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Pleace, Nicholas [orcid.org/0000-0002-2133-2667](https://orcid.org/0000-0002-2133-2667) and Lloyd, Charlie [orcid.org/0000-0003-3524-0947](https://orcid.org/0000-0003-3524-0947) (2022) *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*. Research Report.

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European Monitoring Centre  
for Drugs and Drug Addiction

# 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

## Authors

Nicholas Pleace, Charlie Lloyd

2020

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Background paper commissioned by the EMCDDA

Nicholas Pleace

Charlie Lloyd

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This paper was commissioned by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to provide background information to inform and contribute to the drafting of Health and social responses to drug problems: a European guide.

This background paper was produced under contract CT.19.HEA.0092.1.0 and we are grateful for the valuable contribution of the author. The paper has been cited within Health and social responses to drug problems and is also being made available online for those who would like further information on the topic. However, the views, interpretations and conclusions set out in this publication are those of the author and are not necessarily those of the EMCDDA or its partners, any EU Member State or any agency or institution of the European Union.

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## Introduction

This paper explores the evidence base for services designed to meet the needs of people who experience homelessness and use drugs (PEHAD). Through a delimited analysis of existing systematic and rapid evidence reviews, it considers the key lessons for the development of effective homelessness services in Europe. The aims of the paper are two-fold. Its first objective is to identify the gaps and limitations in our understanding of what constitutes homelessness, as well as the holes in the existing evidence base around service provision for those experiencing homelessness. The second goal is to draw on the available research to explore what is available in terms of practical knowledge transfer, i.e. evidence that might enhance homelessness prevention and services.

The associations between long-term and repeated homelessness, alcohol dependency and high-risk drug use have been highlighted by a large number of studies over several decades (Pleace, 2008; Nilsson et al., 2019). Assumptions regarding a simple causal relationship between alcohol, drug use and homelessness have been challenged in the last 20 years, and marked variations in the prevalence of high-risk drug use have been observed across different groups of people experiencing homelessness. Overall, among those experiencing chronic and episodic homelessness, high-risk drug use is often very prevalent, and is frequently combined with serious mental illness and poor physical health.

The paper begins with an overview of its methods and limitations. As highlighted, the range and amount of data on homelessness and homelessness services in Europe is extremely variable and can often be very limited, to the extent that there are several EU Member States without any data on the scale of homelessness or related service provision. Further, this paper presents a discussion on the definitions of what constitutes homelessness, which vary between countries, across organisations and between academic disciplines. Because viewpoints as to what 'homelessness' is vary, this leads to challenges in determining how homelessness and high-risk drug use intersect. Drawing on the available research, this paper explores the different pathways or patterns that characterise homelessness, within which apparently consistent associations with high-risk drug use appear.

The paper goes on to present a broad overview of the evidence on homelessness services and what is known specifically about different responses to high-risk drug use among people who experience homelessness. Several different types of homelessness services are reviewed in turn, including a discussion of what is meant by 'effectiveness' with regard to these services. Overall, the evidence suggests that meeting the high and complex needs of those who experience chronic and episodic homelessness is particularly important in reducing the mutually reinforcing relationship between substance use and homelessness

(Kemp et al., 2006), and that integrated services are most effective in meeting the full array of needs presented by those affected by these issues.

Lastly, the paper explores issues around high-risk drug use and homelessness in Europe, providing a broad picture of the service models and strategies used across the continent. Only a brief overview of COVID-19 and homelessness is given here, as the impact of the pandemic was still unfolding at the time of writing. The paper concludes by considering opportunities for successfully meeting the needs of PEHAD in Europe.

## Methods and discussion of limitations

This paper offers a limited analysis of existing systematic and rapid evidence reviews regarding the intersection and associations between homelessness and high-risk drug use. Existing reviews were supplemented with searches (using Google Scholar and the extensive bibliographic resources at the University of York, including Medline and Web of Science), focusing on the most recently published research (appearing in 2019/20) at the time of writing. It is therefore an updated review of reviews and does not constitute a systematic review or a rapid evidence review.

The range and extent of data on homelessness and homelessness services in Europe is highly variable and can often be very limited (FAP and FEANTSA, 2015, 2017, 2018, 2019), to the extent that there are several EU Member States that have no data on the scale or nature of homelessness or related service provision (Pleace et al., 2018). Data within specific countries can also be highly variable and, again, limited in both scope and geographical coverage. Moreover, variations in the definitions used for homelessness (see the following section) mean that a strong comparative and comprehensive evidence base is lacking. Nonetheless, there is evidence regarding trends in homelessness in individual countries, examples of good practice in terms of service design and strategies to deal with homelessness, and some detailed analyses of people's experiences of homelessness.

There are significant challenges in accurately counting, or indeed estimating, the homeless populations in most of Europe. In addition to variations in definitions of homelessness and eligibility for services between countries, services tend to be organised locally, i.e. at the level of individual local authorities or municipalities. There is therefore considerable disparity in how data on need and provision are collected within individual countries.

Another key point to note is that while responses to homelessness can be implemented via national strategies, as is the case in countries like Denmark, Finland or Scotland, these are often not standardised because they are organised at the local level. This means that a specific type of service is not going to be found in all areas of the same country, even if it is

part of that country's national strategy. Health-led interventions, such as specialist primary care and mental health provision and associated addiction services, also may or may not be available and may or may not be organised in coordination with the broader homelessness sector. As such, the nature and extent of the homelessness sector within a country can be highly variable, with provision ranging from food distribution, basic emergency shelters and day centres through to highly resourced specialist supported housing models, including those designed particularly for people who experience homelessness and use drugs (PEHAD).

In much of the south and east of Europe, resources for services to deal with addiction and individual homelessness tend to be limited (Pleace et al., 2018). Even in the European countries that have higher a Gross Domestic Product (GDP), more extensive welfare, health and social housing services, and which tend to spend more on homelessness, the extent and nature of homelessness service provision is highly variable. More extensive services only tend to be present in major cities and, again, are not necessarily delivered in consistent forms or within aligned organisational structures or strategies. Research on these services sometimes includes strategic-level analysis (i.e. national or regional strategy, e.g. Benjaminsen, 2013; Pleace et al., 2015; Benjaminsen and Knutagård, 2016), but many studies focus on individual services or programmes in particular locations and are thus not easily generalisable (Pleace, 2008, 2018). There has consequently been a tendency to draw on the more extensive North American evidence base in trying both to understand the nature of needs in relation to high-risk drug use among people who experience homelessness and to make judgements about which services will be most effective (Pleace, 2016b), with all the problems of comparison that this necessarily brings (Benjaminsen and Andrade, 2015).

