Enhancing European Social and Healthcare Services for People Experiencing Homelessness: A Discussion Paper [1]

Nicholas Pleace

University of York, UK

Abstract_ *This paper explores evidence on effective delivery of health, mental health, addiction, and social (care) services 2 for people experiencing homelessness in Europe. The paper draws on a rapid evidence review conducted for a Mutual Learning Event in support of the European Platform on Combatting Homelessness in 2023. An overview of treatment, care, and support needs among people experiencing homelessness is followed by discussion of the barriers to mainstream services. The paper then considers the evidence on existing health and social services practice in relation to homelessness. It is argued that the case for creating integrated systems and strategies that fully incorporate health and social services working alongside homelessness and other services is becoming ever stronger in relation to both preventing and reducing homelessness. It is only through integrated housing-led/Housing First strategy, (with full collaboration among homelessness prevention and reduction services, housing providers, health, mental health, addiction, and social services, alongside criminal justice, welfare, and other relevant systems) that European homelessness can be effectively prevented and reduced. However, each EU Member State has variable resources and faces different challenges, so there is a need for guidance and support that has the ability to effectively support integrated homelessness strategies in different European contexts.*

1 This article draws on work undertaken for a discussion paper prepared by the author for the European Commission. The views presented reflect the views of its **author only**. The European Commission is not liable for any consequences deriving from the reuse of material from the original discussion paper which is available at: https://ec.europa.eu/social/BlobServlet?docId=27155&langId=en §

2 The term social services has been supplanted by 'social care' in some European countries, social services is used here to describe both social work and personal care services.

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Introduction

This paper draws upon a rapid evidence review requested by the European Commission in support of the third Mutual Learning Event (MLE), involving Finland, France, the Netherlands, and Poland, in support of the goals of European Platform on Combatting Homelessness (EPOCH). The MLE was held in Brussels in March 2023.[3]

A rapid evidence review is both a broader and looser methodology than a systematic review, particularly in terms of encompassing qualitative, observational, and quasi-experimental evidence, rather than focusing on experimental trials reported in highly ranked peer reviewed journals. Much of the most highly rated peer reviewed research on health, social services, and homelessness is North American, rather than European. While similar peer reviewed evidence does exist for Europe, there is also significant 'grey' (non-peer reviewed) literature which has been produced by charities, NGOs, and governments that encompasses a wider range of European medical and social services for people experiencing homelessness. The limitation of the rapid evidence review approach, which in this instance was also a time constrained exercise, is that the evidence incorporated is not necessarily of the highest possible standard, nor is it necessarily consistent. In this instance, the decision was taken to include the widest possible array of evidence, rather than restrict the scope of the analysis, while working to ensure that the data that were included had been collected in replicable, methodologically robust ways.

The strength of the evidence base can be a wider issue with regard to European homelessness. For example, a number of randomised control trials (RCTs) on Housing First have been undertaken, including the evaluation of the French *Un chez-soi d'abord* programme (Aubry et al., 2021). However, the bulk of RCT evidence on Housing First is North American (Padgett et al., 2016) and there is a much larger, specifically European, evidence base on the effectiveness and operation of Housing First that includes many observational studies and a considerable 'grey' literature (Raitakari and Juhila, 2015).

The evidence around health, social services, and homelessness in Europe has some other limitations that are worth noting. The first point here is that, alongside broader patterns of evidence and data and homelessness at the EU level, research on health, social services, and homelessness is more commonplace in North

[3] https://ec.europa.eu/social/main.jsp?catId=1624&langId=en

Western Europe and the Nordic countries than in the other EU Member states. The second point is that evidence tends to be focused on particular populations, i.e., people sleeping rough (street homeless) and in emergency shelters or other residential homelessness services (hostels/communal and congregate supported housing). Less attention has been paid to the health and wellbeing of children and families experiencing homelessness or to populations experiencing 'hidden' forms of homelessness.

