The Influence of Substance-use to Recurring Homelessness in Utrecht

Social Policy and Public Health

Key Issues

Diana Schokker

6823807

Master Thesis

Words: 9991

Date: 22-06-20

Dr Tracy Cheung

Content

Abstract

Background: It has become clear that addiction-problems often go hand in hand with a relapse in homelessness. This study investigated the relationship between homelessness and addiction-problems with Fitzpatrick's realist model to consider the influence and relationships of the macro-structural to the micro-individual factors on homelessness and substance-use. Accordingly, the study aimed to answer the research question: *How does substance-use relate to homelessness and what factors contribute to this relationship?*

Methods: Qualitative, semi-structured interviews were conducted among 41 respondents at two time points**.**

Results: Results showed that indeed addiction-problems are often associated with homelessness and relapse in homelessness. Furthermore, the results show that the relationship between addiction and homelessness is bi-directional. This means that addiction can be the cause of homelessness, but that homelessness can also be the cause of addiction. Furthermore, respondents clearly indicate that multiple factors play a role in becoming homeless, including debts, the loss of important contacts (friends, family, divorce), and nuisance in the home. However, it appears that in most cases these other factors are related to the respondent's addiction-problems. This clearly illustrates Fitzpatrick's idea of interrelationships between the factors causing homelessness.

Conclusion: The relationship between addiction and homelessness is complex, as addiction-problems affect a host of other factors that play a role in becoming homeless. This makes tackling addiction among the homeless very valuable. Therefore a review has been done on the two existing programs that focus on tackling addiction and homelessness, namely the continuum-of-care program and housing-first program. What appears is that both approaches are probably ineffective because they focus on one factor at the time, as this research found that addiction and homelessness always co-occur and should therefore be tackled together.

Introduction

Previous research concludes that 50% of the visitors to the night shelter have been homeless before (Van Everdingen, 2016), thereby highlighting that recurring homelessness as a prevalent issue in the municipality of Utrecht (Boesveldt et al, 2019). This calls for a more sustainable outflow of homeless people where continued care is provided even after being homed (Boesveldt et al, 2019). People who are homeless experience a decrease in well-being, satisfaction with life, mental and physical health, social currency, and an increase in acute health problems, stigma, discrimination as well as a lack of health services (Johnstone et al, 2015; Padget et al ,2008; Stergiopoulos et al, 2018; Aubry et al, 2016). Furthermore, having a substance-addiction is one of the most important factors that can cause a relapse among homeless people (Boesveldt et al, 2018). It is therefore of great importance that there is a good approach to tackle this specific problem. However, the two main approaches that currently exist cannot sufficiently prove to be effective (Crane et al, 2012). They contradict when it comes to the solution for (recurring) homelessness. Where the housing-first model states that housing is a basic right and should therefore be done as soon as possible, the continuum-of-care program concludes that mental healthcare must first be given before homeless people are ready to live on their own. This inconsistency, is one of the complications that has arisen in solving homelessness and asks for more research into what is the right approach for addiction in combination with homelessness.

One possible explanation for the shortcoming of these approaches, is that substance-misuse is too often seen as an individual problem (McQuistion et al, 2014, Aubry et al, 2016). Furthermore, even when this issue is viewed from a more interpersonal or structural level, only one possible factor (e.g., support systems, or housing quality) is considered at any given time and so the *interrelationships* of factors are not considered (Rhoades et al, 2011; Kim et al, 2006). In response, Fitzpatrick (2005) proposes a new theoretical framework, namely the realist framework, where both individual, interpersonal and structural factors are taken into account. Its main claim is that it looks at the interrelationships of the different levels and multiple factors influencing homelessness simultaneously. Examples of this interrelationship can for example be: the influence of housing quality (structural level) on mental state (individual level) leading to alcohol and drug problems, the influence of financial stability (economic level) on housing quality, and the influence of addictions (individual level) on financial stability (Aubry et al, 2016). The consideration of these different factors at different levels means that this theoretical framework has a multidisciplinary viewpoint.

The current study is a qualitative study conducted within an internship at the Utrecht University on the project “Repeated Homelessness in Utrecht”, investigated the following research question: *How does substance-use relate to homelessness and what factors contribute to this relationship?* Accordingly, the following sub questions were examined to draw insights: What are the factors contributing to homelessness and to substance-use? How do these factors interrelate? Knowing this, how could this help

improve existing approaches?

Considering that research on the relationship between substance-use and homelessness from multidisciplinary viewpoint remains scare (Fitzpatrick, 2005), this study adds to the existing literature by using the realist framework to consider the influence and relationships of the macro-structural to the micro-individual factors on homelessness and substance-use. The novelty of the current research is its consideration of the interrelationships to explain why homelessness is a recurring problem.

Furthermore by focussing on the subject substance-use, more insight has also been shed on why the two existing approaches have been inconsistent in tackling homelessness. Substance-use is after all the factor which brings the debate on what is the best approach. With the knowledge gained using the multidisciplinary focus, more can be known on which factors should be tackled in order to tackle the homelessness problem. This could bring us to a new reconciled approach, where the best elements of the two approaches are brought together.

Finally, this research may contribute to more knowledge in understanding homelessness and substance-use which can provide more clarity on designing more sustainable outflow strategies and policies to prevent recurring homelessness.

Literature Review

The literature review consists of three main components. Firstly, the problems that homelessness entails for individual health and society. Secondly, the various factors associated with homelessness, as well as the various projects which have attempted to combat and/or reduce homelessness, are described. Finally, a new theoretical framework will be discussed.

The problem of homelessness

Homelessness has major consequences for the health of homeless individuals as well as the population at large. Several studies have investigated the correlation between homelessness and well-being. Homeless people experienced decreased well-being, state of mind, satisfaction with life and a lack of social currency (Johnstone et al, 2015; Padget et al, 2008). Compared to the general population, the homeless suffer more from chronic and acute health problems, including addictions and mental disorders, cardiovascular infectious diseases, stress and cognitive disorders. This means they need more health services. However, they experience a lot of barriers to gain access to this, including unavailability, fragmentation of services, and stigma and discrimination (Stergiopoulos et al, 2018).

In addition to the individual health consequences, homelessness has consequences for society at large. To support the homeless and prevent public nuisance, they must receive care and shelter, which

requires considerable (financial) help and commitment from the municipalities, who are responsible for financing social medical care, GGD case-managers and facilities (van Laere et al, 2018). This attempt to tackle homelessness can only be successful if the factors that cause homelessness are known.

Factors Causing Homelessness

There are several studies that have investigated which factors can cause homelessness. Socio-economic setbacks can ultimately lead to homelessness. The person thereby runs the risk of mental illness and addiction due to reduced self-efficacy, hopelessness, and social alienation (Kim et al., 2010). It further appears that not only general housing is important to prevent these adverse effects, also the quality of housing has an effect on mental health, psychological distress, and physical health (Aubry et al, 2016). Psychological trauma and PTSD can be the cause of socio-economic setbacks. Psychological trauma can prosecute itself in psychological disorders and substance-abuse, or reinforce these existing disorders. Kim et al (2010) further proposed that financial stability and stable housing are necessary for a productive life and ultimately recovery for the homeless. To achieve this, supportive housing, job creation, and additional interventions in therapy and social services are needed. They add that possible trauma and associated illnesses ask for proactive, preventive and long-term care, unlike sporadic services that only take place at times of crisis.

One of the associated illnesses is an alcohol/drug-addiction which is seen by many studies as an additional risk factor for becoming homeless (Aubry et al, 2016; Mann et al., 2003; Rhoades et al, 2011, etc.). Chronically homeless people are generally more often confronted with mental disorders, which are exacerbated by disorders and substance-use (Tsemberis et al, 2004). In addition, substance-use go hand in hand with high financial spending potentially resulting in debt, which in turn is a direct cause of homelessness (Crane et al, 2012). The population of homeless is more likely to be confronted with a drug-addiction (Fazel et al, 2008). The relation between these two factors can be bi-directional. That is, substance-addictions can be the cause for homelessness as well as the result of homeless life. Living without shelter can cause extra vulnerability and risky living patterns that can increase the chance of substance-use (Mann et al., 2003) which can cause several health problems for this population. Homelessness was by Heuchemer & Josephsson (2006) described as a way of living with high intensity within a limited time-perspective. For the women in this study, drug-use was considered as a solution to handle the current life situation that was seen as hard or even impossible to cope with, as drugs can create a feeling of happiness and enlightenment at the time of ingestion. The research by Fazel et al (2008) states that homelessness can cause higher levels of depression. The association of depression with substance-abuse (because of the after-dip) can further explain why they have an increased risk to have this problem (Rhoades et al, 2011).

Until now, substance-use and addiction have been described as an individual problem. However, there are also other factors from beyond the individual level that play a role. One of which is the social

environment for example, where being surrounded by alcohol and drug-users has a negative effect on the individual's addiction (Rhoades et al, 2011). Furthermore, the homeless are a vulnerable group and are therefore extra sensitive for peer-pressure. Rhoades et al (2011) thus indicate that it matters what kind of people find themselves in the immediate social environment. The study by Kim et al. (2006) also revealed that different relationships with parents, friends, children, colleagues, etc., each have a different effect on the recovery of drug-using homeless people. Especially children and long-term relationships with family had the most positive effect on the recovery among those with a substance-addiction. Furthermore, when someone is dependent on friends or family for housing, a supportive social network and the absence of aggressive and violent behaviour are important (Caton et al., (2005). Contrarily, when someone is looking for their own place, there is more demand for employment and income.