The rest of this paper is divided into two main sections: the first focusing on what we know about homelessness and drug use in Europe; the second looking at responses to homelessness and drug use. At the time of writing, data on the impacts of COVID-19 were only just starting to appear, but the emergent literature is briefly discussed.

## Homelessness and drug use

Before considering the prevalence of drug use among different groups of people who experience homelessness and use drugs (PEHAD), it is necessary to address the fundamental question of how homelessness is defined and measured.

### The challenge of defining and measuring homelessness

There is no single definition of homelessness across Europe. Most countries regard people sleeping rough, i.e. living on the street, or in the open, as being 'homeless'. This is usually,

although not universally, extended to include people living in emergency accommodation, such as shelters. Other countries, such as Denmark, Finland and the United Kingdom (UK), define homelessness more widely, as including people living in derelict or out of use housing, empty buildings, tents or caravans and, importantly, those falling back on informal arrangements, i.e. living with family or friends to keep a roof over their heads. This latter group are sometimes referred as experiencing 'hidden homelessness' because they are not visible in the streets or in homelessness services (Busch-Geertsema et al., 2014).

Comparative maps and tables are sometimes produced showing levels of 'homelessness' in Europe<sup>(1)</sup>, but these have significant methodological limitations. First, the definitions of what constitutes 'homelessness' vary considerably. For example, French counts of homelessness include people living rough and in receipt of homelessness services and temporary accommodation, while Finnish statistics include people who are experiencing 'hidden' homelessness. Meanwhile, Portugal defines homelessness in terms of two groups, those living rough (roofless) and people who are without housing but are living in temporary accommodation. This means that Finnish figures are actually compiled using a far *wider* definition of people experiencing homelessness than is employed in much of the rest of Europe, whereas the French and Portuguese are not defining or counting homelessness in quite the same way (Busch-Geertsema et al., 2014; Allen et al., 2020).

Second, data are collected using different methodologies. For example, Danish statistics combine surveys with longitudinal data analysis that links being recorded as homeless and using services to the national population database<sup>(2)</sup>. By contrast, France and Spain conduct periodic cross-sectional (point-in-time) homelessness surveys that do not cover every area, but instead focus on population centres above a certain size. In essence, the Danish figures are much more likely to be accurate and also contain far more data (Baptista et al., 2012; Allen et al., 2020) than, for example, those of France and Spain. In the UK, data on people seeking assistance under the homelessness laws are quite detailed, but most of the available homelessness data are based on administrative systems. This means that while the data provides information on people experiencing homelessness who are seeking help from the relevant services, they do not represent data on homelessness as a whole.

Third, people who are experiencing homelessness are inherently difficult to count. One reason for this is that those who are living on the street often tend to hide for safety reasons.

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<sup>(1)</sup> See for example: <https://www.oecd.org/els/family/HC3-1-Homeless-population.pdf>

<sup>(2)</sup> Denmark in effect has a continuous population census, using a constantly updated database, rather than collecting data on its population every 10 years.



Another is that not all people experiencing homelessness use homelessness services. Instead, they may, for example, employ informal arrangements to keep a roof over their heads. Those using such informal methods, and who are experiencing 'hidden' homelessness, are hard to count because this population lives in other people's houses and also tends to move around. For example, young people experiencing homelessness may often 'sofa surf', i.e. move from one highly precarious arrangement with friends or relatives to another (Quilgars et al., 2008). In addition, recent research indicates that women's experience of homelessness may have been seriously undercounted because they may react to homelessness by using such informal means to keep a roof over their head more frequently than men (Bretherton, 2017).

In response to these challenges in measuring the problem, several attempts have been made to introduce standardised definitions of homelessness and shared systems for enumerating those experiencing homelessness across Europe. This includes the European Commission-funded Mutual Progress on Homelessness through Advancing and Strengthening Information Systems (MPHASIS) (2007–2009) programme (Busch-Geertsema, 2010) and the current COST<sup>(3)</sup> action Measuring Homelessness in Europe (2016–2021). Standardisation has proved difficult because of the inconsistencies in definitions of homelessness, in addition to the logistical challenges around finding a methodology that would be effective and feasible across all of Europe.

The most significant progress towards a shared definition is represented by the European Typology of Homelessness (ETHOS) framework (Busch-Geertsema, 2010). ETHOS defines homelessness in reference to three 'domains' which are defined as constituting a 'home'. These domains are the *physical domain*, the *social domain* and the *legal domain* (see Box 1).

**Box 1. ETHOS Definition of homelessness domains**

*'In order to define homelessness in an operational way, we identified three domains which constitute a home, the absence of which can be taken to delineate homelessness. Having a home can be understood as: having an adequate dwelling (or space) over which a person and his/her family can exercise exclusive possession (physical domain); being able to maintain privacy and enjoy relations (social domain) and having legal title to occupation (legal domain)' (Edgar et al., 2004, p. 5).*

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<sup>(3)</sup> The European Cooperation in Science and Technology (COST).

ETHOS has been seen as contentious (Amore et al., 2011) and has been modified (Busch-Geertsema, 2010), leading to the development of an ETHOS 'light' framework designed to directly inform pan-EU homelessness counts. This new framework defines as 'homeless' people who are 'living temporarily in conventional housing with family and friends (due to lack of housing)', i.e. hidden homelessness, which the original framework did not. For example, under the ETHOS 'light' framework, someone would be defined as experiencing 'homelessness' while living with family or a friend under the following circumstances: they want and need their own home and also don't control their own living space (*physical domain*); nor do they have privacy in the way that they would in a home of their own (*social domain*), and, as it is not their home, they have no legal right to be there (*legal domain*).

There is, however, still an element of imprecision in defining homelessness in this way. For example, while some hidden homelessness might be seen as very obvious, such as two families having to live in housing designed for one family, or someone sleeping on a different sofa every few nights because they have nowhere else to go, it is possible to think of examples where the definition might be seen as inaccurate. For example, the terms of reference include someone living comfortably in a self-contained space in someone else's home. Furthermore, the line between what in some countries would be defined as 'overcrowding' and in others would be defined as 'hidden homelessness' is somewhat blurred. Despite some limitations, ETHOS has become influential in shaping how homelessness is defined and measured outside Europe, and it has also been proposed as the basis for attempts to generate a global homelessness count (Busch-Geertsema et al., 2016).

## Experience of homelessness and links with drug use

There is evidence showing that people take different pathways through homelessness, which indicates that there are patterns within homelessness (Pleace, 2016b). It is in these particular patterns of homelessness that apparently consistent associations with high-risk drug use appear (Pleace, 2008).