Patterns of Treatment and Support Needs

Much of the global and European research on health and social care needs among people experiencing homelessness emphasises a high prevalence of severe, complex, and intersecting treatment, care, and support needs. Extremely high prevalence of mental illness, physically limiting illness, disability, and high rates of bloodborne (Hepatitis, HIV) and respiratory (tuberculosis) infection are reported, alongside very high rates of early mortality (Aldridge et al., 2018; 2018a; Beijer et al., 2012; Wolf et al., 2012). 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). Addiction, both in the sense of problematic drug use and alcohol dependency, is reported at similarly high rates, often in association with mental illness and other health problems (Bowen et al., 2019; Fond et al., 2020; Greenwood et al., 2020). A 'mutually reinforcing' relationship between long-term and repeated homelessness and addiction, mental illness, and limiting illness and disability has been repeatedly reported (Kemp et al., 2006; O'Sullivan, 2022).

As has been noted elsewhere, a tendency to focus on people sleeping on the street and in emergency shelters has created some distorting effects in homelessness research, which has included some statistical errors (O'Sullivan et al., 2020). These errors centre on cross-sectional samples drawn only from specific subpopulations of people experiencing homelessness. One error is that people sleeping on the street and in emergency shelters are not a representative sample of 'homelessness', but of the extremes of homelessness, i.e., it omits the hidden homeless population and groups in temporary accommodation, like families experiencing homelessness. Another statistical error centres on the interrelationships between recurrent and sustained homelessness and health. People experiencing recurrent and sustained street-based sleeping and emergency shelter use have a very high prevalence of multiple, high, and complex treatment, care, and support needs. Health research has quite often *oversampled* people experiencing homelessness who have multiple and complex needs, because it inadvertently oversampled

people experiencing homelessness, living on the street, and in emergency shelters, who were long-term or repeatedly homeless (Culhane and Kuhn, 1998; O'Sullivan et al., 2020; O'Sullivan, 2022).

Women, children, people who identify as LGBTQI+, and migrant populations who are homeless are less likely to be present among people sleeping on the street and in emergency shelters and more likely to be experiencing hidden homelessness (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. Lone women experiencing homelessness are also often parents who have lost contact with children because they have placed them with relatives or had them taken into social work care (Bretherton 2017; Bretherton and Mayock, 2021). Other groups experiencing hidden homelessness, like young people leaving care and people who identify as LGBTQI+, can also have high treatment, care, and support needs (Shelton and Bond, 2017; McCarthy and Parr, 2022). Lone women, LGBTQI+, and young people leaving care can have experienced stigmatisation, rejection, and abuse at high rates, and these sorts of experience can sometimes be the trigger for homelessness. Children experiencing homelessness in families, often headed by lone women parents, can face both increased risks to mental and physical health and barriers to health and social services. These children also experience or witness domestic abuse at high rates, which is often a trigger event for family homelessness, where many of the households containing children are headed by lone women parents who have had to leave the familial home (Bretherton and Mayock, 2021; Grant et al., 2007; Rosenthal et al., 2020). Certain groups, including young people leaving care, people leaving prison, people leaving institutional care, and people leaving psychiatric treatment, as well as groups like people identifying as LGBTQI+, some cultural and ethnic minorities, and some migrants, including undocumented people, can be at heightened risk of homelessness in Europe and relatively likely to present with treatment, care, and support needs (O'Sullivan, 2022; Mackie, 2023).

Populations experiencing hidden homelessness are overwhelmingly poor and do not appear to present with higher rates of addiction or severe mental illness than other low income populations. Not everyone experiencing homelessness in Europe has the same treatment and support needs as people experiencing long-term or recurrent street-based sleeping and emergency shelter use (Pleace and Hermans, 2020; O'Sullivan, 2022).

Patterns of European homelessness also appear to differ according to the nature and extent of public welfare, health, and social services. In much of Europe, homelessness is very strongly associated with poverty and destitution, with only quite small groups within the homeless population, who are overwhelmingly repeatedly/

long term homeless, appearing to have high, multiple, and complex treatment needs (O'Sullivan, 2022). However, in some Member States, like Denmark and Finland, relatively smaller homeless populations appear much more likely to have high and complex needs. The hypothesis here is that many people, who might otherwise be at risk of homelessness because of destitution, are protected by extensive social protection systems in EU Member States like Denmark and Finland. However, in those Member States with strong social protection systems, people with multiple and complex needs occasionally 'fall through' these various social safety nets and become homeless (Fitzpatrick and Stephens, 2014; Allen et al., 2020; O'Sullivan, 2022).

