European Commission

Social and healthcare services for homeless people: A Discussion Paper

European Platform on Combatting Homelessness

Nicholas Pleace
Centre for Housing Policy, School for Business and Society
University of York, UK

Introduction

This discussion paper supports a mutual learning event for Member States organised as part of the activities of the *European Platform on Combatting Homelessness*. The paper complements earlier papers on homelessness strategies (O'Sullivan, 2022) and prevention (Mackie, 2022). The paper looks at health, care and support needs among people experiencing homelessness (PEH), at barriers to services and at evidence on effective health and social services for PEH. The paper concludes with some key questions around the roles of health and social services in combating homelessness in Europe.

Health, care and support needs among people experiencing homelessness

Research published throughout the EU and comparable countries repeatedly describes people experiencing homelessness (PEH) as having multiple and complex needs from both a health and social perspective.

For example, research identifies an *extremely* high prevalence among PEH of mental illness, limiting illness, disability and high rates of bloodborne (Hepatitis, HIV) and respiratory (tuberculosis) infection which cause them to die, on average, decades younger than general population (e.g. Aldridge et al. 2018 and 2018a; Beijer et al. 2012; Wolf et al. 2016). Studies also highlight high rates of autism (Churchard et al. 2019) attention deficit hyperactivity disorder, learning difficulties and other forms of cognitive impairment (Stone et al. 2019) and brain injury (Gilchrist and Morrison, 2005).

Very high rates of problematic drug and alcohol use (addiction) are frequently reported, particularly illegal drug use that is present alongside mental health problems and one or more physical health problems[1] (Greenwood et al. 2020; Bowen et al. 2019; Fond et al. 2020). There is particularly strong evidence of a 'mutually reinforcing' relationship between long-term and repeated homelessness and addiction, mental illness and limiting illness and disability (Kemp et al. 2006; O'Sullivan, 2022).

At the same time, some research has been criticised as 'medicalising' homelessness at the individual level, when there are many other factors involved in the causation and experience of homelessness, and in preventing and reducing it (Craig and Timms, 1992; Lyon Callo, 2000; O'Sullivan et al, 2020). Some groups of EU citizens with multiple and complex needs, including young people leaving child protection services, people leaving

1 Comorbidity of serious illness, addiction and limiting illness and disability

prison (particularly those experiencing repeated short-term prison sentences), long stay hospitals and other institutions, appear to be at heightened risk of homelessness. People at heightened risk of homelessness in Europe can also include those who identify as LGBTQI+, some cultural and ethnic minorities and other groups experiencing stigmatisation and prejudice(Mackie, 2022). Women's homelessness is often closely associated with experiences of domestic abuse (Bretherton and Mayock, 2021).

However, in many EU Member States overall homelessness is more clearly associated with *poverty* than with multiple and complex needs (O'Sullivan, 2022), a pattern also seen in comparable countries (Bramley and Fitzpatrick, 2018; Colburn and Aldern, 2022; O'Flaherty, 2010; Johnson et al. 2019; Lohman, 2021; O'Sullivan, 2020). There is broad evidence that homelessness reflects the nature and extent of social protection systems. Where social protection is extensive, as in Member States like Denmark and Finland, small groups of PEH with multiple and complex needs are present, with little homelessness being triggered by poverty. Where social protection systems are less extensive, homelessness is more commonly associated with poverty and people with multiple and complex needs, whose homelessness tends to be sustained or recurrent are only a minority of PEH (Fitzpatrick and Stephens, 2014; Allen et al. 2020; O'Sullivan, 2022).

Research on prevalence of disease among PEH has often tended to focus on people sleeping rough and living in shelters and to be conducted over short periods of time. People with multiple and complex needs are *also* the long-term and repeatedly homeless population, so whenever health research is conducted among people living on the street or in emergency shelters, they are the people who are most likely to be there (Culhane and Kuhn, 1998; O'Sullivan et al. 2020; O'Sullivan, 2022). In essence, a lot of European and other health research has often *oversampled* PEH with multiple and complex needs.

This is important, as there are many other PEH in EU Member States who have different sorts of treatment and support needs. Women, children, people who identify as LGBTQI+ and migrant populations who are homeless are less likely to be present among people sleeping rough and in shelters and more likely to be experiencing hidden homelessness. Hidden homelessness means that someone is living precariously with friends, relatives or acquaintances because they have nowhere else to go, they have no housing rights, no control over their own living space and can be in unsafe or abusive situations (Pleace and Hermans, 2020). There is evidence that lone women in situations of hidden homelessness can have multiple and complex needs, often associated with the trauma of domestic abuse and ongoing abuse, while other groups experiencing hidden homelessness, like young people and LGBTQI+ can also be highly vulnerable (Bretherton 2017; Bretherton and Mayock, 2021; Shelton and Bond, 2017; McCarthy and Parr, 2022). Children experiencing homelessness, often in various forms of temporary accommodation across Europe, particularly in Member States like France and Ireland, can face multiple barriers to health and social services (Grant et al. 2007; Rosenthal et al. 2020).

The need for specialised health and social services

PEH often *expect* to be rejected by health and social services. Sometimes there is experience of negative, judgemental behaviour by health and social services, but the expectation that this will be encountered means PEH never get as far as opening the door to services (Pleace and Quilgars, 1996; Lester and Bradley, 2001; Canavan et al. 2012; Ha et al. 2015; Cernadas and Fernández, 2021). These attitudinal barriers, 'I won't try to get help, because I will be refused because I am homeless', have been associated with late presentation, i.e. someone only seeking help when pain or other symptoms become unbearable (Lewer et al. 2019), which may mean that treatment might be less effective than if they had sought help earlier.

Health and social services often require a settled address within their administrative boundaries. People in situations of hidden homelessness, or who are being moved between temporary accommodation lack the 'settled' address these systems expect, as of course, does anyone in a shelter or living rough (Baptista et al. 2015). Migrants experiencing homelessness may struggle with dealing with bureaucratic systems using different logic, different assumptions and a different language, or if they are undocumented, they will often be prohibited from using some of these services (Mostowska, 2014).

Mainstream health and social services can refuse to engage with someone, on the basis they are seen as a potential risk and sometimes popular images, associating PEH with addiction and severe mental illness, will be enough to block access to services (Pleace and Bretherton, 2020). There is longstanding evidence of a need for specialist combined mental health and addiction services for people experiencing long-term and recurrent homelessness, as mainstream versions of these services can still sometimes operate separately from one another (Pleace and Quilgars, 1996; Canavan et al. 2012).

It is important to note that PEH may be dealing with administrative staff who follow set protocols, who cannot necessarily be flexible, and who may not have much training or information to work with. On the other hand, there may be systems in place specifically to allow for PEH, or one worker will interpret service protocols more liberally than another, meaning that being recognised as in need and getting treatment, care and support can sometimes be a matter of luck (Bretherton et al. 2013).