North American research has suggested that there are groups of people who enter homelessness without high support needs, but who, when unable to exit, develop serious mental illness (SMI) and drug use, rather than their homelessness being triggered by high-risk drug use or SMI (Culhane et al., 2013). Thus, even though people in countries lacking extensive social protection may become homeless without significant levels of high-risk drug use, there is a risk of them developing substance use problems once they experience homelessness. Research carried out in Australia and elsewhere also suggests that entry into longer-term homelessness may often be 'bad luck', in the sense that some people are more

at risk from adverse changes to their environment than others, particularly where their own capacity is limited by issues like serious mental illness, poor access to social support from friends and family, and a lack of formal assistance mechanisms (O’Flaherty, 2010; Johnson et al., 2019), with some European research highlighting the same issues (Meert and Bourgeois, 2005). There is also older research showing high-risk drug use arising both before and during homelessness, alongside evidence that further demonstrates high-risk drug use remaining constant while someone enters, experiences and then exits homelessness (Pleace, 2008).

The following sub-sections will explore three ‘types’ of homelessness and their links with drug use: family homelessness; short-term or transient homelessness; and ‘archetypal’, long-term/recurrent homelessness. Lastly, we turn to consider patterns of homelessness and drug use in the context of gender.

### Family homelessness

Family homelessness is strongly gendered, being disproportionately associated with lone female parents who have dependent children, with causation linked to both relationship breakdowns and to domestic violence and abuse. Protections against child destitution vary across Europe, but are present everywhere. Both these protection systems and, in some cases such as the UK, specific legal provision to prevent child homelessness tend to be the main source of support for families at risk of homelessness (Baptista et al., 2017). Families experiencing homelessness in Europe do not appear to show higher rates of high-risk drug use than the general population, nor do they exhibit specific patterns of high-risk drug use (Baptista et al., 2017). The overwhelming characteristic of family homelessness is poverty, with non-violent and violent/abusive relationship breakdown being the main triggers (Pleace, 2016b).

One of the largest studies of family homelessness in Europe, conducted in 2005–2008 in England, found low rates of high-risk drug use in families experiencing homelessness, in marked contrast to data on lone young adults experiencing homelessness, which showed a very high level of problematic drug use in this cohort (Pleace et al., 2008). A similar pattern was also reported in a large-scale analysis among families experiencing homelessness undertaken in the United States (US), where rates of high-risk drug use were also low (Metraux et al., 2018).

### Short-term homelessness

The short-term experience of homelessness, sometimes referred to as transitional homelessness, is also not associated with high-risk drug use (Culhane, 2018). Again, while the European evidence base has significant limitations (Pleace, 2016b), the available data

indicate that when homelessness is triggered primarily by economic and social factors and someone is in a position to self-exit from homelessness, without the support of housing and other homelessness services, high-risk drug use is not present at higher rates than is found in the general population. More generally, there are data indicating that far from homelessness being something that can ‘happen to anyone’, it is the poorest in society who tend to be at heightened risk, particularly in countries where the provision of welfare systems is limited (Bramley and Fitzpatrick, 2018).

### Long-term and recurrent homelessness and drug use

The archetypical homeless population, which is the focus of mass media and social media images of homelessness, is made up of lone men with histories of living rough and who use emergency homelessness services on a recurrent and sustained basis. While this group represents just one element of the homeless population<sup>(4)</sup>, it has been the focus of much medical research, including work on the associations between homelessness and high-risk drug use.

Although analysis has tended to focus on this most easily located group of people experiencing prolonged periods of living rough (street homelessness) or long-term homelessness in emergency shelters, they represent a small proportion of all those who experience homelessness over time. As O’Sullivan (2020, p. 36) notes:

*Research has fairly convincingly shown that in the Global North, the population of those with a long-term experience of homelessness who oscillate between the street and temporary shelters accounts for roughly 10 per cent of those who experience homelessness over time.*

This small population exists alongside another group, of a broadly similar size, who are characterised by *repeated* experiences of homelessness. In both groups of people (Culhane, 2018; O’Sullivan, 2020), i.e. the long-term (or chronically) homeless population (around 10 % of total homelessness) and those who experience recurrent (episodic) homelessness (also around 10 %), the prevalence of high-risk drug use is very marked and often combined

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<sup>(4)</sup> There is some evidence to suggest that in countries with highly developed and extensive social protection (welfare), social housing and public health systems, homelessness tends to exist at very low levels and is largely confined to people with multiple and complex needs. Examples of this include Denmark and Finland (see Benjaminsen and Andrade, 2015). Elsewhere, homelessness can exist in other forms, the bulk being linked to poverty in the context of limited social protection systems. For example, most of the homelessness in the UK, or a country outside Europe like the US or Australia, is probably driven by poverty (see discussion below and Bramley and Fitzpatrick, 2018).

with serious mental illness and poor physical health. People experiencing these forms of homelessness also tend to be characterised by sustained worklessness and high rates of contact with criminal justice systems. Focusing on these two populations, research has found what has been termed ‘mutually reinforcing’ relationships between long-term and repeated homelessness, high-risk drug use, poor mental and physical health and repeated periods of short-term imprisonment (Kemp et al., 2006; Parsell, 2018).

Cross-sectional studies, i.e. ‘snapshot’ or point-in-time (PIT) surveys of homeless populations, focusing on people using emergency shelters and living on the streets, have found high rates of addiction. Many of the largest studies have come from America, and alongside high rates of drug use have also reported a high prevalence of severe mental illness, sustained worklessness, social isolation, life-limiting illness and disability, and high rates of contact with the criminal justice system. Data from a smaller number of European studies initially appeared to confirm this picture of people experiencing homelessness as a population characterised by a very high prevalence of drug use (Pleace, 2008; O’Sullivan, 2008; Culhane, 2018).

However, these cross-sectional/PIT studies were later found to be flawed because they oversampled a minority of the homeless population, i.e. those living rough and using emergency shelters on a long-term (chronic) or repeated (episodic) basis. The patterns of smaller ‘chronic’ and ‘episodic’ populations, who tend to be in homelessness services (particularly shelters) for much longer or on a much more frequent basis were not known, which meant that the possibility of oversampling a subset of those experiencing homelessness was not considered. When American longitudinal data, looking at homelessness over time, were first gathered, it was realised that people experiencing homelessness along with drug use problems and complex needs were a subgroup of a much larger homeless population<sup>(5)</sup>. The first American longitudinal research found that while long-term or chronically homeless people represented 10 % of the people using shelters, they would typically be 50 % of the people using a shelter on any one day (Culhane, 2018).

