Homeless children and young people

A review of interventions supporting access to healthcare services

Employment, Social Affairs and Inclusion

1. Policy context

This research note was produced as part of the European Platform for Investing in Children (EPIC) ([1]). Established in 2013, EPIC monitors key and innovative developments in child and family policy across the European Union (EU). The platform hosts resources to support Member States (MS) in the implementation of the 2013 European Commission Recommendation, 'Investing in children: breaking the cycle of disadvantage' (European Commission, 2013). The Recommendation's overarching objective is 'combating child poverty and social exclusion and promoting child well-being' (European Commission, 2013). It consists of three main pillars, which are: 1) access to adequate resources, 2) accesses to affordable quality services, and 3) children's rights to participate. As part of pillar 2, one objective is 'to improve the responsiveness of health systems to address the needs of disadvantaged children' (European Commission, 2013). This section stipulates that Member States are encouraged to '[e]nsure that all children can make full use of their universal right to health care, including through disease prevention and health promotion as well as access to quality health services' (European Commission, 2013).

The issue of homeless youth health is also addressed by the Council recommendation establishing the European Child Guarantee, which calls upon Member States, amongst others, to provide children in need with free and effective access to healthcare and to guarantee for children in need effective access to adequate housing. The European Child Guarantee recommendation was adopted unanimously on 14 June 2021, and its implementation will be closely monitored by the European Commission.

1 For more information about the European Platform for Investing in Children, see European Commission (2021a).

2. Introduction

The number of homeless people has risen in most parts of Europe, and while adult males have traditionally made up a large proportion of homeless people, the number of families, young people and children without secure housing is on the rise (European Commission, 2021b). Absence of secure housing is an important cause for concern, which is why the European Commission's definition for homelessness extends beyond individuals sleeping outside on streets to include those living in temporary or insecure housing (European Commission, 2013).

Aside from the immediate dangers of not having a roof over your head, being homeless has a range of other negative consequences for children, one of which is difficulty in accessing healthcare services. Healthcare encompasses a range of services including: primary care, including care provided by, for example, a general practitioner (GP), health visitor, dentist, optician or audiologist; secondary care, including elective, urgent and emergency care; and specialist tertiary care, both in relation to the prevention of illness and treatment (NHS Providers, 2019). Homeless people often only seek healthcare in case of an emergency (FEANTSA, 2011). Their healthcare can be fragmented and lack coordination and people may face stigma when attempting to access care (FEANTSA, 2011). While there are policies aimed at preventing and reducing homelessness among young people in Europe, it seems that less is done for this group to access healthcare. While there appears to be much research and discussion on access to healthcare for homeless populations (including interventions to support access), there seems to be less available information specifically focused on children and families in Europe. In addition, EU-level data on homeless children's access to healthcare is lacking in general.

The second phase report on the feasibility of establishing a Child Guarantee emphasises the importance of providing support children who are homeless (e.g. by ensuring adequate emergency accommodation for homeless children and families), as well as guaranteeing access to quality healthcare for all children (European Commission, 2021c). This research note collates the available research and evidence on ways of supporting homeless children to access healthcare services.

2.1. Objectives and research approach

The objective of this research note is:

To understand the healthcare needs of homeless children and young people and to identify examples of interventions that support homeless children and young people to access healthcare services.

Accordingly, this research note provides information on the existing evidence-base on the following two research questions:

1. What are the healthcare needs (both met and unmet) of homeless children and young people in Europe and what are the barriers for this group to access healthcare services?
2. What type of interventions or practices facilitates homeless children and young people's access to healthcare services (both preventative and curative), according to available evidence?
    a. Which kind of interventions have been shown to be effective (or not) in facilitating access to healthcare for homeless children and young people?
    b. What are the key issues to consider in the implementation of these interventions?

This research note focuses on children, i.e. people under 18, while recognising that many interventions found in the literature cover an age group that includes both children and slightly older persons (up to the age of 25).

This research note reviews evidence identified through a targeted search of literature published since 2010. We created a search protocol with a relevant search string, selected databases and defined inclusion and exclusion criteria. This can be found in Annex A. This search strategy resulted in a total number of 34 included studies in this review.

3. Homelessness among children and young people: Statistics, common health issues and challenges in accessing healthcare services

Before summarising the findings of the 34 studies covered by this review, it should be noted that the findings in this review are based only on the reviewed studies and not on the wider literature. The information below provides an overview of the sources:

31 were relevant to the first question (about the healthcare needs) and nine to the second (about types of interventions) (2);

in terms of article type, 26 were peer-reviewed journal articles, eight were non-peer-reviewed sources and one was a database;

the sources covered a number of different countries. From Europe, this included the UK (14 sources), France (six), Germany (two), Ireland (one), Norway (one) and Portugal (one). Outside of Europe, studies covered Canada (three studies) and Australia (two). In addition, five sources covered more general geographic areas, such as all EU MS and high-income countries. Finally, one study covered 14 EU Member States (3), one was for all OECD countries and one study did not specify the location of interest (4);

the types of health conditions of focus included general health (15 sources), mental health (seven), oral health (four), alcohol and drug use (two), anaemia (one), asthma (one), HIV (one), respiratory diseases (one) and vaccinations (one) (5).

3.1. Statistics on the extent of homelessness among children and young people

National-level data on homelessness in European countries are often not available. If available, they are difficult to compare due to the various definitions of homelessness and ways of collecting data on homelessness, for example using administrative data, street counts or census data (Baptista & Marlier, 2019; Baptista et al., 2017; OECD, 2020). The Organisation for Economic Co-operation and Development (OECD) reported that in nearly all countries that took part in the Questionnaire on Affordable and Social Housing (6), less than 1 % of the population is homeless (OECD, 2020). There are, however, variations in the estimates of the number of homeless people in European countries provided by the OECD and the European Social Policy Network due to the different definitions used (Baptista & Marlier, 2019; OECD, 2020).

