ENGLISH

HOME4HEALTH

EU Guidelines: Supporting Local Governments in Addressing Homelessness and Complex Health Issues.

Coordinated by: ABD Welfare and Development Association

In partnership with: CRES CER, HVO QUERIDO, Cáritas Diocesana

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https://abd.ong/en/programs/home4health/
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Summary

1. Executive Summary

Homelessness in Europe represents a **profound social and public health crisis closely intertwined with drug addiction.** People experiencing homelessness often face multiple and overlapping challenges, including untreated physical and mental health conditions, trauma, social exclusion, and substance use disorders, which mutually reinforce one another and perpetuate cycles of housing instability. Traditional, crisis-oriented responses have proven insufficient to address these complex and interconnected needs, leading to persisting situations of homelessness and poor health outcomes. Structural factors such as rising housing costs, shortages of affordable housing, and fragmented policy responses further exacerbate the problem, underscoring the need for integrated, trauma-informed and harm-reduction-based approaches that place dignity, wellbeing, and long-term social inclusion at the center of homelessness responses.

In this sense, housing availability must be understood as a structural determinant of homelessness prevention. While health, trauma, and substance use are critical dimensions, the lack of affordable and stable housing is often the primary driver of homelessness. Effective responses, therefore, require strong housing policies alongside integrated health and social support services. Although Housing First models offer proven solutions, local authorities must also consider complementary housing options—such as emergency, transitional, and supported housing—particularly for individuals with complex needs who may require gradual stabilization.

The EU Guidelines "Supporting Local Governments in Addressing Homelessness and Complex Health Issues" provide a comprehensive framework for developing **innovative, inclusive, and evidence-based approaches to address the social and individual problem of homelessness with complex health issues and trauma challenges, including substance use disorders**. These Guidelines are the result of collaborative work within the Home4Health project, engaging 10 European organizations, 4 specialized platforms, and local authorities across multiple pilot territories.

The Guidelines provide evidence-based guidance and aim to support local and regional authorities in shifting from crisis-based interventions toward long-term, preventive, and harm-reduction-oriented strategies in a renewed momentum to improve the measurement of homelessness and housing exclusion, and to design and implement public policies to end homelessness. Above all, they are **grounded in a holistic, person-centred framework that requires coordinated action across all sectors of society — including health services, social services, and other community actors — to ensure coherent and sustainable support in the prevention of social vulnerabilities.** Within this overarching approach, the Guidelines emphasize trauma-informed care, gender sensitivity, cultural inclusiveness, and the integration of mental health, substance use treatment, and social support services. Key principles include Housing First approaches, community participation, empowerment of affected individuals, peer workers and strong multilateral coordination across services.

Drawing on evidence from project pilots, expert input, and stakeholder consultations, the Guidelines present actionable recommendations across **five priority areas which directly intersect with Homelessness: mental health, gender, drug**

use, violence, and transcultural approaches. Each section provides practical strategies, policy recommendations, and illustrative case studies to guide local governments in designing services that are accessible, effective, and responsive to the specific needs of diverse populations.

The Guidelines allow local governments to move from crisis management to sustainable and preventive models, reducing social costs. They are designed for easy adoption and adaptation by local governments across the EU and are complemented by tools, templates, and contact networks to facilitate implementation. By fostering collaboration, promoting best practices, and sharing lessons learned, the Guidelines aim to improve the autonomy, well-being, and social inclusion of people experiencing homelessness, ultimately contributing to more inclusive and resilient communities across Europe.

2. Introduction

Home4Health is a European project, funded by the Erasmus+ program and implemented in partnership with **Asociación Bienestar y Desarrollo (ABD, Spain)** as project coordinator, **CRESCER (Portugal)**, **HVO-Querido (Netherlands)**, and **Cork Simon Community (Ireland)**. Running from January 2024 to June 2026, the project aims to promote more effective, inclusive, and sustainable approaches to homelessness, substance use, and social support across Europe.

Leveraging the expertise of its partners, Home4Health addresses the urgent need to support people experiencing homelessness who face complex health and mental health challenges and traumas, including addiction. Adopting a socially inclusive perspective, the project fosters collaboration among civil society organizations, institutions, and public authorities. It also seeks to align vocational education and training (VET) organizations with evolving labor market needs. By responding to the transition toward inclusive socioeconomic systems and the growing demand for specialized skills in the health and social sectors, Home4Health aims to enhance professional development opportunities and facilitate the exchange of best practices and experiences at the European level. On a more practical level, it is expected that the development of these materials can also support municipalities in making informed and operational decisions on how to structure services and policies.

This project draws from the **understanding that homelessness across the European Union constitutes both a deeply rooted social problem and a public health crisis.** Recent estimates suggest that on any given night, nearly 895,000 people in Europe are homeless, though this number likely undercounts “hidden homelessness” due to fragmented data collection (FEANTSA & Fondation Abbé Pierre, 2023). Structural drivers such as soaring housing costs, a shortage of affordable social housing, and insufficient policy coordination amplify this crisis (Euronews, 2024; FEANTSA, 2023).

People experiencing homelessness often face multiple, overlapping challenges, including complex physical and mental health needs, substance use disorders, exposure to violence, and social exclusion. Traditional crisis-driven interventions frequently fail to address these interconnected issues, resulting in repeated episodes of homelessness, poor health outcomes, and limited social reintegration.

From a health perspective, people experiencing homelessness face dramatically worse outcomes compared to the general population. According to a FEANTSA report, their average life expectancy is significantly reduced, and the absence of stable housing contributes to elevated morbidity and mortality (FEANTSA, 2024). Mental health challenges are disproportionately common: depression, anxiety, and post-traumatic stress disorder (PTSD) frequently co-occur with homelessness (FEANTSA, 2023). Compounding this, access to mental health services is often limited by stigma, insufficient outreach, and eligibility gaps (Mental Health Europe, 2013). In this sense, trauma is a core component of homelessness, particularly for young people, making trauma-informed care essential to support both the resilience of young people experiencing homelessness and the wellbeing of the staff who assist them.

Additionally, substance use and addiction further complicate the landscape: according to a guide published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), there is a mutually reinforcing relationship between high-risk drug use, serious mental illness, and long-term or recurrent homelessness (EMCDDA, 2022). Also, many people experiencing homelessness use substances as a coping mechanism, increasing their risk of overdose, infectious disease, and social marginalization (EMCDDA, 2022).

Given these interlinked challenges — housing exclusion, trauma, mental health, and addiction — it is clear that local governments must adopt holistic, integrated, and humane approaches.

Objectives of the Guidelines

The objectives of these guidelines can be summarised as follows:

1. Provide a consistent framew	For local and regional authorities to design and implement innovative, inclusive, and trauma-informed services for people experiencing homelessness with complex health and addiction issues.
2. Promote long-term, preventive, and harm-reduction	Approaches, moving beyond crisis-driven interventions to improve autonomy, well-being, and social inclusion.
3. Integrate cross-cutting principles	Such as gender sensitivity, cultural competence, and intersectional approaches to address the diverse needs of women, LGBTQ+ individuals, migrants, and other marginalized populations.
4. Share evidence-based best practices and lessons learned	From the Home4Health project and European Support Network, including effective strategies in mental health care, housing, harm reduction, violence prevention, and social support.
5. Enhance cooperation and knowledge exchange	Among local/regional authorities, NGOs, and European networks, fostering a collaborative European approach to homelessness and complex health challenges.
6. Facilitate accessibility and practical application	Ensuring the Guidelines are usable in multiple languages and contexts, and support dissemination and advocacy efforts at local, regional, and EU levels.

3. Point of departure

In recent decades, **public policy frameworks** addressing complex social vulnerabilities—such as homelessness and problematic drug use—have undergone a profound erosion in their normative foundations. What was once anchored in principles of social justice, universalism, and collective responsibility is increasingly shaped by the logics of urban sanitation and control, moral judgment, and defensive governance. This shift does not occur in a vacuum: it reflects **broader transformations in contemporary societies,** in which trust in collective progress erodes, social cohesion fractures, and institutions often appear incapable of guaranteeing security or predictability.

In response, policies increasingly favor securitization and the displacement of populations and municipal strategies often oscillate between two contrasting approaches: the *displacement* of "unwanted populations" to peripheral spaces or out of sight, and the *digestion* of vulnerabilities within urban territories through limited, containment-oriented services. Both strategies, while politically expedient, fail to address structural determinants of homelessness and addiction and generate profound costs for society—economic, social, personal, and urban. Particularly the strategy of displacement increases marginalization, reduces access to essential services, and contributes to long-term social instability, while inadequate integration or containment risks perpetuating cycles of vulnerability, public health crises, and neighborhood fragmentation. The failure to address these issues proactively imposes a measurable burden on healthcare systems, social services, urban infrastructure, and the collective well-being of cities and communities.

The progressive degradation of social and ethical foundations in public policy is not simply a matter of budget constraints or administrative inefficiency; it reflects a deeper erosion of collective imaginaries, civic trust, and long-term political vision. Increasing precarity, widening inequalities, and the normalization of insecurity have transformed the relationship between states, citizens, and those who rely most on public systems for protection. One of the clearest manifestations of this shift is the rise of policies that prioritize order, visibility management, and punitive control over social investment and human development. Strategies aimed at "cleaning" or "ordering" the city—through policing, displacement, or exclusionary regulations—replace policies once grounded in rights, social justice, and solidarity. In this climate, homelessness and addiction are reframed less as social issues requiring structural solutions and more as urban disturbances to be managed, often through short-term, disciplinary measures. Such tendencies reveal a policy environment increasingly shaped by fear, fragmentation, and political short-termism.

This broader transformation seems to be connected to a cultural atmosphere marked by loss of future-oriented confidence. As societies experience the combined pressures of inequality, technological disruption, and perceived social decline, there is a growing retreat into idealized or selective visions of the past. This backward gaze legitimizes exclusionary tendencies, moral judgment toward marginalized groups, and nostalgia for forms of authority that promise order rather than empowerment.