What becomes clear from the literature is that numerous factors that are related to homelessness and substance-use have been identified. As for the factors related to substance-use, the literature considers the individual level to be the former cause. When other levels are taken into account, only one level of influence is being reviewed at the time. This gives us a limited view about the actual relationship of substance-use and homelessness as we are now unable to take into account interrelationships between the different factors. This limitation is reflected in how this problem can be addressed in policy terms, which will now become apparent with discussing the two approaches that have devised an intervention.

Homelessness Projects

So far, the factors related to homelessness have been discussed. The current section will continue to elaborate on two approaches, namely the housing-first and continuum-of-care program. These two projects will first be reviewed and the additional inconsistencies that exist between them will be discussed.

In 1995 The continuum-of-care program was introduced by the Department of Housing and Urban Development in the US. It is designed to look at the needs of the chronic homeless through transitional housing, treatment, and permanent supportive housing. By encouraging sobriety and giving psychiatric treatment, housing readiness is enhanced. It assumes that with psychiatric disabilities and/or addictions, a person is not able to live independently (Tsemberis et al, 2004).

There is quite some criticism on this program. Greenwood et al (2017) say that continuum-of-care programs tend to be provider-driven, rather than consumer-driven, through all kinds of restrictions. The residents' ability to choose in life is completely gone because of the sequence, frequency, duration and intensity of treatment. Their main argument is that restricting choice is not always in the interest of the consumer, even if the choices they make seem unhealthy or incomprehensible (Greenwood et al, 2017). Collins et al (2013) add that those with addictions are, more than thought, interested in housing, but are unlikely to secure housing with most programs requiring alcohol abstinence. Wong et al (2006) and Locke

et al (2007) further critique the program is “not as a sequential series of placements but rather as a menu of options”. To conclude, there is quite a bit of criticism about the functioning of the continuum-of-care approach.

The same goes for a much discussed approach called the housing-first program. The main idea of this approach is to keep treatment separate from the issue of housing (Tsemberis et al, 2004). It sees housing as a basic right. Another important principle is harm reduction, which states that it is important to reduce the adverse consequences of psychiatric symptoms and substance-abuse, by recognizing that every participant is in a different stage of the process and therefore needs tailored care. It is consumer-based which means that the participants are therefore released in their own choices (to use medication, drugs, alcohol, or not) without threatening their housing status. They are treated, but always have the space to live on their own (Tsemberis et al, 2004)

However, the housing-first program has led to much discussion (Crane and Coward, 2012). For instance, Kertesz et al (2009) found no evidence that housing-first could actually reduce substance-use, since people who had participated in the project had no serious addiction-problems. Evaluations in the US and Sweden also showed that this approach was not effective for everyone, since it did not help the chronic homeless achieve sobriety on the long-term and because it had difficulties providing permanent housing due to shortages and affordability (Crane and Coward, 2012). Tsemberis et al (2004) on the other hand, says that psychiatric diagnosis is not related to anyone's ability to live independently. So when it does not seem to work for people with a drug-addiction or mental illness, it is also no longer harmful, to accommodate these people before they have been remedied.

On one there are studies that show that the housing-first model does not work for people with alcohol- and drug-addictions, and studies that refute this by saying that it actually has a better effect if addicts are immediately housed in their own accommodation. On the other, the same is apparent for the continuum-of-care program, where no consistency was achieved on the effectiveness of the approach. Neither approach has been proven sufficiently effective. Therefore new insights must arise on what is the best approach to tackle this problem.

A New Theoretical Approach

A new theoretical framework is therefore needed to determine which factors are most important to tackle in order to combat homelessness. Several studies have indicated that such a framework needs to be multidisciplinary to first fully understand the source of the problem before finding a solution, such that the influence of factors from the individual to structural level, as well as their interplay, are considered holistically in how they engender homelessness. For instance, Stergiopoulos et al. (2018) argue that a multidisciplinary intervention is needed to improve health outcomes among the homeless. Moreover, Aubry et al. (2016) and Wenzel et al. (2009) propose a multidisciplinary approach through an ecological model by investigating individual, community and interpersonal levels.

This call for 'multidisciplinarity' is realized by Fitzpatrick (2005) new realist framework, which incorporates both macro-structural and individual factors to examine homelessness. Although various causes of homelessness have been identified, such as having to deal with domestic violence, poverty, unemployment, mental illness, housing shortage, relationship breakdown, nonetheless little is known about how these different factors interact (Fitzpatrick, 2005). Fitzpatrick therefore indicates that it is important to research the interrelationships of these various factors (See figure 1 for a visual representation of Fitzpatrikck's model).

Denvall (2016) agrees that homelessness is insufficiently seen as a problem situated at different levels. The same goes for substance-use which is often seen as an individual problem (McQuistion et al, 2014, Aubry et al, 2016). Batterham (2019) concludes that the Fitzpatrick framework is promising and agrees that more research is needed to sufficiently demonstrate causality among the different factors. *"Drawing on the philosophy of social science literature on causation, I argued that homelessness is likely the result of multi-levelled conjunctural causation, that is, a number of causes at multiple levels interacting to bring about the outcome"* (Batterham, 2019, 16-17).

Fitzpatrick's framework has not yet been used in studies other than her own, which makes it even more relevant to test the model for its application in different scenarios. In one of her own studies, she concludes that poverty is the leading factor for homelessness (Bramley and Fitzpatrick, 2017). However, due to multidirectional causal relationships, the possibility that poverty can also be a result of homelessness is not ignored. Furthermore, the research showed that social networks and the housing market are important. However, they also appear to depend on the economic status of a person. In addition to the fact that the framework has not yet been used in other studies, it has also not yet been used with the primary focus on substance-use as will be done in this study. One of Fitzpatrick's studies did however show that substance-abuse and health problems are associated with childhood trauma, and therefore occur early in individual paths, after which homelessness and other adverse events usually

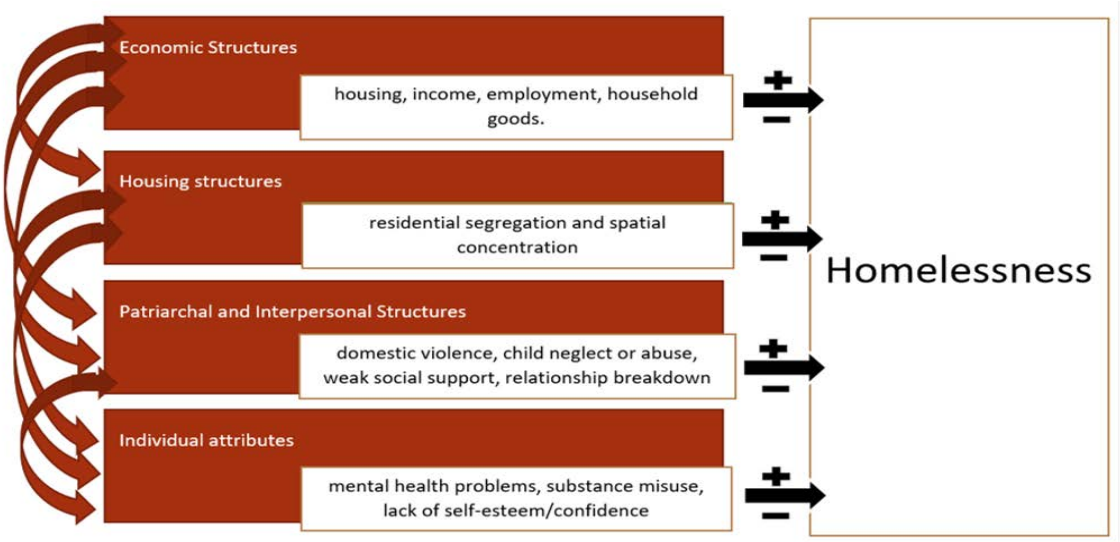

Figure 1
A visual representation of Fitzpatrick's model, illustrating the 4 levels of the model (economic, housing, patriarchal/interpersonal and indivual level). The arrows represent the interrelationships between the different factors within the levels.

occur later (Fitzpatrick et al, 2012). The conclusion is that these later events are largely effects rather than causes, which is important to keep in mind for future policy implications as well as for this study. In addition, the current study will investigate which other potential factors play a role in the relationship between substance-misuse and homelessness.

As Figure 1 shows, structural factors (housing, spatial concentration) create the environmental conditions that can cause homelessness. However only few individuals will experience homelessness, due to their individual characteristics, which are mental health problems, lack of self-esteem and substance-misuse. Structural factors including economic, housing, patriarchal and interpersonal structures, as well as individual factors, all contribute to the eventual homelessness according to this framework (see Figure 1).

The different factors have non-linear dynamics, which means that one factorial change can have major consequences at another level (as demonstrated by the arrows in Figure 1), with the final framework only being able to explain/predict the outcome. In addition, all the different factors are dependent on each other. For example, income (e.g., poverty) as an economic factor and spatial concentration as an housing-structure factor, are inextricably linked (Fitzpatrick,2005), just like housing quality and mental health (Aubry et al, 2016). Furthermore, all relationships can be seen as both potentially positive as negative. This framework considers the possibility of all factors to be both protective factors as risk factors. This creates a web of interrelationships. Protective factors are the ones that prevent or reduce homelessness. Examples of this are personal resilience and family support, which can ensure that those who are poor, have experienced domestic violence, or have other risk factors, do not become homeless (Fitzpatrick, 2005).

This multidisciplinary framework is promising, since it takes several factors into account, which creates a holistic picture about the problem, what factors play a role, and therefore which factors on what levels (individual, interpersonal, and/or structural) should be targeted. This might shed some light on where the inconsistency between the two approaches comes from, and how to potentially reconcile the best of both approaches.