This means there are, in approximate terms, three sets of treatment, personal care, and support needs among people experiencing homelessness. The first is the group most frequently identified by health research, i.e., a predominantly lone, male population experiencing recurrent and sustained homelessness, centred on street-based sleeping and/or emergency shelter use. This group has very high prevalence of multiple treatment and support needs, including addiction, severe mental illness, blood borne and respiratory infections, limiting illness, and disability. The second encompasses groups of people who may be at heightened risk of homelessness due to their needs, characteristics, and experiences, so, for example, groups like ex-prisoners who can have high rates of mental illness and addiction (Filipovič Hrast et al., 2023), or people whose risk of homelessness and whose risks to health and wellbeing are linked to stigmatisation, rejection, or abuse, such as people identifying as LGBTQI+ or lone women and women with children experiencing homelessness. The third group is people whose homelessness has been triggered by destitution and poverty in EU Member States, a pattern which is also seen in comparable OECD countries (Bramley and Fitzpatrick, 2018; Colburn and Page Aldern, 2022; O'Flaherty, 2010; Johnson et al., 2019; Lohmann, 2021; O'Sullivan, 2020). Here, the issues around health and wellbeing are linked to the wider social gradient of health, i.e., low income and, particularly, destitute populations tend to have much poorer mental and physical health than more affluent people, which extends to people who essentially become homeless because of their precarious economic position (Marmot, 2018).

It has been argued elsewhere that it is important not to 'medicalise' homelessness, i.e., to present it as a problem of addiction and mental illness, because this artificially constrains and distorts analysis, discussion, and effective policy responses. Medical, care, and support needs exist across homeless populations, but those populations are not one group of addicted, mentally ill people sleeping on the street. People experiencing homelessness need treatment, personal social services care,

social workers, and other supports, just as any group of people do, but those needs are not a constant and, again, can often stem from being poor, rather than issues like addiction (Craig and Timms, 1992; Lyon-Callo, 2000; O'Sullivan et al., 2020).

European homelessness is caused by systemic failures exacerbating inequality, limitations within welfare systems, insufficient affordable housing supply, and inadequate coordination of services, as well as gaps and flaws in public health and social services. Associations with addiction and severe mental illness do exist among a specific group of people experiencing long-term and recurrent homelessness, but even here, there is evidence that these treatment needs can emerge *after* homelessness has occurred, rather than necessarily triggering it (Culhane et al., 2013). An unmet treatment need for severe mental illness might be presented as a trigger event for homelessness, but it is important to consider whether this is really an individual factor or systemic, because it is arguable that a properly functioning mental health system should never allow someone with a serious mental illness to potentially end up living on the street, in a shelter, or experience hidden homelessness.

Barriers to Health and Social Services

There is some evidence that people experiencing homelessness often expect to be rejected by health and social services. Sometimes this stems from experience of negative, judgemental behaviour by staff, but the *expectation* that they will be prevented from accessing services can stop people experiencing homelessness from even getting as far as seeking help (Pleace and Quilgars, 1996; Lester and Bradley, 2001; Canavan et al., 2012; Ha et al., 2015; Cernadas and Fernández, 2021). These attitudinal barriers are associated with late presentation, i.e., someone only seeking help when pain or other symptoms become unbearable (Lewer et al., 2019), which might mean treatment will be less effective, or even ineffective.

Homelessness often means frequent, unwanted moves, and this can create serious barriers to some treatment, care, and support when health and social services systems are organised on a municipal or regional basis that requires someone to demonstrate an administratively recognised local connection with that area, usually in the form of a fixed, recognised address (Baptista et al., 2015). Access to emergency treatment will generally still be accessible, because publicly funded hospital A&E/ERs will often be open services, but if access to something like outpatient treatment or social (care) services support requires a local connection, someone experiencing homelessness may be confronted with significant administrative barriers. 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 at least some health and social services (Mostowska, 2014).