Under this context, public policy can drift toward managerialism, risk-avoidance, and moralizing frameworks, weakening the commitment to evidence-based, rights-centered, and person-focused approaches. Structural determinants of homelessness—poverty, housing markets, health inequities, discrimination—are often neglected, while visible symptoms are targeted, reinforcing cycles of marginalization. The duality of displacement and digestion exemplifies this

dynamic: whether populations are pushed out or superficially integrated, the underlying social, economic, and health inequities remain unaddressed, generating high costs across society, from increased healthcare and social service burdens to urban deterioration and the erosion of social cohesion.

Seen through this lens, **the normative regression in some public policies is not accidental but symptomatic of a broader societal drift:** When the future feels threatening and the present unstable, the commitment to inclusive, rights-based interventions weakens. What emerges instead is a desire to restore imagined past orders—more disciplined, more homogeneous, more hierarchical—even if such reconstructions contradict evidence or exacerbate marginalization. This dynamic, sometimes described as **retrotopian** (Bauman, 2017), reflects a societal turn toward selective stability, where the uncertainties of the present and future are countered with visions of a controlled, idealized past, often at the expense of vulnerable populations.

Against this backdrop, the challenge for contemporary social policy is to **reaffirm the values that once anchored social protection systems: dignity, solidarity, inclusion, and a belief in collective capacity to produce better futures.** Rebuilding these foundations requires resisting the drift toward punitive governance, reclaiming the public sphere as a space where vulnerabilities are met not with suspicion or exclusion but with responsibility, care, and long-term investment. Human rights must be central to this endeavor: the protection of rights to housing, health, social inclusion, and non-discrimination provides both the ethical and legal basis for action. Recognizing the retrotopian currents shaping societal imagination is essential: defending value-driven, rights-based approaches demands confronting the cultural narratives, fears, and nostalgias that currently influence public opinion and institutional behavior.

Only by understanding and addressing these dynamics can we rebuild policy frameworks that place dignity, solidarity, and social justice at their core, ensuring interventions for homelessness, drug use, and other forms of complex vulnerability remain effective, inclusive, and ethically grounded.

4. Methodology for the development of the Guidelines

4.1 Description of the methodology

The development of these guidelines was based on a combination of complementary methods designed to ensure a multidimensional approach and incorporate a wide range of perspectives on the complex issues addressed. By integrating multiple sources of evidence and stakeholder insights, the methodology aimed to produce comprehensive and practical guidance for local governments and practitioners.

One of the foundational documents informing this process was the **Good Practices and GAP Analysis Report**, which provided a synthesis of existing initiatives, evidence, and lessons learned. The project built sequentially on previous tasks and outputs, ensuring continuity and coherence in the development of the guidelines.

To capture diverse perspectives, a structured participatory process was undertaken. An initial **stakeholders meeting** brought together 29 participants from across Europe. Discussions were organized both in plenary sessions and in smaller thematic groups, focusing on key topics previously established by the project partners and transversal to all territories involved, which were:

1	2	3	4	5
Mental health and homelessness	**Gender and homelessness**	**Drug use and homelessness**	**Violence and homelessness**	**Transcultural approaches**

In addition to the group discussions, **targeted interviews** were conducted with key stakeholders from the participating countries to gather in-depth insights into local practices, challenges, and opportunities:

- **Paulo Santos,** Lisbon Townhall (CML), Lisbon, Portugal
- **Maria dels Àngels Guiteras**, President, of the Catalan Federation of Drugs, Spain
- **Joost Ravensteijn**, HVO-Querido, Amsterdam, the Netherlands
- **Amy Roche**, Health Service Executive (HSE), Cork, Ireland
- **Josep Rovira**, Director of the Drugs Area in ABD, Spain

These interviews provided detailed, country-specific perspectives, uncovered needs as well as European trends and allowed for the identification of both common challenges and context-specific solutions.

Subsequently, a second stakeholder meeting was held to validate the guidelines, bringing together 23 participants. During this session, a draft version was presented, and participants worked in groups to identify key areas for improvement, as well as those that already met the expectations of the partners.

Finally, the perspectives and expertise of all partners from the four organizations involved in developing the project—**ABD (Spain), CRESCER (Portugal), HVO-Querido (Netherlands), and Cork Simon Community (Ireland)**—were systematically integrated into the guidelines. Their contributions were carefully considered throughout the development process to ensure that the recommendations reflect a diverse range of experiences, insights, and contextual knowledge from all participating countries.

4.2 Limitations and scope

While the EU Guidelines aim to provide a comprehensive framework for supporting local authorities in addressing homelessness and complex health issues, certain limitations should be acknowledged. The diversity of social, legal, and healthcare contexts across EU territories means that recommendations may need to be adapted to local circumstances, resources, and policies. Data on homelessness, trauma, and substance use is often incomplete or inconsistent, which may affect the generalizability of some guidance. Similarly, differences in the capacity of local authorities—including staffing, funding, and infrastructure—may influence the feasibility of implementing certain approaches.

The Guidelines reflect current knowledge and practices at the time of publication, but rapidly evolving social and health challenges may require updates over time. While input was gathered from a broad range of stakeholders, including European organizations, specialized platforms, and local authorities, not all relevant actors or marginalized populations could be directly consulted. Finally, some recommended approaches, such as mobile health clinics, integrated care models, or specialized shelters, can be resource-intensive, and authorities may need additional support or phased implementation to achieve the intended outcomes. Despite these limitations, the Guidelines offer practical, evidence-informed strategies to improve accessibility, equity, and well-being for people experiencing homelessness across Europe.

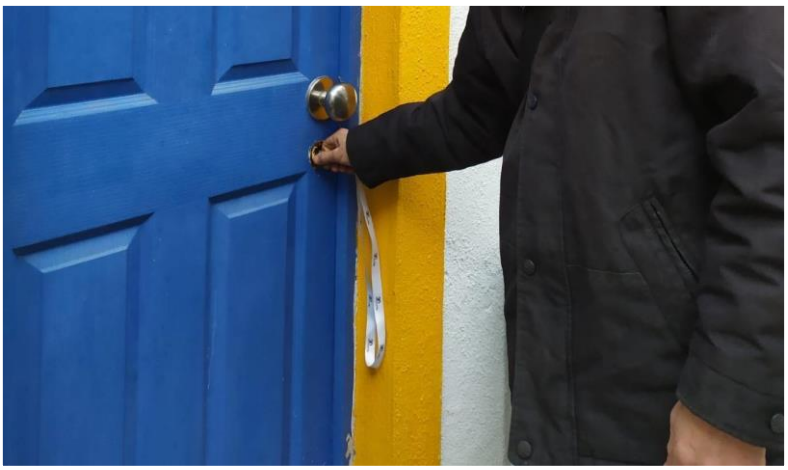
5. Inspiring case studies

In addition to the fieldwork conducted through direct interviews and the inclusion of stakeholder input, several case studies of best practices were analysed to provide concrete examples of policies that have received positive feedback and demonstrated effective results. These cases are presented below:

CASE STUDY 1:
Housing First Programme, Lisbon (CRESCER)

Context & Background

Launched in 2013 by the NGO CRESCER in partnership with the Municipality of Lisbon and the Portuguese Institute of Social Security, the “É UMA CASA” programme was a response to the failure of traditional "staircase" models to house people with the most complex needs. Before this, individuals were required to prove "housing readiness" through abstinence or psychiatric stability—requirements that often excluded those in chronic homelessness.



Operational Implementation

1.	**Multidisciplinary Teams**	The programme deploys teams consisting of psychologists, social workers, doctors, nurses, and peer support workers who provide assertive outreach and intensive case management.
2.	**No Preconditions**	Housing is provided in scattered-site apartments across the city to promote social mixing and reduce stigma. There are no requirements for sobriety or psychiatric treatment to maintain the lease.
3.	**Funding Model**	A sustainable public-NGO partnership where the municipality and national social security fund the support services, while the NGO manages the housing stock and tenant relations.

Impact & Evidence

1.	**Housing Stability**	Data from 2013–2022 shows a 90% retention rate, with the vast majority of participants never returning to the streets.
2.	**Health Outcomes**	84% of tenants reported significant improvements in their overall health and well-being.
3.	**Substance Use**	Approximately 50% of participants either reduced or completely ceased problematic substance use after entering the programme, despite no mandate to do so.

Policy Lessons for Local Governments

1.	**Housing as a Right**	Decoupling housing from treatment is the most effective way to engage "hard-to-reach" populations.
2.	**Investment in Support**	Success depends on high-intensity, mobile support teams that meet the person where they are, rather than requiring them to visit a clinic.

CASE STUDY 2:
Social Hotel for Homeless People with Drug Dependence, Barcelona

Context & Background

Initially launched in 2020 as an emergency response to the COVID-19 pandemic, the Social Hotel, in Barcelona, Spain, filled a critical gap: traditional emergency shelters were often unable to manage individuals with active, high-risk drug dependencies during lockdowns. Recognising its success, the Barcelona City Council and the Barcelona Public Health Agency (ASPB) consolidated it into a permanent fixture of the city's drug and homelessness strategy, with the service managed by the ABD Group.

Operational Implementation

1.	**Low-Threshold Access**	The hotel operates on a harm-reduction basis, meaning abstinence is not required. It specifically targets those previously excluded from the shelter system.
2.	**Integrated Harm Reduction**	Unlike traditional hostels, the Social Hotel includes supervised consumption spaces on-site, ensuring that residents who use drugs do so in a safe, medically monitored environment.
3.	**Gender-Responsive**	A significant portion of the hotel is dedicated to women and non-binary individuals, acknowledging that they often face higher levels of violence in mixed-gender emergency settings.

Impact & Evidence

1.	**Scale**	In its first phase, it accommodated 120 people (74 men, 42 women, 4 non-binary).
2.	**Stabilisation**	Residents showed a marked reduction in public space consumption and a decrease in overdose-related incidents. Many successfully transitioned from the hotel to more stable, long-term Housing First placements.

Policy Lessons for Local Governments

1.	Pandemic-era innovations can provide evidence for permanent policy shifts. On-site Services: Integrating supervised consumption within housing facilities reduces "revolving door" homelessness for people with active addictions.

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CASE STUDY 3:
METZINERES: HARM REDUCTION AND SHELTER FOR WOMEN WHO USE DRUGS

Context & Backgroun

Metzineres is the first non-profit cooperative in Spain to deploy "Environments of Shelter" specifically for women and gender-diverse people who use drugs and have survived multiple forms of violence. It was born from the realisation that mainstream harm reduction and homelessness services are often designed for men, leaving women uniquely vulnerable.