Due to the differences in homelessness data between European countries, **it is difficult to provide an overall figure on homelessness among children and young people in Europe** (Baptista & Marlier, 2019). It is, however, possible to provide information on individual countries and general trends. A study on homelessness in the 27 EU MS and seven candidate and potential candidate countries (7) included reports from some national experts on the situation of homeless children using the most recent available data in that country (Baptista & Marlier, 2019). It was reported, for example, that in Ireland in 2019, children made up 38 % of the homeless population. In Bosnia and Herzegovina in 2013, children and young people between 0 and 19 were reported by the national experts as making up 17 % of the 313 rough sleeping people (Baptista & Marlier, 2019). Additionally, experts in Austria, Denmark, Finland, Malta and North Macedonia reported a large presence of young people between 15 and 29 years old (Baptista & Marlier, 2019). Experts in Germany, Ireland, Italy, the Netherlands, Romania and Slovenia reported an increasing share of this age group in the homeless population (Baptista & Marlier, 2019). This is in line with findings from other EU MS, and France in particular, where families represent the fastest-growing segment in the homeless population, especially in urban areas (Fazel et al., 2014; Vandentorren et al., 2016).

2 Note this does not add up to 34 as some sources were relevant to more than one RQ.
3 These were: Belgium, Denmark, France, Germany, Greece, Hungary, Ireland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK.
4 Note this does not add up to 34 as some sources covered more than one country.
5 One study was not about health but provided statistics related to homeless children and young people (OECD, 2020).
6 Australia, Austria, Brazil, Canada, Chile, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Latvia, Lithuania, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovenia, Slovak Republic, Spain, Sweden, the United Kingdom (UK) and the United States (US).
7 Albania, Bosnia and Herzegovina, Montenegro, North Macedonia, Serbia, Turkey and Kosovo.

Besides the number of cases, experts have specifically reported a **lack of data on the situation of homeless families that include children and young people**. This may be due to homeless families having low rates of contact with homelessness support services, instead relying on informal support from family members and friends (Baptista et al., 2017).

Taken together, these data suggest that in recent years **there has been an increase in homelessness among children and young people**. Yet, providing one overall figure on the prevalence of homelessness among children and young people is not possible due to variations in the available data across Europe.

3.2. Healthcare needs of homeless children and young people

The healthcare needs reported in the sources identified in this research related to a **higher prevalence of physical health and mental health issues among homeless children and young people** compared to their non-homeless counterparts.

Homeless children and youth have a **higher probability of contracting infectious diseases,** for example, because they do not have access to vaccinations or due to unprotected sex, which increases the risk of sexually transmitted infections (Crowley, 2012; Health & Wellbeing Alliance, 2018; Leng, 2017; Mastro et al., 2012; Quintyne & Harpin, 2020; Rosenthal & Lakhanpaul, 2020). Moreover, homeless children and young people are **more likely to experience food insecurity** than other children or they are more likely to consume a diet with less fruit and vegetables (Croft et al., 2020; Crowley, 2012; Leng, 2017; Society for Adolescent Health & Medicine, 2018; Vandentorren et al., 2016). A poorer and more limited diet can impact the health of homeless children. For example, one study found that household food insecurity was linked to moderate or severe anaemia for children between six months and 12 years old (Arnaud et al., 2018). Additionally, homeless children and young people generally have **poorer oral health** and are more likely to have unaddressed dental problems (Beaton et al., 2018; Rowan et al., 2013; Stormon et al., 2019). For instance, they are more likely to have decayed, broken or missing teeth and periodontal disease (Rowan et al., 2013; Stormon et al., 2019), while at the same time being less likely to attend dental services (Beaton et al., 2018).

Although the physical health of homeless children and young people is often poorer than that of their housed counterparts, the mental health of homeless children and young people is noted as a main issue of concern for homeless young people, with **mental health issues being diagnosed late or not at all** (Crowley, 2012; Rosenthal & Lakhanpaul, 2020; Society for Adolescent Health & Medicine, 2018; Summerside, 2013). In particular, **rates of conduct disorder, post-traumatic stress disorder, major depression, anxiety, behavioural issues, suicidality and stress are high** among homeless children and youth (Fazel et al., 2014; Leng, 2017; Morisseau-Guillot et al., 2020; Society for Adolescent Health & Medicine, 2018). For example, a study on the mental health of 90 homeless young people in the UK, including 46 children under 18, found that 88 % of them had a psychiatric disorder, compared to 32 % in the age-matched general population (Hodgson et al., 2014) ([8]). Yet, only 31 % of the young people in the study had accessed a form of mental health service (Hodgson et al., 2014). In addition, homeless youth are **more likely to have alcohol and/or substance dependence**, which in turn can affect their physical health as well (Hodgson et al., 2014; Morisseau-Guillot et al., 2020).

In addition to physical and mental health issues, homeless children run a **higher risk of experiencing abuse and assault**. On the one hand, some children or young people may become homeless because they are fleeing an abusive environment (FEANTSA, 2011; Health & Wellbeing Alliance, 2018). On the other hand, sleeping on the street increases the likelihood of being assaulted or sexually victimised (Fazel et al., 2014; Quintyne & Harpin, 2020).

Finally, some studies found that **even when children and young people find housing, they may continue to suffer from high levels of mental disorders and persistent mental health problems compared to their stably housed counterparts** (Morisseau-Guillot et al., 2020; Rosenthal & Lakhanpaul, 2020; Vandentorren et al., 2016). This may, in part, be due to the traumatic nature of being homeless as a young person (Morisseau-Guillot et al., 2020).

Overall, several studies identified healthcare needs of homeless children and young people. They have a **higher risk of both physical and mental health issues** compared to those who benefit from stable housing, with mental health being a particular issue of concern for homeless children and young people.

3.3. Challenges in accessing healthcare services for homeless children and young people

Although their need for mental and physical healthcare is higher, homeless children and young people experience

8 Although the study looked at both under and over 18-year olds, no differences in psychiatric disorders were found between those participants under and over 18.

several challenges in accessing and using health and care services, including practical issues such as a lack of money or health insurance, institutional barriers and distrust or perceived stigma.[9]

Firstly, there are **practical issues** that prevent homeless children and young people from accessing healthcare services. For instance, for services that are not free at the point of use, children and young people might not have the financial resources to pay for healthcare and/or might not have health insurance (Coles et al., 2011; Crowley, 2012; Mastro et al., 2012; Stormon et al., 2019). Homeless children and young people may also not have a fixed (postal) address, which might be required to verify access to primary care services (Coles et al., 2011; Health & Wellbeing Alliance, 2018; Quintyne & Harpin, 2020; Society for Adolescent Health & Medicine, 2018). Similarly, this group may not have official documentation needed to access some services, such as social security details or formal identification (Bouhamam et al., 2012; Society for Adolescent Health & Medicine, 2018). Related to this is the fact that if contact information is outdated and/or changes frequently, patients may not receive information relating to healthcare appointments or test results (Health & Wellbeing Alliance, 2018). Homeless children and young people may also not be able to travel to appointments. This may be because they do not have enough financial resources for travel to healthcare services (Bouhamam et al., 2012). Additionally, they may lack the required phone or internet connection to book an appointment (Health & Wellbeing Alliance, 2018).