In practice, this means that homeless populations often contain a large proportion of people who are not characterised by high rates of drug use, i.e. families and individuals experiencing short-term homelessness. Simultaneously, there are smaller groups within the homeless population, i.e. people experiencing long-term and repeated homelessness, who

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<sup>(5)</sup> See the preceding footnote, this may not be the case for countries with highly developed and extensive welfare and public health systems.

often show very high rates of drug use. Alongside this, there is evidence that people with high and complex needs who have experienced traumatic events in their lives and who have had contact with state institutions also tend to be overrepresented among long-term (chronic) and repeated (episodic) homeless populations. This group includes young people who were in the care of social services as children, and people, often with mental health problems, who have been convicted and imprisoned for multiple minor offences, and who are again characterised by high rates of drug use (Bramley and Fitzpatrick, 2018; Kemp et al., 2006).

In some European countries with extensive social protection systems, i.e. universal or highly accessible health, welfare and social housing provision, people with significant and complex needs, including high-risk drug use and serious mental illness (SMI) and/or psychiatric disorders (PDs), form the bulk of people experiencing homelessness. Examples of such countries include Denmark (Benjaminsen and Andrade, 2015) and Finland (Pleace et al., 2015), and the numbers of people experiencing homelessness here are relatively small. The main cause for this is thought to be that in a context of extensive social protection systems, only a small group of people with high and complex needs fall through the safety nets that generally prevent homelessness being generated by poverty alone (Allen et al., 2020).

By contrast, the bulk of North American homelessness appears to be comprised of low-income individuals who do not typically engage in high-risk drug use or suffer from SMI/PDs, and who experience short-term homelessness and then self-exit ('transitional' homelessness). There is also evidence of a similar pattern in several European countries such as Ireland, the UK and Belgium. In these countries, a small group with very severe needs and a high prevalence of high-risk drug use and SMI can be identified who experience long-term and repeated homelessness, alongside a larger number of homeless people who have much lower support needs and who tend to self-exit (Waldron et al., 2019; Jones and Pleace, 2010; Meert and Bourgeois, 2005).

A number of European studies on the prevalence of drug use among homeless populations have followed the US model and have tended to oversample people experiencing long-term and repeated homelessness who are living rough and using emergency shelters. This has led to an over-representation in these studies of homeless people who have complex needs, including high rates of drug use. Fazel et al.'s (2008) systematic review of mental disorders among people experiencing homelessness in Western countries (Western Europe and North America) found drug dependence to range from 4.5 % to 54.2 % across seven studies, six of which were European. Another individual study not included in this review found the prevalence of heroin dependency to be 36 % among a sample of 389 people sleeping rough in London (Fountain et al., 2003). A more recent systematic review of mental illness among

homeless populations in Germany found the most common disorders to be substance-related, with a pooled prevalence of 13.9 % for drug dependency and a considerably higher prevalence of 24.6 % among women (Schreiter et al., 2017). In considering the reasons for these high levels of substance dependency, the review suggests that the extent to which supported housing options in Germany demand abstinence on the part of residents may affect the prevalence of drug use in their homeless populations. Thus, it is plausible that countries whose supported housing provision demands abstinence may have higher rates of dependent users among those experiencing street homelessness simply because these individuals have been refused housing or been asked to leave their accommodation.

Finally, it is important to recognise that drug dependency among some homeless populations is particularly risky, with drug overdose being the leading cause of death in certain groups of people experiencing homelessness in the US (Baggett et al., 2013).

## Gender

Gender has also consistently been associated with ‘differentiated trajectories through homelessness in Europe’ (Bretherton, 2017, p. 1). For example, long-term and repeated homelessness among women may include multiple or prolonged stays with friends, relatives and acquaintances, and moving between precarious living arrangements. This type of behaviour may be less common among men, who appear more likely to use homelessness services than women (Mayock et al., 2015b). As highlighted previously, research indicates that women experiencing homelessness may be underrepresented in data collection and research because, in general, they make less use of services and are less likely to sleep rough, and are therefore missed in homelessness counts (Bretherton, 2017).

Women experiencing long-term and recurring homelessness may have different needs than men, including often having been the victim of domestic and gender-based violence and/or having had their children taken into social work care as a result of homelessness, drug use, SMI/PDs and/or criminal activity (Bretherton, 2017; Mayock et al., 2016). In addition, there is some evidence that women’s patterns of drug use while experiencing homelessness may also vary from those of men (Mayock et al., 2015a), meaning that effective interventions in relation to homelessness and drug-use among women probably need to be designed in different ways.

As noted, people who have a history of contact with child protection and social work services during childhood are over-represented among those who are long-term and recurrently homeless, including young people with complex needs, and there is a general association between these forms of homelessness and multiple adverse childhood experiences (ACEs), alongside SMI and high-risk drug use (Fitzpatrick et al., 2013). The challenges around

meeting the needs of PEHAD are therefore focused on long-term and recurrently homeless populations, characterised not only by an increased prevalence of high-risk drug use, but also SMI and PDs. This has meant that services often concentrate on men with high and complex needs, including high-risk drug use, who experience long-term and repeated homelessness, and can be found in emergency and supported accommodation and living rough.

Women experiencing long-term homelessness associated with high-risk drug use, who may be more likely to sofa surf (i.e. live precariously in other people's houses), may therefore be missed by these services (Bretherton, 2017). By contrast, long-term and repeatedly homeless men are more likely to be characterised by high rates of contact with homelessness services, emergency health providers, mental health facilities, the criminal justice system and hospitals.

## Responses to homelessness

### An overview of homelessness services

There is no standardised structure or array of homelessness services that exists in a consistent form in Europe. Responses can be relatively coordinated, but it is equally the case that there may often be no specific service provision at all. Homelessness services are far more diverse, far more inconsistent and subject to more extreme variations in the level of resources available to them than is the case for other health and social services. A city might have an integrated structure, in which a combination of outreach services, emergency shelters, housing support services and addiction and mental health services are coordinated. Equally, there are European cities where homelessness services do not extend beyond a basic emergency shelter offering food and a bed. If addiction services are available to people experiencing homelessness in such situations, they will be the services available to the general population rather than interventions specifically designed for this group of people (Pleace et al., 2018). Furthermore, there are no standardised models of addiction services for PEHAD that are widely used, or used in consistent ways, within coherent and comparable strategies. Overall, the homelessness sector and services within Europe are highly inconsistent.

The challenges around effective interventions to support PEHAD centre on the absence of a settled place in which to live, making the pursuit of harm reduction and/or recovery inherently difficult. In addition, instability, insecurity, unwanted moves, exposure to multiple sources of risk and stress, undiagnosed and unmet mental and physical treatment needs, and simply the lack of somewhere safe, settled and adequate to sleep all present challenges



to providing effective treatment or support for PEHAD (Pleace, 2008; ACMD, 2019).

Alongside this, the tendency of some addiction services not to work with people with SMI or PDs and, equally, of some mental health services not to work with people with high-risk drug use creates barriers to accessing mainstream health and addiction services for people who are experiencing long-term and recurrent homelessness (Pleace, 2008).