Maintaining continuity of treatment and support can be challenging for PEH. The lack of *stability* is important here:

- Unwanted moves while homeless may cause disruption in ongoing treatment cause it cease altogether, e.g. diabetes may be neglected, or a treatment course for a tuberculosis or hepatitis infection may not be completed, or it might be difficult to maintain access to prescription drugs and therapy for a mental health problem.
- Instability from lacking a settled home may disrupt routine contact with medical services, including routine screening, making it more likely that warning signs of potentially serious conditions are missed.
- Unmet treatment and support needs may be an issue in themselves, e.g. in making it less likely that someone can reliably attend medical appointments, such as unmet needs for support with addiction or severe mental illness.

Instability in accommodation, particularly when PEH are having to move around frequently (or are moved around by homelessness and other services) may cut access to health and social services because even a move of a few kilometres takes someone into another administrative area, or somewhere where they cannot afford transport costs (Pleace and Bretherton, 2020). The original Housing First model developed in New York by Sam Tsemberis. was in fact designed for PEH with severe mental illness who were not consistently able to access treatment and support because of their residential instability (Tsemberis et al. 2004).

These issues are also a management concern for health and social services. To use British NHS terminology, there is international evidence of a 'frequent flyer' population who are long-term and recurrently homeless, have complex needs, and who make *very* frequent use of emergency health and social services (Pleace and Culhane, 2016; Pleace and Bretherton, 2020). In the US, this pattern is sometimes referred to as the 'million dollar Murray' phenomenon (Gladwell, 2006), originally referring to long-term homeless individual, who eventually died on the street, after making repeated use of emergency health, addiction, mental health services and high frequency contact with criminal justice services, none of which resolved their homelessness. This is the key point around experience of 'frequent flyer' and 'million dollar Murray' patterns in health and social service use: homelessness associated with complex needs *persists,* despite frequent emergency service use, so both the human and financial costs are high (Pleace and Culhane, 2016; Reilly et al. 2020; Lewer et al. 2019).

The evidence on health and social services

Health services

There is no standard approach to meeting health, care and support needs among PEH. Some of the more common models can be summarised as follows:

- Information and help points, case management services and shared assessment and referral systems that are designed to enhance access to mainstream health and social services for PEH (Cream et al. 2020).
- Specialist addiction and mental health services for PEH. This includes services that can support and treat people presenting with both severe mental illness and addiction. These services may be mobile, using an outreach approach, be part of, or visit homelessness services, or have their own clinic and other facilities at a fixed site. Services can also include supervised consumption interventions, i.e. safe injecting sites/ drug consumption rooms, but these are neither widespread in Europe nor necessarily culturally, ethically and politically accepted (Pleace, 2008; Pleace and Lloyd, 2020; Pottie et al. 2020; Magwood et al. 2020).
- Specialist homelessness medical services that offer can offer different mixes of primary care, e.g. general practice (family) doctors, nurses and sometimes other services like dentistry, podiatry, occupational therapy and social work. Again, these can be delivered in several ways: as fixed site services, within existing homelessness services (particularly daycentres[2]) and/or, in various forms, as outreach services including 'street medicine' models. These services include 'hub' and 'one-stop' services which offer interdisciplinary teams from whom PEH can receive a single, multi-agency (health, social services and other services) assessment and a coordinated response to their needs(Kertesz et al. 2021; Jego et al. 2019; Schiffler et al. 2023; Roche et al. 2018).
- Hospital discharge services for PEH. These services are designed to produce better treatment outcomes from hospital stays by PEH and to prevent unnecessary readmission. There are examples of specially designed services such as the Pathway model (see below) and use of critical time intervention (CTI) and also Housing First to support effective hospital discharge for PEH (Cornes et al. 2021; Luchenski et al. 2018; Blackburn et al. 2017; Tinland et al. 2020; Tomita and Herman, 2012; Buchanan et al. 2006).
- Incorporation of medical treatment models into homelessness services. This includes use of psychologically informed environment (PIE), trauma informed care (TIC) and reflective practice which are designed to understand the emotional and psychological needs of PEH and the trauma they may have experienced (Homeless Link, 2017a and 2017b). Harm reduction, which is used in some EU Member States more than others, is an approach aims to reduce harm and work towards reducing use, rather than seeking to compel detoxification and/or abstinence (Rosenheck, 2010). Harm reduction is at the core of the Housing First, which in the highest fidelity forms has its own teams of mental health practitioners, social workers, addiction specialists and clinicians (Tinland et al. 2020; Tsemberis et al. 2014).

Research on effective health services for PEH is most commonly focused on people with multiple and complex needs. Studies have been conducted in many EU Member States, although it is notable that there are large numbers of studies from North America and from the UK (O'Sullivan et al. 2020).

The evidence base is weaker on effective health services for women experiencing homelessness (Bretherton and Mayock, 2021), with evidence gaps around effective responses to the trauma of domestic abuse, the high incidence of separation from children among lone homeless women and reproductive health, including access to contraception and experience of 'period poverty' (Poncet et al. 2019; Vora, 2020). Services for homeless children and families have also received some attention (Rosenthal et al. 2020), although quite of lot the evidence around homeless children's access to healthcare appears to be older research (Lissauer et al. 1993) and there are some evidence gaps.

Access to health services including dentistry (Paisi et al. 2019) and chiropody (podiatry) for PEH appears to often be poor (To et al. 2016). It is important to note that studies looking at service needs in areas like dentistry and chiropody tend to only look at barriers for people experiencing long-term and recurrent homelessness. The

2 Daycentres offer food, support, activities (sometimes including education, training and support with labour market activation) and other services during daylight hours. They do not provide accommodation for PEH.

field of effective palliative (end of life) care for PEH is still in development, although more work has started to be done in this field, focusing on building better services (Armstrong et al. 2021).

There is a longstanding debate about how much specialist health service provision there should be for PEH. This centres on the degree to which that specialist provision should operate as a conduit to mainstream health services and the degree to which mainstream health services should be expected to modify themselves to become more accessible to PEH (Pleace and Quilgars, 1996).

Specialist homelessness services need a critical mass, i.e. there have to be enough PEH to make expenditure make sense, which means there is a marked tendency for specialist homelessness health services to be only be present in urban areas in EU Member States and comparable countries (Cream et al. 2020). Arguments have also been made that specialist services, if they do not quickly connect PEH with mainstream health services, risk prolonging the stigma and possibly experience of homelessness, although there is no hard evidence to support this assertion.