Other barriers to healthcare include **homeless children and young people's perception of healthcare and health issues**. They may not consider health as a priority but instead focus on housing, accessing benefits or getting a job (Croft et al., 2020; Crowley, 2012; FEANTSA, 2011; Health & Wellbeing Alliance, 2018; Summerside, 2013). They could also lack the confidence to seek healthcare (Crowley, 2012) or overestimate their own ability to cope with a health problem, particularly mental health issues (Chaturvedi, 2016). Additionally, they may not be aware of what healthcare services are available and what services they offer (Health & Wellbeing Alliance, 2018; Robards et al., 2018; Rowan et al., 2013).

Institutional barriers may also inhibit homeless children and youth to access healthcare services. Healthcare services may not be available when homeless children and youth require them, for example, due to long waiting times (Bouhamam et al., 2012; Health & Wellbeing Alliance, 2018; Jenkins & Parylo, 2011). In a survey of 49 homeless families, respondents indicated that they would like to be able to have drop-in sessions, same-day appointments and flexible service provision at their healthcare services (Jenkins & Parylo, 2011). Several researchers who conducted interviews with healthcare staff and sought responses to questionnaires from young people (both homeless and housed) indicate that homeless young people may not experience continuity of care, such as when they move temporary accommodation or when they move from paediatric to adult services and experience challenges in accessing adult services, due, for example, to long waiting times or the threshold to receive treatment (particularly for a mental health disorder) being higher (Crowley, 2012; Health & Wellbeing Alliance, 2018; Hodgson et al., 2014; Summerside, 2013). This lack of continuity of care can, in turn, be a problem, as it may result in homeless young people not persisting with treatment or medication or not having the confidence to seek help (Crowley, 2012; Rowan et al., 2013).

Moreover, **health programmes may not address the most vulnerable young people**. For instance, an HIV prevention programme aimed at the general youth population may not address the needs of most-at-risk youth, including homeless youth, as it may not take into consideration the lack of resources this group can experience (Mastro et al., 2012). Conversely, programmes addressed at most-at-risk people may not sufficiently consider the complicated needs of adolescents, who could lack parental care or may not be able to sustain themselves (Mastro et al., 2012).

Finally, **some homeless children and youth report perceiving stigma, mistrust and judgement from healthcare providers** (Chaturvedi, 2016; Mastro et al., 2012; Robards et al., 2018; Society for Adolescent Health & Medicine, 2018). Some homeless families indicated that they had experienced discrimination and rudeness and felt that they were not listened to by healthcare providers (Jenkins & Parylo, 2011; Health & Wellbeing Alliance, 2018; Morisseau-Guillot et al., 2020). Some homeless children and youth may even distrust or fear healthcare providers due to previous negative experiences with public service providers, such as experiences of stigma (Health & Wellbeing Alliance, 2018; Mastro et al., 2012; Rowan et al., 2013). Looking more broadly, stigma at the institutional level may lead to underfunding of healthcare services to support homeless youth and a lack of recognition that this vulnerable group has the same rights to access healthcare as housed children and young people (Society for Adolescent Health & Medicine, 2018).

In short, homeless children and young people can experience several challenges in accessing healthcare. They may need to overcome practical issues, personal perceptions of healthcare, institutional barriers or perceived stigma and judgement.

9 It can be noted that these challenges are not necessarily always specific to homeless children and young people, but may also be faced by homeless adults and other groups in society.

4. Interventions aimed at supporting children and young people to access healthcare services

Across the 34 articles reviewed for this research note, only nine discussed the implementation of interventions aimed at supporting homeless children and young people to access healthcare services (covering 10 interventions). This includes interventions introduced in Europe, but also Australia and Canada. The search was expanded to these additional two OECD countries after it was identified that very few interventions had been delivered in the EU ([10]). Table 1 below outlines the nine studies and the interventions they covered ([11]).

In addition to the interventions in the table below, some of the reviewed studies reflected on factors that can enable homeless children and young people to access healthcare services but did not refer to this in relation to a specific intervention. These factors have been reflected on in this section in terms of what to consider when designing future interventions to increase the chance of reaching their objectives.

This section will reflect on the interventions covered by the reviewed literature, including an overview of the outcomes of the intervention and discussion of what was found to work and what the challenges have been. The discussion of what has been found to work will draw more broadly on the information from the literature presented in Chapter 3 to discuss factors that can support homeless children and young people to access healthcare services but that was not specifically linked to an intervention.

10 This expanded search included New Zealand but no relevant articles on interventions were found. It was decided than the US would be excluded from this review due to key differences in healthcare service provision between the US and EU. This may mean interventions identified from the US would not be applicable to EU contexts (i.e. focus on providing not-for profit services that are free at the point of use in the EU). In addition, the impact of US interventions tend to be lessened when introduced in the EU as there can be greater support from social and health services in the EU.

11 The authors note that very few non-English language articles were identified that appeared relevant (and where possible, these were translated and included in this review).