There is longstanding evidence that stereotypical images of people experiencing homelessness as 'risky' individuals, who are expected to have high rates of addiction (with associated criminality) and severe mental illness, can be enough to block access to some health and social services (Pleace and Quilgars, 1996; Canavan et al., 2012; Pleace and Bretherton, 2020). Experience, training, and attitudes can all be important, as different bureaucrats in the same system may react differently when presented with someone experiencing homelessness. One worker may interpret service protocols more liberally than another, meaning that getting treatment, care, and support will sometimes be a matter of luck (Bretherton et al., 2013).

Maintaining continuity of treatment and support is difficult for people experiencing homelessness. Unwanted moves while homeless may cause disruption to treatment and care, because someone moves from one administrative area to another or further away from medical and social services and cannot afford transport. Routine screening and health checks tend to be organised on the basis of contacting someone at a (relatively) fixed address. Unmet treatment, care, and support needs may also disrupt someone's capacity to organise and reach appointments and engage with services, i.e., they may need help from medical and social services, or from services that provide case management like Housing First, in order to use those services in the first place (Pleace and Bretherton, 2020). The original US Housing First projects designed by Sam Tsemberis where built for people with severe mental illness who could not access treatment, care, and support because of their homelessness (Padgett et al., 2016).

Services for People Experiencing Homelessness

There are incentives for public health and social services systems to enhance access for people experiencing homelessness. The British NHS uses the slightly unfortunate term of 'frequent flyer' to describe homeless and other marginalised populations whose primary contact with health systems centres on sustained and repeated use of emergency services. This is costly at both a human and financial level because it ultimately does not provide lasting improvements to health, not least because their homelessness is not being resolved, and these emergency health services are highly expensive (Pleace and Bretherton, 2020). In the US, this pattern has been called the million dollar Murray phenomenon (Gladwell, 2006). Million dollar 'Murray' was a long-term, homeless individual, who eventually died on the street, after making repeated – expensive – use of emergency health,

addiction, mental health services, and having high frequency contact with the criminal justice system, none of which resolved their homelessness. The problem is that the drivers of poor mental and physical health are not being addressed, so treatment, care, and support needs persist or recur endlessly. One dimension of this is that the lack of residential stability can hamper access to mainstream, non-emergency health and social services, another is that homelessness itself presents ongoing risks to mental and physical health that will not cease until homelessness is brought to an end (Reilly et al., 2020; Lewer et al., 2019).

Probably the most common response to these challenges has been to build specific services to enhance access for people experiencing homelessness. Sometimes these services are improvised using little or no resources, but there can also be significant investment in specialist services. These services can range from enhancements to information systems and case management/navigator services to enable better access to mainstream health and social services through to specialist, separate health care provision targeted at people experiencing homelessness (Cream et al., 2020). Specialist provision can include different mixes of primary care, e.g., general practice (family) doctors and nurses as well as other services like dentistry, podiatry, occupational therapy, social work, and addiction (drug and alcohol) workers (Pleace, 2008; Pleace and Lloyd, 2020; Pottie et al., 2020; Magwood et al., 2020). Mobile services, like 'street medicine' models or peripatetic health and social work teams, that visit daycentres and other homelessness services are also used. Over time, street medicine and similar models have shifted from simply providing immediate treatment toward case management, adopting approaches that seek to provide lasting routes out of homelessness through coordinated, multiagency packages of support (Kertesz et al., 2021; Jego et al., 2018; Schiffler et al., 2023; Roche et al., 2018).

There are also hospital discharge services that are designed to prevent repeated, unnecessary, and expensive readmissions. Again, these services centre on creating interagency case-managed packages of treatment, care, and support, which can include settled, adequate, and affordable housing. While their development was led by medical professionals, these models that case manage the process of leaving hospital within a multidisciplinary, collaborative case management approach share their core characteristics with services like Housing First and Critical Time Intervention (CTI) (Cornes et al., 2021; Luchenski et al., 2018; Blackburn et al., 2017; Tinland et al., 2020; Tomita and Herman, 2012; Buchanan et al., 2006).