There are logistical limits in public health policy which means that building an entirely separate *system* of healthcare for PEH is unlikely to be practical in any EU Member State. A key point here is that treatment needs can - and will - exceed those that can be met by a specialist medical service, or a homelessness service with extensive, integrated medical support[3] - can effectively treat and support (Aubry et al. 2020). At least some of time, specialist medical services for PEH will still need to be able to coordinate with mainstream health services, if they are going to provide effective treatment.

Street medicine and outreach, alongside other low threshold specialist medical services for PEH, can provide a quick and accessible route to medical care, which might otherwise not be available. However, if someone's particular treatment needs cannot be effectively managed while living rough or in an emergency shelter, or simply need treatments that a street medicine/outreach service cannot provide, ensuring that strong connection to mainstream health and social services becomes vital (Enich et al. 2022). Equally, street medicine services can function in ways that parallel outreach homelessness services (or form part of such outreach services) enabling rapid, low-threshold, access to treatment and support through effective coordination with other health, social and homelessness services that PEH need (Kopanitsa et al. 2023).

Conversely, there are also limits to what mainstream public health services can do for some PEH. Homelessness constitutes only a *tiny* amount of overall patient need in EU Member States. The main pressures come from a rapidly ageing European population. There are limits around how much public health money can be spent on adapting mainstream health services to work as effectively as possible with PEH because of all the other demands public health systems face.

As noted, there can also be considerable inconsistency in how specialist health services and systems for PEH are designed and how they operate. There is no standard European model of health services for PEH and, just as is the case for European homelessness services (Pleace et al. 2018), there can be a lot of variation both across and *within* EU Member States. Services can range from extremely well resourced, highly connected interdisciplinary teams, to someone volunteering their time to run an informal surgery out of the back of their car. A recent European evidence review found all sorts of differences in the nature and extent of addiction services for PEH (Pleace and Lloyd, 2020). This is also true across comparable countries. Another evidence review on street medicine services found a lot of differences, both in terms of what sorts of treatment street medicine services provided and in how they operated (Enich et al. 2022).

An overview of social services

For the purposes of this discussion paper, social services are being defined as social work, which provide case management and the provision of social/personal care, e.g. help with eating, bathing or dressing, including in nursing homes or residential settings, but as not including any form of medical treatment or as encompassing welfare systems.

Social work concerns with homelessness centre on how social workers can most effectively support vulnerable people who are homeless or at risk of becoming homeless. The intersectional nature of homelessness is emphasised, i.e. social workers are told to recognise and respond to both individual needs, characteristics, experiences and choices, while also being aware of how systemic disadvantage, such as experiencing

3 i.e. Assertive Community Treatment (ACT) models of Housing First and equivalents in other forms of homelessness service.

stigmatisation or being socioeconomically marginalised, might be contributing to someone's homelessness (Zufferey, 2016; Sen et al. 2022).

Existing research and best practice tends to recommend that social workers use holistic case management when seeking to prevent and to end homelessness. Case management does not exist in a single form across or within EU Member States, but the approach involves practical assistance, emotional support and connecting and facilitating use of other services and support. So for example, a social worker supporting someone with mental health problems who is homeless, might work on their behalf to secure access to mental health services, support their use of those services (perhaps coming with them to appointments, at least initially) and might also work with private or social rented landlords to try to find them suitable housing. Effective practice in social work is often centred on how social workers should *react* to homelessness, rather than being focused on developing specialist social work services or systems that are exclusively for people experiencing homelessness (Gerull, 2023 and 2021). There have been calls to enhance social work training in relation to homelessness outside Europe (Watson et al. 2021).

Guidance for social workers and social services can be described as covering the following areas (Gerull, 2023; Sen et al. 2022; OECD, 2015):

- How social workers employed by social services and by other agencies can most effectively support PEH, again with the emphasis on case management which tries to fully recognise all the dimensions of homelessness.
- The roles of social workers within specialist homelessness services using interdisciplinary teams, i.e. joint teams that also involve health professionals.
- The roles of social workers within homelessness service that employ qualified social workers.

In some EU Member States, mainstream social services are the main form of support available to PEH who have support and treatment needs. For example, in Slovenia, PEH with treatment and support needs can get assistance from publicly funded Centres for Social Work, which cover the whole population, as well as PEH (Pleace et al. 2018). Guidance and research often assumes social workers are in this sort of position, i.e. employed by mainstream social services to support and case manage vulnerable individuals and households, *some* of whom may be homeless or at risk of homelessness.

Specialist health services, including street medicine services, fixed-site services and projects designed to support PEH with addiction and mental illness, can have a mix of clinical and social work staff. Sometimes social work staff on these teams might have had additional bespoke training, around understanding homelessness itself and the kinds of need that PEH can have (Gerull, 2023).

Homelessness services that employ trained social workers, including some models of linear residential treatment/ staircase services and Housing First are sometimes identified as a form of specially targeted 'social service' for PEH, essentially because they employ social workers (OECD, 2015). Germany is one example of an EU Member State where some homelessness services routinely employ trained social workers (Pleace *et al*, 2018).

Evidence on effective social work practice with PEH is less extensive than is the case for health services (Gerull, 2023). There are some unanswered questions around the wider role of social services in preventing and reducing homelessness in Europe. One question surrounds the use of fixed-site social services, i.e. residential care and nursing facilities, e.g. for people who become frail in later life, if they reach a point where they cannot live independently or be effectively cared for in ordinary housing. There are a few examples of residential care facilities for PEH, such as the Danish Skæve Huse model, a form of small, sheltered congregate housing for formerly homeless people with high support needs (Allen et al. 2020). While the evidence base is very limited, some research suggests that frail older people with experience of homelessness face barriers to mainstream residential and nursing care services (Crane and Warnes, 2007). Another question surrounds the role of occupational therapy (which can be provided by health and by social services), which can enable people with limiting illness or disability to undertake more activities and enhance quality of life. There is some evidence of occupational therapy making positive changes in the lives of PEH, but more research is needed (Thomas et al. 2011; Marshall et al. 2021).

Effective practice

There is longstanding evidence that health and social services, operating in isolation, cannot always meet the needs of PEH. Again, this is because as soon as homelessness means that treatment, care and support cannot be effectively administered, or as soon as someone's needs exceed what a specialist health team or integrated health and social work team can provide, there will not be a good outcome. Alongside this, homelessness presents a number of ongoing risks to health and wellbeing, from exposure to constant stress, trauma that led to homelessness being ongoing (e.g. domestic abusers following a woman who has become homeless), poor diet, poor living conditions and, if someone is living rough, exposure to the elements. Importantly, there is evidence that addiction, mental illness, infection, limiting illness and disability *increase* among people who experience long-term and repeated homelessness (Culhane et al. 2013) and evidence that some long-term homeless populations are ageing rapidly, i.e. they are starting to – also - need the health care and social services needed by people in later life (Culhane et al. 2019; Crane and Warnes, 2007).