Operational Implementation

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1.	**Peer-Led Model**	The project is designed and managed with the active participation of the women themselves. This "for and by" approach builds high levels of trust and engagement.
2.	**Holistic Support**	Services go beyond health to include a 24/7 safe space, legal aid, childcare support, and "Metzineres TV"—a project that uses media to empower participants and challenge social stigma.
3.	**Violence-Centred Care**	Every intervention is filtered through a lens of trauma-informed care, specifically addressing the intersection of drug use and gender-based violence.

Impact & Evidence

1.	**Engagement**	Metzineres has successfully reached women who had been disconnected from any form of public support for years.
2.	**Social Inclusion**	Participants report a high sense of belonging and community, which acts as a protective factor against overdose and further violence.

Policy Lessons for Local Governments

1.	**Gender-Specific Design**	Generic services are often inaccessible to women. Dedicated, women-only spaces are essential for safety and adherence.
2.	**Community empowerment as a form of Healthcare**	Cultural and community activities are as important as medical interventions for long-term recovery and stability.

6. Main conclusions from the research methods used

6.1 General main conclusions

The methodological approach used to develop these guidelines enabled a comprehensive understanding of homelessness, health, trauma, and substance use across different European contexts. By combining desk research, previous project outputs, and targeted interviews with stakeholders in Ireland, Portugal, and the Netherlands, the project captured both the diversity of local experiences and the common challenges faced by people experiencing homelessness. Contributions from all four partner organizations were systematically integrated, ensuring that perspectives from a range of professional backgrounds and organizational roles informed the guidelines. The findings presented in this chapter directly informed the next chapter, which outlines the specific guidelines for local governments.

Across all contexts, homelessness was described as a **multifaceted crisis**, shaped by structural housing shortages, rising complexity of needs, and insufficient political and financial commitment to long-term solutions. Despite differences between regions, stakeholders consistently noted that homelessness cannot be separated from broader housing market dynamics: scarcity of affordable housing, long social-housing waiting lists, and urban pressures such as tourism and gentrification exacerbate vulnerability, particularly among low-income groups. Furthermore, local service models often struggle to meet the complex needs of people experiencing homelessness, who may face mental health challenges, trauma, chronic illnesses, substance use, or belong to vulnerable groups such as youth, migrants, and undocumented individuals. These realities underscore the need for **guidelines that explicitly integrate trauma-informed care, harm reduction, and multidisciplinary approaches**.

Mental health and homelessness emerged as a priority area, with stakeholders emphasizing the importance of **long-term, preventive, and harm-reduction approaches**. Effective programs rely on proactive outreach, key workers or support staff, small caseloads, and enough time to build relationships. Integration of mental health services across all projects, including support for formerly incarcerated individuals, is essential, as is incorporating education and training to promote social reintegration. Accessibility is a key concern; reducing stigma, simplifying bureaucratic processes, offering multilingual services, and including digital access points were highlighted as strategies to ensure services reach those in need. Stakeholders also advocated for Models of Care to demonstrate program efficacy and to convince local authorities to commit to long-term interventions, recognizing housing as a fundamental human right.

Existing intervention models for addressing complex social vulnerabilities, particularly the Housing First approach, are widely regarded as effective in promoting stability, health, and social inclusion for people experiencing homelessness. Evidence from both practice and research highlights their capacity to produce meaningful, long-term outcomes. However, insights gathered from interviews with practitioners, service users, and stakeholders reveal **ongoing concerns regarding the extent to which political will aligns with these evidence-based strategies**. While the models themselves are sound, their full potential is often constrained by shifting policy priorities, competing interests, or decisions that may unintentionally undermine the values that underpin successful interventions. This tension underscores the importance of not only implementing effective models but also fostering a political and social environment that actively supports and sustains them.

Another perspective on **intervention models is that these must be continuously reviewed and adapted, as social realities are constantly changing**. At their core, these models are sustained by values such as respect, dialogue, fraternity, commitment, cooperation, and diversity. These values not only guide practice but also shape the objectives and ethos of the projects themselves. While certain principles—freedom, dialogue, cooperation, and inclusivity—have proven effective and contributed to the development of a socially-oriented Europe, they are not universally shared across countries or contexts. It is therefore essential to explicitly articulate and defend these values, particularly in environments where political or symbolic decisions may challenge them—for example, when local authorities enact policies that undermine access to services for vulnerable populations. Building consensus around shared cooperative values allows stakeholders to work collectively and maintain a consistent ethical framework, even amid negotiation and compromise that often result in policies of minimal standards. Maintaining vigilance and active engagement ensures that interventions remain both principled and responsive to evolving social needs.

Gender and intersectional considerations were similarly emphasized. Local stakeholders highlighted the vulnerabilities of women, especially migrant women, LGBTQ+ individuals, and other marginalized groups, noting that traditional shelters and services often fail to accommodate the specific needs of women who have experienced gender-based violence or who use substances. Recommendations included the creation of **gender-sensitive, trauma-informed services**, specialized shelters, low-threshold harm reduction facilities for women who use drugs, and partnerships with organizations providing legal, counseling, and childcare support. These strategies ensure that all individuals can access safe and dignified housing and support, and that services address both immediate safety concerns and long-term wellbeing.

Substance use and homelessness were consistently framed through a **harm reduction lens**. Participants emphasized the need for low-threshold services that do not exclude based on substance use, legal status, or other restrictive criteria. Supervised consumption sites, mobile clinics, and 24/7 drug consumption facilities were cited as essential components, alongside integrated support for mental health, housing, and social services. Peer-led interventions, naloxone training, and overdose prevention programs were highlighted as effective strategies to empower individuals and foster community resilience. Stakeholders also stressed the importance of reducing stigma, decriminalizing drug use, and ensuring dedicated funding and evidence-based policy approaches.

Violence and discrimination emerged as cross-cutting issues. Stakeholders recommended recognizing **aporophobia as a hate crime**, reforming law enforcement practices, and providing inclusive employment opportunities. They highlighted the detrimental impact of hostile urban architecture and the need for accessible, 24/7 safe spaces, particularly for victims of gender-based or other forms of violence. Training and awareness programs for law enforcement were consistently identified as critical for reducing systemic violence, ensuring protection, and facilitating access to services.

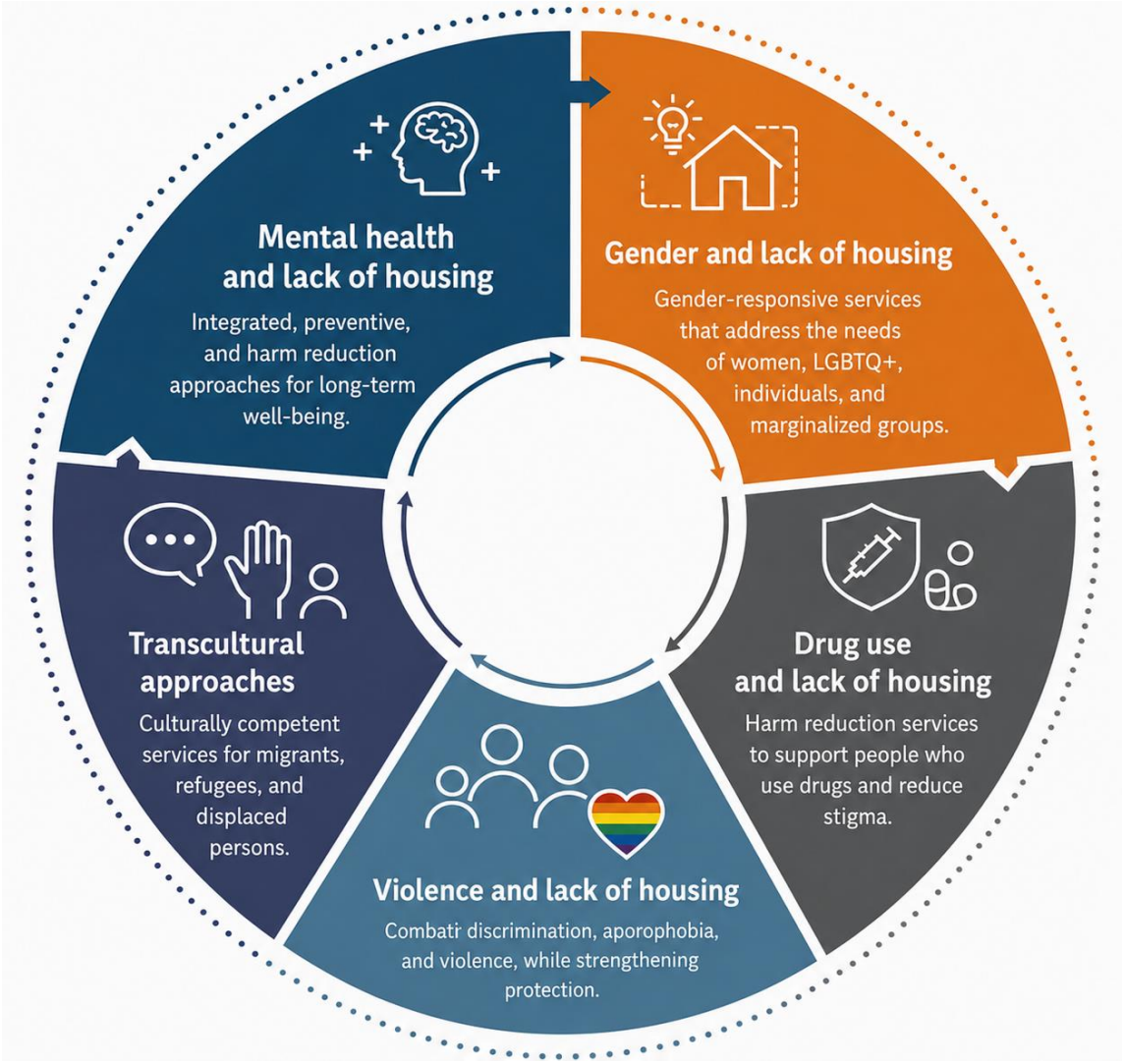
Finally, **transcultural approaches** were emphasized as essential for ensuring equitable access to services for migrants, refugees, and ethnic minorities. Stakeholders recommended culturally competent staff, multilingual services, cultural

mediators, and translated materials to bridge communication gaps. Services should accommodate both documented and undocumented individuals and provide healthcare that respects cultural differences and past trauma. Establishing common reference frameworks across countries for defining homelessness was also suggested to prevent invisibility among precariously housed populations.