In the homeless sector, what were originally relatively basic services, such as daycentres that originally only offered food and shelter, have sometimes expanded into integrated healthcare provision. This might be in partnership with mobile services, like 'street medicine' models or through the direct employment of social

work, drug, and alcohol workers and nursing and other clinical staff. These adaptions to service design can also include importing models of treatment, care, and support from medical practice, such as psychologically informed environments (PIE) and trauma informed care (TIC), alongside other reflective practice designed to fully understand the emotional and psychological needs of people experiencing homelessness and the trauma they may have experienced (Homeless Link, 2017a; 2017b). Harm reduction is closely interlinked with Housing First (Tinland et al., 2020; Padgett et al., 2016), which has the approach at the core of its operational principles, but has long been mainstreamed across the entire homelessness systems of countries like Finland and the UK (Allen et al., 2020).

Evidence on these various clinical models and systems is skewed toward specialist services that focus on people sleeping on the street and in emergency shelters rather than hidden homelessness, and much of the data, in peer reviewed journals, is from North America and the UK (O'Sullivan et al., 2020). Research coverage is uneven within the EU itself, again because more complex and multifaceted responses to homelessness and health, including specific provision to meet treatment, care, and support needs, are more common in North Western Europe and the Nordic countries.

Reflecting the wider patterns within homelessness research, there is less work on meeting the treatment, care, and support needs of women experiencing homelessness. This includes data around meeting the needs of women experiencing homelessness around reproductive health, including access to contraception and period poverty (Poncet et al., 2019; Vora, 2020; Bretherton and Mayock, 2021). Research on services for children and families experiencing homelessness is also less common (Rosenthal et al., 2020; Lissauer et al., 1993). Bespoke services designed to meet specific needs such as dentistry (Paisi et al., 2019) and chiropody (podiatry) for people experiencing homelessness has also been conducted, generally reporting that access to these services is poor (To et al., 2016). There are some data on palliative, i.e., end of life, medical, care, and support services for people experiencing homelessness, but this field is in the early stages of development (Armstrong et al., 2021).

There are longstanding debates about the efficacy of building separate, specialist health and social services systems for people experiencing homelessness. Four limitations with the approach have been repeatedly identified for several decades (Pleace and Quilgars, 1996). The first is that there is only so much a specialist service can handle on its own, particularly for people experiencing homelessness who have high and complex treatment and support needs, and that there will very often be a need for mainstream health and social services to step in. Given that situation, enhancing access to the mainstream services, so the argument goes, is

better than trying to build expensive, separate systems that ultimately cannot cope on their own. The second argument is that separate, specialist provision reinforces the stigmatisation and marginalisation of homelessness, as rather than being treated and supported with everyone else, people experiencing homelessness are instead being kept separate from the rest of society. The third argument is that however accessible specialised, sensitive, and informed the care, support, and treatment on offer is, freestanding medical models are inherently limited, as you cannot provide effective treatment to someone living on the street or in a shelter, or experiencing hidden homelessness, because unless their homelessness is resolved, higher risks to mental and physical health will be ever present. The fourth argument is that specialist health and social services for people experiencing homelessness need a critical mass, i.e., they have to have enough patients and service users to justify their existence and the expenditure involved. This results in a marked tendency for specialist homelessness health services to be only be present in large urban areas in EU Member States and comparable countries, so they can never be rolled out on a truly comprehensive basis (Cream et al., 2020).

The counterargument to all this is that one cannot, from a human perspective, do nothing about widespread unmet treatment, care, and support needs among people experiencing homelessness. Where there is clear evidence of systemic failures blocking access to mainstream health and social services for people experiencing homelessness, developing a street medicine team or building a specialist clinic, while such approaches also arrive with a set of disadvantages, is still often seen as better than doing nothing.

