Homelessness and drugs: health and social responses

Introduction

This miniguide is one of a larger set, which together comprise *Health and social responses to drug problems: a European guide*. It provides an overview of the most important aspects to consider when planning or delivering health and social responses for people experiencing homelessness and using drugs, and reviews the availability and effectiveness of the responses. It also considers implications for policy and practice.

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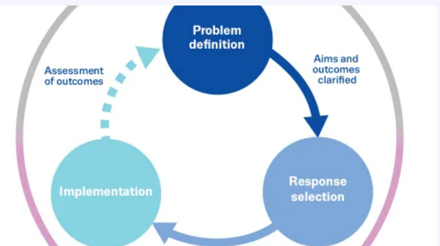

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Overview

Key issues

Homelessness is considered to be an intense form of social exclusion. It negatively affects physical and mental health, quality of life and access to employment and other economic, social and health services. However, there are wide differences in defining what homelessness constitutes. This has caused a number of challenges, such as in assessing the prevalence of homelessness and comparing such assessments within and between countries. Broadly, homelessness encompasses individuals without stable, permanent and acceptable housing, or those lacking the prospect, means and ability of acquiring it. Under these conditions, people who use drugs face intersecting social, mental and physical health risks that significantly increase their morbidity and mortality.

The relationship between homelessness and drug use is complex with marked variations in the prevalence of high-risk drug use across groups of people who experience homelessness. For example, there is a clear intersection between homelessness and high-risk drug use among the two distinct groups of people experiencing long-term (chronic) and recurrent (episodic) homelessness. In contrast, high-risk drug use among those experiencing short-term or transitional homelessness does not seem to be higher than among the general population. Importantly, drug use and homelessness are interconnected in two directions: they may be contributing causes and consequences of each other.

There is a lack of information on some groups of people experiencing homelessness, such as women, youth, children, refugees and migrants, particularly in terms of patterns of substance use. As a result, some of these groups may be under-represented in data collection on homelessness and they may be missed by existing services.

Evidence and responses

Overall, there is no standard or agreed set of responses implemented in Europe for people who experience homelessness and use drugs. This group typically uses generic low-threshold homelessness and drug services, where they may comprise a large proportion of all service users. Such services may include drug consumption rooms, opioid agonist treatment, needle and syringe programmes, and mobile clinics. Effective measures to support people who experience homelessness and use drugs are challenging because of the lack of a settled place to live. This group often faces significant barriers to accessing health care, drug treatment and social services.

Guiding principles for effective drug services for people experiencing homelessness usually centre on stable housing, provision of harm reduction and integrated strategies. Stable housing is often regarded as a fundamental component of treatment and social integration, as discharging people from treatment into an environment where they face homelessness, or

providing treatment without housing, may lead to further harms. Provision of harm reduction for people who experience homelessness and use drugs may be best delivered in low-threshold services and when access is rapid, easy and adapted to the clients' needs. Integrated strategies move beyond single-model interventions, such as a clinic only providing a certain form of treatment. Instead, they form a network of interlinked support by connecting several services (e.g., housing, drug treatment and psychosocial services, among others) based on the client's needs.