The Current Proposed Research

The objective of the current research is to investigate the relationship between substance-use and homelessness. As highlighted by the literature review, substance-use is still too often seen as an individual problem, which is problematic because structural and environmental factors play a role in the development of substance-use (Rhoades et al, 2011; Caton et al, 2005; Kim et al, 2006). Using Fitzpatrick's (2005) realist framework, the current research aimed to extend to existing literature by studying the relationship between substance-use and homelessness by considering factors from the individual, interpersonal and structural levels, as well as their interrelationships. Rather than seeing factors in isolation, this approach attempted to create a more holistic view, by giving a more accurate

representation on how all the different factors simultaneously contribute to addiction and homelessness. The two existing approaches are inconsistent in how they perceive solving addiction among homeless people, possibly because, through their narrow focus, they have overlooked the influence of other factors. This research may therefore be able to correct this inconsistency and provide valuable information for the improvement of future policy.

In collaboration with the project "Repeated Homelessness in Utrecht", the current research employs qualitative, semi-structured interviews (with clients of protected housing or homeless shelters) to generate insights to the main research question: *How does substance-use relate to homelessness and what factors contribute to this relationship?* Accordingly, the following sub questions will be examined to draw insights: 1) What are the factors contributing to homelessness and to substance-use? 2) How do these factors interrelate? And 3) Knowing this, how could this help us improving existing approaches?

Answering these research questions would offer a clearer picture on the contributing factors on homeless and drug-use, which would have implications on which approach (e.g., offering housing-first, or eradicating drug-use as a problem) would work better for homeless people with an alcohol/drugs-problem. Drawing from reviewed literature (e.g., Kim et al, 2006; Rhoades et al, 2011) it is expected that especially social contacts and different neighbourhoods will be related to addiction and relapse into homelessness. Moreover, in addition to these factors, financial self-reliance and formal assistance (social support) are also included in the analysis for understanding drug-use and homelessness.

Methods

Design

The current proposed research was situated within an internship with the project "Repeated Homelessness in Utrecht" led by the principal investigator Dr. Nienke Boesveldt, which has the aim to collect knowledge from the client's perspective about homelessness and received care. It further aims to develop informed policy plans to reduce the percentage of homeless who relapse after a stay in social shelter or protected living. This ongoing project has a longitudinal research design, whereby several measuring moments will take place in five years. The first measurement took place in 2019, and the second measurement in 2020.

The current proposed research is a qualitative study in order to answer the main research question: *How does alcohol- and drug-addiction relate to homelessness and what factors contribute to this relation?* Insights to answer this research question were generated from both existing data and self-collected data. This research refers to a longitudinal design, since two measurement-moments were used in the analysis (Bryman, 2016). This qualitative research involves an inductive process, meaning that the

observations are fed back to the theory in order to be able to draw generalizable conclusions from the results (Bryman, 2016).

Sample

The data consists of both existing and self-acquired data. The original data set consists of 69 (former) homeless people divided into three different groups: 1) those in protected living, 2) in social shelters and 3) those who relapsed. The first group consists of 20 re-registering persons who have relapsed in homelessness. The second group consists of 22 individuals living in short-term social care, from which is expected to move within three months (outflow) to an independent home, and the third group are 27 people living in a protected living facility, of which this outflow is expected within eight months. All respondents have a Dutch nationality or a residence permit, stay in one of the accommodation facilities within the region or made use of support services, and are twenty-three years or older.

Last year, the respondents were recruited with the help of representatives in Stichting Tussenvoorziening, Leger des Heils, Lister, Kwintes and Buurt Teams and employees of Herstart, NOIZ, SleepINN and Stadsteam Herstel. This year, the same respondents were attempted to be contacted again using the contact details provided last year.

In this study, only respondents with addiction-problems were looked at. From the original dataset, 41 respondents have been selected because they once had or are still dealing with a certain addiction-problem. It is this group of respondents that has been looked at over the two measurements.

Research Methods and Data Instrument

This research employed qualitative, semi-structured interviews. This method is used because of its possibility to ask for specific topics, while still leaving room to delve deeper into specific topics that are important to the respondent (Bryman, 2016). The interviews were guided by a predesigned schedule that covered a list of relevant topics. The following topics are examples that were asked during the interviews of the first measurement (Boesveldt et al, 2019). Questions were asked about the care they received: which care, how much care and how much continuity in care? How did they experience this care and what role does this care play in preventing relapse in homelessness? Furthermore, the general mental health of the respondents was asked and whether they receive psychological support for this.

In addition, several questions were asked about potential alcohol- or drug-addictions. What kind of addictions do the participants experience? What kind of care do they receive for this? To what extent has this help affected their relapse? What would respondents like to see differently in this help received? Have they been asked to solve their alcohol/drug problem before they were relocated? Coming back to Fitzpatrick's (2005) model, these questions can be linked to the individual part where addiction is classified. The same goes for the questions about mental health.

Finally several questions were asked about: housing, quality of housing, and the composition of

the neighbourhood, which can be linked to the housing structure of Fitzpatrick's (2005) model. Regarding the economic structure of the model, the income, employment, and financial self-reliance was asked. Finally, the support of family and friends was discussed, on behalf of the Patriarchal and interpersonal structure of the model.

Similar questions were asked in the second measurement, but in a follow-up form. The same topics were discussed focused on how they have changed in the past year. In addition, questions were asked about various life events from the past year and about the outflow that has or has not taken place.

The interviews have been conducted in duo's, consisting of a social scientist and an expert from the field. Furthermore, the duration of the interviews was approximately one hour. In times of the Covid-19 crisis, interviews were conducted online. Topics that have had a great deal of influence on the homelessness process for the specific respondent have been given extra attention. Examples of different topics that were discussed are: substance-use, received care (during the period of homelessness and beyond) and financial self-reliance.

Procedure and ethics

The study has been approved by the Facultaire Ethische Toetsingscommissie FSW. All steps of the research comply with the APA ethical guidelines. The full ethical assessment of the research project is set out in the ethical assessment form in the annex.

The interviews were scheduled by the project "Repeated homelessness in Utrecht". Researchers met with the respondent at a quiet confidential place, mostly at their own home. At least a week before the interview, an extensive information letter was sent by email to the participants. This mail contained more information about the investigation procedure and measures, including the analysis and the storage of the data. This was to guarantee the confidentiality and anonymity of the interview. Potential participants were allowed to decide themselves whether they wanted to participate or not.

In addition, an informed consent was issued before the start of each interview and was asked to be signed by the participant. This was also discussed verbally with the participants prior to the interview. In times of the covid-19 crisis the informed consent was send by mail and not signed but confirmed verbally on the recording. Through this informed consent, participants were informed that they can withdraw at any time during the interview and that participation is at all times on a completely voluntary basis. Furthermore, it provided information about who they can turn to with questions, that the information they share remains anonymous at all times, and that the interview is only recorded with their permission. All this is important because it concerns a sensitive subject. Homelessness and addiction are subjects people often don't want to talk about.

The final data therefore ensured to keep the respondent as anonymous as possible. Afterwards, the recordings of the interviews were, via a secure environment forwarded to Amberscript, a company that transcribes recordings, who typed them out within five days. The audio recording was then destroyed

and the transcript was sent to the main investigator, encrypted, and stored on the secure disk. Storage was done with security to ensure the anonymity of the participant by using different separate disks. The data was only available to the principal investigator and employees employed by the university. For privacy reasons, I did not use cloud computing methods like OneDrive, Dropbox etc, but an external drive. More information regarding the ethics is available in the annex.

Data Analysis

After the data was transcribed by Amberscript, the data was coded and analysed using Atlas Ti. An existing codebook from the project was used to encode the interviews. Because the codebook was established in advance, only a few new codes could be created specially designed for the current research, namely the codes: "addiction", "relapse into addiction", and "cause and effect". First, a deductive process was employed as existing codes from the initial codebook were used to analyse the interviews on topics related to the four levels of Fitzpatrick's (2005) model. Since the interviews from the first measurement were coded by another researcher, the interviews were reviewed and additional codes related to drug use were added by the principal investigator of the current research.

A thematic analysis was used, in which different subjects, problems, attitudes and ideas are explained, creating different recurring themes (Braun & Clarke, 2006). These topics and ideas were already classified in existing codes, where clusters of these codes were used to analyse the interviews. The existing codebook uses nine themes consisting of multiple codes. Of these themes, the following were used for the analysis: 1) financial self-reliance, 2) informal network, 3) relapse, and 4) outflow. The entire codebook can be found in the appendix. A selection of the most relevant codes has been made within these themes.

In addition to this deductive process, an inductive process has also been used in which new themes have arisen by clustering different codes. These new themes are inspired by the four structures of Fitzpatrick model, but have been given shape based on the data content. For example, when respondents talk about financial self-reliance (debt, making ends meet), in relation to their addiction (as illustrated in Figure 2), or when addiction has been discussed in relation with having informal, sometimes risky, contacts (see Figure 3).