Having said all this, the available evidence base does highlight a couple of important issues. There are, clearly, real logistical limits in public health policy which means that building an entirely separate *system* of healthcare for people experiencing homelessness is unlikely to be practical in any EU Member State. There cannot be shadow health systems for people experiencing homelessness, not least because the population experiencing homelessness is not large enough for that to make logistical sense. Even if there might be something far too close to 1 million people experiencing homelessness in the EU at any one point, that would be within a population of some 448 million, i.e., homelessness would be around 0.2% of the European population.[4] This has driven medical models, like street medicine, to move toward increasingly integrated responses, still providing treatment, but also

[4] This is *extremely* difficult to estimate with any accuracy at European level at the time of writing because data are often inconsistent between some Member States or do not exist in others, but there have been attempts, e.g. https://www.feantsa.org/en/press-release/2023/09/05/?bcParent=27#:~:text=In%202022%2C%20at%20least%20895%2C000,street%20or%20in%20hidden%20homelessness.

seeking to provide coordinated, multiagency exits from homelessness as the only effective way to help improve health and wellbeing on a sustained basis (Kopanitsa et al., 2023; Enich et al., 2022).

Lessons have also been learned over time. Attempts to address clinical need without also addressing homelessness have been found to replicate the 'frequent flyer' problem, i.e., rather than repeatedly turning up at A&E/ERs in hospitals without having their homelessness resolved, while their health continues to deteriorate over time, people experiencing homelessness instead repeatedly turn up at specialist medical services, because their homelessness is not being resolved. There has sometimes been evidence of outright, indeed catastrophic, policy failure, perhaps best exemplified in attempts to use abstinence-based models to end addiction among people sleeping on the street and in emergency accommodation, without doing anything at all to alleviate homelessness, which had the unfortunate distinction of being *totally* ineffective (Pleace, 2008). Again, clinician led models are increasingly based on ending homelessness through multiagency working within integrated strategies as the sine qua non for delivering effective health and social care for people experiencing homelessness.

European social work tends to take a different approach to homelessness. In some EU Member States, particularly in Southern, Central, and Eastern regions, social service departments have responsibility for people with treatment, care, and support needs experiencing homelessness, as part of their core duties. In these and other Member States, including countries like Denmark and Germany, trained social workers are the core staff for homelessness services (Pleace et al., 2018).

Debates in social work tend to focus on how services can most effectively support people experiencing, or at risk of, homelessness. Reflecting broader practices in social work training, there is a tendency to emphasise the intersectional nature of homelessness, i.e., how individual experience, needs, and systemic factors can contribute to homelessness, and to emphasise a need for holistic case management (OECD, 2015; Zufferey, 2016; Sen et al., 2022; Gerull, 2021; 2023; Watson et al., 2021). This means that homelessness is often being dealt with as part of the general social work role, rather than being regarded as something which requires specialised systems and approaches, unlike some European public health systems. Evidence on effective social work practice with people experiencing homelessness is less extensive than is the case for health services, and there are calls to increase awareness of effective practice (Gerull, 2023).

There is little data on the use of fixed-site social services, for example residential care and nursing facilities for people who become frail in later life, albeit that there is evidence that some long-term and repeatedly homeless populations are ageing in place (Crane and Warnes, 2007; Culhane et al., 2019). There are a few examples

of residential care facilities for people experiencing homelessness, 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). There is also some evidence of occupational therapy (which may be administered by social services and/or public health systems) making positive changes in the lives of people experiencing homelessness, but those working in the field say more research is needed (Thomas et al., 2011; Marshall et al., 2021).

New Strategic Responses

Responses to the treatment, care, and support needs of people experiencing homelessness are starting to coalesce around the idea of an integrated strategy. Housing First, both in terms of the North American service model (Padgett et al., 2016) and in terms of the uniquely Finnish housing-led approach to an integrated, preventative homelessness strategy, which is also called 'Housing First' (Allen et al., 2020), depends on joint working within an integrated strategy. The baseline model of North American Housing First, which centres on the variations on an intensive case management (ICM) model, is dependent on coordination with health and social services. The assertive community treatment (ACT) form of Housing First, where elements of clinical, mental health, and addiction support are baked into a Housing First service's own interdisciplinary team, is also still ultimately dependent on joint working with external health and social services (Padgett et al., 2016).