European picture

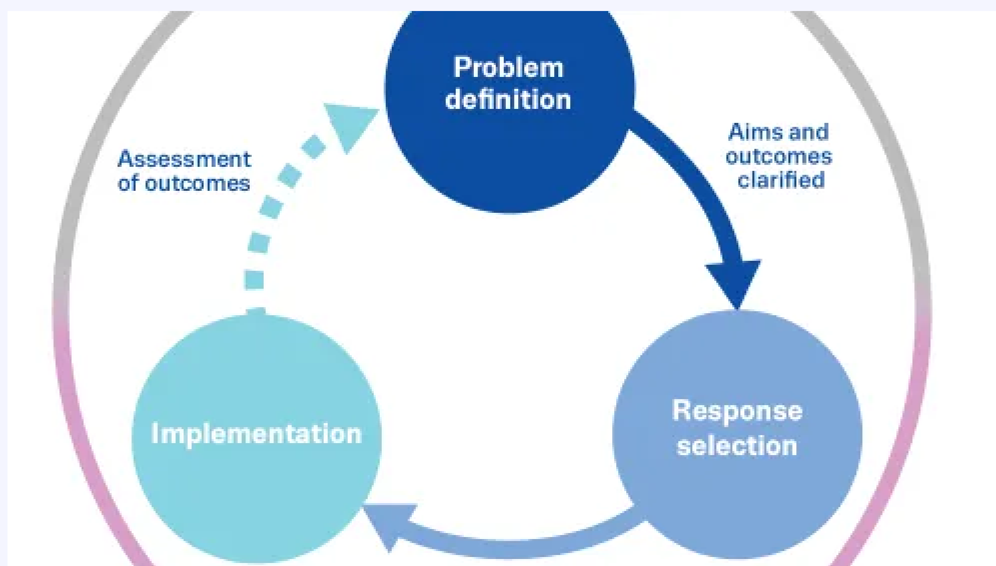
While an estimated 700 000 people faced homelessness across Europe prior to the COVID-19 pandemic, the nature of homelessness varies across the continent because cultural attitudes, stigma and varied service provision influence what it means to experience homelessness and which services can be accessed. Where homelessness services exist, the sector and the services offered within it vary widely. As data are often not collected or analysed at national level, there is no clear, comprehensive picture of service provision for people who experience homelessness broadly, and those who use drugs specifically, across the European Union or within individual Member States.

At EU level, the European Parliament has called for an end to homelessness by 2030 in line with the United Nations Sustainable Development Goals. At Member State level, many European countries include people who experience homelessness in their national drug policy action plans. Some countries include dedicated service provision for this group of people in their national frameworks, while others respond to this group's needs by using mainstream social, health and addiction services. While service provision for specific subgroups among people who experience homelessness and use drugs, such as youth, children, women and migrants, is seemingly not widespread in Europe, there are exceptions in individual countries.

COVID-19 has raised important questions about how homelessness services will operate in the future. While COVID-19 exposed many vulnerabilities in health and social service provision, in some European countries the pandemic response has led to positive developments for people who experience homelessness. In some countries, access to housing has improved, access to harm reduction measures have been expanded and some drug treatment restrictions have been relaxed.

Action framework for developing health and social responses to drug problems

The three broad stages of developing responses to drug problems



Health and social responses to drug problems are any actions or interventions that are undertaken to address the negative health and social consequences of illicit drug use, such as deaths, infectious diseases, dependency, mental health problems and social exclusion. Developing and implementing such responses, whether at EU, national, local or individual level, involves three basic steps:

- identifying the nature of the drug problems to be addressed;
- selecting potentially effective interventions to tackle these problems; and
- implementing, monitoring and evaluating the impact of these interventions.

The action framework details the most important factors that need to be considered at each stage.

Key issues related to homelessness and drug use

People who experience homelessness are a heterogeneous group of individuals, but all are typically living under conditions where they face a range of social, mental and physical health risks that can significantly increase morbidity and mortality. Their socioeconomic status may also make them particularly vulnerable to poor health, a factor compounded by the barriers they often face in accessing health care. In this overall context, drug use among some groups of people who experience homelessness can be extremely risky.

Homelessness can be defined in a number of different ways. This can make it a challenge to monitor drug use among people experiencing this form of social exclusion.

The European Typology of Homelessness (ETHOS) framework is helpful here. It proposes four homelessness and housing exclusion categories, namely:

- rooflessness (e.g. people living rough or staying in a night shelter);
- houselessness (e.g. people living in accommodation for those experiencing homelessness);
- insecure housing (e.g. people living under threat of violence or eviction);
- inadequate housing (e.g. people living in extreme overcrowding).