The types of intervention in place for people experiencing homelessness can be summarised as follows:

- Fixed-site clinics or facilities where addiction services are offered;
- Mobile clinics;
- 'Staircase' or linear residential treatment (LRT) services;
- Supported housing models;
- Integrated services;
- Housing First and related models.

### Fixed-site clinics

Fixed-site clinics specifically intended for people experiencing homelessness were initially found to achieve very limited results when operating in isolation from other services, because treatment and support were seriously undermined by clients' continued experience of homelessness (Pleace, 2008). However, some European fixed-site clinics for people experiencing homelessness now tend to operate within a network of services, sometimes in collaboration with other providers and sometimes through building their own holistic and multidisciplinary service networks.

Clinics can have outreach services, offering support with education, training and employment, and access to peer and other social networks, mental health services, and temporary accommodation or permanent housing. This renders such a clinic the setting for a 'hub and spoke' or 'core and cluster' approach, i.e. it becomes the centre of a networked and holistic response to both addiction and homelessness (Kasper et al., 2018; FEANTSA, 2017). For example, for people who inject drugs (PWID) drug consumption rooms have proved to be effective in bringing hard-to-reach PEHAD into contact with services, and, depending on the type of model, offering a range of additional services alongside safer drug use spaces (EMCDDA, 2018). However, drug consumption rooms are currently not widely used in Europe or globally.

### Mobile clinics

The evidence base on mobile clinics, which may operate on their own or be attached to one or more fixed-site services, is limited. Based on the experience of fixed-site services,

standalone attempts to treat or reduce harm that are not coordinated with other services and/or not incorporated within a network of support that can also address homelessness itself, would be expected to perform relatively poorly. However, interventions like mobile injecting facilities may help keep PEHAD alive, even when operating in isolation (EMCDDA, 2018; Kasper et al., 2018; FEANTSA, 2017).

### **‘Staircase’ and linear residential treatment (LRT)**

Staircase or linear residential treatment (LRT) services are modelled on supported housing models that were originally designed to enable the effective and humanitarian discharge of long-term psychiatric patients from hospital into the community (Ridgway and Zippel, 1990; Tsemberis, 2010). Using a series of stages or steps (hence the use of the term ‘staircase’ which can mean physically moving between different stages or experiencing shifts in the nature of support within the same service), people experiencing homelessness are prepared and equipped to live independently in the community. This means they are taught life skills – i.e. how to manage their own home after a sustained experience of homelessness – and, often in institutional settings, receive treatment and support for high-risk drug use, SMI/PDs and other health or social care needs. These services were established specifically for long-term PEHAD with SMI/PDs and designed to offer a mix of addiction and mental health services (Rosenheck et al., 2003; Pleace, 2008).

Criticism of LRT services emerged in the 1990s, centred around the relative effectiveness of LRT services compared to Housing First (Tsemberis, 2010; Padgett et al., 2016). Strict regimes requiring PEHAD to become entirely abstinent and treatment-compliant with regard to mental and physical health problems and to follow certain behavioural requirements have been a feature of some North American LRT services, although there have also been examples of more liberal person-centred and flexible approaches (Rosenheck, 2010). Some European LRT services, which have tended to be used more often in Northern Europe (e.g. in countries with a higher GDP like Sweden), have followed a similar design. As in America, a number of people who were experiencing homelessness and had high and complex needs exited the strict European LRT services or became ‘stuck’ because they could not advance to the next step in the pathway to independent housing (Sahlin, 2005; Busch-Geertsema and Sahlin, 2007).

Those who defend the LRT approach argue that it does have successes, even if not with the majority of people experiencing homelessness in addition to those having complex needs who embark on this programme. Proponents of the approach claim that when it succeeds, a formerly homeless person with high and complex needs, including problematic drug use, can have their treatment needs met and their addiction ended, as well as becoming equipped

with the skills needed to live within society as an ordinary citizen (Rosenheck, 2010; Stanhope and Dunn, 2011). One objection to moving away from using LRT in North America has been that such service models were not given a chance to operate properly, as the necessary funding and other resources were not in place to allow them to function as intended (Rosenheck, 2010).

However, high operational costs and a model that focuses on addressing homelessness, problematic drug use, SMI and other severe and complex needs primarily through behavioural modification have raised doubts about the effectiveness and the ethics of LRT services (Lyon-Callo, 2000; Pleace, 2008; Hansen-Löfstrand and Juhila, 2012). Rates of success measured by sustained rehousing, treatment compliance and abstinence from drugs and alcohol range from around 40 % to 60 % for these services (Pleace, 2008).

### Supported housing

Homelessness services can also take the form of single-site supported housing. These services follow a harm reduction model and offer communal or congregate accommodation, with on-site staff who provide direct support and case management/service brokering to connect people to the support they need. For example, the UK has 'wet' hostel provision for people experiencing homelessness. These are supportive living environments for people experiencing homelessness and high-risk alcohol use that tolerate on-site alcohol consumption within a harm reduction framework. In the Netherlands, supported accommodation has been developed where the use of both alcohol and drugs is also allowed (EMCDDA, 2018). There are also supported housing services that do not use formal 'steps', i.e. they do not expect specific stages to be completed in a particular way, but take a much more flexible approach, or that provide a settled, supported home on a long-term or permanent basis (Pleace, 2008; Rosenheck, 2010; Johnsen and Teixeira, 2010; Pleace et al., 2018). These services exist in countries such as the UK and Germany, among others.

### Integrated services

Moving beyond single model interventions, integrated strategies designed to reduce high-risk drug use among people experiencing homelessness are employed in some parts of Europe. These responses are not a single project, like a clinic or an LRT service. As with the approach taken by some free-standing and mobile clinics, this intervention is not based around a single service, but instead features a *network* of interlinked support. This can include harm reduction, treatment, education, training, employment and support services, as well as emergency and temporary accommodation, settled/permanent housing and supported housing. Within such systems, the response to high-risk drug use among PEHAD is integrated and strategic (Kasper et al., 2018), while a recent review by the Advisory

Council on the Misuse of Drugs (ACMD, 2019) has advocated this cohesive, holistic and systemic approach.

The available evidence further indicates that the effectiveness of any and all approaches to treating and supporting PEHAD will be undermined if such services are not delivered within an integrated strategy that meets the full array of needs presented by this group. One issue here is that the absence of an adequate, settled home appears likely to be a negative effect modifier (i.e. associated with worse outcomes) for any form of treatment or support designed to reduce high-risk drug use, and, equally, the high prevalence of SMI and PDs in this same population means attention must also be given to mental health services.