Clinicians and health researchers are also following similar approaches, in that there is the acceptance that a single form of service intervention, such as simply treating a health condition, cannot work if that intervention is happening without coordination with other services that will end homelessness. This reflects wider developments in public health that centre on dealing with 'the causes of the causes' of ill health. Evidence of a social gradient in health is now overwhelming (Marmot, 2018) and as homelessness represents the extreme of the socioeconomic marginalisation and destitution that is powerfully associated with poor mental and physical health, a holistic approach addressing the 'causes of the causes', i.e., ending homelessness, is seen as the logical direction to take (Clark et al., 2022; Luchenski et al., 2018; Blackburn et al., 2017). Alongside this, there is the increasing emphasis on patient involvement and patient centred care, i.e., treatment and support plans are a *collaboration* between patient and doctor, which tends to produce better outcomes, including for people experiencing homelessness (Finlayson et al., 2016). Again, this emphasis on consumer choice or coproduction in how services are designed and delivered closely mirrors Housing First and similar service models.

A model like the *Pathway* hospital discharge service, which began in London and now operates more widely in the UK[5], has many similarities to Housing First, although it has been developed by clinicians rather than the homelessness sector. A Pathway team is led by specialist doctors and nursing staff and can include occupational therapists, social workers, and mental health clinicians. Care 'Navigators' have a case management function, assembling the package of housing, treatment, care, and support to enable someone to make a lasting exit from homelessness as they leave hospital (Cornes et al., 2021), and there is some evidence of effectiveness (Onapa et al., 2022; Stone et al., 2019; Luchenski et al., 2022). Again, it is the emphasis on cross-disciplinary and interagency working to end homelessness, which can equally be seen in the French Housing First programme (Tinland et al., 2020; Fond et al., 2020) or Danish Housing First and CTI services (Allen et al., 2020), that is the key feature of these sorts of services.

As has been noted elsewhere, the hurried policy responses to COVID-19 in relation to people sleeping on the street and in shared air (common/shared sleeping area) emergency shelters were not primarily motivated by a sudden wish to reduce the injustices of homelessness, but by fear that a population with poor overall health and many secondary conditions would increase strain on already hopelessly overtaxed hospitals (Parsell et al., 2022). However, rapidly improvised services that brought people sleeping on the street into hotels and established interagency working to support them saw some surprisingly rapid and positive results (Pleace et al., 2021; Neale et al., 2022). Again, even rapidly improvised attempts to use combinations of services to address complex needs, addressing the 'causes of the causes' of homelessness, generated positive outcomes.

Examples of effective practice, centred on interagency working within an integrated strategic response to homelessness, can be seen at local, regional, and national levels among EU Member States. Where these integrated systems include prevention, the last piece of the puzzle, capacity to anticipate and stop *potential* homelessness associated with ill health, as well as simply react to homelessness associated with unmet treatment, care, and support needs, is in place (Mackie, 2023).

However, it is also the case that much of Europe has not yet moved in the direction of greater strategic integration, including health and social services, in relation to preventing and reducing homelessness. One reason for this is an uneven access to resources, i.e., development of integrated multiagency services and strategies is limited by the variable resource levels available in different EU Member States. Another reason is that, while models like Housing First are becoming more widespread, they are far from universal. There is clear evidence that much older service models for people experiencing homelessness still predominate in much of Europe.

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

This sometimes includes staircase/linear residential treatment approaches using abstinence-based approaches and requiring treatment compliance that predated Housing First, but more frequently, this means that homelessness services are primarily in the form of basic emergency shelters and daycentres. Nor is it the case that homelessness services and systems exist at a consistent level within individual Member States. Basic emergency shelters and daycentres, soup runs (food distribution for people sleeping on the street), and similar services, operated by charities and community groups, still exist even in countries with advanced, integrated, and well-resourced homelessness strategies (Pleace et al., 2018).

There are EU Member States whose social protection and public health systems are relatively under-resourced and who face pressures on public expenditure that mean homelessness is 'competing' against an array of other serious social problems for inherently limited funding. Telling these Member States to build integrated homelessness strategies is challenging, because it is likely to involve reorienting existing service provision and finding some additional money, just to enable a shift in direction and, in some instances, there will be very little expenditure to reorient and little or no additional money which can be secured.