Coexisting high-risk drug use and mental health issues

Homelessness may result from a combination of structural factors, system failures and individual circumstances. Dependence and other problems associated with substance use and mental health problems are two common issues for this population, alongside a range of other health and social challenges. The relationship between homelessness and high-risk drug use is complex. High-risk drug use can put people at an increased risk of homelessness but also be caused and exacerbated by experiencing homelessness. Associations with high-risk drug use appear to be more consistent among certain groups, particularly those who experience long-term (chronic) and recurrent (episodic) homelessness. Substance use among specific sub-groups of the population experiencing homelessness, such as youth, women, refugees and migrants, remain under-studied.

Mental health problems are commonly observed among people experiencing homelessness, with indications that the more severe the level of homelessness, for example among those experiencing long-term and recurrent homelessness, the poorer the level of mental health. As with high-risk drug use, the direction of causality is not clear. Some studies suggest that mental health problems may increase the risk of homelessness, while others indicate that homelessness may increase the risks of experiencing mental health problems. The reach of local and national welfare systems is also likely to play a role. Overall, those who experience

homelessness and suffer from mental illnesses are among the most stigmatised people in society, which is further compounded if they also use drugs. Stigma is a major barrier to accessing health services for these groups.

Long-term and recurrent homelessness

People who experience long-term or recurrent episodes of homelessness – and experience high levels of high-risk drug use and serious mental illness – are an important focus for interventions in many countries. They may experience long periods of street homelessness or prolonged stays in emergency shelters. These groups also tend to be characterised by long-term unemployment and high rates of contact with the criminal justice system. Among these groups, there is seemingly a 'mutually reinforcing' relationship between homelessness, high-risk drug use, serious mental illness and poor physical health.

The long-term and recurrent homelessness are thought to represent around 20 % of all those who experience homelessness. These groups have been the focus of much research, particularly on the associations between homelessness and high-risk drug use.

Short-term homelessness

Short-term experiences of homelessness, sometimes referred to as transitional homelessness, do not tend to be associated with high-risk drug use. While the European research base has significant limitations, the available data indicate that if homelessness is triggered primarily by economic and social factors and the person is able to eventually self-exit from homelessness, high-risk drug use is not present at a higher rate than in the general population. However, the intersecting social, mental and physical health problems that people experiencing homelessness are exposed to can exacerbate the risks associated with problematic drug use.

Women and homelessness

Gender has consistently been associated with differentiated trajectories through homelessness. Among women, long-term and recurrent homelessness may include multiple or prolonged stays with friends, relatives and acquaintances and moving between precarious living arrangements. As a result, women experiencing homelessness may be under-represented in data collection and research because they generally make less use of homelessness services and are less likely to sleep rough.

Women experiencing long-term and recurrent homelessness are likely to have different needs to men. For example, they may need gender-specific, trauma-informed care due to experiences of domestic and gender-based violence. Further, they may face increased vulnerability to violence and exploitation during homelessness. For instance, they may be living in insecure housing due to abusive relationships. However, due to high levels of stigma

and a lack of services with a gender-informed approach they may be less likely to seek help.

Women's patterns of drug use during homelessness may differ from those of men. Women may, for example, be more likely to initiate heroin use at a younger age, to inject and to be introduced to the drug by a sexual partner. Trauma and gender-based violence may also be potential contributing factors to high-risk drug use. As such, effective interventions in relation to homelessness and drug use may need to adopt a gendered approach. In particular, women-only services for those experiencing homelessness who use drugs seem to be lacking. It has been indicated that women sometimes have no option but to access services where they may feel vulnerable and unsafe (see Women and drugs: health and social responses).

Evidence and responses to drug-related problems for people experiencing homelessness

The challenges of effective responses to support people who experience homelessness and use drugs centre on the absence of a settled place in which to live. This makes the pursuit of improved health and social outcomes and the reduction of harms inherently difficult to achieve. Instability, insecurity, unwanted moves, exposure to multiple sources of risk and stress, undiagnosed and unmet physical and mental health treatment needs and simply the lack of somewhere safe, settled and adequate to sleep all present challenges to effective responses for this group.