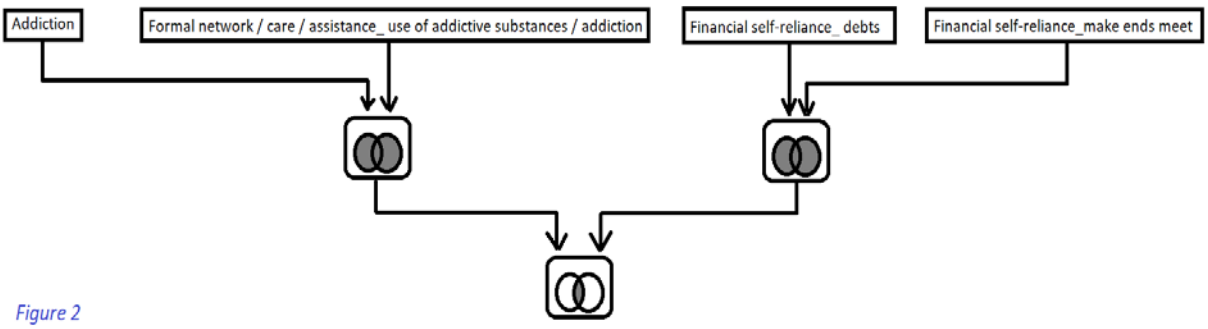

Figure 2

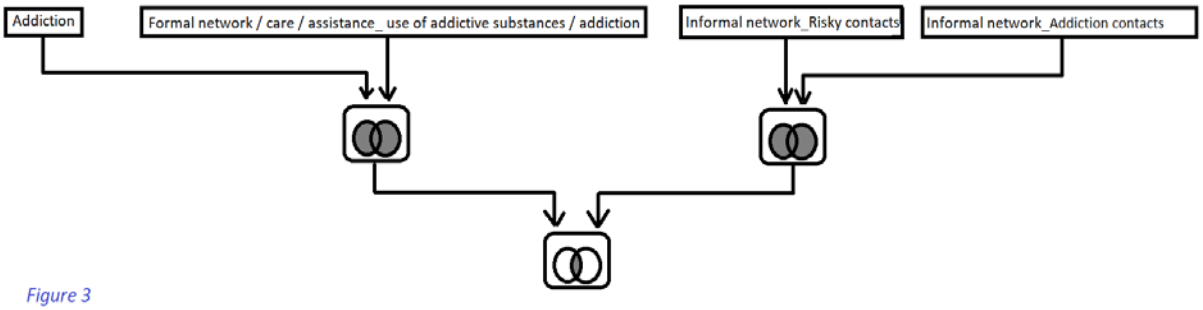

Figure 3

To avoid getting missed data, sometimes similar codes “Risky Contacts” and “Addiction contacts” (Figure 3) have both been used. This was necessary because of inconsistency in using one or the other.

Results

The results are divided into chapters using the themes that emerged from the analysis. These themes are also telling of how Fitzpatrick's framework's four structures, consisting of the Patriarchal/Interpersonal, Economic, Housing, and Individual structure influence homelessness and relapse. Within the structures, only the subjects that applied to the collected data are discussed.

Demographic Features

Most respondents are between 40 and 60 years old with an average age of 48. Respondents were evenly distributed among the three groups consisting of respondents from social shelters, those in protected living and respondents who had a relapse. Most respondents are of Dutch nationality. Other origins were: Indonesia, Suriname, Ukraine, Turkey, South Africa, Curacao, Venezuela, Syria, and Morocco. The average age was around 48 years. Only five respondents were female. Due to the underrepresentation of women in the sample, no statements can be made about the differences between men and women. Of the sample, twenty-six respondents have a hard-drug addiction, seven of which are addicted to heroin. Fifteen respondents are addicted to alcohol/soft-drugs. About seven respondents indicate that they are now clean. In addition, there are also a few who no longer use hard-drugs, but still have a drinking-problem or smoke weed daily. In the second measurement, there were seven drop-outs. Of these, four have indicated that they no longer want to participate. The others could not be interviewed in time due to circumstances surrounding the Covid-19 crisus.

Individual Attributes

Addiction and Homelessness

As mentioned in Fitzpatrick's (2005) model, the relationship between addiction and homelessness is bi-directional. This means that addiction can cause homelessness, but homelessness can also lead to addiction (Mann et al., 2003).

For a number of respondents, becoming homeless meant a risk factor for developing an addiction. Several indicated that they became addicted after they became homeless. For them drugs was a way to deal with the current life situation that is experienced as very difficult. Night shelters were described as an unsafe, restless, and unpleasant environments to stay in. In addition, respondents say that drugs are easy to come by in these shelters. Respondents have to deal with other homeless contacts who create temptation and pose a risk, the so-called junkies. Thus, homelessness puts respondents in a situations that some find difficult to manage without being sedated by alcohol or drugs, which is in line with the study of Heuchemer and Josephsson (2006).

On the other hand, it has also been shown that an addiction, in combination with other factors, can ultimately lead to homelessness. Several respondents admitted that at the time they became homeless, they were already addicted with all its consequences. Examples of reasons why respondents became addicted include nuisance at home because of drug-dealers, debts, and the loss of important contacts (family/partner/friends). These factors will later be discussed further. For 19 respondents substance-addiction played a role in becoming homeless. In most cases it concerns a multiple-problem with several underlying factors that cause homelessness.

Professional Addiction Treatment

Of all respondents, seventeen have been in an institution or are still accompanied by (outpatient) help. Some have only done a detox for drug withdrawal but also indicate that this is too short a process to get rid of addiction-problems in a sustainable way. In addition, after detox there is little attention to the follow-up process. As one respondent described: *"Detox is only to be admitted, detox and ksst, out the door."* This example corroborates with previous research that has shown that homeless people with addiction-problems need proactive, long-term and sustainable care (Kim et al, 2010).

Two respondents explained they were rejected for detox because they did not have the proper living space. The rejection of a request for help occurs in many cases. Nineteen respondents did not receive help for their addiction, of which some chose themselves not to ask for any help. For most, the lack of a home address is the reason for not being able to receive help. This is an extension of what has just been discussed, that a night shelter is not a suitable place to get rid of an addiction-problem. As long as people reside here, treatment is considered useless. However, what is poignant is that the requirement for outflow is that they should get their addiction under control first as the chance for relapse would otherwise be too great.

> *"But there you get another story, most addicts also have psychiatric disorders. Then you say I first want to go to Altrecht and Altrecht says no, you must first get clean. Jellinek says you must have a place first. And there we go.."*

This shows a major problem, in which respondents remain in a vicious circle of homelessness and addiction.

Mental Health Problems

What already emerged from the literature, is that homeless people often suffer from mental health problems (Kim et al, 2010). It was therefore no surprise that as many as 22 respondents reported experiencing mental health problems. What is striking, unlike addiction care, is that almost everyone did receive mental health care. Psychological problems mainly included PTSD, social trauma, psychoses, and depression. A few respondents indicated that their mental health was related to their addiction-problems. One responded indicated his addiction is enhanced by his ADHD and that he is calmed down by hard-drugs. The same goes for another respondent who used Speed for his ADD. He now receives good medication and therapy and no longer needs Speed. Finally, one other respondent indicated that therapy helps him to avoid relapse. For him, his mental problem poses an additional risk of relapse in drug use. These findings strikingly show that psychological problems were quite common among the respondents with addiction. However, figuring out the direction of that relationship is nonetheless difficult.

Housing structure

As it became clear earlier, the environment affects alcohol and drug use. The night shelter was called an unpleasant environment where people quickly reach for substances. Firstly, because it is a way for them to deal with the situation, but secondly, because alcohol/drugs are easy to obtain. This applies not only to night shelters but also to the social shelters and certain sections of sheltered housing that have a lot of alcohol and drug addicts inside. This causes a lot of drug dealing and addicts kindle each other to take more alcohol/drugs. In addition, respondent 31 indicates:

> *"I heard from someone that alcoholics and hard drug users really hate each other. "..." It sometimes clashes. Because alcoholics often have a lot to drink at the end of the day and then you get niggles. That has happened before. Then there is a suspension."*

One respondent therefore says that locating addicts together is not smart, as this only aggravates the situation. He continues by mentioning that it is not effective to place these addicts in the middle of the center where all drugs are easy to buy. This is an extension of what the research by Rhoades et al (2011) shows that having more alcohol and drug users at your side has a negative effect on your addiction. It is counter effective for addicts to be somewhere where drugs are easy to buy. It would be better for them to live somewhere without temptations

Residential and Spatial Segregation

Moreover, when the respondents talk about outflow to a home, it is often mentioned that they do not appreciate certain neighborhoods. This is often because they are afraid to encounter old contacts, other (homeless) people with an alcohol or drug addiction. Moreover, they see these contacts as a risk factor for relapse in their addiction as well as for becoming homeless again, a scenario that Rhoades et al (2011) confirm. This was especially true for those who became homeless by bringing in other homeless people in their homes.

In the second measurement, it appeared that having a preference for a certain neighborhood had not been a major problem for them to find accommodation. They probably waited longer than usual, but most respondents' wishes were fulfilled within a year. Those who now live in neighborhoods where several other addicts live, simply ignore these neighbors. However, it is clear that more attention is warranted to consider of where addiction-prone clients are housed.

The neighborhoods where respondents end up are characterized by either high flats or small houses, and residents with a low socio-economic status. Furthermore, some respondents specifically mentioned criminal activities in the area. Unfortunately, this study has not provided sufficient evidence that this actually has an impact on relapse in addiction or homelessness. It is believed though that this could be the case based on existing literature, as Aubrey et al, 2016 state that the quality of housing has an effect on mental health, psychological distress, and physical health.

For a few, old contacts and addiction-contacts mean such a great risk that they no longer want to live in Utrecht. However, in the Netherlands there are regulations that one must have regional ties (Regiobinding) to receive care as a homeless person and therefore also regarding the outflow from this circuit.

Patriarchal and Interpersonal Structure

Child Neglect/Abuse and Domestic Violence

Childhood neglect and abuse has emerged several times as a reason for becoming homeless, with addiction later on. Social traumas from the past had quite an influence on most respondents wellbeing. Two respondents ended up in a boarding school due to their home situation. *"Sorry to say it, but boarding schools in the Netherlands are simply the breeding ground of injustice."* This shows that a person's youth can have a lot of influence on the further course of life.