Across all thematic areas, a set of **common principles** emerged: the importance of integrated, multidisciplinary care; long-term and stable housing solutions; culturally and gender-sensitive approaches; and practical, evidence-informed guidance grounded in lived experience. Stakeholders emphasized that **guidelines must be actionable, concrete, and flexible**, incorporating case studies, lived experience narratives, implementation checklists, and scenario-based tools. Political engagement, consistent funding, and formalized interagency collaboration were identified as prerequisites for successful implementation, as was a broader cultural shift toward acknowledging the realities of homelessness and addressing stigma with honesty and human rights-based approaches.

These combined insights highlight that effective interventions require both structural reforms and operational best practices, linking local governance, civil society, and community participation. They provide a robust foundation for the development of practical guidelines capable of supporting local authorities in addressing the complex, intersecting challenges of homelessness, mental health, trauma, and substance use across Europe.

6.2 Priority areas identified



6.2.1. Mental Health and Homelessness

Addressing mental health among people experiencing homelessness requires long-term, preventive, and harm-reduction approaches that respond to both immediate and ongoing needs. Ensuring accessibility is essential, including strategies to reduce stigma, simplify bureaucratic processes, and overcome language barriers. Integrated, multi-disciplinary teams combining healthcare, social services, and housing support provide more effective and coordinated care. Examples of best practices illustrate how these approaches can be successfully implemented in diverse contexts.

6.2.2. Gender and Homelessness

Services must be gender-sensitive and responsive to the unique needs of women, LGBTQ+ individuals, and other marginalized groups. Key considerations include addressing gender-based violence, reproductive health, childcare, and access to safe housing. Low-threshold harm reduction shelters and partnerships with specialized organizations are essential to provide safe, supportive, and tailored interventions.

Gender-based violence is a major pathway into homelessness for women. Services should therefore incorporate prevention and protection mechanisms, including safe shelters, trauma-informed support, and specialized harm reduction services for women who experience violence and substance use simultaneously.

6.2.3 Drug Use and Homelessness

Harm reduction services, such as supervised consumption sites, mobile clinics, and low-barrier treatment options, are central to supporting people who use drugs. Reducing stigma, implementing inclusive policies, and fostering peer-led interventions—including overdose prevention initiatives—enhance the effectiveness of these programs. Policy measures addressing decriminalization and resource allocation provide a foundation for sustainable, evidence-informed approaches.

6.2.4 Violence and Homelessness

Strategies to combat violence among people experiencing homelessness include reducing discrimination, stigma, and aporophobia, alongside strengthening protective services and inclusive employment programs. Training and reforms within law enforcement, together with the provision of safe spaces and 24/7 support services, help ensure that individuals are protected and supported effectively.

6.2.5 Transcultural Approaches

Culturally competent services are vital for migrants, refugees, and ethnic minorities experiencing homelessness. Overcoming language and legal barriers, employing cultural mediators and multilingual staff, and providing translated materials promote equitable access. Inclusive frameworks must consider the needs of both documented and undocumented individuals, fostering trust and ensuring that services are responsive to diverse cultural contexts.

7. Foundational principles of the guidelines

The following principles provide the foundation for the design and delivery of services for people experiencing homelessness with complex health and social needs. They are derived from the project's empirical findings and reflect evidence-based, rights-based, trauma-informed, and harm reduction approaches. Together, they aim to ensure that interventions are effective, inclusive, and sustainable across diverse European contexts. These principles are intended to guide policy development, service design, and day-to-day professional practice.

1. Person-centred and rights-based approaches

Services must be designed around the individual, recognizing their rights, dignity, preferences, and lived experiences. A person-centred approach goes beyond individualized care by actively involving service users, and where appropriate their families and support networks, in the design, implementation, and evaluation of services and policies that affect them. This relational and participatory dimension strengthens responsiveness, continuity of care, and ensures that interventions are grounded in real-life needs and social contexts. Embedding a rights-based perspective reinforces access to housing, health, and social support as fundamental rights rather than discretionary benefits, promoting dignity, autonomy, and social inclusion.

2. Community Participation and lived experience involvement

The active involvement of people with lived experience of homelessness is essential for developing effective, legitimate, and responsive interventions. Community participation should be embedded at all levels of service planning, delivery, evaluation, and governance, ensuring that those affected are meaningfully included in decision-making processes. This principle recognizes lived experience as a form of expertise that complements professional knowledge and strengthens the relevance and sustainability of responses, while also emphasizing empowerment by placing individuals at the centre of decisions that affect their lives. Through co-production approaches, peer-led initiatives, feedback mechanisms, and collaborative problem-solving, individuals are enabled to exercise agency, build self-efficacy, and strengthen ownership of services, while also enhancing trust, accountability, and the overall quality of interventions.

3. Harm Reduction as a Core Principle

Harm reduction is a fundamental principle in supporting people experiencing homelessness with substance use challenges. It recognizes that substance use is a health and social issue and prioritizes minimizing harm rather than insisting on abstinence. By providing non-judgmental, evidence-based interventions—such as overdose prevention, safer consumption guidance, and access to healthcare—this principle ensures individuals can engage safely with services. Harm reduction is essential because it protects health, preserves dignity, and creates pathways for engagement, recovery, and long-term social inclusion.

4. Integration of Health, Social, and Support Services

Effective support for people experiencing homelessness requires a holistic, integrated approach that brings together healthcare, mental health services, substance use treatment, social support, and housing assistance. Coordinated, multi-disciplinary teams, shared information systems, and streamlined service pathways reduce fragmentation, improve accessibility, and enhance outcomes. Crucially, this principle emphasizes working in a network: building strong partnerships between public agencies, non-governmental organizations from the civil society, community groups, and service users ensures continuity of care, avoids duplication, and allows resources to be deployed more efficiently. By bridging gaps across sectors and fostering collaborative networks, interventions can address the complex, interconnected challenges faced by individuals, promoting more sustainable and person-centered outcomes.

5. Housing First and Long-Term Support methods

The Housing First principle asserts that safe, stable, and permanent housing is a fundamental human right and the foundation for recovery, autonomy, and social inclusion. By prioritizing immediate access to housing without preconditions, combined with tailored support services for mental health, substance use, and social reintegration, this approach enables individuals to rebuild their lives effectively. Housing First models emphasize long-term solutions rather than temporary shelters, fostering stability, dignity, and empowerment for those experiencing homelessness.

6. Governance and Territorial Coordination

Governance and territorial coordination must underpin all effective interventions for homelessness. This principle asserts that strong collaboration between municipalities, public authorities, civil society, and service providers is essential to design coherent, efficient, and context-sensitive services. By aligning policies, sharing information, and coordinating resources across territorial levels, local authorities can maximize impact, avoid duplication, and ensure sustainability. Governance and coordination are fundamental because they allow municipalities to implement integrated solutions that respond to local needs while ensuring accountability and strategic oversight.

7. Meaningful Participation of People with Lived Experience

The meaningful participation of people with lived experience is a guiding principle for designing and delivering effective services. It asserts that interventions are most relevant and sustainable when informed directly by those who have experienced homelessness. Involving service users in planning, governance, and peer-led initiatives ensures that programs address real-world challenges and build trust, empowerment, and social inclusion. This principle is fundamental because it strengthens accountability, improves service quality, and fosters co-created solutions that respond to complex vulnerabilities such as trauma, mental health challenges, and substance use.

8. Gender-Sensitive and Intersectional Approaches

Gender-sensitive and intersectional approaches ensure that services are tailored to the unique experiences and vulnerabilities of women, LGBTQ+ individuals, and other marginalized groups. Recognizing the compounding effects of gender, sexuality, ethnicity, migration status, and other factors, these approaches promote equity and inclusiveness in service delivery. This principle emphasizes specialized support, such as gender-specific shelters, childcare and reproductive health services, and training for staff to understand and address the diverse needs of all populations experiencing homelessness.

9. Trauma-Informed Care

Trauma-informed care recognizes that many people experiencing homelessness have been exposed to physical, emotional, or structural trauma, which can profoundly affect their trust, behavior, and engagement with services. By prioritizing safety, trustworthiness, empowerment, and collaboration, trauma-informed approaches create environments where individuals feel respected, supported, and able to participate in their own care. This principle encourages service providers to understand the root causes of behaviors, avoid re-traumatization, and design interventions that address both immediate needs and long-term well-being.

10. Cultural Competence and Inclusiveness

Inclusive and culturally competent approaches acknowledge and address the diverse backgrounds, languages, and cultural practices of people experiencing homelessness, including migrants, refugees, and ethnic minorities. By providing multilingual staff, cultural mediators, translated materials, and culturally sensitive health services, local authorities can reduce barriers to access, build trust, and ensure equitable support. This principle reinforces the importance of designing services that respect different experiences and perspectives, while promoting social cohesion and integration.

8. Guidelines and Recommendations

This chapter presents a set of integrated guidelines and policy recommendations aimed at supporting local authorities, service providers, and partner organisations in addressing homelessness in contexts of complex and intersecting needs, including mental health challenges, substance use, trauma, and experiences of violence and migration-related vulnerability. The recommendations are grounded in the findings of the research process, which combined desk review, stakeholder consultations, and comparative analysis of existing practices across different European contexts.

The purpose of this chapter is to translate evidence into **operational and actionable guidance**, moving beyond conceptual understanding toward concrete strategies that can be implemented at municipal and regional levels. The guidelines are designed to support decision-making in real-world conditions, where services often face resource constraints, fragmented systems, and rapidly evolving social needs. As such, they prioritise feasibility, adaptability, and scalability, while maintaining a strong commitment to human rights, social inclusion, and evidence-based practice.

A central premise of this chapter is that homelessness cannot be addressed through isolated or purely reactive interventions. Instead, effective responses require **integrated, multi-sectoral approaches** that connect housing, health, mental health, addiction services, and social support within coherent systems of care. Within this framework, **Housing First is recognised as a key evidence-based model**, widely supported by international research and practice as an effective approach for supporting people experiencing homelessness with complex needs. By prioritising immediate access to stable housing without preconditions, and combining it with voluntary, person-centred support, Housing First has demonstrated strong outcomes in terms of housing stability, improved health, reduced service use, and enhanced social inclusion. The recommendations in this chapter build on this evidence base and reinforce the importance of long-term, housing-led solutions as the foundation for sustainable responses to homelessness.

