic in Ljubljana, which was supposed to operate for a limited time until the difficulties of those with no insurance would be solved, will celebrate its ninth anniversary in January 2011 reveals that the health care system in Slovenia has run into a cul-de-sac of exclusion of those who are most vulnerable. In the first five years, the clinic in Ljubljana, which is not included into the public health care network, provided approximately 40,000 services. It should be noted, however, that the most vulnerable group – homeless users of illegal drugs – is not allowed into the clinic, because the public residing nearby explicitly demanded during the establishment that those who are addicted to illegal drugs be prohibited from entering the clinic in their neighbourhood.

Even homeless individuals who have basic insurance but no additional insurance experience difficulties in accessing the public health care system, in spite of the fact that a 2009 amendment to the Health Care and Health Insurance Act guarantees that those who have
basic insurance but no other form (are not employed, retired or farmers) and whose monthly earnings and assets do not exceed 50% of the minimum wage receive free additional insurance. The consequences and possible obstacles in the implementation of this provision have not yet been studied. One of the specific problems of the homeless is that although the public health care system does not completely exclude them they cannot afford to buy the prescribed medicine or obtain the prescribed treatment because of their poverty or a lack of additional medical insurance. This again necessitates systematic measures which would allow the poor and socially excluded the same level of access to medical services as is afforded to other citizens.

Sample group description and results

After the aforementioned survey of homelessness in Ljubljana (Dekleva & Razpotnik, 2007) we conducted a survey on homelessness and access to medical services together with The Ministry of Health’s Department of Health Care for Vulnerable Groups. We included in the quantitative part of the research a sample group of 122 homeless individuals living in the street (the most visible group in a diverse group of homeless and excluded individuals) from six Slovenian cities. The majority (64%) were from Ljubljana, while the others were from Maribor, Celje, Kranj, Koper and Murska Sobota. Our choice of interviewees was random in the sense that we did not have any limiting criteria for individuals we wanted to include in the sample. Our formal definition of those we wished to interview was: Experiencing homelessness means sleeping outside, in basements, doorways, temporary shelters, asylums and other temporary residential care institutions intended for the homeless, housing communities for the homeless; not having a guaranteed roof over his/her head, nor an own home, facing eviction and having no place to go.

16% of the respondents were female, 84% were males. Their age varied between 20 and 77, the average age being 42,7 years. The males were on average five years older than the females. The most common level of education was a secondary school education (49,5%), almost as common was a primary school education (41,8%), with very few exceptions with a higher or lower level of education.
Most of them were single (52.5 %) or divorced (31.2 %). 58.2 % were childless, while the rest were equally divided into those who had one and those with more than one child, without greater differences between the sexes. Homeless parents were equally divided into those who had had contact with their children in the previous year and those that had not. 95.1 % were legal citizens of Slovenia. 86.1 % of respondents had been employed at some point in their life and had some work experience. On average, they had 12.3 years of working experience. At the time of the survey, 63.9 % of the respondents had no employment whatsoever, 2.5 % were permanently employed, the remainder performed occasional work and menial work.

The age at which respondents first experienced homelessness varied from early childhood to old age (67). For 80 % of them this age varied between 17 and 50 years, with a total average of 33 years as the age at which they first experienced homelessness. The average duration of homelessness was approximately five years, with 21.3 % of the respondents having been homeless for more than ten years.

In order to illustrate the central thesis of this article that changed social conditions may increase the risk of extreme social exclusion for the most vulnerable segment of young people, let us look at how the subset of young homeless people differs from the remaining sample group. The subset includes individuals between the ages of 20 and 35. There were no individuals younger than 20 in our sample group. The results are merely illustrative and should not be taken as generalizations since the sample group is relatively small.