Table 1: Overview of interventions identified in the literature

Name of intervention	Short description	Health condition	Preventative/curative	Age group[12]	Study	Location
Smile4life	An oral health intervention for homeless people which includes a guide for practitioners covering important oral health information for the homeless population, details on the intervention and how to deliver it effectively.	Oral health	Both	Young people and families	Beaton et al. (2018)	UK
Outpatient clinic in a refugee emergency accommodation centre	'The outpatient clinic intended to facilitate access to health care for the tenants in the emergency accommodation... The outpatient clinic offered basic medical care and was a first health contact point for the refugees.' The clinic ran one session a week dedicated to seeing children.	Any	Curative	Young persons	Borgschulte et al. (2018)	Germany
Posters on intravenous drug use dangers	'Researchers placed posters depicting the dangers of intravenous drug use in areas that street-involved youth frequented'	Drug use	Preventative	14 to 23 years old	Connolly & Joly (2012)	Canada
YouthLink	HIV outreach work in Australia, such as providing information on HIV prevention, and HIV services provided in the area, as well as practical services such as HIV counselling and testing.	HIV	Both	14 to 21 years old		Australia
Health advocacy intervention	A health advocate intervened and supported the individual early in their stay in temporary housing. 'The health advocate was to: give adequate information, both written and verbal, and not assume that people knew how to access primary health-care services; provide health checks, family planning information and practical advice, act as a liaison and provide referrals to social services, child protection services, health visitors, and more.'	Any	Preventive	Children	Rosenthal et al. (2019)	UK
Réseau d'intervention de proximité auprès des Jeunes de la Rue (RIPAJ) (Montreal Homeless Youth Network)	A network supporting youth in unstable housing situations to access appropriate and timely mental health care. The types of services offered by the network include free of charge consultations and interventions with psychologists, including for youth with severe mental health issues. It also includes case management, liaising and coordinating with other relevant organisations on behalf of the young person, developing a trusting relationship with the young person, support access to other forms of healthcare and health insurance and follow-up support.	Mental health	Both	Youth	Morisseau-Guillot et al. (2020)	Canada
Interdisciplinary, Teaching Medical and Dental Clinic for Inner City Street Youth	'The clinic was created to address a need for: (1) more accessible health services for "street youth" and (2) family medical residents and dental hygiene students to have more hands-on training experiences in delivering primary care services to youth.' The clinic 'is decorated in a youth friendly atmosphere with bright paint, health education posters, baskets of free condoms and sunscreen. Services are delivered to street youth, generally between the ages 12–20 years, who are not currently receiving primary health care services from another provider.'	Medical and dental hygiene	Both	12 to 20 years old	Rowan et al. (2013)	Canada
Community based dental clinic	The clinic performs free dental exams, cleaning, dental procedures and other preventive and dental education services. It also offers information on oral hygiene, diet and smoking. The clinic is staffed by volunteer dentistry staff.	Oral health	Both	16 to 25 years old	Stormon et al. (2019)	Australia
The Point Greenwich	'The Point enables young people, aged 16–19 to access a range of information, advice and guidance services including housing, health and wellbeing, education and skills, employment and volunteering, crime and justice, financial inclusion and community'	Any	Preventative	16 to 19 years old	Leng (2017)	UK
Healthy Child Programme	Health visitors and school nurses 'cover a huge number of important roles for homeless families and young people including GP and dental registration, immunisations, supporting breast feeding, nutrition and growth, supporting developmental progress, parenting and attachment, linking to education, signposting to other services and identifying health and wellbeing issues early.'	Any	Preventative	Families and young people	Health & Wellbeing Alliance (2018)	UK

12 As mentioned in the referenced study. Some intervention may have broader age groups, but the intervention studied only focuses on a specific age group.

4.1. Outcomes of the interventions

The outcomes of the interventions (where the article provided them) will be discussed in terms of the health condition the intervention is focused on. These health conditions are oral health, mental health, intravenous drug use and general health. It is important to note here that one of the research questions for this review aimed to explore the effectiveness of the interventions (i.e. *how* the interventions led to these outcomes). The published literature, however, provided little detail on how the outcomes were linked to the intervention and so we are not able to conclude whether these interventions have been effective. Therefore, we focus this section on the outcomes of the interventions.

Outcomes of interventions focused on promoting oral health

Two of the interventions focused on the promotion of oral health, both preventing poor oral health and providing dentistry services. Rowan et al. (2013) found that the Interdisciplinary, Teaching Medical and Dental Clinic for Inner City Street Youth was successful in reaching reach its target group of street youth. This enabled these youth to access dentistry services that they are usually unable to engage with (Rowan et al., 2013). The study also found that users of the clinic were comfortable in making use of the services and most returned to the clinic afterwards. It was, however, noted that the clinic is likely reaching the more 'mainstream' of street youth and those who are 'higher functioning', rather than youth that are more marginalised and on the edges of society. Overall, however, users of the clinic reported that if the clinic had not been available, they would not have gone elsewhere to access oral health services. For the community-based dental clinic in Australia, two-thirds of surveyed participants reported having excellent experiences at their dentist appointment, with only 2 % reporting fair/poor experiences (Stormon et al., 2019). Almost all of the participants felt the service was suitable to them (97 %) and they would use the clinic again (98 %). Most respondents felt that the information on oral health and accessing external dental clinics was of high quality. The authors of this study also noted that the cost of setting up the clinic was exceeded by the estimated value of the services delivered, and the clinic could be run at a low-cost due to the sustained reliance on volunteer dentist staff. The authors also speculated that hospital admissions associated with untreated dental issues and their associated costs could be reduced as a result of the clinic.

Outcomes of interventions focused on promoting mental health

One intervention focused on mental health: the Montreal Homeless Youth Network (Morisseau-Guillot et al., 2020). This intervention provided mental health services for homeless youth and helps to coordinate mental health support for this group. The study discussed how professional staff members of the network felt they were able to provide personalised care to the homeless youth seeking support and could support the young person to access timely and appropriate mental health care. The publication, however, did not provide any information on the outcomes related to the users of the network. Instead, it offered an overview of what the intervention offers to homeless children and young people, but did not analyse its outcomes.

Outcomes of interventions focused on reducing substance misuse

Reducing intravenous drug use was the focus of one intervention, which aimed to do so by placing posters on the dangers of intravenous drug use across Montreal (Connolly & Joly, 2012). The youth engaging with the posters reported that this approach encouraged homeless youth to reflect on their drug use and they were able to use the posters as a method of resisting peer pressure. Youth also commented that having information on a programme can encourage them to access support services as it is seen as reducing stigma and reduces concerns about their confidentiality.

Example: the Point Greenwich

Finally, one of the interventions provides information and guidance in a range of areas, including general health and paying for healthcare, and discussed the successes of this intervention. The Point Greenwich, which supports young people to access a range of support services, saw over 130,000 young people across 2016-17 (Leng, 2017). The 2016 Ofsted inspection found that the intervention provided good practice and 'an excellent range of multiagency services to support young people in crisis'. This included specific support for homeless young people.