Equally important, the guidelines are informed by a **trauma-informed and intersectional perspective**, acknowledging that experiences of homelessness are shaped by structural inequalities, including gender-based violence, poverty, discrimination, and migration status. This perspective underscores the need for services that are not only accessible and effective, but also sensitive to the diverse pathways that lead individuals into homelessness.

Finally, the chapter is intended as a practical tool for implementation. Each recommendation is accompanied by examples of concrete measures that local governments and service providers can adapt to their specific context. The aim is to support the development of coherent, sustainable, and rights-based systems that improve outcomes for individuals while strengthening the overall capacity of local welfare and housing systems.

8.1 Strategic Policy Recommendations

8.1.1 Adopt Rights-Based, Integration-Oriented Approaches

Policies must be firmly grounded in human rights, dignity, and equality, ensuring that people experiencing homelessness and substance use are recognized as rights-bearing citizens rather than as objects of control, management, or exclusion. A rights-based approach requires that access to housing, healthcare, and social services is guaranteed as an entitlement, not conditioned on sobriety, employment status, or behavioural compliance. Local authorities should embed human rights impact assessments into all relevant policy areas, including housing regulation, urban planning, and social service provision, to prevent unintended exclusionary effects.

In practice, local governments should:

a) **Develop rights-based service charters** that clearly define entitlements to housing pathways, emergency support, and healthcare access;

b) **Establish independent monitoring mechanisms** or ombudsperson structures to address complaints related to discrimination or exclusion in services;

c) **Integrate human rights criteria** into procurement processes for service providers to that contracted organisations adhere to non-discriminatory and inclusive standards;

d) **Implement "no wrong door" policies,** ensuring that individuals accessing any municipal service—whether health, housing, or social welfare—are automatically connected to appropriate support pathways without bureaucratic barriers or repeated referrals. This reduces systemic fragmentation and reinforces the principle of universal access.

e) **Invest in training programmes for public officials** and service providers on human rights-based practice, including modules on structural inequality, stigma reduction, and trauma-informed engagement. This ensures that rights-based principles are not only embedded in policy documents but translated into everyday institutional practice;

f) **Ensure non-discriminatory access to harm reduction services** including supervised consumption rooms, opioid substitution therapy (OST), and drug checking services, without requiring abstinence or registration barriers;

g) **Integrate mental health crisis support within rights-based housing access systems** ensuring that acute psychiatric distress or substance use does not exclude individuals from housing eligibility.

h) **Introduce participatory rights governance mechanisms** where people with lived experience of homelessness are formally involved in oversight boards, budget allocation discussions, and policy evaluation processes. This ensures that rights are not only protected in principle but co-governed in practice, reinforcing accountability and legitimacy.

8.1.2 Prioritize Integration over Displacement or Containment

Instead of relying on displacement or containment strategies, local governments should develop integrated, place-based systems of support that ensure continuity of care, stability, and sustained access to services within the same territorial and social environment. This requires shifting from reactive "removal-based" responses to coordinated, long-term inclusion strategies that address both immediate needs and structural drivers of homelessness.

In practice, local governments should:

a) **implement multi-agency outreach teams** that combine social workers, healthcare professionals, housing officers, and where appropriate mental health or addiction specialists. These teams operate directly in public spaces, informal settlements, or emergency contexts, not to displace individuals but to establish trust and immediately connect them to housing pathways and services. For example, instead of dismantling an encampment, a coordinated team may conduct daily outreach visits, provide basic health care, register individuals into housing systems, and accompany them through the administrative process of housing allocation.

b) **Develop "housing-led engagement protocols",** where any interaction with a person experiencing homelessness in public space automatically triggers a coordinated offer of housing assessment and support rather than enforcement. This can include guaranteed referral pathways to **Housing First programmes, emergency accommodation with navigation support, or transitional housing units linked to long-term solutions**;

c) Replace drug-use-related policing or eviction in public spaces with **coordinated outreach involving harm reduction teams,** providing safer use guidance, naloxone distribution, and immediate referral to health services;

d) **Develop "no eviction without support" protocols for substance use-related behaviours,** ensuring that housing disruption triggers care coordination rather than removal;de l'habitatge desencadeni la coordinació de l'atenció en lloc del desallotjament;

e) **Establish integrated service hubs or community anchor centres,** strategically located in areas with high levels of homelessness. These hubs bring together housing services, primary healthcare, mental health support, addiction services, legal aid, and social welfare offices in one accessible location. For instance, a person engaged through outreach can be directly accompanied to a hub where they receive same-day health assessment, housing registration, and income support application assistance, avoiding fragmentation and repeated exclusion.

f) **Implement continuity-of-care case tracking systems** ensuring that individuals remain connected to services even if they move between neighbourhoods or temporarily disengage. This can include shared digital case management platforms used across housing, health, and social services (with appropriate data protection safeguards), so that support is not interrupted when individuals change location.

g) **Replace punitive displacement practices with coordinated "place stabilization strategies",** where the goal is not to remove people from visible areas but to stabilize their situation in situ until housing solutions are available. For example, instead of clearing a public space, municipalities may install temporary sanitation facilities, deploy mobile health units, and assign dedicated outreach workers to maintain regular contact and support pathways into housing.

h) **Establish interdepartmental rapid response protocols,** ensuring that any situation involving visible homelessness is addressed through a coordinated welfare response rather than a security-led intervention. This typically involves predefined collaboration between housing departments, health services, and social emergency teams, ensuring that every intervention prioritizes engagement, stabilization, and housing access rather than displacement.

8.1. 3 Invest in Preventive and Early-Intervention Services

Preventive and early-intervention strategies are essential to reduce the inflow into chronic homelessness, substance use-related harm, and repeated crisis cycles. Rather than responding only once situations have deteriorated, local governments should develop systems that identify vulnerability early and intervene before housing loss becomes entrenched. This requires shifting from reactive emergency management to proactive, cross-sectoral prevention systems embedded across housing, health, education, and social protection structures.

In practical terms, municipalities should:

a) **Establish early identification systems for housing instability,** integrated into existing public services. For example, social services, primary healthcare providers, schools, and employment offices can be trained and mandated to screen for early warning signs such as rent arrears, repeated emergency service use, domestic violence, or discharge from institutional settings. Once identified, individuals should be automatically referred to a preventive support pathway, rather than waiting until homelessness is formally declared.

b) **Implement hospital and institutional discharge prevention protocols.** Local governments can require hospitals, psychiatric units, and correctional facilities to coordinate discharge planning with housing and social services at least several days or weeks before release. For instance, a person leaving prison or psychiatric care should not be discharged without a confirmed housing plan, whether through Housing First placement,

transitional housing, or supported accommodation. This reduces the well-documented "discharge-to-homelessness" pipeline and ensures continuity of care;

c) **Implement early warning systems for overdose risk or psychiatric crisis**, using indicators such as repeated emergency visits, non-fatal overdoses, or missed mental health appointments to trigger proactive outreach;

d) **Expand pre-eviction harm reduction prevention pathways**, where tenants at risk of homelessness and using drugs are offered combined housing mediation, addiction support, and mental health follow-up;

e) **Develop rapid intervention and eviction prevention teams**, which are activated when individuals or families are at risk of losing their housing. These teams typically include social workers, housing advisors, and financial counsellors who can intervene by negotiating with landlords, restructuring rent arrears, or linking individuals to emergency income support. For example, a tenant facing eviction due to unpaid rent may receive immediate mediation support combined with temporary financial assistance and legal advice, preventing homelessness before it occurs.

f) **Strengthen low-threshold outreach and community-based early support services,** including mobile units and drop-in centres that offer immediate access to social support, mental health care, and housing advice without bureaucratic barriers. For example, mobile outreach teams operating in neighbourhoods with high deprivation can provide on-the-spot housing assessments, benefit applications, and referral to addiction or mental health services.

g) **Ensure rapid access to trauma-informed counselling, legal protection measures, income support, and long-term housing solutions for victims of Gender Based Violence**, recognising that housing instability often continues beyond the immediate crisis of violence. For example, a woman leaving an abusive partner should be able to access safe accommodation within hours, alongside coordinated support for legal proceedings and housing relocation, without being forced into generic shelter systems that may not be safe or appropriate and without having to lose her house to be safe from the perpetrator.

h) **Integrate a migration-sensitive prevention lens**, recognising that migrants, refugees, and undocumented individuals face heightened risks of homelessness due to precarious employment, administrative exclusion, discrimination, and lack of housing access. Local authorities should therefore ensure that early-intervention systems are accessible regardless of legal status and do not require standard documentation that excludes irregular migrants. Practical measures include **multilingual outreach services, cultural mediation, and dedicated migrant support desks** within housing or social services.

i) **Invest in data-informed early warning systems**, integrating information from housing services, healthcare usage, and social welfare systems (within strict data protection frameworks) to identify patterns of risk. For

instance, repeated emergency room visits combined with housing instability indicators can trigger proactive outreach before homelessness becomes chronic.

8.1. 4 Provide Tailored, High-Intensity Support

People experiencing homelessness often present an heterogeneous profile of complex, intersecting needs including mental health conditions, substance use, trauma histories, chronic illness, disability, and experiences of violence. These overlapping vulnerabilities require flexible, continuous, and highly individualised responses rather than standardised or time-limited interventions.