Some drug treatment services may not work with people experiencing homelessness or serious mental illness and some mental health services not to work with people with high-risk drug use. This can create additional barriers to mainstream health and drug treatment services for people who experience homelessness and use drugs. For example, some treatment services may require new patients to have a fixed or permanent address before treatment can start. Accessing housing can also challenging for people who are using drugs, as for example some temporary housing responses do not allow on-site consumption and may not accept people when they are intoxicated.

In Europe, no standard set of responses has been implemented for people who experience homelessness and use drugs. 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 health services for people living rough and in emergency shelters, which may be funded by the state, charities or both. Responses can be relatively coordinated, but it is equally the case that there may be no specific service provision at all. Overall, homelessness services are far more diverse, inconsistent and subject to extreme variations in the level of resources they have available than is the case for other health and social services.

There is generally a lack of services specifically targeted at people who experience homelessness and use drugs. Consequently, such people typically make use of other low-threshold homelessness or drug services. They sometimes make up a large proportion of all clients in services targeted at the most vulnerable, marginalised groups of people who use drugs, such as drug consumption rooms, mobile harm reduction clinics, and needle and syringe programmes. These services sometimes have specific features targeted at the needs of people who experience homelessness. For example, drug consumption rooms may provide food, access to showers, lockers and clothing and be linked to shelters providing overnight accommodation. More broadly, they may also facilitate referral to social welfare and other treatment programmes, some of which may be targeted at those experiencing homelessness.

Guiding principles for effective service provision

Those engaged in responding to the needs of this population often mention three key guiding principles for effective drug services for people experiencing homelessness. The principles are stable housing, provision of harm reduction and implementation of integrated strategies.

Stable housing

Stable housing is regarded as a fundamental component of the response to homelessness. Risk behaviour is often correlated with housing instability, with the highest levels of risk and harms experienced among rough sleepers and those in emergency accommodation. Discharging people from treatment into an environment where they face homelessness, or providing treatment without housing, may lead to further harms. As such, housing is often seen as the first response, combined with a holistic mix of support to ensure individual needs are met and reintegration into society is facilitated.

Housing First is an example of a service that provides housing as the first response to homelessness in a number of European countries. It provides a holistic mix of support to ensure that the unique needs of the clients are met and to promote reintegration into society. It operates as a network of interlinked support. The nature and extent of support in Housing First is structured around each client’s expressed needs and preferences, and draws on principles of harm reduction.

Housing First is designed for people experiencing homelessness with high and complex needs, including those with high-risk drug use, serious mental illness and psychiatric disorders. Some Housing First services only work with people who have a psychiatric diagnosis. Within this service, substance use is not a barrier to housing, nor is continued residence in housing linked to cessation of drug or alcohol use.

In two major randomised control trials in France and Canada and in evaluations of individual programmes across Europe, Housing First services have shown promise in ending homelessness for people with high and complex needs. Outcomes related to reducing high-risk drug use are more variable, although some positive results have been reported.

Harm reduction

Harm reduction is an essential component of service provision for people experiencing homelessness. Provision of harm reduction services to these groups can often be best delivered in low-threshold services where access is rapid, easy and adapted to the clients' needs. Services might include needle exchange programmes, drug consumption rooms, mobile clinics and access to pharmacological treatment for substance use disorder, such as opioid agonist treatment (OAT), and the provision of naloxone to reverse the respiratory depression caused by opioid overdose.

Some of these low-threshold services, particularly drug consumption rooms and mobile clinics, may already have a large proportion of clients who experience homelessness. Several studies have shown that harm reduction may be effective in improving health and well-being for people who use drugs and experience homelessness. The participation of peers may also improve engagement with these sorts of services.