4.2. Challenges for the interventions supporting access to healthcare services for homeless children and young people

Of the articles outlining the interventions available to support homeless youth to access healthcare services, a small number discussed the challenges in implementing the interventions. These will be discussed here, outlining the challenges faced by each intervention in turn.

The oral health intervention, Smile4life, implemented in Scotland, faced a number of challenges during implementation (Beaton et al., 2018). Oral health practitioners frequently approached the service user about the intervention (rather than vice versa) and this was often opportunistic rather than being offered to all homeless service users. In some situations, the space the practitioner had to work in meant that the service user had to approach them (e.g. medical room, meeting room away from communal space) which blocked the practitioner from being able to engage with the service user. The spaces were sometimes small and cramped, reducing the number of people the practitioners could engage with at any one time. In addition, there could be hostility or disinterest from service users in listening to oral health advice. They may also be disruptive and aggressive, demanding to see a dentist immediately. Finally, the authors argued that uncooperative working between third sector staff (e.g. social workers) working for homeless support services (who needed to provide access to the potential service users), and oral health practitioners often occurred. For example, third sector staff needed to advertise and promote the service to homeless people, but they did not always do this according to (Beaton et al., 2018).

Although the staff employed at the outpatient clinic in the German refugee emergency accommodation felt that the paper-based system for consultations worked well (discussed previously), there were also concerns about documents going missing, not being standardised or not being legible enough (Borgschulte et al., 2018). In addition, almost all staff surveyed for the study reported language as a barrier to offering healthcare services, which sometimes led to medical staff thinking a patient had a particular health condition but were unable to formally diagnose them. Other barriers during patient contact included the patient's level of education and the social situation.

In the study on YouthLink, an HIV outreach programme, service users reported feeling 'irritated' if staff pushed for parental involvement in their care if the youth had to wait for long periods for services and when the peer workers who were also current drug users were seen to 'lecture' youth on drug use (Connolly & Joly, 2012).

The Canadian intervention, Interdisciplinary, Teaching Medical and Dental Clinic for Inner City Street Youth, reported a number of challenges. There were also some concerns about the accessibility of the clinic. For example, some clinical staff felt that doctors needed to be present at the clinic more often than they were to reduce waiting times for service users and that there was a lack of awareness among youth both about the services available to them and the role of the different healthcare professionals at the clinic. As mentioned previously, there were also concerns that homeless youth who are more vulnerable and marginalised (and so most in need of the clinic's services) were not accessing the clinic (Rowan et al., 2013).

Finally, the community-based dental clinic introduced in Australia faced one important challenges (Stormon et al., 2019). The clinic faced issues with people not attending their booked appointments despite multiple reminders. The nature of the living circumstance of the service users meant the clinic could often not follow-up to re-book the appointment. The authors noted that while drop-in appointments may be preferable for homeless youth, this can cause challenges in providing continuity of care and ensuring treatments have been completed.

4.3. Facilitators of the interventions supporting access to healthcare services for homeless children and young people

As mentioned previously, this review identified articles that discuss general facilitators in supporting homeless children and young people to access healthcare services, as well as factors that supported the identified interventions to be successful. This section provides an overview of these key facilitators, drawing on information from the articles

covering interventions (in boxes), but also the other articles identified in this review. The types of facilitators cover: healthcare professional attitude and communication style; practical facilitators; collaboration and governance; sharing information about the intervention; and staff skillsets.

4.3.1. Professional attitude and clear communication style from healthcare professionals

An important factor in facilitating access to healthcare relate to that of the healthcare professionals attitude and ways of communicating with the individual. Some sources noted **the importance of clear communication, using informal and simple language, and making it clear to the young people why they need to use the healthcare service** (which is especially relevant when accessing mental health support) (Chaturvedi, 2016). Healthcare professionals also need to present to the young person with an appropriate attitude; including actively listening and being welcoming, open-minded empathetic and non-judgemental (Beaton et al., 2018; Chaturvedi, 2016; Connolly & Joly, 2012; Leng, 2017; Robards et al., 2018). This can facilitate the development of relationships between staff and young people (Crowley, 2012), which may encourage children and young people to approach services and then continue using them.

Smile4life initiative, a Scottish oral health intervention for homeless people, reported that the attitudes of the oral health practitioners were seen as important. Staff needed to be sensitive and empathetic while at the same time tolerate potentially disruptive and offensive behaviour (Beaton et al., 2018).

YouthLink, an HIV outreach programme for street-involved youth in Australia, found that youth felt able to engage with the programme because they felt the staff would be trained to deal with young people and the youth appreciate being listened to and understood. This may be as simple as calling the young person by their name (Connolly & Joly, 2012).

4.3.2. Practical facilitators (like same-day appointemnts and one-stop shops) support access

There are also practical aspects that can support children and young people to access healthcare services. For example, **providing flexible and/or same-day health appointments** are valued by homeless families due to their unpredictable living situations (Borgschulte et al., 2018; Crowley, 2012; Jenkins & Parylo, 2011). In addition, offering **multiple types of health services in one building** supports homeless youth to access all the support they may need in one go (Leng, 2017). **Being able to access healthcare services without having a fixed address** is also beneficial. In addition, one of the challenges for homeless children and young people in the transition from paediatric to adult health services, and having continuity of staff providing care can help to bridge this gap (Crowley, 2012).

For the intervention which set up an **outpatient clinic in a German emergency accommodation centre for refugees**, 75 % of the clinic staff felt that the opening hours to see adults and children were sufficient (Borgschulte et al., 2018). In addition, 69 % of staff felt that the system of patients bringing their paper records with them to consultations was useful.

The authors of the study on **The Point Greenwich programme**, which offers young people health information and guidance in the UK, provides a range of services being offered in the same location. This allows young people to access all the services they may need in one go and means they do not need to 'tell their story again and again' (Leng, 2017).

The study on the **Canadian Interdisciplinary, Teaching Medical and Dental Clinic for Inner City Street Youth** reported that there was little overlap in the schedules of healthcare providers working in the clinic (Rowan et al., 2013).