Concerning domestic violence, no cases have emerged except for one respondent, who has fled her home due to the extreme alcohol addiction and domestic violence of her ex-husband. Divorce, however, is very common as a reason for becoming homeless. The ex-partner remains in the house, leaving the respondent without a house. This is also the reason why many say they do not want to live

together with their partner in the future. They want to be independent and do not want to run the risk of losing their house again.

Social Support and Relation Breakdown.

Breaking-up a relationship involves not only losing the house, but also a lot of change, sadness, and loneliness. For some, it was one of the reasons they got on the wrong path. In contrast, there are also relationships that are broken because the partner has an addiction that had a negative effect on the respondent. In this case, the termination of the relationship had a positive effect on the withdrawal of drugs. This is related to the aforementioned risk contacts that respondents say they want to avoid. As became clear, these risk contacts are usually other homeless people. Ironically, some also indicate that it is precisely these fellow homeless people that they regard as their social network.

Many of the respondents have a limited informal network they can rely on. They indicate that they receive the most support from their personal coach. For some, substance-use has resulted in the loss of important social contacts, including old friends and relatives. A reason may be that these contacts no longer want to have anything to do with them. Another reason was that they have chosen not to bother important contacts with their addiction-problems. Research has shown that it is precisely these contacts that can be important for the client's rehab, as Kim et al (2006) indicate that children and long-term relationships with family have the most positive effect on the recovery among those with a substance-addiction. For instance, one respondent indicated that parental support was crucial for him to stay sober and to remain on the right path. It namely appears that those who want to or have quit alcohol or drug use, usually now have a reason to live because of their loved ones. For instance, one respondent explained that his health was so damaged that he had to stop using to maintain a future perspective. He was completely off alcohol and drugs because he wanted to see his grandchild grow up. Others indicate that they have urine tests done to show their loved ones that they are clean from drugs.

Economic Structure

Addiction and Financial Self-Reliance

The majority have been found to be dealing with debt. More than half are currently in debt and others who are not currently in debt say they have experienced it in the past. In the second measurement, several managed to get out of debt during the year. This was usually resolved through professional administration and debt restructuring.

In the data, various connections have been found between economic structures and a person's addiction. In many cases, respondents had built up debt through their addiction, as they spent all their income on alcohol/drugs and were therefore unable to pay the rent. Others have debts with their drugs-

dealer which they cannot possibly repay, after which they are often threatened by these persons.

Besides the negative effect of addiction on financial stability, not being able to make ends meet, affects whether or not respondents buy alcohol/drugs. For example, one respondent described that he was unable to buy beers while he was not receiving benefits. As soon as he received money, this went to shag and whiskey. In addition, some do no longer use drugs, but have switched to alcohol because it is cheaper.

In the second measurement, it is increasingly common that now that respondents have left to their own home, they have trouble making ends meet. It is mainly this change that ensures that they do not buy alcohol or drugs. They are afraid of getting back into debt and do not consider this worth the alcohol or drugs.

Relapse in Addiction and Homelessness

Of the full sample of 69 respondents, 35% has experienced a relapse in homelessness, once or several times. Of this group, 71% has addiction-problems. Causes of relapse in homelessness mentioned are (rent)debts / financial problems, relationship break-up, problems with social network (e.g. risky contacts, nuisance, loneliness), psychiatric problems, departure abroad, unstable residence, imprisonment, and drug-use. In most cases drug-use was also related to the other factors, as became apparent in the aforementioned paragraphs.

As for the first measurement, for at least six relapse in homelessness was caused by their substance-addiction. They say they were let go too early while they were far from controlling their drug-addiction. As it turns out, a relapse in addiction does not always have to turn into a relapse in homelessness. Through assistance and the respondent's willpower, some managed to keep a relapse incidentally and recovered in time. This was especially evident from the second measurement, in which several mentioned having a slight fallback in the past year, but not becoming homeless again. In this case, it was mainly the support of family members and assistance from their personal supervisor that helped them.

Respondents with addiction-problems mainly indicate that they received too little support at the time of relapse. They need better professional advice because they don't ask about these things themselves. This group is more likely to avoid care, while it needs care so much. In addition, people with an addiction are released too quickly and are not prepared enough for outflow.

“Yes. You get a house and you figure it out. Sometimes you have those flip-over contracts, that they keep an eye on you for another year. But most people who come back here are still people with psychological or addiction-problems. They are guided in groups. The addiction is not being worked on. They are not prepared.”

For the those without addiction-problems, it was mainly social network problems that caused them to become homeless again.

In the second measurement, only two people relapsed in homelessness within one year. For one, this was due to a relapse in drug use. Due to his Legal Authorization, he is now in the closed department of Altrecht. For the other, it was due to a nuisance in his home resulting in eviction.

Outflow, Addiction and Other Changes in the Past Year

In the second measurement, at least 16 were unable to move out to their own home. Since the first measurement only interviewed people who would leave within a year, it can be concluded that relatively few have left the shelter. This shows that the outflow leaves much to be desired. Some have just recently started to control their addiction. However, there is not enough proof for this relationship, as people often blame other factors, among which the staff of social sheltering, for their delay in outflow. For the others, they managed to get an independent home, mostly with a fold-over contract. Most say that the success of their outflow is mainly due to guidance they receive from their personal supervisor. For most, this means drinking coffee together once a week, a listening ear, someone they can present their problems to.

Regarding respondents' addictions, nine report having relapsed in the past year or did not stop using at all. Some only in soft drugs, others completely back to scratch. A few indicated that they have now become addicted to the medication that was given to them for drug-withdrawal. *"Well, in that sense it has gone from illegal drugs to legal drugs, right?"* Except for one, all respondents now say they want to go into the right direction.

Finally, there were a number of striking details in this second measurement. For example, two respondents last year claimed to have no addiction background and this year it turned out that this was not true. For respondent 16, it is even the case that she only completely got clean from soft drugs since last year. Respondent 4 firmly stated that she was not addicted and kept repeating this several times. This year she indicated that she was addicted for a long time. These findings suggest shame and stigma can often influence interview results.

At last, we also have a respondent who was only slightly addicted to weed last year and now has an addiction to Speed. This year we met him in a farm specially equipped for people with a permanent addiction, also known as the "wet spots". He was placed here because of his physical health, but feels isolated and out of place among these addicts. He feels a constant suspicion from the supervisors as they always think in terms of drug use when he asks for support or advice. This clearly shows that the place where someone is located can have a big influence.

Discussion

This study looked at the relationship between addiction and homelessness using the Fitzpatrick 's (2005) framework in order to answer the research question: *How does substance-use relate to homelessness and what factors contribute to this relationship*? The following sub-questions were examined: what are the factors contributing to homelessness and to substance-use? How do these factors interrelate? Knowing this, how could this help improve existing approaches?

Accordingly, qualitative semi-structured interviews were conducted among 41 respondents in two waves. It should be acknowledged that there were seven drop-outs in the second measurement. Of these, four have indicated that they no longer want to participate. They have been asked what their situation now looks like, so that, to a certain extent, something could be said about all respondents outflow, also known as "intention to treat". The others could not be interviewed in time. Because of the Covid-19 crisis, ten interviews in the second measurement have been done online. This may have caused missing data, as Jowett et al (2011) state that compared to face-to-face interviews, digital interviewing lacks several socio-emotional expressions as for example the audiovisual qualities, tone of voice and causing facial expressions.

This research has used a multidisciplinary viewpoint using the realist framework of Fitzpatrick (2005) where addiction is seen as one of the factors related to homelessness. In this model, addiction is classified as one of the individual factors. However, the results show that addiction is anything but an individual problem as it is related to so many different aspects at different levels. This is particularly important to address because existing literature has mainly looked at individual factors in isolation.

Using the four structures of this model, several factors that influence the relationship between addiction and homelessness have emerged. The aim of the research was to consider the interrelationships to explain why homelessness is a recurring problem. Findings shedding light on the first two sub research-questions (i.e., What are the factors contributing to homelessness and to substance-use? And How do these factors interrelate?) will first be discussed.

Substance-addiction was mentioned relatively often as reason for homelessness, which corroborates with extension of existing literature (e.g., Aubry et al, 2016; Fazel et al, 2008). However, respondents always indicate that multiple factors have played a role in becoming homeless, which is in line with previous research (Batterham,2019). Other factors associated with homelessness are breakups, debt, risky contacts/nuisance, going abroad, being imprisoned, and mental health problems. However, most of these factors are also indirectly linked to addiction-problems, which demonstrates Fitzpatrick's idea of interrelationships.

Some examples of how addiction is related to different aspects of homelessness have come forward in this research. Firstly, the debts that respondents mention for losing their homes were often related with substance-use. Crane et al, (2012) had already found that homeless people often report

difficulties with their finances. In addition, this research illustrates how respondents in some cases spent their money on alcohol or drugs, which means that they can no longer pay the normal bills.

Secondly, high-risk contacts that caused nuisance in respondents' houses with eviction as a result, were almost always indirectly connected with substance-use. These high-risk contacts were mostly junkies and dealers who brought drugs into the house. Possession of drugs in large quantities is punishable and respondents were fined for this. In addition, dealing drugs is often the cause for the experienced nuisance by the neighborhood. Our expectation that social contacts would play a big part into the relationship of addiction and relapse into homelessness is hereby supported.

Lastly, breakups and loss of other important contacts were often called as a factor causing homelessness. Kim et al (2016) had previously emphasized how important these contacts can be for the recovery of drug-using homeless people. This loss can therefore cause respondents to go astray because of the change and sadness that comes along with it. Conversely, the loss of these contacts may also have been caused by the respondent's addiction.