Integrated services

Integrated strategies move beyond single-model interventions, such as a clinic that only provides a certain form of treatment, to form a network of interlinked support. Such networks have shown promise in addressing homelessness itself and the complex needs of people who experience homelessness and use drugs. Integrated strategies can include harm reduction, treatment, education, employment and support services, emergency and temporary accommodation or settled and permanent housing, all operating as an integrated network.

For example, after having secured access to housing, clients are provided with additional support according to their individual needs, without having to seek support from service providers themselves. Within such networks, the response to high-risk drug use is integrated and strategic. Several EU Member States have advocated this approach and some Housing First services offer examples of integrated services. The assertive community treatment model is another such approach, although it is rare in Europe and there is no evidence of its effectiveness. This model was originally developed for patients with severe mental illness. It provides personalised, high intensity, holistic and integrated multidisciplinary community care services.

Overview of the evidence concerning interventions for people who experience homelessness

Statement	Evidence	
	Effect	Quality
Permanent supportive housing to improve housing stability for homeless individuals	Beneficial	Moderate
Opioid agonist treatment (OAT) to reduce mortality, morbidity, and substance use in homeless and vulnerably housed persons	Beneficial	Low
Drug consumption rooms (DCRs) may have a beneficial impact on access to health care services and harm reduction services on hard-to-reach target groups.	Beneficial	Low

Evidence effect key:
Beneficial: Evidence of benefit in the intended direction. **Unclear:** It is not clear whether the intervention produces the intended benefit. **Potential harm:** Evidence of potential harm, or evidence that the intervention has the opposite effect to that intended (e.g. increasing rather than decreasing drug use).

Evidence quality key:
High: We can have a high level of confidence in the evidence available. **Moderate:** We have reasonable confidence in the evidence available. **Low:** We have limited confidence in the evidence available. **Very low:** The evidence available is currently insufficient and therefore considerable uncertainty exists as to whether the intervention will produce the intended outcome.

European picture: availability of interventions for people experiencing homelessness

Prior to the COVID-19 pandemic, it was estimated that over 700 000 people faced homelessness each night in Europe. The groups included in this count are those sleeping rough or living in emergency or temporary accommodation. This represents a 70 % increase over the past decade, likely due to rising housing costs and the reduction of funding for social programmes and benefits. This estimate does not include those experiencing what has been termed ‘hidden homelessness’, for example, people using informal living arrangements with friends and family or living outside formal society in unregulated settlements (such as in derelict housing, caravans or tents).

The nature of homelessness varies across Europe because cultural attitudes, stigma and varied service provision can alter what it means to experience homelessness and which services can be accessed. In some countries, people experiencing homelessness, including those with complex needs, may be much more reliant on family, friends, acquaintances or living outside formal society in unregulated settlements because there are fewer services. In some European cities, homelessness services do not extend beyond a basic emergency

shelter offering food and a bed. Where addiction services are available to people experiencing homelessness in such situations, they will usually be the services available to the general population and not specifically designed for people who experience homelessness. In other countries, there are relatively extensive homelessness services, such as stable housing, some of which are specifically targeted at people who experience homelessness and use drugs.

Where homelessness services exist, the sector and the services offered within it vary widely but tend to be organised at subnational level and are often run by civil society organisations. This means that data are often not collected or analysed at national level. As a result, there is not a clear, comprehensive picture of service provision for people who experience homelessness broadly, and those who use drugs specifically, across the EU or within individual Member States. Where the use of drug-related treatment services by individuals experiencing housing instability are collected at a national level, definitional differences make it difficult to compare coverage.

Policy frameworks

At EU level, the Lisbon Declaration on the European Platform on Combatting Homelessness was adopted in June 2021. In line with the United Nations (UN) Sustainable Development Goals (SDGs), the declaration reaffirms the EU’s work towards ending homelessness by 2030. It envisages the launch of a European platform on combatting homelessness to support Member States and service providers in sharing best practices and identifying efficient, innovative approaches, including promoting access to affordable housing for all.