## Housing First

Housing First uses a harm reduction<sup>(6)</sup> approach alongside a recovery orientation<sup>(7)</sup>. The strategy for this service is centred around providing housing as the first response to homelessness as well as arranging a holistic mix of support to ensure the individual's needs are met and to promote integration into society in terms of economic, social and community life. Rather than being provided with housing after treatment, the service user is given accommodation immediately, and, unlike some other services, Housing First has a strong focus on 'consumer choice' and coproduction, meaning that the nature and extent of support is determined largely by the person experiencing homelessness. As a result of this approach, Housing First does not set goals for each service user that need to be achieved

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<sup>(6)</sup> The *Housing First guide Europe* (<https://housingfirsteurope.eu/guide/>) describes harm reduction within Housing First in the following terms:

*A holistic (whole person) approach that seeks to address all the causes and consequences of drug and alcohol use is central to the harm reduction philosophy. Equally, harm reduction seeks to persuade and support people to modify drug and alcohol use that causes them harm. Harm reduction offers support, help and treatment, but does not require abstinence from drugs and alcohol.*

<sup>(7)</sup> The *Housing First guide Europe* (<https://housingfirsteurope.eu/guide/>) describes a recovery orientation in the following terms:

*A service with a recovery orientation focuses on the overall well-being of an individual. This includes their physical and mental health, their level of social support (from a partner, family or friends) and their level of social integration, i.e. being part of a community and taking an active part in society. Promoting recovery can include enabling access to education or helping someone find a rewarding leisure activity. Following a recovery orientation is something far wider and more ambitious than just regulating drug or alcohol use or supporting engagement with treatment. It is about delivering a secure and rewarding life for someone, creating a life that integrates them into a community, into housing and into wider social and economic life in a positive way.*

within a set timeframe. Rather, it structures support around the expressed needs and preferences of each individual. Like LRT, Housing First is designed for people experiencing homelessness who also have significant and complex needs, including those exhibiting both high-risk drug use and SMI/PDs, with some services, including the original version of Housing First, only working with people with a psychiatric diagnosis (Tsemberis, 2010).

A key difference with some other service models is that the continued use of drugs and alcohol is tolerated by Housing First. Substance use is not a barrier to securing housing, nor is continued residence linked to the cessation of drug or alcohol use, beyond the requirements of the lease or tenancy and local laws. This said, Housing First is not a passive model with respect to high-risk drug use: its harm reduction approach lies within the aforementioned 'recovery orientation'. This means something wider and more ambitious than just harm reduction or supporting engagement with treatment. Housing First aims to secure a rewarding life for the service user, integrating people into the community and the wider social and economic world in a positive way. As has been noted elsewhere, this is the same goal that is pursued by LRT services (Hansen-Löfstrand and Juhila, 2012). However, as Housing First uses a more flexible and co-productive approach, there is not the same expectation to complete 'steps' to reach the goal of being housed. Instead, housing is provided first and the process of 'recovery' is determined largely by the person using the service.

Housing First uses either assertive community treatment (ACT), which involves a multidisciplinary team, and/or an intensive case management (ICM) model<sup>(8)</sup>, which provides direct support but relies heavily on joint working and referral to external services. Housing First services featuring ACT is intended for people with the most complex needs. ICM-only models of Housing First are relatively common in Europe, but ACT/ICM services operate in Denmark and in France. There is some variation in how Housing First has been implemented in Europe, reflecting differences between European welfare, health, social

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<sup>(8)</sup> The *Housing First guide Europe* (<https://housingfirsteurope.eu/guide/>) describes ACT/ICM in the following terms:

*Intensive case management (ICM) or a similar form of high-intensity case management, which provides some support and creates connections between service users and treatment and support provided by other health, support and social work services. An assertive community treatment (ACT) team, or another multidisciplinary team that directly provides treatment for many needs, including mental health problems, drug/alcohol problems and poor physical health, and provides the case management needed to help the person access treatment from other services as required. This approach tends to be used for homeless people with very high support needs.*

work and social housing systems (Knutagård and Kristiansen, 2013; Busch-Geertsema, 2013; Bretherton and Pleace, 2015; Pleace et al., 2019).

Housing First has consistently demonstrated high effectiveness in ending homelessness among people with high and complex needs, including in two major randomised control trials (RCTs) undertaken in France and Canada (DIHAL 2016; Goering et al., 2014) and in multiple evaluations of individual services and programmes across the European Union (EU) (Greenwood et al., 2018) and elsewhere in Europe, such as Norway (Dyb, 2017). As such, the success of Housing First services in ending homelessness for people with high and complex needs, across many European countries, is supported by considerable evidence.

However, the programme's performance in relation to reducing high-risk drug use has been reported as more variable. There have been some positive results in terms of harm reduction and a certain amount of cessation of the use of high-risk substances, plus Housing First has not been associated with increases in high-risk drug use. Nevertheless, the successes reported in relation to ending homelessness have not been replicated with respect to high-risk drug use (Padgett, 2007; Johnson et al., 2012; Stergiopoulos et al., 2015; Somers et al., 2017; Baxter et al., 2019), nor have the same studies demonstrated consistent successes in respect of SMI. Moreover, smaller-scale evaluative research of Housing First within Europe has also suggested inconsistent results around the cessation of high-risk drug use (Busch-Geertsema, 2013; Bretherton and Pleace, 2015; Greenwood et al., 2018).

Housing First is seen as a success because it ends homelessness among people with significant and complex needs at a higher rate than many other interventions. This is usually measured in terms of days successfully housed/retention of settled housing for one to three years, with success rates of around 80 %. However, Housing First has been criticised as achieving 'less' than abstinence-based LRT services that have an average success rate of between 40 % and 60 % in ending homelessness and drug use for 1–3 years. This is because high-risk drug use continues among some of the successfully housed Housing First beneficiaries with complex needs. Importantly, the Housing First model is a homelessness service, centred on the ideas of housing as a human right and extending choice and control to service users, which is designed to be suitable for people experiencing homelessness who have complex needs, including high-risk drug use. As such, it is not intended to function as a service to deal with high-risk drug use.

## The 'effectiveness' of homelessness services

As with divergences in opinion of what 'success' means in relation to homelessness services, there are also cultural and professional differences around definitions of

effectiveness that are useful to highlight here. From the perspective of advocates of services like Housing First, which are designed to be holistic, integrated and led by the service users, an addiction service targeted at people experiencing homelessness that is not addressing homelessness itself has, at best, limited utility (even where such a service may demonstrate clinical effectiveness in ending addiction).