4.3.3. Collaboration between organisations involved and supportive governance structures

Effective collaboration between organisations involved in the implementation of the intervention and **supportive governance structures** were noted as important facilitators of some of the interventions (Beaton

et al., 2018; Leng, 2017; Morisseau-Guillot et al., 2020). Collaboration across various organisations and partners can, for example, facilitate the healthcare professionals delivering the intervention to access the target group, increase the likelihood of long-term funding for the intervention and allow for a higher quality of service provision.

For **Smile4Life**, effective collaboration and cooperation between third sector homeless services and the Smile4life oral health practitioners were seen as 'crucial' in allowing the practitioners access to the groups of people in need of the intervention (Beaton et al., 2018).

The **Montreal Homeless Youth Network** article noted the importance of governance and stakeholder engagement through 'discussions with potential institutional partners,' which can help to overcome some of the barriers faced by homeless children and young people in accessing healthcare, such as the transition between child and adult services. In addition, the article notes the value of integrating additional partners to provide varied services to homeless youth, being proactive in ensuring the sustainability of funding, holding regular meetings between psychologists and managers within the network and holding regular stakeholder meetings with the network and a variety of community organisations to support knowledge exchange (Morisseau-Guillot et al., 2020).

For **The Point Greenwich**, it was noted that the programme is benefited by strong collaborations with partner organisation which provides specialist skills and experiences and allows for an understanding of best practice and effective knowledge sharing (Leng, 2017).

4.3.4. Sharing information about the intervention and raising awareness

Sharing information on the intervention and raising awareness of the available services with the intended service use population was also identified as an important facilitator (Connolly & Joly, 2012; Morisseau-Guillot et al., 2020). This ensured that those who may benefit from the intervention are aware of the services they can access and have enough information to decide to make use of the intervention. The use of incentives to encourage homeless youth to engage with the service was also noted (Beaton et al., 2018).

Incentives were found to be of use for **Smile4Life** to getting homeless people to engage with the intervention, such as free toothbrushes and toothpaste. Practitioners felt that these incentives could also act as icebreakers when approaching potential service users (Beaton et al., 2018).

For **YouthLink**, providing information on the programme at the first outreach contact was seen as important by users who stated that 'knowledge about the program was a key factor in their decision of whether or not to engage' (Connolly & Joly, 2012).

For the **Montreal Homeless Youth Network**, a number of awareness-raising activities were undertaken by the network, aimed at a varied audience. This includes promotion of the network for relevant political departments, local healthcare organisations and academic circles (e.g. conferences and journal publications). Awareness-raising was also directed at the public and potential service users, such as media interviews which aimed to reduce stigma, and informal discussions with homeless youth attending healthcare clinics (Morisseau-Guillot et al., 2020).

4.3.5. Appropriate staff skillset and training

An appropriate mix of staff skills and providing relevant staff training was noted as important for two interventions (Morisseau-Guillot et al. 2020; Rowan et al. 2013).

The **Montreal Homeless Youth Network** offered mental health training to partners of the network, such as to identify signs of early psychosis (Morisseau-Guillot et al., 2020).

The study on the **Canadian Interdisciplinary, Teaching Medical and Dental Clinic for Inner City Street Youth** included a medical team that was multidisciplinary but had a particular focus on youth sexual health (Rowan et al., 2013).

4.4. Summary of interventions aiming to support homeless youth to access healthcare services

Overall, it appears that the **existing literature is lacking in studies evaluating interventions to support homeless children and young people to access the healthcare services they need**, including studies exploring what does and does not work for these types of interventions. Despite this, some important lessons can still be learnt from the literature reviewed for this research note. With regards to outcomes, the evidence reported was largely positive, with the interventions allowing appropriate and timely care to be provided to children and young people. In addition, **the interventions enabled homeless children and young people to access services they may not have been able to before**, and **service users reported good experiences when using the intervention**. The attitude and communication style of healthcare professionals involved in delivering the intervention were one of the key factors in supporting the success of an intervention. Those **staff who were more friendly, clear in their communication and who actively listened** were more likely to have better engagement from service users than those who were seen as being judgemental. In addition, **practical aspects** of the intervention are important in determining success, such as flexible appointments, along with effective collaboration between partner organisations delivering the intervention. A **lack of effective and supportive working relationships between partners** can cause challenges in reaching the desired intervention outcomes. Finally, other challenges include factors such as **language barriers** and **difficulties in reaching the most at-risk children and young people**.

5. Summary

The demographic make-up of the homeless population across Europe seems to be shifting towards a greater share of families, children and young people. Aside from the challenge of being deprived of one of the basic human needs, a roof over one's head, homelessness (including among young people) is also associated with healthcare challenges. **Homeless children and young people have specific health needs (such as the greater risk of mental health conditions and the consequences of a poor diet), and at the same time face difficulties in accessing the required healthcare services.** The objective of this research note was to provide an overview of existing evidence on the needs of homeless children and young people and the challenges this group faces in accessing care, as well as summarising interventions aimed at supporting access to healthcare for this population.

In terms of the **current situation of homeless children and young people across Europe, there do**

not appear to be accurate, up-to-date statistics on the size of this group. In part, this is due to challenges with different countries using a variety of definitions for homelessness. Data, however, from individual European countries do indicate that the **number of homeless children and young people has been increasing over time.** The reviewed articles demonstrate that this population has specific health and care needs that need to be considered. It appears that homeless children and young people are at increased risk of poor health in general, with the literature identifying infections, the health impacts of poor diet and nutrition, poor oral health, abuse and mental health issues (including addiction) as being of particular concern for this group.

While homeless children and young people are at a greater risk of these poor health outcomes, at the same time they face challenges in being able to access the health services they need. This includes **practical challenges** (such as the cost of healthcare or health insurance, as well as arranging and paying for travel) and **institutional barriers** (such as lack of continuity of care, and inflexible appointments/opening times). There are also challenges in homeless young people's **perceptions of healthcare and the stigma** associated with it. For example, this population group may not see health as a priority, healthcare professionals may stigmatise homeless young people or not listen to patients, and there may be institutional stigma that impacts the services available to homeless children and young people.