Within the subset of young homeless people, slightly more than half of them had finished primary school, slightly more than 40 % had finished secondary school, while the rest failed to complete primary school. In comparison to the whole sample group, we can ascertain a trend, whereby young homeless people are on average less qualified. 79 % of them were male, 21 % were female, however, it must be pointed out that women often hide in secluded contexts and are therefore difficult to include in such surveys. 70 % were single at the time of the survey. 76.3 % of them were childless, 18.4 % had one child, while 5.3 % had more than one child. 70 % of respondents had been employed at some point in their life, while 30 % had never been employed.

None of the young homeless people were in a permanent employment relationship at the time of the survey. 2.6 % said they
were working but not for an indefinite period, 31.6 % worked occasionally or regularly sold a newspaper published by the homeless, 60.5 % of the respondents had no employment whatsoever, while 5.3 % said they had a different employment status that the rest.

The table below shows how many of the respondents have experienced various predicaments and extreme difficulties in the past. Because the sample group is small, I did not investigate the statistical significance of the differences, the comparison only serves as an illustration.

Table 1: Percentage of respondents who have experienced various difficult situations in their life.

<table>
<thead>
<tr>
<th>Type of experience:</th>
<th>Pertaining to the whole sample group</th>
<th>Pertaining to the subset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious and long-term altercations and arguments with parents</td>
<td>61.5 %</td>
<td>78.9 %</td>
</tr>
<tr>
<td>Eviction from home by their parents</td>
<td>38.3 %</td>
<td>63.2 %</td>
</tr>
<tr>
<td>Physical abuse at the hands of parents (or other individuals close to them)</td>
<td>42.0 %</td>
<td>45.9 %</td>
</tr>
<tr>
<td>Sexual abuse at the hands of parents (or other individuals close to them)</td>
<td>7.6 %</td>
<td>10.8 %</td>
</tr>
<tr>
<td>Exploitation at the hands of parents (or other individuals close to them)</td>
<td>36.1 %</td>
<td>37.8 %</td>
</tr>
<tr>
<td>Expulsion from school</td>
<td>23.5 %</td>
<td>54.1 %</td>
</tr>
<tr>
<td>Eviction from home by force</td>
<td>43.7 %</td>
<td>25.0 %</td>
</tr>
</tbody>
</table>

There is a stark difference between the two groups in terms of expulsion from school, with more than twice as many young people having been expelled. Additionally, there is a great difference between the high percentage of those who were evicted by their parents in the subset (63.2 %) and the percentage of those who were evicted by their parents in the whole sample group (38.3 %).

The respondents had experienced living in the following institutions: 27 % (subset – 31 %) had at some point lived in youth homes, residential care institutions, correctional homes or maternity homes; 26 % had been in institutions for the treatment of alcohol and drug addiction; 45 % had been incarcerated; 6 % had served in the military as professionals; 31 % had been to a mental institution; 52 % had been to other medical institutions (for a period of more than one
month at a time); 9% (subset – 13.9%) of them had lived in communes for individuals with mental health issues. When we compare the whole sample group with the subset, we cannot find many drastic differences between the two, which should be a cause for concern since it shows that young people experienced institutionalization to the same extent (with regard to psychiatric wards, communes for those with mental health issues) or to a greater extent (with regard to prisons), in spite of their youth. There is a considerable difference between the two groups in the category of living in a youth home, residential care institution or a correctional home, whereby a larger share of young people had resided in such facilities.

In general, the results of the survey of the whole sample group reveal with considerable certainty that the examined population is at a much greater risk in terms of health and that the psycho-bio-social state of the group is much worse than that of the general (Slovenian) population. This finding applies mainly to the areas of mental health and addiction, as well as to other illnesses related to a lifestyle in the streets. The results also correspond with the findings of many similar surveys conducted elsewhere in the world. If we examine only the subset of young people, we can see that the most commonly diagnosed illness for this group is hepatitis (27.8%), followed by a diagnosed addiction to illegal substances. As I have mentioned, in general it holds true that the homeless population resorts to medical services when it is already too late, therefore, many problems remain undetected, especially in the case of young homeless people.