The lessons from Finland are that building a broad consensus, including municipalities and the homeless sector, was at the core of delivering effective change, which ultimately did involve existing services being radically repurposed and redirection of existing expenditure, as well as new funding (Allen et al., 2020). Portugal has been pursuing these challenges in a less well-resourced policy environment, following a model like Finland, again building a more integrated strategic approach through creating a consensus, bringing agencies like social services and the homeless sector together in new ways and, as in Finland, shifting debate and expectation. There is a shift toward a housing-led/Housing First logic in which housing, health, social services, and other systems work together to prevent and alleviate homelessness in Portugal (Baptista, 2023).

In other EU Member States, there are excellent examples of integrated systems, but their coverage is partial. France possesses a highly developed national Housing First strategy which is proving effective in addressing long term and repeated homelessness associated with severe mental illness (Fond et al., 2020; Loubière et al., 2022). However, other elements of the homelessness system are not as well integrated as Housing First, such as the very heavy and sustained use of temporary accommodation in France (Pleace et al., 2022). Introducing ideas like Housing First can also be a slow and difficult process, as, for example, in Poland, where there is movement to adopt these ideas, but where resource levels around homelessness policy are not very high and where Housing First represents a significant cultural shift in responses to homelessness (Wygnańska, 2016). In essence, while there are

examples like Finland and Portugal, wholesale revision of strategic responses may not be an easily implemented option where resources are tight and when major shifts in mindset and administrative practice are needed to internalise the paradigm of integrated services, systems, and strategies.

One further point here is that homelessness may not be within national level political competency, i.e., political responsibility often lies partially or wholly at the regional or municipality/local authority level. In Finland, a devolved policy landscape was handled by building consensus and consistency among local actors, including the municipalities (Y Foundation, 2017). However, localism in political control can mean that while some local agencies and authorities accept the idea of an integrated, preventative homelessness strategy, others will not. In essence, there can be administrative barriers to these kinds of ideas where political control is variable at local or regional level and some municipalities, public health bodies, or social services departments refuse to sign up. Shifts in mindset can flow from new ideas and debates, with the obvious example being the increasingly widespread acceptance of Housing First at the European level, albeit that it still may be more talked about than actually implemented in many Member States at the time of writing (Pleace et al., 2022). Nevertheless, meeting the challenges in addressing the treatment, care, and support needs among people experiencing homelessness are not as simple as recommending that every Member State adopt an integrated, preventative homelessness strategy which is housing-led, as a lot of practical, political, cultural, administrative, and financial hurdles can stand in the way. Member States like Finland and Portugal show that progress can be achieved, in spite of these challenges, but even this is not guaranteed, as clouds are gathering around the sustained Finnish successes at the time of writing, following a change in government.

Ultimately, addressing treatment, care, and support needs must be framed as a strategic, not a service-level, question. There is no model of street medicine, specialist clinic, peripatetic medical, and social work team or other approach that can effectively improve health and wellbeing among people experiencing, or at risk of, homelessness in Europe on its own. This has been recognised by health professionals, through the logic of 'causes of the causes' approaches to public health and is seen in models like the *Pathway* and other multidimensional case managed responses to homelessness from clinicians that focus on ending homelessness as integral to effective treatment. That these clinical models mirror, indeed in many respects replicate, the ideas of Housing First and related models like CTI, while the homelessness sector in turn adopts approaches like trauma-informed care, is a very positive development. When the various elements that need to come together to improve the health and wellbeing of people experiencing homelessness are already thinking along similar lines, that momentum can be important in delivering lasting change.

We have been in this position of understanding the need for service and system integration, to respond to every dimension of treatment, care, support, and of course *housing* needs, to provide effective prevention and reduction of homelessness, for some considerable time. It was evident that standalone health-led services that were not integrated with other systems and services in ways that would provide lasting exits from homelessness were inherently ineffective decades ago (Pleace and Quilgars, 1996). Progress is being made at the time of writing, but it is important to recognise that the barriers to change cannot be overcome simply by issuing generic guidance, each EU Member State has to be encouraged, supported, and sometimes externally resourced to deliver the lasting change that is needed.

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