Of the articles providing information on interventions to support homeless children and young people to access healthcare services, only two EU countries were covered by these articles (the UK and Germany), with the other articles relevant to interventions implemented in Australia and Canada. This demonstrates a relatively **thin evidence base of what works (and what does not work) in terms of facilitating homeless youth to access healthcare services in Europe.** We have demonstrated that this is a serious concern. Anecdotally, the research team noted that there appeared to be a larger evidence base relating to interventions introduced in the US. While there are some significant differences between the healthcare systems in Europe and the US (which is why studies from the US were not included in this review), it may be that some relevant learnings and knowledge could be obtained from US-based interventions. Furthermore, the small number and varied nature of interventions make it difficult to reach firm conclusions. Yet, some general themes can be discussed in terms of outcomes, what has been shown to work and where the challenges lie in implementing interventions.

The outcomes of the reviewed interventions were largely positive, with authors stating that **service users were positive about their experiences and that users may not have accessed any form of healthcare if the intervention had not been in place.** The interventions also allowed appropriate care to be provided in a timely manner, as well as being tailored to the particular needs of homeless children and young people. One of the research questions was to explore the effectiveness of the interventions. Yet, the articles provided little detail on how the outcomes were linked to the intervention (i.e. *how* the interventions led to these outcomes). Therefore, we cannot make firm conclusions on whether these interventions have been effective.

In terms of what supported the successful implementation the reviewed interventions, **healthcare professional attitude and communication style was of particular importance** in ensuring an intervention was successful. This includes the staff member being open, non-judgemental and actively listening, with a communication style that is not complex and makes clear why the service user could benefit from the particular service. This may be something as simple as using the young person's name during conversations. This is unlikely to be specific to the types of interventions reviewed in this research note; it can be expected that these factors are important when engaging any vulnerable population. There are also **practical aspects about the intervention that are important to consider**, including offering flexible appointment times and/or opening hours, having as many services in one location as possible and not requiring proof of address to access services. From the governance side of the intervention, **effective collaborations between partners are important** in successful implementation, as well as raising awareness among relevant stakeholders about the intervention. Making potential service users aware of the services available is also important.

The sources describing the reviewed interventions also included an overview of some challenges faced during implementation. This includes **not having effective working relationships between intervention partners** or working arrangements for staff not being clear. **Pushy or judgemental staff attitudes** can also impact the likelihood that children and young people use the services. There can also be challenges at the patient level, such as **language and education barriers, or challenges in adhering to set appointments**. Finally, there may be concerns that the intervention does not reach the most vulnerable and marginalised group of homeless children and young people.

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Annex A. Search protocol

A.1. Objectives of the Research Note

To understand the healthcare needs of homeless children and young people and to identify examples of interventions that support homeless children and young people to access healthcare services.

A.1.2. Research Questions

1. What are the healthcare needs (both met and unmet) of homeless children and young people in Europe and what are the barriers for this group to access healthcare services?
2. What type of interventions or practices facilitates homeless children and young people's access to healthcare services (both preventative and curative), according to available evidence?
    a) Which kind of interventions have been shown to be effective (or not) in facilitating access to healthcare for homeless children and young people?
    b) What are the key issues to consider in the implementation of these interventions?

A.2. Scope of the review

A.2.1. Key concepts and definitions

A **child** is anyone under the age of 18, in line with the definition of the UN Convention on the Rights of the Child.

Healthcare is any service accessed through primary care (including GP/family physician, dentist and optician services), secondary care (including elective, urgent and emergency care) and specialist tertiary care.

Homelessness is not just sleeping rough, but also includes other forms of temporary or insecure living arrangements. Statutory homelessness is being legally recognised as homeless by local authorities due to lacking a secure place to live or not reasonably being able to stay. In the case of hidden homelessness, there is no requirement for local authorities to support individuals or individuals do not approach local authorities for support, such as those living in hostels, B&Bs, squats or concealed housing, such as at friends' or family's homes.

An **intervention** is a broad but formalised approach with specific aims (in this case to support access to healthcare for homeless children, young people and families) delivered by a specific organisation, charity, or foundation.

A.3. Search methodology: Targeted review

The targeted review was conducted following the adapted principles of reviewing as set out in the guidance published by the Centre for Reviews and Dissemination (CRD) (Centre for Reviews & Dissemination, 2009) and the Cochrane Handbook (Higgins & Green, 2011). The review comprised the following steps and each of these is briefly expanded upon below:

Step 1 framing the research questions and developing the protocol,

Step 2 identifying relevant literature (database searching),

Step 3 study selection,

Step 4 complementary evidence gathering,

Step 5 review and data extraction,

Step 6 analysis and synthesis of the evidence.

A.3.1. Step 1: Framing the research questions and developing the protocol

The first stage of the review involved defining and refining the research questions and drafting this search protocol.

A.3.2. Step 2: Identifying relevant literature

The following databases were searched for literature:

- PubMed: Includes health and life sciences articles which focus on improvements to health,
- ProQuest (social services): Includes articles relating to social services, policy and welfare,
- Scopus: Articles cover a broad range of topics, including health sciences and social sciences,
- Web of Science: Covers a range of disciplines, including social sciences,
- targeted Google searches for non-peer-reviewed literature (first 10 pages): To relevant literature published outside of academic journals.

To ensure the consistency and replicability of our reviews, we used the same search terms for all databases (with the format of the search tailored to specific database requirements). We undertook test searches to see which databases and search terms seemed to return the most relevant results. The search terms below are the final set which have been tested and refined to obtain the most relevant results and a manageable number of hits.