Together, these aforementioned findings highlight Fitzpatrick's' idea of bi-directional relationships, where in this case the loss of contacts can lead to an addiction, but also, that the addiction can lead to the loss of contacts (Fitzpatrick, 2005). The same goes more broadly for becoming homeless and building up an addiction, where an addiction is sometimes followed with homelessness and vice versa homelessness resulting in an addiction. So what turns out is that it should not be one thing over the other that needs to be tackled. Since homelessness and addiction co-occur together, it is important to address them together to get the right effect.

This brings us to why the two existing programs, housing-first and continuum-of-care, did not have been proven effective. Looking at the two existing projects, the question they focus on is when addiction-care should take place, before or after outflow to a home. Housing-first states that housing someone is priority one, and that other problems can be solved later. The continuum-of-care emphasizes that addiction has to be under control before someone can live independently. Housing-first does not seem to work, as respondents who are housed before having their addiction under control, quickly relapse in homelessness. The continuum-of-care program also appears ineffective, as addiction-care does not work while staying in a (night) shelter. The problem lies in the fact that they want to solve one factor at once, both in a different order, while it might seem best to tackle addiction and homelessness at the same time.

Respondents say they need more support especially during outflow, in order to prevent a relapse into addiction and ultimately homelessness. The solution therefore lies in obtaining a home with personal guidance, while at the same time receiving addiction care. Good support in drug withdrawal must take place during the first critical period of outflow, as research has shown that it is mainly the first months where people relapse (Van Everdingen, 2016).

Furthermore, what has become clear is that this inconsistency and not choosing between the two

approaches has led to poor policy. It has caused a vicious circle of homeless looking for a home when being told to get get clean first, then start looking for addiction care after which they are told to first get a home of their own. What makes this extra problematic is that it is mainly this group that often tends to avoid care, while needing it so badly. This was also emphasized by Stergioupolos et al (2018), who say that homeless people experience a lot of barriers to gain access to care, including unavailability, fragmentation of services, and stigma/discrimination. Instead, they should be encouraged to accept assistance, rather than discouraged as what is happening now. To conclude, this research has shown that policy will have to work on improving the provision of addiction care by tackling addiction and homelessness simultaneously.

Suggestions for Future Research

What should be recognized is that this study used Fitzpatrick's model, but that this model was not incorporated into the questionnaire or codebook. This may have affected the analysis and results. A good follow-up study could improve the questionnaire and codebook and so make the results more complete.

This study only looked at Fitzpatrick's framework. There are many other models, as for example the Social Adaptation Framework (Johnson and Chamberlain, 2008), Pathways Framework (Clapham, 2003), and Population and High-Risk framework (Apicello, 2010), that look at homelessness in relation to addiction. Future research could also discuss these other frameworks in order to make comparisons between the different models.

For this study it was not possible to go deeply into all subjects. Subjects that could have been further deepened are; the relationship between mental health and addiction-problems, the influence of housing quality on relapse in addiction, and addiction in relation to trust of loved ones. For the latter, it was already discussed that urine tests were done to show loved ones they are clean. It is interesting to investigate how this affects people with addiction-problems.

Furthermore, the sample contained too few women to demonstrate the differences between men and women. Large-scale research with a more representative sample is necessary to be able to do this. However, the question must be asked to what extent this sample might be a good representation of the population. Deeper research should be done using Utrecht's statistics on the homeless within the municipality in order to make statements about this.

In addition, this study only looked at the municipality of Utrecht. Further research can be done into national policy and the differences between the different municipalities. This study only concerned 41 respondents, with larger-scale research potentially providing even richer information.

Finally, it stays interesting to follow the respondents for the full five years of the research to see how relapse and outflow then occurs, as will be done by the project.

Conclusion

This study looked at the relationship between homelessness and addiction using Fitzpatrick's model. The main question of how the relationship between addiction and homelessness works can be answered with: complex. Respondents always mention multiple factors as cause for their homelessness. However, in most cases addiction can be linked to the other factors mentioned. The found interrelationships show that addiction is an important factor to pay attention to when it comes to preventing relapse in homelessness. Tackling this problem has already been done through two existing approaches, the housing-first program and the continuum-of-care program. However, they both have not been proven effective in properly addressing the problem. It can be concluded that the reason for this this is that they see factors in isolation, have overlooked the interrelationships between factors, and focus too much on tackling one factor at the time. This research has shown that it is better to tackle homelessness and addiction together, because it appears that the two co-occur.

References

Apicello, J., (2010), A Paradigm Shift in Housing and Homeless Services: Applying the Population and High-Risk Framework to Preventing Homelessness, *The Open Health Services and Policy Journal*, New York, 3, 41-52

Aubry, T., Duhoux, A., Klodawsky, F., Ecker, J., & Hay, E. (2016). A longitudinal study of predictors of housing stability, housing quality, and mental health functioning among single homeless individuals staying in emergency shelters. American Journal of Community Psychology, 58(1-2), 123–135.

Clapham, D., Pathways approaches to homelessness research, *Journal of Community & Applied Social Psychology*, Volume 13, issue 2, pp 119-127

Batterham, D., (2019) Defining "At-risk of Homelessness": Reconnecting Causes, Mechanisms and Risk, Housing, Theory and Society, 36:1, 1-24

Boesveldt, N, Kuijpers, M., Bochem, M., Dries, van den S., (2019) Rapportage, Voorkomen Terugval Utrecht, Eerste meting van vijfjarig onderzoek naar recidive dakloosheid in Utrecht, Universiteit Utrecht

Bramley, G., Fitzpatrick, S., (2017) Homelessness in the UK: who is most at risk? Housing studies, 96-116

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bryman, A. (2016). *Social Research Methods.* Oxford: Oxford University Press

Caton, C.L.M., Domingues, B., Schanzer, B., Hasin, D.S., Shrout, P.E., Felix, A., McQuistion, H., Opler, L.A., Hsu, E., (2005) Risk Factors for Long-Term Homelessness: Findings From a Longitudinal Study of First-Time Homeless Single Adults, American Journal of Public Health, (95, 10)

Collins, S. E., Malone, D. K., & Clifasefi, S. L. (2013). Housing retention in single-site housing-first for chronically homeless individuals with severe alcohol problems. American Journal of Public Health, 103(S2), S269–S274.

Crane, M., Warnes, A. M., & Coward, S. (2012). Preparing homeless people for independent living and its influence on resettlement outcomes. European Journal of Homelessness, 6, 17-45

Denvall, V., (2017) Evaluating homelessness – a comparative analysis of top 10 articles from the US and Europe, European Journal of Social Work, 20:5, 724-740

Doré-Gauthier, V., Miron, J., Jutras-Aswad, D., Ouellet-Plamondon C., Abdel-Baki, A., (2019) Specialized assertive community treatment intervention for homeless youth with first episode psychosis and substance-use disorder: A 2-year follow-up study, Early Intervention in Psychiatry, John Wiley & Sons Australia, 1-8

Fazel S, Khosla V, Doll H, Geddes J. (2008) The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS Med; 5:e225

Fitzpatrick S., (2005) Explaining Homelessness: a Critical Realist Perspective, Housing, Theory and Society, Volume 22:1, 1-17

Fitzpatrick, S., Bramley, G., Johnsen, S., (2012) Pathways into multiple exclusion of homelessness in seven UK cities, Research Article

Greenwood, R.M., Manning, R.M., Mastery (2017) Matters: consumer choice, psychiatric symptoms and problematic substance-use among adults with histories of homelessness, Health and Social Care in the Community. Volume 25(3), 1050–106, Department of Psychology,

Heuchemer, B., Josephsson, S., (2006) Leaving homelessness and addiction: Narratives of an occupational transition, Scandinavian Journal of Occupational Therapy, 13:3, 160-169.

Johnson, G., Chamberlain. C., (2008) Homelessness and Substance Abuse: Which Comes First?, Australian Social Work 61(4), 342-356

Johnstone, M., Parsell, C., Jetten, J., Dingle, G., & Walter, Z. (2016). Breaking the cycle of homelessness: Housing stability and social support as predictors of long-term well-being. Housing Studies, 31, 410–426.

Jowett, A., Peel, E., and Shaw, R.L., (2011) Online Interviewing in Psychology: Reflections on the Process, *Qualitative Research in Psychology*

Kertesz, S.G., Crouch, K., Milby, J.B., Cusimano, R.E. and Schumacher, J.E. (2009) Housing-first for Homeless Persons with Active Addiction: Are we Overreaching? Milbank Quarterly 87(2) 495-534.

Kim, K.L., Davis M.I., Jason L.A., Ferrari J.R., (2006) Chapter 8, Journal of Prevention & Intervention in the Community, 31:1-2, 85-94,

Kim, M.M., Ford, J.D., Howard, D.L., Bradford, D.W., (2010) Assessing Trauma, Substance Abuse, and Mental Health in a Sample of Homeless Men, Health & Social Work, V35,

Laere van, I., Smit, R.,, Muijsenbergh, van den M., (2018) Op weg naar toegankelijke en goede sociaal medische zorg voor dak- en thuislozen in Nederland, Nederlandse Straatdokters Groep, Radboudumc Nijmegen

Mann, R.; Smart, R.; Govoni, R. (2003) The Epidemiology of Alcoholic Liver Disease, Part I -An Overview. National Institute on Alcohol Abuse and Alcoholism; Bethesda.