At Member State level, homelessness and drug use feature in the national drug policy action plans of several European countries, which often identify people in these circumstances as a particularly vulnerable group. Some countries include dedicated service provision for people who experience homelessness in their national policy frameworks, such as housing and harm reduction services, either as stand-alone interventions or as integrated programmes. Others respond to the needs of this group by using mainstream social, health and addiction services.

Supported housing

In November 2020, the European Parliament called for Member States to adopt the principles of Housing First, based on the concept of a home being a fundamental human right. In some European countries, supported housing is part of an integrated multi-agency response to long-term and recurrent homelessness, a population characterised by a high prevalence of high-risk drug use. In Finland, the integrated strategy on homelessness reflects a broadly defined Housing First approach that uses an array of services to prioritise rapid provision of housing alongside support of specific needs. Thus, it operates as a type of integrated service. This has shown some success in reducing housing insecurity among those who experience long-term homelessness.

In other European countries, supported housing is provided for people who use drugs and have just ended treatment. Housing is provided to support reintegration into society and to prevent relapse and homelessness. One project in Croatia encompasses interventions to include people who use drugs in community life when they have completed their treatment in a health care institution or therapeutic community or at the end of their prison sentence. The project assists with housing or organised housing and psychosocial support, retraining and employment. Another example is provided by CRESCER in Portugal, an organisation that has implemented three social businesses as employability responses for people experiencing homelessness. It has opened three restaurants whose employees are people who were in a homeless situation and are provided with in-work training in several hospitality services.

Low-threshold and targeted services

People who experience homelessness and use drugs often make up a large proportion of service users in low-threshold drug treatment and harm reduction services across Europe. Some of these services are explicitly targeted at this group or include specific features targeted at them (e.g. showers and shelters in connection with drug consumption rooms), while others are broad services for people who use drugs. For example, in Liège (Belgium) and Paris (France) it has been reported that the majority of service users in drug consumption rooms are experiencing homelessness or living in substandard housing or without a fixed address.

While service provision for specific subgroups among people who experience homelessness and use drugs, such as youth, women and migrants, is seemingly not widespread, there are exceptions in individual countries. In France, the programme*Travail alternatif payé à la journée* (TAPAJ) promotes the social inclusion of street youth who struggle to find employment, some of whom use psychoactive substances. The programme fosters the continuity of health, social and housing interventions for vulnerable youth who experience highly unstable living situations. A similar programme in Ireland, known as UBU Your Place Your Space, was launched in 2019. This programme targets 10- to 21-year-olds in areas characterised by high-risk drug use, unemployment and homelessness. The prevention and reduction of drug use is a specific focus of the programme.

Gender-responsive harm reduction services for people experiencing homelessness have been implemented in Catalonia, Spain, by Metzineres, a non-profit cooperative based on harm reduction, human rights and gender mainstreaming. Metzineres provides a safe shelter environment and harm reduction responses for women and non-binary people who use drugs.

COVID-19 and homelessness

COVID-19 has disproportionately impacted already vulnerable and marginalised groups of people who use drugs, including people who experience homelessness (see Spotlight on... Health and social responses to drug problems during the COVID-19 pandemic). The

intersecting health risks and high rates of physical and mental health conditions faced by people who experience homelessness, particularly those who experience long-term and recurrent homelessness, place them at higher risk of serious adverse consequences of the virus. As a result of COVID-19 and the associated pandemic guidelines and lockdown orders, many homelessness programmes have had to adapt their services. Services where people congregate or that are communal, for example homelessness shelters in which people share sleeping and living space, have been affected.

COVID-19 has raised important questions about how fixed-site services for people experiencing homelessness will operate in the future, both in terms of providing emergency and temporary accommodation and access to services such as drug treatment. While COVID-19 exposed many vulnerabilities in health and social service provision, in several European countries the pandemic response led to some positive developments. In some countries, access to housing for people who experience homelessness has improved, access to harm reduction measures has expanded and some restrictions, for example on take-home OAT medication, have been relaxed.