In our study of the accessibility of medical services to the homeless (Razpotnik & Dekleva, 2009) we found significant correlations between various factors which increase risk and a poor rating of the quality of the medical system. The larger the number of factors putting a certain subgroup of homeless people at risk, the worse their rating is of the quality of the medical system, because they experience more difficulties in accessing and taking advantage of the system. In this respect, those with the worst experiences are individuals who became homeless at an early age, individuals who have lived in a youth home, a correctional home or have been imprisoned, persons with a weak social support structure, persons addicted to alcohol, persons addicted to illegal substances, individuals who show signs of mental health problems or those who have been committed to psychiatric hospitals, as well as persons
suffering from comorbidity, i.e. from more than one affliction; all of them rate the medical system poorly and experience it as less accessible.

The table below centres on experiences with the health care system whereby a sense of stigmatization was present during treatment of homeless users of illicit substances.

*Table 2: A sense of discrimination due to homelessness/substance abuse during treatment in health care institutions.*

<table>
<thead>
<tr>
<th>Have you ever felt that you had been treated differently in health care institutions because you are homeless/use drugs?</th>
<th>To whom does the question pertain?</th>
<th>Pertains to the entire sample group</th>
<th>Pertains only to the subset of young people</th>
<th>Pertains to drug users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, in a negative sense (stigmatization, isolation, avoidance, insults …)</td>
<td>33,9 %</td>
<td>34,2 %</td>
<td>50,0 %</td>
<td></td>
</tr>
<tr>
<td>Yes, in a positive sense (special privileges, additional attention from the medical personnel and social services …)</td>
<td>8,3 %</td>
<td>5,3 %</td>
<td>11,4 %</td>
<td></td>
</tr>
<tr>
<td>I did not feel I had been treated differently because I am homeless/a drug user</td>
<td>36,4 %</td>
<td>26,3 %</td>
<td>13,6 %</td>
<td></td>
</tr>
<tr>
<td>I do not think the medical personnel knew I was homeless/a drug user</td>
<td>14,0 %</td>
<td>21,1 %</td>
<td>9,1 %</td>
<td></td>
</tr>
<tr>
<td>I have never been hospitalized</td>
<td>7,4 %</td>
<td>13,2 %</td>
<td>15,9 %</td>
<td></td>
</tr>
</tbody>
</table>

The table shows that the entire group of homeless people, and homeless drug users in particular, often (34,2 % of young people, 50 % of drug users) expressed the sense of having been treated differently in a negative sense by the health care system. A sense of having been treated differently in a positive manner was less frequent, while young people more frequently felt that the personnel had not realised that they were homeless. This is not unusual since in our culture young people do not fit the image of a ‘typical’ homeless person and the public is only slowly becoming aware of this group. Significant systematic changes need to be implemented so that our society does not become accustomed to the notion that anybody, especially young people, can become homeless. In my conclusion I will sum up and enumerate a few suggestions for such changes.
Discussion

According to Williamson (2003), the connection between status zero and the underclass lays in the fact that status zero youth have the greatest potential to fill in the category of the underclass, which is currently only a vague notion lacking any concrete definition and is typically used as an ideological or political device. In order to prevent this from becoming reality, society must attempt to integrate these individuals into the social structures of health care, education and employment.

A case study dealing with experiences with employment of ten young homeless persons who have had in the past very few positive experiences with the educational and employment system (Razpotnik, 2007) concludes with an appeal for elaborate and multilayered measures, at the centre of which it places housing policy and attributes an important role to the development of flexible, individualized, ‘middle way’ (in the sense of mitigating the transition into independence) programs, which would assist young people in making the necessary transitions in their own environment, support an autonomous and healthy lifestyle, contribute to alleviating the damages caused by a hazardous lifestyle and contribute to raising functional literacy. It also assigns an important role to staff training, whereby personnel must be instructed in how to approach this population at risk, how to treat individuals in a dignified manner and how to establish good relations, which would enable mutual planning. Frequently we hear that professionals are unable to relate to young people, whom they are supposed to assist, advise and instruct. This pessimism in the profession is particularly disconcerting when it pertains to a population at risk which urgently requires well trained and confident experts to help strengthen the position of a vulnerable group of young people.