Local governments should:

a) **Implement intensive case management systems**, where each person is assigned a dedicated key worker responsible for coordinating housing, health, and social support pathways. For example, an individual with severe mental health needs and substance use issues may receive coordinated support from a social worker, psychiatric nurse, and addiction specialist working under a single integrated care plan, avoiding duplicity and revictimization;

b) **Develop Assertive Community Treatment (ACT)-style outreach teams**, which actively engage individuals who are not in contact with services, including those living in informal settlements or street situations. These teams provide sustained, long-term engagement rather than short-term interventions, ensuring continuity even during periods of service disengagement;

c) **Develop dual-diagnosis assertive outreach teams** (mental health + substance use + housing), ensuring continuous engagement for individuals with complex needs who are not in stable contact with services;

d) **Introduce flexible "stabilisation housing units" with integrated clinical support**, allowing people in active substance use or psychiatric crisis to remain housed while receiving intensive care;

e) **Implement flexible intensity support models**, where service levels adapt over time depending on the person's situation. For instance, support may increase during crises such as relapse, eviction risk, or post-hospital discharge, and gradually decrease during stabilisation phases, ensuring both responsiveness and autonomy.

f) **Ensure specialised high-intensity pathways for high-risk groups**, including survivors of gender-based violence in all its forms, young people leaving care, and undocumented or vulnerable migrants. These groups may require additional legal, psychological, and housing navigation support, including rapid access to safe accommodation, trauma-informed counselling, and protection-oriented case management.

8.1. 5 Address Stigma and Promote Inclusion

Stigma, discrimination, and moral judgement significantly shape how homelessness and substance use are experienced, often reinforcing exclusion and limiting access to services. These dynamics are particularly acute for women experiencing GBV, people who use drugs, and migrants facing administrative or cultural discrimination.

Local governments should:

a) **Implement systematic anti-stigma training programmes** for all frontline professionals, including police officers, emergency staff, housing officers, and social service providers. For example, training should include de-escalation techniques **for overdose, psychosis, or intoxication situations**, trauma-informed communication, and awareness of structural causes of homelessness;

b) **Launch anti-stigma campaigns specifically addressing drug use and mental illness**, highlighting recovery, harm reduction, and lived experience narratives;

c) **Develop public narrative and communication campaigns** that explicitly challenge stereotypes and reframe homelessness as a structural issue linked to housing markets, inequality, and social policy gaps. These campaigns can include lived experience testimonies, media partnerships, and school-based education initiatives;

d) **Redesign of public services and urban spaces to ensure non-exclusionary access**, such as removing sobriety requirements for shelter entry, ensuring 24/7 access to hygiene facilities, and eliminating hostile architectural elements that discourage public space use. For example, cities can replace punitive seating or sleeping deterrents with inclusive urban infrastructure such as rest areas, water access points, and safe night shelters;

e) **Develop community-based inclusion and bridging programmes**, designed to support long-term social reintegration and reduce isolation. These initiatives can include structured peer mentorship schemes, where individuals with lived experience who have successfully transitioned out of homelessness are trained and supported to accompany others through housing and recovery pathways;

f) **Fund neighbourhood-led integration projects**, such as supported volunteering opportunities, community arts or employment programmes, and mixed-housing initiatives that facilitate interaction between formerly homeless individuals and the wider community. For example, municipalities may partner with local NGOs to create “inclusion hubs” where service users can engage in skills training, social activities, and community participation, helping to rebuild social networks and reduce stigma-driven exclusion in everyday environments.

8.1. 6 Implement Long-Term, Coordinated Governance Structures

Effective responses to homelessness require stable governance frameworks that extend beyond electoral cycles and short-term funding logic. Fragmentation between housing, health, and social services often leads to inefficiency and inconsistent support pathways.

Local governments should:

a) **Establish permanent intersectoral coordination units** that bring together housing departments, health services, social services, NGOs, and relevant migrant and GBV specialist organisations, among other vulnerables groups according to the city. These units can oversee strategic planning, resource allocation, and service coordination;

b) **Create joint governance protocols between housing, mental health, and addiction services**, ensuring shared accountability for outcomes such as overdose reduction and housing retention;

c) **Fund multi-year integrated harm reduction + mental health service contracts**, avoiding short-term project cycles that disrupt continuity of care;

d) **Introduce multi-annual funding agreements** (e.g., 3–5 years) for key interventions such as Housing First programmes, outreach services, and integrated care teams. This ensures continuity and reduces the instability caused by annual funding cycles.

e) **Develop of shared digital case management systems**, allowing authorised professionals across sectors to coordinate support in real time. For example, a hospital, housing service, and NGO could jointly update and access a single care plan (with GDPR safeguards), preventing duplication, revictimisation and service loss during transitions:

f) **Establish formal governance boards** including public authorities, service providers, and lived experience representatives, ensuring accountability, transparency, and participatory oversight.

8.1. 7 Integrate Holistic, Multidisciplinary Support Models

Homelessness and substance use are multi-dimensional issues requiring integrated responses across housing, health, mental health, employment, legal, and social protection systems. Fragmented services create barriers that disproportionately affect the most vulnerable.

Local governments should:

a) **Develop integrated service hubs ("one-stop centres")** where individuals can access housing assessments, healthcare, social welfare, and legal support in a single location. For example, a person at risk of eviction could

receive same-day legal advice, housing mediation, and financial assistance without navigating multiple institutions;

b) **Establish integrated "complex needs teams" combining housing, psychiatry, addiction medicine, and social work,** operating under a single case plan for each individual;

c) **Develop co-located harm reduction and mental health hubs,** where supervised consumption, psychiatric support, and housing navigation are available in the same space;

d) **Implement co-located multidisciplinary teams,** where professionals from different sectors work physically together. A single service point might include a nurse, social worker, peer workers, housing officer, and addiction specialist collaborating on shared cases;

e) **Develop integrated care planning tools,** ensuring that all professionals involved in a case contribute to a shared intervention strategy. This is particularly important for individuals with dual diagnosis, survivors of GBV, or migrants navigating complex administrative systems.

8.1. 8 Ensure Metropolitan and Regional Coordination

Homelessness is inherently a trans-territorial phenomenon, meaning that individuals often move across municipal boundaries due to service availability, policing practices, housing costs, or personal survival strategies. Without coordinated governance, this can lead to unequal service provision, "service dumping" between jurisdictions, and repeated disruptions in care trajectories. Local governments therefore need to move beyond isolated municipal responses and develop structured metropolitan and regional governance systems that guarantee continuity, equity, and shared responsibility.

Local governments should:

a) **Establish formal metropolitan homelessness governance bodies,** bringing together municipalities within the same functional urban area. These structures should have not only advisory roles but also operational coordination capacity, including shared planning of housing supply for vulnerable groups, joint commissioning of services, and coordinated outreach strategies. For example, in a metropolitan area, a central coordination unit could ensure that Housing First placements and emergency accommodation are distributed according to need rather than administrative boundaries, preventing concentration of pressure in specific cities.

b) **Implement shared regional data and monitoring systems,** allowing municipalities to track mobility patterns, service use, and unmet needs across territories. These systems should include harmonised indicators (e.g., repeated shelter use, cross-municipal movement, or discharge from institutions) so that regional trends can be

identified early. For instance, if a rise in evictions is detected in one municipality, neighbouring areas can anticipate increased demand for emergency housing and coordinate preventive responses;

c) **Create regional overdose prevention and response networks**, coordinating naloxone distribution, drug alerts, and emergency responses across municipalities;

d) **Harmonise access to addiction treatment and mental health services across regions**, ensuring continuity of OST or psychiatric care when individuals move between cities;

e) **Develop cross-municipal funding mechanisms**, where costs for high-need or complex cases are distributed across the region rather than concentrated in a single local authority. This is particularly relevant for individuals requiring long-term Housing First support, intensive mental health care, or integrated services involving multiple agencies. A pooled funding model can ensure that no municipality is disincentivised from supporting complex cases due to budget constraints.

f) **Establish standardised minimum service guarantees across the region**, ensuring that access to emergency accommodation, outreach services, and housing support does not vary significantly between neighbouring municipalities. This could include agreed minimum standards such as 24/7 emergency access, non-restrictive shelter entry criteria, and guaranteed referral pathways into long-term housing programmes;

g) **Develop cross-jurisdictional case continuity agreements**, ensuring that individuals retain access to services even when they move or are relocated. For example, if a person begins receiving support in one municipality but relocates to another, their case management plan, housing application status, and support network should transfer seamlessly without requiring re-registration or loss of entitlements. This is particularly important for migrants, survivors of gender-based violence, and individuals leaving institutions, who often experience forced or repeated mobility;

h) **Create regional "no-discharge-to-homelessness" agreements**, particularly between hospitals, prisons, child protection systems, and municipalities. These agreements would ensure that individuals exiting institutions are not discharged into homelessness regardless of territorial jurisdiction. For example, a prison discharge protocol at regional level would require that housing arrangements are confirmed and funded before release, with responsibility shared across municipalities depending on the individual's origin, destination, and support network.

8.1. 9 Prioritize Evidence-Based and Cost-Aware Decision-Making

Effective responses to homelessness, substance use, and complex social vulnerability require public policies that are firmly grounded in robust empirical evidence, longitudinal evaluation, and transparent cost–benefit analysis. In contexts where resources are limited and needs are increasing, decision-making cannot rely solely on political cycles, public

perception, or short-term visibility of results. Instead, municipalities must adopt an approach that systematically evaluates what works, for whom, under which conditions, and at what long-term social and economic cost.

This evidence-based orientation is particularly important in the field of homelessness, where **policy choices often generate significant downstream costs** across healthcare systems, emergency services, criminal justice, and social protection systems. For example, failure to invest in preventive housing measures frequently results in higher expenditures on emergency accommodation, hospital admissions, and crisis interventions. A cost-aware approach therefore does not reduce social investment; rather, it reallocates resources towards interventions that demonstrate sustained impact and structural effectiveness over time.

Local governments should:

a) **Integrate continuous learning systems into policy design**, ensuring that programmes are not only implemented but actively monitored, evaluated, and adapted based on real-world outcomes. This includes the systematic collection of quantitative indicators (such as housing retention rates, emergency service usage, and health outcomes) alongside qualitative evidence drawn from service users, frontline professionals, and community stakeholders. In this way, evidence is understood as both statistical and experiential, reflecting the complexity of lived realities;

b) **Implement cost-comparison tools** that evaluate the economic impact of emergency responses (e.g., policing, shelters, hospitalisation) versus housing-led interventions such as Housing First or preventive support systems. For example, evidence often shows that stable housing significantly reduces emergency healthcare and policing costs;

c) **Track cost savings from harm reduction interventions** (e.g., supervised consumption rooms reducing emergency hospital admissions and police interventions) to guide scaling decisions;

d) **Use real-time overdose and mental health crisis data dashboards** to adjust service deployment (mobile units, outreach teams) dynamically;

e) **Establish regular evaluation cycles (6–12 months)** to monitor outcomes such as housing retention, health improvements, reduction in emergency service use, and reintegration indicators;

f) **Use pilot programmes before scaling**, allowing municipalities to test interventions (e.g., integrated hubs, outreach models, eviction prevention teams) in specific districts before broader implementation;

g) **Create and apply data dashboards and real-time monitoring systems** which can support continuous adaptation of policies, ensuring that interventions migratòries.