The COVID-19 pandemic was an unfortunate illustration of these twin challenges. It was impossible to manage the risks of mass infection among people living rough and in shared-air (communal) emergency shelters, unless they were accommodated in hotels or shelters were rearranged. There was also an imperative to accommodate many people experiencing these forms of homelessness in situations where they could self-isolate, because they had many underlying/secondary health conditions that meant serious infection and death from COVID-19 was much more likely than among the general population (Parsell et al. 2022; Pleace et al. 2021; Neale et al. 2021). As one clinician working with PEH once put it, 'you cannot effectively treat someone who is living in a cardboard box' (Pleace and Quilgars, 1996).

Health researchers and clinicians initially reacted to these challenges by suggesting the use of respite or intermediate care centres, essentially a mixture of hospital ward and recuperation centre where PEH could stay until treatment was complete, with experiments being conducted in the management of tuberculosis and short-stay residential detoxification services. The effectiveness of some of these services, for example short-stay residential detoxification, was very limited (Pleace, 2008).

Health services and social work practice have increasingly adopted holistic models of treatment and care, an approach to health and social services care that is framed by the idea of treating 'the causes of the causes'. This stems from the strong evidence of a social gradient in health, which means the lower the socioeconomic position of an individual, the worse their health is (Marmot, 2018). When this sort of clinical perspective is adopted across medicine and health care more generally, addressing homelessness itself becomes a crucial part of treatment and support for PEH (Clark et al. 2022; Luchenski et al. 2018; Blackburn et al. 2017).

In practical terms, this has meant health services creating interdisciplinary teams designed to address needs for treatment, care, support and housing among PEH (Clark et al. 2022). These approaches have also become increasingly characterised by patient involvement and patient centred care, i.e. treatment and support plans are a *collaboration* between PEH and these services, as there is evidence that this sort of co-productive working leads to better outcomes (Finlayson et al. 2016).[4]

An example of this sort of approach is the integrated care hospital discharge service called the *Pathway* approach, which began in London and now operates more widely in the UK.[5] Pathway services are based in hospitals and they are designed to provide an interdisciplinary package of support when PEH are admitted to hospital, centred on ensuring that when they leave hospital, they will continue to have access to all the treatment, support and housing that they need. The teams are led by specialist general practitioners (doctors) and nursing staff, and work towards ensuring PEH who are hospital patients can access the accommodation, care and support they need to recover and have a better life 'pathway' following their stay in hospital. Some larger Pathway teams also include occupational therapists, social workers, mental health clinicians, 'care navigators' who are case managers with their own lived experience of homelessness and housing specialists. The evidence base for this relatively new model appears to be strong (Cornes et al. 2021) and, in the UK, the National Institute for Health and Care Excellence (NICE), which makes recommendations to public health services based on systematic evidence reviews, has issued guidance *on Integrated health and social care for people experiencing homelessness*[6].

4 See also: https://groundswell.org.uk/healthnow/

5 https://www.pathway.org.uk

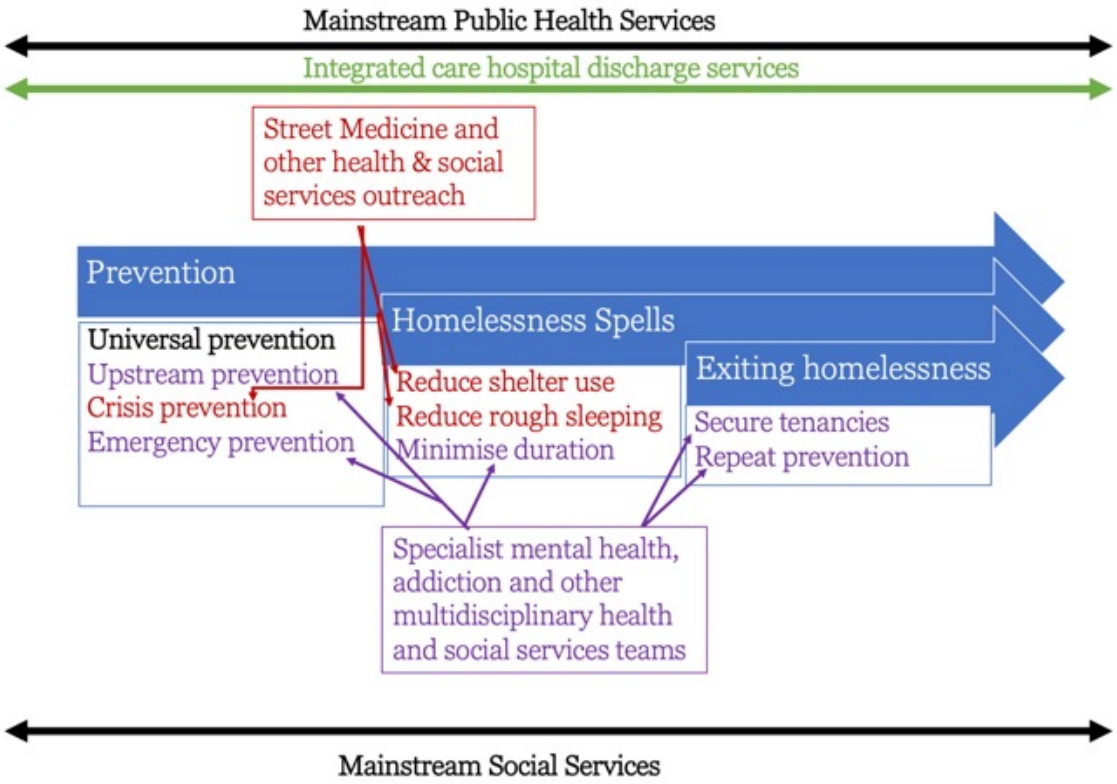
6 https://www.nice.org.uk/guidance/ng214 Please note that the UK has developed a habit of referring to social services as 'social care'.

The wider global evidence base on these sorts of hospital-based integrated care for PEH has recently been described as underdeveloped (Luchenski et al. 2022). However, other health research has also started to explore these more holistic approaches, tracking the clinical effects of providing housing as well as treatment and support to PEH and finding, perhaps rather unsurprisingly, that better treatment and support outcomes occur (Onapa et al. 2022; Stone et al. 2019).