(child OR children OR youth OR adolescent* OR teen* OR infant* OR newborn* OR baby OR babies OR neonat* OR juvenile* OR "young people" OR "young person")

AND

(homeless* OR "temporary housing" OR "temporary accommodation" OR squat* OR "statutory homelessness" OR "hidden homelessness" OR "hidden homeless" OR shelter* OR hostel* OR refuge OR "sofa surfing" OR "couch surfer" OR runaway OR "run away" OR "unstable housing" OR "unstable home" OR "unstably housed" OR "housing instability" OR "unaccompanied homeless" OR evict* OR "marginally housed" or "precarious housing" OR "precariously housed" OR houseless* OR unhoused OR "without a roof" OR roofless OR "rough sleeper" OR "rough sleepers" OR "sleeping rough" OR "emergency accommodation" OR "insecure housing" OR houseless)

AND

(healthcare OR "health care" OR "health services" OR "health service" OR "healthcare services" OR "health service" OR "health program" OR "health programme" OR "health promotion" OR therap* OR treatment* OR nursing OR medical OR "primary care" OR "secondary care" OR "tertiary care" OR hospital* OR "general practice" OR "general practices" OR GP OR physician* OR pharmac* OR "community health" OR dental OR dentist OR optician* OR audiolo* OR "health visitor" OR "healthcare clinic" OR "healthcare clinics" OR screening OR "well-baby check-up" OR "well baby check-up" OR "well-baby check up" OR "well baby check up" OR "well-baby exam" OR "growth monitoring" OR "monitoring growth" OR "development review" OR "development reviews" OR "health review" OR "health reviews" OR "health monitoring")

A.3.3. Inclusion and exclusion criteria

The following inclusion/exclusion criteria were applied to the literature search and screening.

Criteria	Include	Exclude
Publication date	2010- 2020	Pre-2010
Population	Aged under 18	Aged 18 and above
	Homeless, according to our proposed definition	Non-homeless children
Situation	Access to healthcare services (which includes both preventative and curative services)	Any other situation
Language	English and non-English as needed (e.g. highly relevant research where the title/abstract is in English)	Not relevant non-English
Location	Studies conducted in European countries, Australia, Canada or New Zealand (13)	Studies conducted in other countries
Study type	Peer-reviewed journal publications presenting empirical evidence, review papers, non-peer-reviewed literature with clear authorship, book chapter, theses, conference proceedings	Documents without clear organisational authorship, theoretical work, letters, editorials, comments or opinion pieces, book reviews

13 While the initial search was focused on European countries, very few articles on interventions were identified and so the search was broadened. See section A.3.6 for further detail.

A.3.4. Search Results

The table below outlines the additional filters and number of search results from each database search.

Name of Database	Additional Filters	Number of Search Results Selected for Screening
PubMed	2010-2020 English	838
ProQuest (social services)	Abstract only English From 2010 Document types: Annual Report, Article, Back Matter, Biography, Book, Case Study, Conference, Conference Paper, Conference Proceeding, Correction/Retraction, Directory, Dissertation/Thesis, Editorial, Essay, Evidence-Based Healthcare, Feature, Front Matter, General Information, Instructional Material/Guideline, Interview, Literature Review, Market Research, News, Report, Review, Speech/Lecture, Statistics/Data Report, Undefined, Working Paper/Pre-Print	222 (without duplicates removed)
Scopus	From 2010 English language Excluded: Note, letter, retracted article Included only the following subject areas: Medicine, psychology, social sciences, nursing, multi-disciplinary, health professions, arts and humanities, dentistry and undefined	1,217 (without duplicates removed)
Web of Science	English language From 2010 Searched all databases	4,354 (without duplicates removed)
Targeted Google searches for non-peer-reviewed literature		500
Total number of search results before removing duplicates:		7,138
Total results after removal of duplicates:		5,136

A.3.5. Step 3: Study selection

After executing the search, we screened the titles and abstracts against the inclusion/exclusion criteria to confirm whether each source will be selected for full-text review. This step included the removal of duplicates.

A.3.6. Step 4: Complementary evidence gathering

Once we removed all the duplicates and screened the search results for their relevancy, we took stock of the evidence we had gathered to identify gaps in the literature. As discussed, this resulted in the identification that very few studies on interventions had been published in the European context. Therefore, the research team searched for keywords within the pre-identified literature for studies on interventions that had been conducted in Australia, New Zealand and Canada. We identified additional studies for Australia and Canada, but none for New Zealand.

A.3.7. Step 5: Extracting relevant data and information from the selected sources

To ensure consistency across the team when reviewing the sources to be included in the analysis, we created a simple data extraction tool to record information from the reviewed papers. The tool consisted of an Excel spreadsheet containing column headings that pertain to the research questions. Relevant data from the studies were extracted and placed in cells beneath the relevant column headings. The draft extraction table headers can be found

in the table below. This table also included a column to record any relevant literature identified through snowballing (in which one article was identified and extracted).

Column header	Description
Reference number	Unique citation number given to each article
Reference	Full article reference
Include/exclude	Whether, on reviewing the full-text, the article should still be included in the extraction stage
Brief summary	Abstract of the article
Publication type	Dropdown selection: Journal article, report, book chapter, conference proceedings, thesis, other
Study type	Dropdown selection: empirical study, review/systematic review/meta-analysis; case report; other
Methodology type	dropdown selection: quantitative - primary data collection, quantitative - secondary data, qualitative, mixed methods, case report, narrative review, systematic review, systematic review and meta-analysis, scoping review, other
Methodology detail	Further information on the study methodology
Geography	Country the study was conducted in
Study population size	Number of study participants
Study population type	Type of study participants (e.g. children under four).
Health condition of focus	What types of health conditions the study focused on (e.g. mental health? asthma)
Current children and young people homelessness situation	Information/data on the current issue with children and young people being homeless in the EU (e.g. number of homeless children and young people)
Challenges in homeless children and young people access healthcare	Information on the types of challenges homeless children and young people in accessing healthcare and how healthcare is accessed by this group
Healthcare needs of homeless children and young people	Information on healthcare needs specific to homeless children and young people
Name of intervention	Name/short description of the intervention to support homeless children and young people to access healthcare services
Description of intervention	Description of what the intervention is and how it hopes to improve access to healthcare services
Is the intervention preventative or curative?	Dropdown selection: Preventative, curative, both
Impact of the intervention	The impacts (positive or negative) relating to access to healthcare services that occurred as a result of the intervention
Enablers of the intervention	What supported and facilitated the successful implementation of the intervention
Challenges with the intervention	Any challenges identified when implementing the intervention and how these were overcome
Study limitations	Limitations as reported by the study authors and further limitations identified by the article reviewer
Study strengths	Strengths as reported by the study authors and further limitations identified by the article reviewer
Additional comments	Any additional notes on the article

A.3.8. Step 6: Analysis and synthesis of the evidence

Synthesis of findings from the different data sources was tabular with a narrative commentary. In synthesising findings, we brought together relevant evidence from the different data sources into a cohesive in-depth analysis of the identified evidence.

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