8.1. 10 Engage Politically and Culturally for Sustainable Change

Sustainable transformation requires both technical interventions and long-term political and cultural commitment. Without public legitimacy, even effective policies risk being undermined by stigma, fear-based narratives, or short-term political cycles.

Local governments should:

a) **Develop structured public communication strategies** that explain evidence-based approaches such as Housing First, harm reduction, and integrated care models in accessible and transparent language. For example, municipalities can publish simplified policy briefs, infographics, and public forums explaining how these models reduce costs and improve outcomes;

b) **Implement public education campaigns explaining harm reduction effectiveness**, including overdose prevention, safer use practices, and mental health crisis de-escalation;

c) Engage people with lived experience of drug use and mental health conditions in **policy advisory boards**, ensuring that service design reflects real-world needs and reduces stigma-driven policymaking;

d) **Engage schools, media organisations, civil society organisations and community groups** to promote structural understanding of homelessness and reduce stigma. These actors can help shift public discourse away from moral judgement and toward systemic explanations;

e) **Establish citizen advisory panels** that include people with lived experience, ensuring participatory governance and reinforcing democratic legitimacy;

f) **Publish annual homelessness impact reports**, detailing investments, outcomes, and policy progress. This strengthens accountability and helps maintain long-term political commitment to rights-based and inclusion-oriented approaches.

8.2. Guidelines adoption and implementation

Adopting the Guidelines requires tailoring recommendations to local legal, social, and cultural contexts, which may vary greatly. Still, some practical steps for adoption of the guidelines are:

Specialized Practical tools include:

1. Trauma-Informed Organizational Self-Assessment

Utilize the Trauma-Informed Organizational Toolkit to evaluate current practices and identify areas for improvement. This toolkit offers concrete guidelines for modifying policies and procedures to ensure they are responsive to the needs of individuals who have experienced trauma.

1. **Gap analysis**: Map existing services, identify deficiencies, and determine which recommendations are feasible to implement immediately versus those requiring long-term planning.

2. **Stakeholder consultation:** Engage service providers, NGOs, community groups, and people experiencing homelessness to validate the relevance of Guidelines and gather input on local needs and barriers.

3. **Policy alignment:** Integrate the Guidelines into local policy frameworks, strategic plans, and operational procedures, ensuring alignment with national laws and EU regulations.

4. **Capacity assessment**: Evaluate human, financial, and infrastructural resources required to implement recommendations, identifying areas where additional training, funding, or partnerships are needed.

5. **Pilot testing and phased implementation:** Introduce selected interventions on a small scale to test feasibility, gather feedback, and refine approaches before scaling up across the territory.

2. Housing First Implementation Strategy

Develop and test an implementation strategy for the Housing First model, as outlined in the study "Development and testing of an implementation strategy for a complex intervention known as the Housing First model." This protocol provides a structured approach to adapting Housing First to local contexts, emphasizing coordination among multiple stakeholders.

3. Harm Reduction Integration Framework

Adopt the "Integrating Harm Reduction Strategies into Services and Supports for Young Adults Experiencing Homelessness" framework, which offers information and resources about harm reduction services tailored for young adults. This brief provides actionable steps for integrating harm reduction into existing services.

4. Data Collection and Monitoring Tools

Implement trauma-informed data collection practices as recommended by the "Leveraging HMIS to Support Trauma-Informed Care" guide. This resource outlines best practices for building a trauma-informed Homeless Management Information System (HMIS), ensuring that data collection respects the dignity and privacy of individuals experiencing homelessness.

By systematically reviewing, contextualizing, and piloting the recommended approaches, local authorities can ensure that the Guidelines are not only adopted but also operationalized effectively, resulting in tangible improvements in accessibility, quality, and outcomes of services for people experiencing homelessness with complex health and trauma needs.

8.3 Integrating Best Practices into Existing Services

1. **Service mapping**: Identify existing housing, mental health, addiction, and social support services and assess gaps or barriers.

2. **Prioritization:** Determine which evidence-based practices from the Guidelines are most feasible and impactful for immediate implementation.

3. **Staff training**: Provide targeted training on trauma-informed care, cultural competence, gender sensitivity, and harm reduction.

4. **Cross-sector collaboration:** Establish coordination mechanisms between healthcare, social services, law enforcement, and community organizations to ensure integrated service delivery.

5. **Pilot interventions:** Implement small-scale pilot projects to test adaptations before scaling up.

8.4 Monitoring, Evaluation, and Data Collection

Monitoring, evaluation, and data collection are essential components of any local strategy addressing homelessness and substance use. They provide evidence to inform decision-making, improve service delivery, ensure accountability, and demonstrate adherence to human rights principles. A robust system allows authorities to track both individual outcomes and systemic impacts, identify emerging needs, and justify resource allocation.

1. Establish Clear, Measurable Indicators.

Local authorities should **define a set of indicators** that capture not only quantitative outputs (e.g., number of people housed, service uptake) but also qualitative outcomes (e.g., user satisfaction, improved well-being, social inclusion). Indicators should reflect the complexity of homelessness and substance use, including physical and mental health, social integration, and stability over time. Clear measurement frameworks help assess whether

services are achieving their objectives, allow for comparison across programs, and provide a basis for long-term planning.

2. Collect Anonymized and Ethical Data

Data collection must balance comprehensiveness with strict privacy and ethical standards. Authorities should gather anonymized information on service engagement, housing retention, health outcomes, and interactions with support services. **Data management systems should ensure confidentiality, comply with national and EU data protection laws, and prevent stigmatization or profiling.** Ethical data collection reinforces trust with service users, encouraging more accurate reporting and engagement.

3. Incorporate User Feedback

Incorporating the perspectives of people experiencing homelessness and substance use ensures that services remain person-centered and responsive. Feedback mechanisms—such as surveys, interviews, focus groups, and participatory assessment tools—can reveal barriers to access, identify gaps in service provision, and highlight unmet needs. **Listening to lived experiences helps tailor interventions, improves service quality, and empowers service users, reinforcing their agency and dignity.**

4. Regular Review and Adaptive Management

Monitoring is most effective when linked to continuous improvement. Authorities should schedule regular reviews of collected data to evaluate program performance, identify trends, and adjust services accordingly. Adaptive management allows services to respond quickly to changes in population needs, emerging crises, or shifts in urban dynamics, avoiding rigid or reactive policy responses. This iterative process ensures that interventions remain relevant and effective over time.

5. Integrate Multi-Level Reporting and Knowledge Sharing

Local authorities should develop **reporting systems** that communicate outcomes to stakeholders, including municipal departments, NGOs, funders, and European knowledge networks. Reporting should go beyond compliance, highlighting lessons learned, innovations, and areas requiring attention. Sharing data promotes cross-city learning, facilitates benchmarking, and encourages evidence-based policy development across regions.

6. Monitor Systemic and Social Impacts

Beyond individual-level outcomes, authorities should **track broader societal indicators** to evaluate the long-term effects of interventions. Metrics can include reductions in street homelessness, hospital admissions, criminal justice interactions, urban cohesion, and public safety incidents. Monitoring systemic impacts helps quantify the

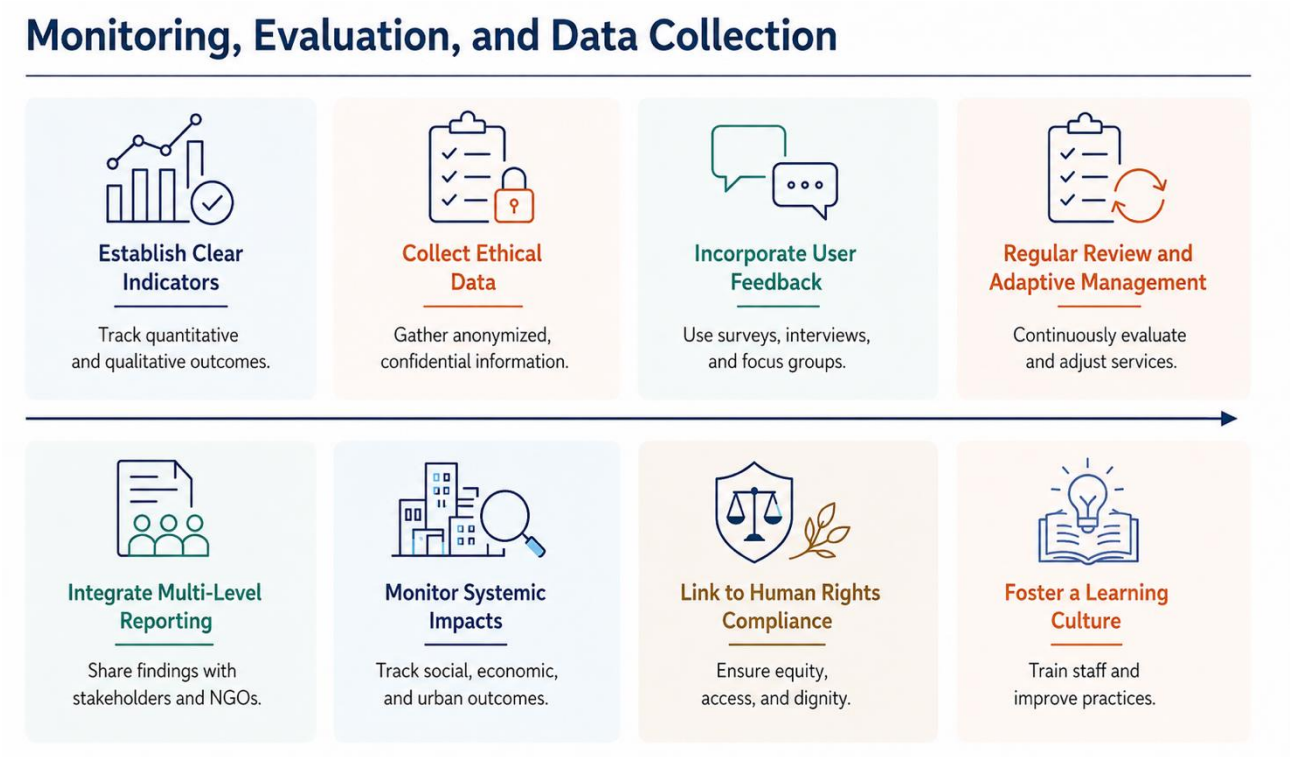
economic, social, and urban costs of failing to address homelessness and substance use, supporting strategic planning and advocacy for sustained investment.