The very strong parallels between these sorts of health-led integrated care approaches and the operational logic and the longstanding practices seen in Housing First and Critical Time Intervention (CTI) are obvious. Like these services, very high-fidelity ACT/ICM Housing First services also employ multidisciplinary teams, including clinicians and social workers, as seen in French Housing First (Tinland et al. 2020; Fond et al. 2020) or in Danish Housing First, the Danes having also experimented with the time-limited, but similar CTI model (Allen et al. 2020). The same emphasis on working with PEH within a co-productive framework is also at the heart of case-management only models of Housing First, which work through coordination with health and social services, across many EU Member States.[7]

7 https://housingfirsteurope.eu

Preventing and ending homelessness



The figure draws on the first two discussion papers in this series. O'Sullivan (2022) uses a conceptual framework that argues that homelessness is a dynamic process, a 'moving target' through distinct stages, which provide different opportunities and challenges in building effective integrated strategies to prevent and end homelessness in Europe (see also Lee et al. 2021 and Fitzpatrick et al. 2021). O'Sullivan argues that the goals of policy should be to *prevent* entries into homelessness and repeated experiences of homelessness and to minimise the *duration* of homelessness when it occurs by enabling rapid *exits* (O'Sullivan, 2022). Mackie's discussion paper looks at effective homelessness prevention (Mackie, 2022). Building on his work with Fitzpatrick et al. (2021) he identifies five levels of prevention: *universal* prevention (the general safety nets and systems that protect EU citizens from homelessness), *upstream* prevention (stopping homelessness from occurring among groups who are known to be at higher risk), *crisis* prevention (stopping evictions), *emergency* prevention (stopping immediate risks, including of sleeping rough) and *repeat* prevention (breaking cycles of long-term and repeated homelessness associated with multiple and complex needs) (Mackie, 2022).

Mainstream public health and social services, which, while they differ in their extent, are available to all EU citizens, have roles in prevention, minimising duration and enabling exits. An important part of this role is universal prevention and, within resource and other constraints, ensuring accessibility to people at risk of homelessness. When PEH have a need for medical and social services, those needs will sometimes be beyond what a specialist health/interdisciplinary team can provide, which means strong and reliable integration with mainstream services will be necessary, i.e. specialist health and social services ultimately depend on mainstream services to ensure their overall effectiveness. Both integrated care models developed within hospitals, such as *Pathway*[8] and specialist homelessness services working with PEH, including those working with people with multiple and complex needs like Housing First, are again heavily reliant on networking and integration with mainstream health and social services in order to function well.

Outreach services have a potentially important role in homelessness prevention if they can be called upon when someone is at risk of eviction because of unmet treatment and support needs. Street medicine/outreach can

8 https://www.pathway.org.uk

also play a useful role when people living rough or in shelters are long-term or recurrently homeless in ways that are associated with unmet treatment and support needs.

Specialist health, mental health/addiction and interdisciplinary health and social services teams can play multiple roles in addressing homelessness across EU Member States. If these services can be integrated into preventative strategy, they can help manage the heightened risks of some groups experiencing homelessness, i.e. be used as part of upstream prevention. If a young person is leaving care, or an ex-offender with mental health problems is leaving prison, these services could provide health and social care that will lessen their risk of homelessness. Finland what is sometimes described as following a housing 'social work' approach as part of its policies for preventing homelessness which adopts some of this logic (Allen et al. 2020). Equally, if PEH have existing treatment and support needs, these sorts of services can be instrumental in minimising the duration of their homelessness and, when someone has long-term or recurrent experience of homelessness associated with multiple and complex needs seeks to successfully exit homelessness, these services may well play a vital role.

Finally, integrated care hospital discharge services, such as the *Pathway* model have roles across homelessness prevention and reduction. The same service might act as part of emergency or crisis prevention, or as a means of repeat homelessness prevention. These services also have the capacity to reduce the number and duration of homelessness spells associated with unmet treatment, care and support needs.

Key questions

- There is no universally accepted and used service model for health and social services across EU Member States, nor in economically comparable countries. Could a consensus be built around a more uniform approach, bearing in mind differences in governance, social protection, social services and public health systems both across and within Member States? What are the key, common cross-country features that could be retained in such an approach across the Member States?
- What are the key challenges in improving the integration and coordination between health and social services for PEH? Is it helpful to have a common point of entry/ information centre for homeless people? Which Member States and cities provide this type of coordinated information and offer to liaise with mainstream services? Are these "info points" in physical locations or also online?
- Specialist health and social services for PEH can have advantages because they reduce administrative, attitudinal and other barriers to health and social services care and support. However, these services may only operate where there is a critical mass of PEH, i.e. there are enough PEH to justify expenditure, which means they tend to be mainly in urban areas.
    - How much of this specialist service provision should there be?
    - How should specialist services and mainstream services work together?
    - Should more resource be going into making mainstream health and social services accessible to PEH so that specialist services become less necessary?
- Specialist health and social services for PEH have tended to focus on specific subsets of the population, i.e. people sleeping rough and in shelters and within those groups, people experiencing long-term and recurrent homelessness associated with multiple and complex needs. Is there scope and arguments to develop targeted approaches to support other more specific groups of PEH? If so, which ones and why? These might include lone women, lone women parents, young homeless people, elderly people, disabled people, migrant homelessness and LGBTQI+ people experiencing homelessness?
- What should the role of health and social services be in homelessness prevention? Many specialist health and social services are reactive, i.e. they are primarily designed for dealing with the effects of (often) long term and recurrent homelessness. Existing specialist services might well contribute to preventing repeat homelessness, but how should health and social care supported crisis, emergency and upstream prevention?
- How can health and social services help ensure continuity of treatment, care and support to PEH who have been recently (re)housed, including for example through joint working with Housing First schemes and other homelessness services? What else can and should be done by health and social services to help prevent repeated homelessness?
- How can social and municipal housing providers and health/ social care services work better together in preventing and reducing homelessness?

Acknowledgements

My thanks to Dr Colm Gallagher who is a Clinical Psychologist in Greater Manchester, UK for sharing his expertise in medical services for people experiencing homelessness.

References

Aldridge, R.W., Hayward, A.C., Hemming, S., Yates, S.K., Ferenando, G., Possas, L., Garber, E., Watson, J.M., Geretti, A.M., McHugh, T.D. and Lipman, M. (2018) High prevalence of latent tuberculosis and bloodborne virus infection in a homeless population. *Thorax*, 73(6), pp.557-564.

Aldridge, R.W., Story, A., Hwang, S.W., Nordentoft, M., Luchenski, S.A., Hartwell, G., Tweed, E.J., Lewer, D., Katikireddi, S.V. and Hayward, A.C. (2018a) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The Lancet*, *391*(10117), pp.241-250.

Armstrong M, Shulman C, Hudson B, et al. (2021) The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff. *Palliative Medicine*. 35(6), pp.1202-1214. doi:10.1177/02692163211006318

Allen, M., Benjaminsen, L., O'Sullivan, E. and Pleace, N. (2020) *Ending Homelessness in Denmark, Finland and Ireland*. Bristol: Policy Press.