The continual and unique risks to individual well-being represented by homelessness are what homelessness services and strategies are designed to tackle. Interventions that focus simply on high-risk drug use without addressing individuals' needs in relation to housing, social support and social integration appear to have inherently limited effectiveness, both in terms of high-risk substance use itself and in reducing homelessness (Pleace, 2008, 2018). Such limitations created the space for service models like Housing First that are more holistic, do not prioritise high-risk drug use above other issues, and are centred on adequate, affordable, stable housing, social integration and other treatment needs (Tsemberis, 2010; Padgett et al., 2016). In the case of Housing First, service provision is focused on long-term and recurrent homelessness associated with high and complex needs. While high-risk drug use is one issue among many others for people experiencing homelessness, for Housing First, addressing this problem is always viewed within the much broader goal of ending and preventing homelessness itself.

As such, the apparent limitations in Housing First have to be seen in the wider context of its successes in ending long-term homelessness. It is important to be aware of the risks in placing unrealistic expectations on Housing First as there is no single, simple solution to all homelessness (Busch-Geertsema, 2012). However, Housing First does deliver some successes around high-risk drug use and in sustainably ending homelessness for a large proportion of its service users with high and complex needs. These services also remove the barriers to accessing effective support and treatment that exist while someone is still experiencing homelessness.

The evidence base on Housing First primarily relates to services that are relatively new across much of Europe. It should also be remembered that Housing First works with a population with very high and complex needs. As such, expecting rapid improvements with regard to high-risk drug use, SMI and other support and treatment needs from a group of people who have often experienced homelessness and high-risk drug use for prolonged periods may not be realistic. In addition, in order to function properly, Housing First requires the presence of an existing network that offers access to drug, alcohol, psychiatric and other services it cannot provide itself. Even where a multidisciplinary ACT team is in place, Housing First is not designed to operate in isolation (Tsemberis, 2010; Padgett et al., 2016).

The available evidence indicates that holistic, integrated systems of services are likely the most effective way to meet the needs of PEHAD. This is because a failure to provide support in one dimension, such as securing adequate housing, is likely to trigger failures in other dimensions, just as providing housing without support around high-risk drug use undermines the chances of sustainably ending homelessness (Pleace, 2008; ACMD, 2019). At a more general level, Finnish interventions around long-term and recurrent homelessness have followed this integrated, multi-agency approach, providing a networked response to all forms of homelessness. The Finnish strategy has developed over time and now reflects a broadly defined 'Housing First' approach. However, this wider 'Housing First' strategy does not rely on one service model, but instead promotes an integrated, holistic response to homelessness using an array of services that prioritises the rapid provision of housing, alongside other forms of support, as the way to reduce homelessness (Allen et al., 2020). Finland is the only EU country to reduce homelessness in recent years (outside the EU, Norway has also achieved a reduction in numbers, Dyb, 2017), with particular successes in terms of reducing long-term homelessness, i.e. populations characterised by a high prevalence of problematic drug use (ARA, 2019). The focus in Finland is on people who, as in Denmark, have 'fallen through' extensive Scandinavian social protection systems that appear to largely prevent homelessness being triggered by poverty (Benjaminsen and Andrade, 2015).

Overall, debates about the effectiveness of Housing First are widespread. Some argue that while much of the Housing First provision in Europe follows the core philosophy of Sam Tsemberis' original Housing First model (which was first developed in the early 1990s in New York), it is a 'low' fidelity version because it does not replicate the operational detail of the original service, and its effectiveness is thus compromised. However, evidence (including from North America) indicates that while high fidelity Housing First services are effective in ending homelessness, services adapted to the radically different operating situation in European countries, e.g. widespread social housing, extensive welfare systems and universal healthcare not seen in the US, can also be highly effective (Pleace, 2016a and 2018).

## Harm reduction and abstinence-based approaches for PEHAD

The evidence base has tended to suggest that harm reduction, a key response to high-risk drug use across Europe (Dale-Perera, 2017), is more effective than abstinence-based approaches with respect to meeting the needs of people who use drugs, including PEHAD (Pleace, 2008; ACMD, 2019). However, when reviewing the data, it is important to consider both the nature of the evidence base and the wider issues around effectively meeting the



needs of PEHAD. There is some guidance available, but this can sometimes be focused on long-term and repeatedly homeless people with high rates of drug use, conflating these specific populations, rather than looking at homelessness as a whole<sup>(9)</sup>.

It has been argued elsewhere that the debates around the efficacy of harm reduction and recovery based on abstinence or opioid agonist therapy (OAT) that advocate one model over another are ultimately unhelpful and that integrated responses offering an array of services to meet different needs and preferences are likely to be most effective (Dale-Perera, 2017). Housing First, in both its original North American form (Tsemberis, 2010) and in respect of services being developed and run in Europe<sup>(10)</sup>, is something of a hybrid, i.e. harm reduction and a recovery orientation are combined with the goal of reducing high-risk drug use. As a choice-led or co-productive model, Housing First should, if it is working properly, enable access to the full range of drug treatment and harm reduction services designed to meet the needs of people with high-risk drug use. Effectively, the person using Housing First chooses the options they think and feel will work best for them.

While opioid agonist therapy (OAT), abstinence and harm reduction approaches have been examined in relation to people experiencing homelessness (Pleace, 2008; ACMD, 2019), and there is also evidence around supervised drug consumption facilities (e.g. safe injecting sites/drug consumption rooms) which tend to target PEHAD (Schatz and Nougier, 2012), the data on heroin assisted treatment (HAT) seems to be less extensive. However, what evidence there is indicates that for long-term street dwelling and street-based populations characterised by extremely high rates of injecting drug use, supervised drug consumption facilities and HAT may be effective ways to help promote stabilisation and enable access to other services within a coordinated response (Bourgois and Schonberg, 2007; Lancione, 2019).

The implementation of these interventions depends on the legislative framework, policy approaches and public attitudes in different European contexts. Across Europe there is some use of outreach teams and mobile clinics, which act as referral points as well as providing direct support and treatment to people who live rough, and these models may be a way in which to reach PEHAD more effectively (Kasper et al., 2018). Again, if outreach and mobile services are operating within a networked, multi-agency, integrated strategy, this may be more effective in both addressing homelessness itself and in moving towards tackling

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<sup>(9)</sup> E.g. <https://gov.wales/substance-misuse-homeless-people-and-those-accommodation-problems>

<sup>(10)</sup> <https://housingfirsteurope.eu/guide/>

high-risk drug use, alongside SMI and PDs, in long-term and recurrently homeless populations.

## Patterns of service provision in Europe

Homelessness services, including addiction-related services, are often organised at the municipal, city or regional level, reflecting the commissioning and funding of homelessness services. As the response to homelessness is largely organised at the sub-national level, data also tend to be held locally and not collected or analysed nationally (Pleace et al., 2018). As a result, there is no clear and comprehensive picture of homelessness service provision across the EU, or within individual Member States (Pleace et al., 2018).