7. Link Evaluation to Human Rights Compliance

Monitoring and evaluation processes should **explicitly assess whether services uphold human rights standards.** This includes evaluating access, equity, inclusion, and respect for dignity. By measuring compliance with rights-based principles, authorities can ensure that interventions avoid harm, do not reinforce stigma, and contribute to social justice objectives, reinforcing both ethical and practical dimensions of service provision.

8. Foster a Culture of Learning

A successful monitoring framework emphasizes **learning and continuous improvement** rather than solely accountability or performance management. Staff at all levels should be trained in data collection, analysis, and interpretation, and empowered to use findings to improve practice. Encouraging reflective practices and open dialogue with service users and partners strengthens program effectiveness and helps create a responsive, adaptive, and rights-based service ecosystem.



9. Dissemination and Next Steps

The effective implementation of these guidelines depends not only on their technical quality, but also on their **wide dissemination, adaptation, and sustained use across different governance levels**. This chapter outlines key strategies for ensuring that the results of this work reach relevant stakeholders at local, regional, and national levels, while also supporting long-term continuity through networks, partnerships, and iterative updates.

9.1 Guidance for dissemination at national and regional levels

To maximise impact, dissemination should follow a **multi-level and multi-channel strategy** targeting public authorities, service providers, and civil society organisations. At national and regional levels, ministries responsible for housing, health, social affairs, and migration should be engaged to ensure that the guidelines inform policy development, funding priorities, and strategic planning frameworks. Regional authorities can play a key role in translating the guidelines into operational frameworks adapted to territorial realities, particularly in areas such as service coordination, funding allocation, and cross-municipal collaboration.

At the local level, municipalities should be supported in integrating the guidelines into **existing homelessness strategies, social inclusion plans, and public health policies**. Practical dissemination tools may include policy briefs, implementation toolkits, training modules for frontline professionals, and stakeholder workshops. In addition, partnerships with universities, training institutes, and professional associations can strengthen knowledge transfer and ensure that the guidelines are embedded in professional practice.

Digital dissemination should also be prioritised through dedicated platforms, ensuring open access to materials, multilingual availability, and user-friendly formats that facilitate uptake by both practitioners and policymakers. Communication strategies should highlight key messages, such as the importance of Housing First, harm reduction, and integrated service models, in order to support evidence-based policy shifts.

9.2 Plans for updates and long-term sustainability

To remain relevant and effective, these guidelines should be understood as a **living document**, subject to periodic review and adaptation. Social conditions, policy environments, and service systems evolve continuously, and guidance must reflect these changes to remain useful.

It is recommended that the guidelines be reviewed on a **regular cycle (e.g. every 2–3 years)**, incorporating new evidence, emerging best practices, and feedback from implementation at local and regional levels. This process should actively include input from practitioners, policymakers, and people with lived experience of homelessness, ensuring that updates reflect both technical knowledge and real-world realities.

Long-term sustainability can be reinforced through the integration of the guidelines into **institutional training programmes, funding frameworks, and strategic policy documents** at national and regional levels. Embedding the principles within formal systems increases the likelihood of consistent application beyond individual projects or funding cycles.

10. Glossary

Addendum for Employees with Lived Experience

A formal organizational document (e.g., at HVO-Querido) outlining competencies, development phases, and recognition of lived experience expertise.

Adverse Childhood Experiences (ACEs)

Potentially traumatic events occurring in childhood, such as abuse, neglect, or household dysfunction, which can impact long-term health and well-being.

Assertive Outreach

Proactive, structured engagement strategies to reach individuals experiencing homelessness, ensuring they can access services and support.

Attachment

“Attachment” refers to a deep emotional bond, such as that between an infant and a caregiver. It can also describe meaningful bonds in adulthood, including relationships with supportive figures, and plays a crucial role in emotional development, trust, and the ability to form healthy relationships.

Authenticity

The quality of being genuine or real. You’re true to your own personality, values, and spirit, regardless of the pressure that you’re under to act otherwise.

Boundary Management

The ability to recognize and maintain personal and professional boundaries, which is essential in peer work.

Countertransference

Emotional reactions a peer worker has toward a client that stem from their own personal experiences or feelings.

Cultural Competence

The ability of service providers and organizations to understand, respect, and effectively respond to the cultural, linguistic, and social needs of diverse populations.

Cultural Values Conflict

Conflicts between recovery-oriented, lived-experience-based values and existing professional or institutional cultures.

Drug Consumption Facility (DCF) / Drug Consumption Rooms

A supervised facility where people can use drugs in a safer, controlled environment, often linked with harm reduction services, healthcare and psychosocial support.

Emotional Regulation

The ability to manage and regulate one's emotional state, influencing which emotions are experienced, when, and how they are expressed.

Experiential Knowledge / Lived Experience Expertise

The combination of personal experience–that may arise from specific and often disruptive life events–reflection, and professional skills that peer workers apply in support or care contexts.

Free Space

A mental, emotional, and physical space in which clients can reflect, make choices, find meaning, and take steps in their recovery—created and safeguarded by peer workers.

Gender-Sensitive Services

Services designed to recognize and address the specific vulnerabilities, needs, and experiences of women, LGBTQ+ individuals, and other marginalized gender groups.

Harm Reduction

Policies and practices that aim to minimize negative health, social, and legal outcomes associated with drug or alcohol use without requiring abstinence. Examples include needle exchange programs and supervised consumption rooms.

Housing First

An evidence-based approach prioritizing immediate access to permanent, individualized, and scattered housing with support for people experiencing homelessness, without preconditions such as sobriety or treatment compliance.

Intersectionality

The interconnected nature of social categorizations such as gender, race, migration status, and socio-economic status, which create overlapping and interdependent systems of disadvantage.

Low-Threshold Services

Services designed to be easily accessible with minimal requirements, reducing barriers for people experiencing homelessness or substance use challenges. Examples include drop-in centers, emergency accommodation, mobile clinics, and open-access harm reduction programs.

Medication-Assisted Treatment (MAT)

Use of FDA-approved medications (e.g., methadone, buprenorphine, naltrexone) in combination with counseling and behavioral therapies to treat substance use disorders.

Model of Care

A structured framework outlining how services are delivered to meet the needs of a specific population, integrating evidence-based practices and coordinated support.

Outreach

Proactive efforts to engage and provide support to individuals experiencing homelessness and/or using drugs who may not otherwise access services, often involving direct contact, information sharing, and connection to resources.

Overdose Prevention

Strategies, programs, and tools designed to prevent fatal or non-fatal overdoses, such as naloxone distribution, supervised consumption facilities, and education on safer drug use.

Peer Integration

The structured and equitable inclusion of peer workers within teams, organizations, and decision-making processes.

Peer Support

Support provided by individuals with lived experience of homelessness, migration, mental health issues, and/or substance use who offer non-judgmental guidance, mentorship, and assistance with service navigation to vulnerabilized people, advocating side-by-side with clients for better life conditions.

Polysubstance Use

The concurrent or sequential use of multiple substances, which can increase health risks and complicate treatment approaches.

Post Traumatic Growth

Post traumatic growth is the positive psychological change that occurs when a person grapples with a trauma event, leading to personal transformation beyond their pre-trauma functioning.

Recovery-Oriented Practice

An approach emphasizing recovery, empowerment, and a person's ability to live a meaningful and self-directed life, regardless of the severity of their challenges.

Social Inclusion

The process of improving the ability, opportunity, and dignity of individuals to participate fully in society, including access to housing, healthcare, education, and employment.

Stigma / Destigmatization

Stigma refers to negative attitudes, discrimination, or social disapproval directed at individuals who use substances, which can prevent them from accessing care and support. Destigmatization consists of strategies aimed at reducing prejudice, especially around homelessness, substance use, or mental health problems.

Survival Knowledge

Practical knowledge gained through lived experience, such as knowing where to find safe sleeping spaces, how to navigate informal support networks, or how systems work in real life.

Therapeutic Interventions

Therapeutic interventions are treatments or procedures designed to address a health condition, improve well-being, or manage psychological distress.

Trauma-Informed Care

An approach that recognizes the widespread impact of trauma, and that behaviors, including risky behaviors such as substance use, may be linked to trauma and adverse life experiences. Trauma-Informed Care integrates this understanding into policies and practice and delivers services in ways that prevent re-traumatization and promote healing.

Trauma Recovery

Trauma recovery is a continuous process that involves understanding trauma responses and employing coping strategies to manage distress and rebuild a sense of safety, acknowledging that recovery is individual and unfolds over time. (Professional help is not mandatory for trauma recovery).

Recovery-Oriented Approach

A model of care emphasizing personal recovery, autonomy, and social reintegration rather than solely focusing on abstinence or changes in psychiatric symptoms.

Risk Environment

The social, physical, economic, and policy context in which substance use, mental health problems, and other vulnerabilities occur, shaping individual risks and harms, including the experience of traumatic events.

Safe Consumption Rooms

Supervised environments where individuals can use drugs under medical supervision, reducing risks of overdose, infection, and other harms.

Substance Use / Use Disorder Spectrum

A range of substance-related behaviors, from occasional risky use to severe dependence and addiction.

Vicarious Trauma

Vicarious trauma is the emotional and psychological toll on individuals from repeatedly hearing or witnessing the traumatic experiences of others.

Window of Tolerance

The "window of tolerance" is the optimal zone of emotional arousal where a person can function effectively and handle stress.

Withdrawal

The physical and psychological symptoms that occur can range from mild to severe when a person reduces or stops using a substance to which they are dependent.

Wraparound Services

Comprehensive, coordinated, integrated services addressing multiple aspects of a person's needs, including housing, mental health, substance use, employment, and social support.

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