Aubry, T., Bloch, G., Brcic, V., Saad, A., Magwood, O., Abdalla, T., Alkhateeb, Q., Xie, E., Mathew, C., Hannigan, T. and Costello, C. (2020). Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review. *The Lancet Public Health*, *5*(6), pp.e342-e360.

Baptista, I.; Benjaminsen, L.; O'Sullivan, E. and Pleace, N. (2015) *Local Connection Rules and Homelessness in Europe* Brussels: FEANTSA.

Beijer, U., Wolf, A. and Fazel, S. (2012) Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. *The Lancet Infectious Diseases*, *12*(11), pp.859-870.

Blackburn, R.M., Hayward, A., Cornes, M., McKee, M., Lewer, D., Whiteford, M., Menezes, D., Luchenski, S., Story, A., Denaxas, S. and Tinelli, M. (2017) Outcomes of specialist discharge coordination and intermediate care schemes for patients who are homeless: analysis protocol for a population-based historical cohort. *BMJ open*, *7*(12), p.e019282.

Bowen, M., Marwick, S., Marshall, T., Saunders, K., Burwood, S., Yahyouche, A., Stewart, D. and Paudyal, V. (2019) Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice. *British Journal of General Practice*, 69(685), pp.e515-e525.

Bramley, G. and Fitzpatrick, S. (2018) Homelessness in the UK: who is most at risk? *Housing Studies*, 33(1), pp.96-116.

Bretherton, J., Hunter, C. and Johnsen, S. (2013) 'You can judge them on how they look...': Homelessness Officers, Medical Evidence and Decision-Making in England. *European Journal of Homelessness* 7(1), pp. 69-92.

Bretherton, J. (2017) Reconsidering gender in homelessness. *European Journal of Homelessness*, 11(1), pp. 1-21.

Bretherton, J. and Mayock, P. (2021) *Women's homelessness: European evidence review* Brussels: FEANTSA.

Buchanan, D., Doblin, B., Sai, T. and Garcia, P. (2006) The effects of respite care for homeless patients: a cohort study. *American Journal of Public Health*, *96*(7), pp.1278-1281.

Canavan, R., Barry, M.M., Matanov, A. *et al.* (2012) Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. *BMC Health Services Research* **12**, 222 https://doi.org/10.1186/1472-6963-12-222

Cernadas, A. and Fernández, Á., 2021. Healthcare inequities and barriers to access for homeless individuals: a qualitative study in Barcelona (Spain). *International Journal for Equity in Health*, 20(1), pp.1-17.

Churchard, A., Ryder, M., Greenhill, A. and Mandy, W. (2019) The prevalence of autistic traits in a homeless population. *Autism*, 23(3), pp.665-676.

Clark, M.; Cornes, M.; Whiteford, M.; Aldridge, R.; Biswell, E.; Byng, R.; Foster, G.; Fuller, J.S.; Hayward, A.; Hewett, N. and Kilminster, A. (2022) Homelessness and integrated care: an application of integrated care knowledge to understanding services for wicked issues. *Journal of Integrated Care*, 30(1), pp.3-19.

Colburn, G. and Page Aldern, C. (2022) *Homelessness is a Housing Problem: How Structural Factors Explain US Patterns.* Oakland: University of California Press.

Cornes M, Aldridge RW, Biswell E, Byng R, Clark M, Foster G, et al. (2021) Improving care transfers for homeless patients after hospital discharge: a realist evaluation. *Health Services and Delivery Research* 9(17).

Crane, M. and Warnes, A.M. (2007) The outcomes of rehousing older homeless people: a longitudinal study. *Ageing & Society*, 27(6), pp.891-918.

Cream, J.; Fenny, D.; Williams, E.; Baylis, A.; Dahir, S. and Wyatt, H. (2020) *Delivering health and care for people who sleep rough Going above and beyond* London: The King's Fund.

Culhane, D.P. and Kuhn, R. (1998) Patterns and Determinants of Public Shelter Utilization among Homeless Adults in New York City and Philadelphia. *Journal of Policy Analysis and Management*, 17(1), pp. 23–43.

Culhane, D.P., Metraux, S., Byrne, T., Stino, M. and Bainbridge, J. (2013) The age structure of contemporary homelessness: Evidence and implications for public policy. *Analyses of Social Issues and Public Policy*, 13(1), pp.228-244.

Culhane, D., Doran, K., Schretzman, M., Johns, E., Treglia, D., Byrne, T., Metraux, S. and Kuhn, R. (2019) "The Emerging Crisis of Aged Homelessness in the US: Could Cost Avoidance in Health Care Fund Housing Solutions?", *International Journal of Population Data Science*, 4(3). doi: 10.23889/ijpds.v4i3.1185.

Enich, M.; Tiderington, E. and Ure, A. (2022). Street Medicine: A Scoping Review of Program Elements. *International Journal on Homelessness*, 2(2), 1–49. https://doi.org/10.5206/ijoh.2022.2.15134.

Finlayson, S., Boelman, V., Young, R. and Kwan, A. (2016) *Saving lives, saving money: how homeless health peer advocacy reduces health inequalities* London: The Young Foundation, Groundswell, The Oak Foundation.

Fitzpatrick, S., Mackie, P. and Wood, J. (2021) Advancing a five-stage typology of homelessness prevention. *International Journal on Homelessness*, 1(1), pp.79-97.

Fond, G.; Tinland, A.; Boucekine, M.; Girard, V.; Loubière, S.; Boyer, L. and Auquier, P. Improving the treatment and remission of major depression in homeless people with severe mental illness: The multicentric French Housing First (FHF) program (2020) *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, Volume 99, doi.org/10.1016/j.pnpbp.2020.109877.

Gerull, S. (2021) Support Processes in the Housing First Approach–a Paradigm Shift in Social Work? *European Journal of Homelessness* 15(3), pp. 75-86.

Gerull, S. (forthcoming, 2023) Homelessness and Social Work: Current Challenges and Future Opportunities in Bretherton, J. and Pleace, N. (eds) *The Routledge Handbook of Homelessness* London: Routledge, pp. 96-107.

Gilchrist, G. and Morrison, D.S. (2005) Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow. *The European Journal of Public Health*, 15(6), pp.587-588.

Gladwell, M. (2006) Million Dollar Murray. *The New Yorker*, February 13th & 20th, pp. 96–107.

Grant, R., Shapiro, A., Joseph, S., Goldsmith, S., Rigual-Lynch, L. and Redlener, I. (2007) The health of homeless children revisited. *Advances in Paediatrics*, 54(1), pp.173-187.

Greenwood, R.M., Manning, R.M. and O'Shaughnessy, B.R. (2020) Homeless Services Users' Reports of Problem-Related Alcohol and Illicit Substance Use in Eight European Countries. *European Journal of Homelessness* 14(4), pp. 63-89.