McQuistion, H. L., Gorroochurn, P., Hsu, E., & Caton, C. L. (2014). Risk factors associated with recurrent homelessness after a first homeless episode. Community Mental Health Journal, 50, 505-513

Moran, J., (2010) Interdisciplinarity, Taylor & Francis e-Library, Second Edition.

Padgett, D. K., Henwood, B., Abrams, C., & Drake, R. E. (2008). Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. American journal of orthopsychiatry, 78

Rhoades, H., Wenzel, S. L., Golinelli, D., Tucker, J. S., Kennedy, D. P., Green, H. D., & Zhou, A. (2011). The social context of homeless men's substance-use. Drug and Alcohol Dependence, 118(2), 320–325

Stergiopoulos, V., Gozdzik, A., Nisenbaum, R., Durbin, J., Hwang, S.W., O'Campo, P., Tepper, J., Wasylenki, D., (2018) Bridging Hospital and Community Care for Homeless Adults with Mental Health Needs: Outcomes of a Brief Interdisciplinary Intervention, The Canadian Journal of Psychiatry, 63(11), 774-784.

Tsemberis, S.J, Gulcur, L., & Nakae, M. (2004). Housing-first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American journal of public health, 94(4), 651-656

Wenzel, S. L., Green HD, Jr, Tucker, J. S., Golinelli, D., Kennedy, D. P., Ryan, G., & Zhou, A. (2009). The social context of homeless women's alcohol and drug use. Drug and Alcohol Dependence, 105(1), 16–23.

Annex

Ethical assessment form

1. Provide a short summary of the background and research question/s.
Homelessness can be seen as a factor causing major health issues. To prevent recurring homelessness, the project "preventing relapse into homelessness" conducts research in the municipality of Utrecht, to gain more knowledge within 5 years about the perspective of homeless people in order to be able to adjust policies and reduce relapse in homelessness. Research will be done into homelessness, alcohol and drug use, the relationship between these two factors, and the other factors that play a role. The next questions will be addressed: *How does substance-addiction relate to homelessness and what factors contribute to this relation?* Accordingly, the following sub questions will examined to draw insights: What are the factors contributing to homelessness and to alcohol- and drug-addiction? How do these factors interrelate? Knowing this, how could this help us improving existing approaches? These questions will be answered using the dataset from the Homelessness Relapse project in Utrecht.
2. Provide a short description of the intended research population/s.
The sample consists of 69 (former) homeless people. Twenty of these have fallen back into homelessness. Twenty-two living in a social care home, which is expected to move to an independent home within three months. Twenty-seven are also resident in social care home, but will flow out within eight months. The selection of respondents was made on the basis of the outflow figures of the various locations of night shelters and protected living. The location of participants was not disclosed due to privacy. All participants at the time of participation twenty-three years or older, stayed in one of the accommodations in the region or made use of support services, and had Dutch nationality or a residence permit.
3. Provide a short description of the proposed research design and method/s.
It is a qualitative study that will use semi-structured interviews. These interviews will partly be conducted by myself. Interviews take place in pairs, in collaboration with a trained experience expert. In total, the data set consists of 69 interviews. The research design is longitudinal, since it will have 5 measuring moments. This research will deal with the first two measurement moments. The data will be analysed with help of Atlas TI and will be filtered on the relevant issues discussed in the interviews. One of these filtered issues is about alcohol and drug use.
4. Provide a short description of the recruitment strategy/ies:

With the help of representatives of Stichting Tussenvoorziening, Leger des Heils, Lister, Kwintes and the neighborhood teams, different locations have been approached. For the acquisition of the first research group (repeatedly homeless persons), employees of Herstart, NOIZ, SleepINN and Stadsteam Herstel were asked to identify re-registering homeless people. Also for the other two research groups (MO and BW), various locations in the Utrecht region were approached to recruit participants. Flyers have been distributed at these locations to inform potential participants about the research and request to participate in the research.

5. Provide a short description of any risks involved in the research for participants. Also decsribe what measures will be taken to limit the risks for participants?

The sources for information about (re) registering clients are registrations about these clients by the City Team Recovery and the Regional Access to Protected Living of the municipality of Utrecht for the U16. For example, we can see whether the living situation of a participant interviewed by us is changing, or whether a possible explanation for a relapse into homelessness may lie in access to care.

If the interviews are enriched with information from registrations, it is indeed not possible to speak of anonymous information and therefore (according to article 5.3.6 paragraph 1 of the Wmo 2015) permission will be requested from the participant to retrieve data that can be matched with this databases. To request this permission, safeguards have been put in place that ensure that the privacy of the person concerned is not disproportionately damaged (Social Support Act 5.3.6 paragraph 1 sub a) and that the tracing to individuals is prevented (Social Support Act 5.3.6 sub 1) b).

The code of conduct for scientific research and this protocol require that the name of the respondent on the consent form is stored separately from the respondent number and that the link between the name of the respondent and the respondent number together with the raw data (the anonymized) are stored on a secured part of the UU disk. The information letter for respondents includes this information, and also that respondents cannot derive any individual benefit or disadvantage from participation (see appendices at the end of this form). Since there can be no question of anonymous processing, at least pseudonyms are needed to establish a relationship between different registrations.

Inquiry with the Decentral Information Security Officer (DISO) of the municipality of Utrecht shows that the municipality of Utrecht indicates in advance to clients that their data is i.h.k.v. scientific research by the municipality of Utrecht or other parties can be used. This research also falls under this. It is, however, necessary to draw up a delivery agreement that addresses the privacy of the data. In this situation, this supply agreement is then drawn up by Utrecht University.

6. Provide a short description of how informed consent will be obtained:
   a. How will potential participants be informed about the aims and requirements of the research?
   b. How will consent for participation in the research be obtained and recorded?

At least a week before the interview, an extensive information letter was sent by email to the participants. This mail contained more information about the investigation procedure and measures, including the analysis and the storage of their data. In addition, an informed consent was issued before the start of each interview and asked to sign it. This informed consent has also been discussed verbally.
7. Provide a short description of how the privacy of participants will be protected and how the confidentiality of information obtained will be ensured.
When using audio recording, permission is requested from the client via the consent form. The interview will not be recorded without permission (informed consent). The location of the participants is not be announced to ensure the privacy, as will be the name of the participant. Participants will remain anonymous, and in case of mixed methods, permission is needed from the participant and data is pseudonymized. The expectation is that for some clients asking substantive questions about the mental disorder could lead to anger and the (again) active occurrence of disease symptoms, so that the research could be detrimental to the participant. To prevent this, no substantive questions are asked about the disorder and it will be decided not to interview some people on the advice of an expert (confidant, counselor). In this way, we aim for a comfortable interview in which the chance of psychological, emotional damage and unsafe feelings are excluded. The information will be stored safely, and only be used for educational purposes.
8. Provide a short description of who will have access to the data, where and how data will be stored during and after the process of data collection and when and how data will be destroyed.
The traceable data will be stored separately from the raw data. The aim will be storage on different servers. Nothing is known about deleting the data. Only that the recording after writing it down, is destroyed. Only those who need the data for educational purposes will have access to it.

Codebook

	Code
●	1. Intro
○	1.1 Intro age
○	1.2 Intro_origin
○	1.3. Intro_life events last year
○	1.4 Intro living situation last year
○	1.5 Intro residence situation at the moment
○	1.6 Intro time in the shelter

●	2. Relapse
○	2.1 Relapse_living history
○	2.2 Relapse_trigger events
○	2.3. Relapse_ type of residence for fallback
○	2.4 Relapse_contact housing association / landlord
○	2.5 Relapse_ background at the military
○	2.6 Relapse_time abroad
○	2.7 Fallback_ guidance to shelter
○	2.8 Relapse_history of residence after relapse
●	3. Outflow path
○	3.1 Outflow_preparations outflow
○	3.1.0 Preparations outflow_conditions for outflow
○	3.1.1 Preparations for outflow_type of house / rental construction
○	3.1.2 Preparations for outflow_guidance
○	3.1.3 Preparations for outflow_environment / social contacts
○	3.1.4 Preparations for outflow_ (guidance with) finances
○	3.1.5 Preparations outflow_experiences with transfer document
○	3.1.6 Preparations for outflow_experiences with prevention action plan
○	3.1.7 Outflow_contact housing corporation / landlord
○	3.2 Possible fallback triggers
○	3.3 Outflow_ Obstacles to outflow
○	3.3.1 Barriers to outflows_personal factors
○	3.3.2 Barriers to outflow_system factors
○	3.3.3 Obstacles to outflow_other
○	3.4 Outflow_positive factors outflow
○	3.5 Needs / wishes at outflow
	4. Informal network
●	4.1 Informal network_important contacts
○	4.1.1 Informal network_important contacts_family
○	4.1.2 Informal network_important contacts_friends / acquaintances

○	4.1.3 Informal network_important contacts_ neighbors / neighborhood / district facilities
○	4.1.4 Informal network_important contacts_ new contacts
○	4.1.5 Informal network_relation / partner
○	4.1.6. Informal network_ (old) contacts from residence
○	4.1.7 Informal network community of faith / meaningful contacts
○	4.1.8 Informal network_addiction contacts
○	4.1.9 Informal network colleagues / contacts work
○	4.1.91 Informal network_companion contact (veterans, people with similar experiences)
○	4.1.92 Informal network_important contacts_other
○	4.2 Informal network support / helping / protective aspects
○	4.3 Informal network_risky contacts
○	4.4 Informal network_little / no contact
○	4.5 Informal network_experienced barriers
○	4.51 Info-network loneliness
○	4.6 Informal network_support building new contacts
○	4.7 Informal network shame
○	4.8 Informal network_social trauma
○	4.9 Informal network - degree of need for social contact
○	
	5. Work and income
●	5.1 Work and income source of income
○	5.1.1 Work and income source of income from paid work
○	5.1.2 Work and income source of income_assistance / participation benefit
○	5.1.3 Work and income source of income_WW / WIA / WAO benefit
○	5.1.4 Work and income source of income (pre-) pension / AOW
○	5.1.5 Work and income source_Wayong benefit
○	5.1.6 Defense work and income source of income (distribution) (ABP / UGM)
○	5.1.7 Work and income source_black_black (additional jobs)
○	5.1.8 Work and income source of income_other
○	5.2 Work and income_ contact with benefits consultant
○	5.3 Work and income_ compensation for benefit
○	5.4 Work and income_effect on relapse