The homelessness sector also contains a significant element of charitable and NGO activity, sometimes commissioned or working in collaboration with local, regional and national governments, and sometimes working in an independent or quasi-independent way, which again means that activity is not centrally recorded. Finally, the extent to which there is a recognisable homelessness sector varies between countries. While some European countries have specialised services for people experiencing homelessness, including some dedicated provision for PEHAD, such as LRT, supported housing or Housing First, others respond to the needs of PEHAD by using mainstream social, health and addiction services (Pleace et al., 2018). However, patterns of service provision are not consistent because they are generally determined at the local level and will be variable, in addition to which, homelessness services are not standardised in terms of how they operate or how systems or strategies are designed.

Medical responses to the needs of PEHAD can be organised in various ways.

Homelessness services may work in coordination with mainstream health and social care systems. There may also be separate provision of addiction, mental health and other medical services for people living rough and using emergency shelters, which may be state funded and/or charitably supported. For example, in the UK, the National Health Service (NHS) and local authorities commission dedicated, specialist mental health and addiction services for people experiencing homelessness, on a decentralised regional and sub-regional basis, meaning that the range and extent of provision, which is mainly delivered by NGOs, is not consistent.

Specialist health services for people experiencing homelessness are also sometimes commissioned on a freestanding basis, rather than as part of an integrated homelessness strategy. Housing First in the UK is funded by non-health sources, i.e. municipalities (local authorities), as well as national administrations and central government. By contrast, in

France, as in Canada, Housing First has been provided and funded as a mental health service by central government and is intended for people experiencing homelessness with a psychiatric diagnosis. Beyond knowing that different patterns of provision and commissioning of health services for PEHAD exist in Europe, it is, again, impossible to be precise about the mix and extent of services that are on offer. Even in countries where specialist health services operate, they will not be available in all areas, which means that PEHAD will often have to use, or of course they may choose to use, the mainstream treatment services available to any citizen.

There is some evidence to suggest that there may be greater use of abstinence-based approaches in Central and Eastern Europe, where resistance to OAT and other harm reduction services may still be considerable, although it is important to note that data on the extent and nature of homelessness service provision across Europe are not comprehensive and the patterns of delivery remain unclear (Pleace et al., 2018). In Northern Europe, by contrast, many services working with PEHAD appear, based on the available evidence, to follow a harm reduction approach, and in some countries OAT is very widely used.

According to some evidence, the provision of services for PEHAD could be most extensive in those countries where homelessness may be a relatively small, or even residual, social problem. More affluent countries tend to have more extensive social protection systems, combined with a capacity and willingness to devote significant resources to homelessness prevention and reduction. In terms of relative numbers and the extent of unmet need, homelessness may be at its most acute in those European countries that have a lower GDP and are facing multiple and significant socioeconomic challenges, and where the provision of social protection is more limited and direct state expenditure on homelessness services, where it exists, is likely to be low. However, while this pattern appears to exist, as is often the case with homelessness, a lack of clear data means that it is not possible to view it with certainty (Fitzpatrick and Stephens, 2014; Pleace et al., 2018).

In some Southern, Central and Eastern European countries, people experiencing homelessness, including those with complex needs, may be much more reliant on family, friends and acquaintances because there are fewer services to turn to. The response to homelessness among people with high-risk drug use may also be to choose different ways of living, outside formal society, including in unregulated settlements and encampments (Lancione, 2019). While such encampments and settlements, alongside reliance on friends and relatives, exist across Europe, in many Northern European countries there are more likely to be relatively extensive homelessness services on offer, including those specifically tailored for PEHAD. This means that the nature and experience of homelessness can vary somewhat across different countries and regions of Europe, as cultural attitudes, stigma and

the varied nature of service provision can alter what it means to experience homelessness and which services can be accessed (Pleace et al., 2018).

## Homelessness and COVID-19

The impacts of COVID-19 on services for PEHAD were still unfolding at the time of writing. However, the most immediate effects have so far been seen on services that are congregated or communal, in which people share sleeping space and/or living space and are effectively breathing the same air. High infection rates have been reported in some US services and elsewhere, raising important questions about how fixed-site services where people share sleeping space and/or living areas will function going forward, both in the sense of providing emergency and temporary accommodation but also in terms of enabling access to support, health and drug/alcohol services. Initial US modelling of how services may need to be modified envisages a halving of capacity as a first step, creating immediate challenges around where and how new service provision, incorporating social distancing and other measures for infection control, can be quickly developed (Culhane et al., 2020).

Research in Ireland has shown a shift away from abstinence-based approaches and towards harm reduction, within a housing-led (broadly similar to Housing First) framework that was instrumental in containing COVID-19 infection and stopping high mortality from the virus among people experiencing homelessness. Thus, through a combination of using self-contained accommodation and the management of addiction through harm reduction, COVID-19 did not have the impact that was feared on the most vulnerable people experiencing homelessness (O'Carroll et al., 2020). The UK also seems to have largely contained COVID-19 infection and mortality among people experiencing homelessness, which, on initial evidence, seems to be associated with having largely moved away from the use of communal homelessness services over the last three decades, a sustained trend towards harm reduction over the same period, and the near-immediate decision to house people living rough in hotels, enabling them to socially distance (ONS, 2020). By contrast, COVID-19 infection rates in excess of 40 % have been reported in some communal homelessness services in the US (Culhane et al., 2020).

## Conclusions

The available evidence, which, as has been noted in this paper, has some significant limitations, indicates that people who experience homelessness and use drugs (PEHAD) are concentrated in a relatively small, long-term and recurrently homeless population that also presents with a high prevalence of serious mental illness and psychiatric disorders. In terms of treatment options, holistic and integrated service responses appear to be the most

effective in meeting the needs of these homeless populations. It is further proposed that treating and supporting this population to overcome and manage high-risk drug use without addressing their housing needs, wider medical problems, socioeconomic marginalisation, isolation, and sometimes repeated contact with criminal justice systems, would appear to be both impractical and wasteful.

Beyond this, drawing on the homelessness literature and the strategic approaches and service models that appear to be the most effective, it would seem that maximising the choice and control of service delivery exercised by people experiencing homelessness offers the most efficient means of reducing homelessness. This conclusion is based on evidence from examining integrated strategies and, in terms of ending homelessness for people with high and complex needs, the Housing First programme (Busch-Geertsema et al., 2010; Pleace, 2018; Downie et al., 2018). Furthermore, it is suggested that enabling the same degree of choice and control in relation to addiction services for PEHAD will also increase the likelihood of positive results.

Overall, the evidence suggests that no single intervention, operating in isolation, is likely to be effective. Models like Housing First, which are effective in ending long-term and recurrent homelessness, still require support from other services. The successful reduction and prevention of homelessness thus shows that a variety of flexibly-tailored and co-produced support services appear to be needed, particularly in order to effectively meet the needs of people who experience homelessness and use drugs.

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