Finally, it is crucial that these young people actively participate in such programs in order not to become inert or trapped in vicious circles without any possibility of escape, but instead to find a purpose and a sense of personal value.

Focusing on the medical treatment of young homeless people, it must be emphasized that such treatment must involve more than simply medical attention. Worldwide, there are different models for (specialized) care for the homeless. It should be noted that these...
models overlap and complement each other:

- Unhindered access to the general public health care system, primary as well secondary and tertiary.

- Medical and general assistance for homeless people accessible at many different locations (clinics, day centres, shelters, various locations in the field...)

- Specialized integrated and interdisciplinary services offering medical as well as psychosocial assistance to homeless people.

- Specialized flexible services (which do not require appointments and offer assistance to homeless people in overcoming obstacles to accessing the health care system).

- Work in the field (medical attention and care offered on location where homeless people frequently visit – soup kitchens, shelters, and so on).

- Proving itself to be very successful in our country is the model of ‘key workers’, experts in the fields of health care and social work, who continuously monitor an individual and offer comprehensive (extending to other areas of an individual’s life instead of being limited to medical care only) assistance in individual planning. This type of care is based on a trustful working relationship and aims to provide users with information and possible necessities in the field, assistance with paperwork, escorts to institutions, visits in case of hospitalization, and help in finding long-term solutions to medical and other problems.

- There are examples of clinics for young homeless people abroad. Such forms of care for a particular vulnerable social group must be attuned to the lifestyle of young people (e.g. opening hours should be adjusted to the needs of the group) and should endorse awareness on the part of the personnel of the psychosocial features of individuals in care and of the particular (sub)cultural characteristics of this population. They are based on a concern for prevention, which means that the population at risk must be included into the system. The only way to achieve this is to make the system fully accessible to these groups. It is essential that individuals entering the system receive clear answers to their questions, and that they are treated not as patients with a few particular symptoms, but as complex individuals with complex problems.
Two decades ago we could boast that our country’s social system includes the entire population regardless of age, material status, employment status and place of residence. Unfortunately, today that is no longer the case. There are individual initiatives, however, in light of the growing number of people suffering from exclusion, they are only marginally effective (function curatively instead of preventively, respond to emergencies). According to Ule (2008), researchers agree that risk becomes a factor very early, therefore, it is necessary to involve people in intervention programs early on. Preventive schemes should be adjusted to the special needs of young people, should involve a multicultural approach, promote cooperation, mutual respect and self-respect, should seek and award creative solutions, they should motivate the individual and patiently instil learning habits, endorse long-term planning and encourage every person to establish career goals.

In terms of intergenerational perpetuation of the patterns of exclusion, we should examine forms of support on the part of the family to design similar forms of support for those who for different reasons cannot expect to receive it from their families. Flexibility is essential when designing programs for young people experiencing difficulties when passing into adulthood. Without political solutions, there is little hope for change. Although it is expected that people make ‘the right decisions’ when passing into adulthood, according to Baldwin, Coles and Mitchell (2003) these decisions are framed by policies which affect institutions which structure the lives of young people. The fact that a young person spent time in an institution has a long lasting effect on his/her future. Social and pedagogical services have the potential to provide vital assistance in confronting these challenges. Individualized assistance, practices based on empirical evidence and reflexion as well as sponsorship and respectful treatment of young people as individuals with complex needs, who can resolve their problems under improved circumstances, instead of as symptoms or pathological cases, are essential, and experts must provide young people with a safe and conducive environment. The aforementioned discourse about who is or is not deserving of assistance always calls for scrutiny. In public life, they may be unavoidable, especially during periods of crisis and uncertainty; however, they are simply unacceptable in the professional field.
References


*Empirical article, submitted in December 2010.*