Ha, Y., Narendorf, S.C., Santa Maria, D. and Bezette-Flores, N. (2015) Barriers and facilitators to shelter utilization among homeless young adults. *Evaluation and Program Planning*, *53*, pp.25-33.

Homeless Link (2017a) *An introduction to Psychologically Informed Environments and Trauma Informed Care Briefing for Homelessness Services* London: Homeless Link available at: https://homelesslink-1b54.kxcdn.com/media/documents/TIC_PIE_briefing_March_2017_0.pdf

Homeless Link (2017b) *Reflective Practice in Homelessness Services: An introduction* London: Homeless Link available at: https://homelesslink-1b54.kxcdn.com/media/documents/Reflective_practice_briefing_March2017.pdf

Johnson, A.K. and Cnaan, R.A. (1995) Social work practice with homeless persons: State of the art. *Research on Social Work Practice*, *5*(3), pp.340-382.

Jego M.; Abcaya J.; Ștefan D.E.; Calvet-Montredon, C. and Gentile S. (2018) Improving Health Care Management in Primary Care for Homeless People: A Literature Review. *International Journal of Environmental Research and Public Health*. 15(2):309. https://doi.org/10.3390/ijerph15020309

Johnson, G., Scutella, R., Tseng, Y.P. and Wood, G. (2019) How do housing and labour markets affect individual homelessness?. *Housing Studies*, 34(7), pp.1089-1116.

Kaduszkiewicz, H., Bochon, B. and Hansmann-Wiest, J. (2017) The medical treatment of homeless people. *Deutsches Ärzteblatt International*, *114*(40), p.673.

Kemp, P.A., Neale, J. and Robertson, M. (2006) Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health & Social Care in the Community*, *14*(4), pp.319-328.

Kertesz, S.G., DeRussy, A.J., Kim, Y.I., Hoge, A.E., Austin, E.L., Gordon, A.J., Gelberg, L., Gabrielian, S.E., Riggs, K.R., Blosnich, J.R. and Montgomery, A.E. (2021) Comparison of patient experience between primary care settings tailored for homeless clientele and mainstream care settings. *Medical care*, *59*(6), p.495.

Kopanitsa, V.; McWilliams, S.; Leung, R.; Schischa, B.; Sarela, S.; Perelmuter, S.; Sheeran, E.; d'Algue, L.M.; Tan, G.C. and Rosenthal, D.M. (2023) A systematic scoping review of primary health care service outreach for homeless populations. *Family Practice*, 40(1), pp.138-151.

Lee, B.A., Shinn, M. and Culhane, D.P. (2021) Homelessness as a moving target. *The Annals of the American Academy of Political and Social Science*, 693(1), pp.8-26.

Lester, H. and Bradley, C.P. (2001) Barriers to primary healthcare for the homeless: the general practitioner's perspective. *The European Journal of General Practice*, 7(1), pp.6-12.

Lewer, D., Menezes, D., Cornes, M., Blackburn, R., Byng, R., Clark, M., Denaxas, S., Evans, H., Fuller, J., Hewett, N. and Kilmister, A. (2019) Hospital readmissions among PEH: a cohort study of linked hospitalisation and mortality data in England for 3,222 homeless inpatients. *The Lancet* (preprint) Available at SSRN: https://ssrn.com/abstract=3475583 or http://dx.doi.org/10.2139/ssrn.3475583

Lohmann, H. (2021) Hidden Homelessness in Germany: Gathering Evidence on Couch Surfing in Telephone Surveys. *European Journal of Homelessness*, 15(1), p.37-58.

Luchenski, S., Maguire, N., Aldridge, R.W., Hayward, A., Story, A., Perri, P., Withers, J., Clint, S., Fitzpatrick, S. and Hewett, N. (2018) What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *The Lancet*, *391*(10117), pp.266-280.

Luchenski, S.A.; Dawes, J.; Aldridge, R.W.; Stevenson, F.' Tariq, S.; Hewett, N. and Hayward, A.C. (2022) Hospital-based preventative interventions for people experiencing homelessness in high-income countries: A systematic review *eClinicalMedicine*, 54, 101657, https://doi.org/10.1016/j.eclinm.2022.101657.

Lyon-Callo, V. (2000) Medicalizing homelessness: the production of self-blame and self-governing within homeless shelters. *Medical Anthropology Quarterly*, 14(3), pp.328-345.

Magwood, O., Salvalaggio, G., Beder, M., Kendall, C., Kpade, V., Daghmach, W., Habonimana, G., Marshall, Z., Snyder, E., O'Shea, T. and Lennox, R. (2020) The effectiveness of substance use interventions for homeless and vulnerably housed persons: a systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder. *PLoS ONE* 15(1): e0227298. https://doi.org/10.1371/journal.pone.0227298

Marmot, M. (2018) Inclusion health: addressing the causes of the causes *The Lancet*, Volume 391, Issue 10117, pp. 186-188,

Marshall, C.A., Boland, L., Westover, L.A., Isard, R. and Gutman, S.A. (2021) A systematic review of occupational therapy interventions in the transition from homelessness. *Scandinavian Journal of Occupational Therapy*, 28(3), pp.171-187.

Mostowska, M. (2014) 'We Shouldn't but We Do …': Framing the Strategies for Helping Homeless EU migrants in Copenhagen and Dublin The British Journal of Social Work, 44 (1), pp. i18-i34.

McCarthy, L. and Parr, S. (2022) Is LGBT homelessness different? Reviewing the relationship between LGBT identity and homelessness. *Housing Studies* Housing Studies, DOI: 10.1080/02673037.2022.2104819

Neale, J., Parkin, S., Hermann, L., Metrebian, N., Roberts, E., Robson, D. and Strang, J., (2022) Substance use and homelessness: A longitudinal interview study conducted during COVID-19 with implications for policy and practice *International Journal of Drug Policy*, Volume 108, https://doi.org/10.1016/j.drugpo.2022.103818.

OECD (2015) *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery* Paris: OECD.

O'Flaherty, B. (2010) Homelessness as Bad Luck: Implications for Research and Policy, in Ellen, I.G. and B. O'Flaherty (Eds.) *How to House the Homeless* New York: Russell Sage Foundation, pp. 143-182.

Onapa, H., Sharpley, C.F., Bitsika, V., McMillan, M.E., MacLure, K., Smith, L. and Agnew, L.L. (2022) The physical and mental health effects of housing homeless people: A systematic review. *Health and Social Care in the Community*, 30(2), pp.448-468.

O'Sullivan, E., Pleace, N., Busch-Geertsema, V. and Hrast, M.F. (2020) Distorting Tendencies in Understanding Homelessness in Europe. *European Journal of Homelessness*, 14(3) pp.109-135.

O'Sullivan, E. (2022) *Key Elements in Homelessness Strategies to End Homelessness by 2030: A Discussion Paper* Brussels: European Commission.