In Ireland, a shift from abstinence-based approaches to harm reduction within a Housing First framework has shown promise in containing COVID-19 transmission and reducing mortality from the virus among people experiencing homelessness. Two key changes were made to OAT provision. First, national contingency guidelines were issued that allowed for reduced waiting times and a removal of caps on recruitment to OAT programmes at the two clinics that provided treatment to people experiencing homelessness. This resulted in waiting times being reduced from several months to just a few days. Second, access to OAT was improved by expanding service provision to other clinics and by allowing the delivery of OAT medications to clients' accommodation. In terms of housing, people experiencing homelessness were provided with accommodation to allow suspected and positive cases to isolate, including those deemed vulnerable due to age or pre-existing medical conditions.

Accommodation for people experiencing homelessness has been expanded in many other European countries as well. In Greece, so-called 'pandemic hostels' were created in Thessaloniki and Athens. While some of the emergency accommodation provided during the COVID-19 pandemic was temporary, several facilities have become permanent fixtures in the response to homelessness.

Implications for policy and practice

Basics

- High-risk drug use among people who experience homelessness is particularly concentrated among the long-term and recurrently homeless. Serious mental illness and psychiatric disorders are also common among these groups.

- Targeted responses are needed for people who experience homelessness and use drugs, who often face significant barriers to accessing health care, harm reduction and drug treatment.
- Generally, they make use of programmes for other groups of people who use drugs, particularly low-threshold services, where this group may comprise a large proportion of all service users.
- The provision of stable housing, harm reduction and integrated services are central to the guiding principles of many organisations working with people experiencing homelessness.

Opportunities

- Supported housing and harm reduction measures have shown some promise in reducing the harms faced by people who experience homelessness and use drugs.
- A range of flexibly tailored, co-produced support services, within integrated strategies to address homelessness, drug use and mental and physical health issues, appear to be needed to meet the unique needs of this group.
- Rapid response teams may identify and support people experiencing homelessness before their situation deteriorates further.
- People who use drugs who are offered stable accommodation are likely to benefit from continued support and practical help with their substance use problems.
- With improved living conditions, care coordination and continuity of care, the response can shift to treatable conditions, such as HIV and hepatitis C virus infection, substance use disorder, mental illness and tuberculosis.

Gaps

- Data on the extent and nature of service provision for people who experience homelessness and use drugs are limited. Research and monitoring in this area need to be improved.
- More studies are needed to understand the barriers to service entry (including drug treatment and housing services) for this vulnerable population.
- There is a lack of understanding of the risk factors associated with repeat cycles of homelessness and what measures can be put in place to mitigate them.
- The lack of gender-specific services needs to be addressed, in particular interventions for women who experience homelessness and gender-based violence.
- Further research is needed on youth, migrants and refugees, including the unique challenges they may face during homelessness and the services best suited for their

needs.

Further resources

EMCDDA

- European responses to the needs of people who experience homelessness and use drugs, Background paper, 2022.
- Webinar: responding to drugs and homelessness: innovative approaches in Europe, 2021.
- Impact of COVID-19 on drug markets, use, harms and drug services in the community and prisons, 2021.

Other sources

- Lisbon Declaration on the European Platform on Combatting Homelessness, 2021.
- World Health Organization. WHO Housing and health guidelines, 2018.
- FEANTSA, HR4Homelessness: Integrating harm reduction in homeless services (2019-2021).
- EU Parliament News, 'EU should set goal to end homelessness by 2030'.
- European Typology of Homelessness and housing exclusion (ETHOS)

About this miniguide

This miniguide provides an overview of what to consider when planning or delivering health and social responses for people experiencing homelessness and using drugs, and reviews the available interventions and their effectiveness. It also considers implications for policy and practice. This miniguide is one of a larger set, which together comprise *Health and social responses to drug problems: a European guide*.

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