○	5.5 Work and income_positive aspects / wish support
○	5.6 Work and income_experienced obstacle support
●	● 6. Financial self-reliance
○	o 6.1 Financial self-reliance_ management income
○	o 6.1.1 Management of income_administrator (via court)
○	o 6.1.2 Management of income_budget management (voluntary)
○	o 6.2 Financial self-reliance_ debts
○	o 6.2.1 Financial self-reliance_ debts_support debts
○	o 6.2.1.1 Support debt WSNP process (debt restructuring)
○	o 6.2.1.2 Support debt-debt buddy
○	o 6.3 Financial self-reliance
○	o 6.3.1 Financial self-reliance_making ends meet_budget coach
○	o 6.4 Financial self-reliance - influence on relapse
○	o 6.5 Financial self-reliance_wishes / needs support with finances
○	o 6.6 Financial self-reliance_ wishes / needs to manage own finances
●	● 7. Daytime activities and meaning
○	o 7.1 Daytime activities and meaning / work currently
○	o 7.1.1. Daytime activities and meaning_ daytime activities / work currently_paid work
○	o 7.1.2. Daytime activities and meaning / work currently_voluntary work
○	o 7.1.3. Daytime activities and meaning / work currently_daytime activities
○	o 7.2 Daytime activities and meaning_ voluntary work / workplaces last year
○	o 7.3 Daytime activities and meaning of life_ guidance to / preparation for meaningful daytime activities / work
○	o 7.4 Daytime activities and meaning_ extent to which daytime activities / work match personal situation
○	o 7.5 Daytime activities and meaning of the meaning of daytime activities / work
○	o 7.6 Daytime activities and meaning_ support on daytime activities / workplace
○	o 7.6.1 Daytime activities and meaning-positive aspects support
○	o 7.6.2 Daytime activities and meaning_ experience obstacle support
○	o 7.6.3 Daytime activities and meaning / wishes / needs support
○	o 7.7 Daytime activities and meaning_continuity daytime activities / work at outflow

○	○ 7.8 Daytime activities and meaning_effect on relapse
●	● 8. Formal network / care / assistance
○	○ 8.0 Formal network / care / assistance_ use of addictive substances / addiction
○	○ 8.01 Formal network / care / assistance_psychical / psychiatric problems
○	○ 8.02 Formal network / care / assistance_indication (if mentioned)
○	○ 8.1 Formal network / care / assistance_ support for care providers
○	○ 8.1.0 Formal network / care / assistance_buurtteam
○	○ 8.1.1 Formal care_medical / hospital / general practitioner
○	○ 8.1.2 Formal network / care / assistance_ home assistance (TussenVoorziening/ Leger des Heils, Lister, Kwintes)
○	○ 8.1.3 Formal network / care / assistance_ addiction_ support for addiction
○	○ 8.1.3.1 Formal network / care / counseling_ addiction_addict care (treatment / detox / intramural)
○	○ 8.1.3.2 Formal network / care / assistance_adiction_addict care ambulatory (extramural)
○	○ 8.1.4 Formal network / care / assistance_GGZ support
○	○ 8.1.4.1 Formal network / care / assistance_GGZ support (treatment / psychiatrist / with provision)
○	○ 8.1.4.1 Formal network / care / assistance_GGZ outpatient support (FACT / meddling care / home)
○	○ 8.1.5 Formal network / care / assistance_contact police / justice
○	○ 8.1.6 Formal network / care / assistance_ social work / welfare work
○	○ 8.1.7 Formal network / care / assistance_buddy projects
○	○ 8.1.8 Formal network / care / assistance_ Stadsteam Herstel
○	○ 8.1.9 Formal network / care / assistance_ community care / household help
○	○ 8.1.91 Formal network / care / assistance_Expert on the field
○	○ 8.1.92 Formal network / care / assistance_contact municipality
○	○ 8.2 Formal network / care / assistance_ influence on relapse
○	○ 8.3 Formal network / care / assistance_ experiences obstacles support
○	○ 8.4 Formal network_positive factors / experiences / factors important to live independently
○	○ 8.8 Formal network_ shelter support
○	○ 8.9 Formal network_contact landlord
○	○ 8.91 Formal network / care / assistance_ changes in assistance / continuity
●	9. Continuity
○	○ 9.1 Continuity_care

○	○ 9.2 Continuity_effect on relapse
○	○ 9.3 Continuity_experienced obstacles support
●	● 91. Integrated approach
○	○ 91.1 Integral approach_experience cooperation between different healthcare parties
○	○ 91.2 Integrated approach_ perspective client support
○	○ 91.3 Integral approach_ influence on relapse
○	○ 91.4 Integral approach_experienced obstacles support
●	● 92. Looking to the future
○	○ 92.1 View on future client needs independent living
○	○ 92.2 View of future_experienced obstacle support
○	○ 92.3 View on future dreams / wishes
●	● 93. Outflowed
○	○ 93.1 Outflowed_experiences outflow
○	○ 93.1 Outflowed experiences living independently
○	○ 93.2 Outflowed_experiences of neighborhood / location / neighborhood
○	○ 93.3 Outflowed_difficulties to live independent
○	○ 93.4 Outflowed_positive factors
●	● 94. Addiction
○	○ 94.1 Addiction_cause and effect
○	○ 94.1.1 Addiction_cause and effect_effect
○	○ 94.1.2 Addiction_cause and effect_cause
○	○ 94.2 Addiction_relapse in addiction

Topic List

Introduction

• What is your name, how old are you?

• Where are you from?

• Could you briefly tell something about yourself? What is your background and how did you get here?

Have you been homeless before? how come you got homeless again?

Relapse

• Can you give a direct reason for why you have fallen back into homelessness? (eviction, leaving family / friends / admission?)

• Can you tell us about where you stayed before? (Friends / family, private housing / social housing)?

To what extent did you have contact with the housing association / your landlord? Or did your mentor have this? What do you think of this?

Facilities, agencies and networks

Together with you I would like to make a drawing of these different facilities (agencies, help, guidance you get), from your perspective. We would also like to know about informal support that you may receive from neighbors, acquaintances / friends, family.

What matters here is which facilities (care providers, guidance or agencies) are closer to you or further away, for example. Where you have a lot to do or just little. You can then put it further away or closer to the drawing. You can also indicate what you are satisfied with and what you think could be better to help you live independently.

Informal network

- Which people are important to you (family, friends, neighbors)

- How often did you have contact with these people in your network? And how did you experience it

- What support did you receive prior to your relapse from these people?

- What role did this network play in your relapse or was the network a risk for you?

- Is there currently someone who helps you build (new) contacts?

- How do you experience that?

• How were you in contact with the neighbors / other residents of the building? How did you feel in the neighborhood / living environment?

- Have you ever felt alone? What did you do then? Was there someone you could turn to for this (family / friends / neighbors?)

Work and Income

- How did you provide for your income before you relapsed. How did this go? Could you make ends meet?

-Did you have contact with the social assistance or UWV consultant?

-Is there any compensation for your benefit?

Participation / Daytime activities / Reintegration

• Did you have daytime activities or work prior to your relapse, did this continue when you left reception?

• Do you currently have daytime activities / work? How do you experience that? Will daytime activities / work continue if you start living independently?

• Are you now looking into options for daytime activities and work?

• What does it bring you (more income, structure, contact with people, etc.) Would you like to see something changed in this?

Financial self-reliance

- Did you manage your own money? How did this go and did you receive help from someone?

- How's that going now?

- Are you in debt, did you have someone to help you with this?

- How did this affect your relapse?

Did you miss anything in support?

Assistance: social work / community care / neighborhood team / social aid organizations / police

• Which providers did you have contact with before you came here? How did you experience this? - Did you miss anything in this? Did you have a plan for this beforehand?

• Addiction care: Do you have an addiction? Who can help you with this? To what extent has this affected your relapse?

GGZ: are there psychological problems? Who can help you with this?

• Blue → Have you (had) contact with the police? How often? If so, also ask about other judicial contacts, detention, etc.…

Continuity of care

• How often do you have contact with these care providers and how do you experience the contact?

• To what extent did you receive the same support when you started living on your own or did the care / organization change? How did you experience this?

• Are you currently still in contact or do you receive support from these persons?

• What role does this element play in preventing your relapse or is it a risk for you?

Integrated approach to a person-oriented process

• Was there someone who coordinated the care.

• Who had sight / coordination on this network? Did you do that yourself / someone in your environment / professional (a case manager?)?

• What do you find important in the support you received?

• Did you feel that all care parties worked well together?

• What role does this element play in preventing your relapse or is it a risk for you?

Looking to the future

• What do you need to live independently? To flow out successfully? What is success? What not?

• (Where do you want to be in 1 year?)

-What elements are important to save it.

-What the participants give themselves as a reason for their recovery or relapse. According to the participants, what are "recovery moments": what makes a difference to prevent failure? And looking back: what had made a difference to prevent relapse?