Paisi, M, Kay, E, Plessas, A, et al. (2019) Barriers and enablers to accessing dental services for PEH: A systematic review. *Community Dentistry and Oral Epidemiology* 47, pp. 103-111. https://doi.org/10.1111/cdoe.12444

Parsell, C., Clarke, A. and Kuskoff, E. (2022) Understanding responses to homelessness during COVID-19: an examination of Australia. *Housing Studies*, 38(1), pp.8-21.

Pleace, N. and Quilgars, D. (1996) *Health and Homelessness in London: A Review* London: The King's Fund.

Pleace, N. (2008) *Effective Services for Substance Misuse and Homelessness in Scotland: Evidence from an international review* Edinburgh: Scottish Government.

Pleace, N. and Culhane, D.P. (2016) *Better than cure? Testing the case for enhancing prevention of single homelessness in England* London: Crisis.

Pleace, N.; Baptista, I.; Benjaminsen, L. and Busch-Geertsema, V. (2018) *Homelessness Services in Europe* Brussels: FEANTSA.

Pleace, N. and Hermans, K (2020) Counting All Homelessness in Europe: The Case for Ending Separate Enumeration of 'Hidden Homelessness' *European Journal of Homelessness* 14 (3), pp. 35-62.

Pleace, N. and Bretherton, J. (2020) *Health and Care Services for People Sleeping Rough: the views of people with lived experience* The Partnership for Responsive Policy Analysis and Research (PREPARE).

Pleace, N. and Lloyd, C. (2020) *European responses to the needs of people who experience homelessness and use drugs: Background paper commissioned by the EMCDDA for Health and social responses to drug problems: a European guide* EMCDDA: Lisbon.

Pleace, N., Baptista, I., Benjaminsen, L., Busch-Geertsema, V., O'Sullivan, E. and Teller, N. (2021) *European Homelessness and COVID 19* Brussels: FEANTSA.

Poncet, L., Andro, A., Eberhard, M., Fleury, M., Riou, F., Gelly, M., Scodellaro, C., Hassoun, D., Noseda, V. and Spira, A. (2019) Investigating and improving access to reproductive healthcare for vulnerable migrant women in France. *Social Science Protocols*, *2*, pp.1-13.

Pottie, K., Kendall, C. E., Aubry, T., Magwood, O., Andermann, A., Salvalaggio, G., et al. (2020). Clinical guideline for homeless and vulnerably housed people, and people with lived homelessness experience. *CMAJ: Canadian Medical Association Journal*, 192(10), E240. https://doi.org/10.1503/cmaj.190777

Reilly, J., Hassanally, K., Budd, J. and Mercer, S. (2020) Accident and emergency department attendance rates of PEH by GP registration: a retrospective analysis *BJGP Open* 4 (5): bjgpopen20X101089. DOI: 10.3399/bjgpopen20X101089

Roche, M.A., Duffield, C., Smith, J., Kelly, D., Cook, R., Bichel-Findlay, J., Saunders, C. and Carter, D.J. (2018) Nurse-led primary health care for homeless men: a multimethods descriptive study. *International nursing review*, *65*(3), pp.392-399.

Rosenheck, R. (2010) Service models and mental health problems: cost effectiveness and policy relevance, in Ellen, I.G. and O'Flaherty, B. (eds), *How to House the Homeless.* Russell Sage Foundation: New York, pp. 17-36

Rosenthal, D.M., Ucci, M., Heys, M., Hayward, A. and Lakhanpaul, M. (2020) Impacts of COVID-19 on vulnerable children in temporary accommodation in the UK. *The Lancet Public Health*, *5*(5), pp.e241-e242.

Schiffler T, Kapan A, Gansterer A, Pass T, Lehner L, Gil-Salmeron A, McDermott DT, Grabovac I. Characteristics and Effectiveness of Co-Designed Mental Health Interventions in Primary Care for PEH: A Systematic Review (2023) *International Journal of Environmental Research and Public Health.* 20(1):892. https://doi.org/10.3390/irph20010892

Sen, R., Smeeton, J., Thoburn, J. and Tunstill, J. (2022) *Social work with families who are homeless or who have housing needs: A reflective guide for social workers and social work managers. Full Version.* Birmingham: BASW England.

Shelton, J. and Bond, L. (2017) "It just never worked out": How transgender and gender expansive youth understand their pathways into homelessness. *Families in society*, 98(4), pp.284-291.

Stone, B., Dowling, S. and Cameron, A. (2019) Cognitive impairment and homelessness: A scoping review. *Health & Social Care in the Community*, 27(4), pp.e125-e142.

Thomas, Y.; Gray, M. and McGinty, S. (2011) A Systematic Review of Occupational Therapy Interventions With Homeless People *Occupational Therapy In Health Care*, 25(1), pp. 38-53, DOI: 10.3109/07380577.2010.528554

Tinland, A., Loubière, S., Boucekine, M., Boyer, L., Fond, G., Girard, V. and Auquier, P. (2020). Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: A randomised controlled trial. *Epidemiology and Psychiatric Sciences, 29*, E169. doi:10.1017/S2045796020000785

To M.J.; Brothers, T.D. and Van Zoost, C. (2016) Foot Conditions among Homeless Persons: A Systematic Review. *PLoS ONE* 11(12): e0167463. doi.org/10.1371/journal.pone.0167463

Tomita, A. and Herman, D.B. (2012) The impact of critical time intervention in reducing psychiatric rehospitalization after hospital discharge. *Psychiatric services*, *63*(9), pp.935-937.

Tsemberis, S., Gulcur, L. and Nakae, M. (2004) Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), pp. 651–656.

Vora, S. (2020) The realities of period poverty: how homelessness shapes women's lived experiences of menstruation. *The Palgrave Handbook of Critical Menstruation Studies* London: Palgrave, pp.31-47.

Watson, J., Nipperess, S. and Johnson, G. (2021) Social Work Education and Homelessness: Mobilising Academia–Industry Partnerships to Create a Homelessness Subject, *Australian Social Work* DOI: 10.1080/0312407X.2021.1989606

Wolf, J., Anderson, I., van den Dries, L. and Hrast, M.F. The health of homeless women in Mayock, P. and Bretherton J (2016) *Women's homelessness in Europe*, London: Springer pp.155-178.

Zufferey, C. (2016) *Homelessness and Social Work: An intersectional approach.* London: Routledge.

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs & Inclusion
Directorate D – Jobs, Skills and Social Policies
Unit D.3

Contact: Michele Calandrino

E-mail: EMPL-HOMELESSNESS-PLATFORM@ec.europa.eu
European Commission
B-1049 Brussels

Manuscript completed in March 2023.

Luxembourg: Publications Office of the European Union, 2023