Social medical care before and during homelessness in Amsterdam
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chapter 4

Recently homeless adults
Pathways into homelessness: recently homeless adults problems and service use before and after becoming homeless in Amsterdam.

Igor van Laere, Matty de Wit, Niek Klazinga
Background: To improve homelessness prevention practice, we met with recently homeless adults, to explore their pathways into homelessness, problems and service use, before and after becoming homeless.

Methods: Recently homeless adults (last housing loss up to two years ago and legally staying in the Netherlands) were sampled in the streets, day centres and overnight shelters in Amsterdam. In April and May 2004, students conducted interviews and collected data on demographics, self-reported pathways into homelessness, social and medical problems, and service use, before and after becoming homeless.

Results: Among 120 recently homeless adults, (male 88%, Dutch 50%, average age 38 years, mean duration of homelessness 23 weeks), the main reported pathways into homelessness were evictions 38%, relationship problems 35%, prison 6% and other reasons 22%. Compared to the rest of the population, the eviction group was slightly older (average age 39.6 years vs 35.5 years; p = 0.08), belonged more often to a migrant group (p = 0.025), and reported more living single (p < 0.001), more financial debts (p = 0.009), more alcohol problems (p = 0.048) and more contacts with debt control services (p = 0.009). The relationship group reported more domestic conflicts (p < 0.001) and tended to report more drug (cocaine) problems. Before homelessness, in the total group, contacts with any social service were 38% and with any medical service 27%. Despite these contacts, they did not keep their house. During homelessness only contacts with social work and benefit agencies increased, contacts with medical services remained low.

Conclusion: The recently homeless fit the overall profile of the homeless population in Amsterdam: single (Dutch) men, around 40 years, with a mix of financial debts, addiction, mental and/or physical health problems. Contacts with services were fragmented and did not prevent homelessness. For homelessness prevention, systematic and outreach social medical care before and during homelessness should be provided.

Background

There is little evidence on good practice in caring for homeless people in the medical literature [1]. It has been reported that for homeless people life expectancy averages around 45 years, and that lack of access to health care services has too often proved a barrier to recovery, and, as a result, contributes to a downward spiral of deteriorating health and premature death [2]. Therefore, public services strategies should include homelessness prevention.

To prevent and reduce homelessness, strategies that address the general population and/or a targeted population could include housing benefits, welfare benefits, supplementary security income, supportive services for impaired or disabled individuals, programs to ameliorate domestic conflicts, programs to prevent evictions, discharge planning for people being released from institutions and (outreach) care programs for homeless populations [3,4].

Despite all these efforts and investments, and although there is broad consensus among policymakers and service providers that more resources and professional efforts should be dedicated to homelessness prevention, insufficient knowledge is available on how to accomplish this [3-5].

To identify starting points for homelessness prevention strategies in Amsterdam, the Netherlands, we have described in previous articles evictions from ones house as a major pathway of how people enter homelessness [6,7]. We demonstrated that evictions were a neglected public health problem. Despite knowledge about the underlying social and medical problems among households at risk, referrals to social and medical care are insufficiently used as a method to prevent eviction. Furthermore, we concluded that in Amsterdam nobody took the responsibility for the evicted households, predominantly due to rent arrears, whether they become homeless or not.

The absence of integrated social medical care results in a lack of assistance for recently evicted households, many of whom enter homelessness. Once homeless, people are responsible themselves in their search for specific services, organised alongside the mainstream service delivery system [8,9]. The lack of assistance for recently homeless people seems to be in concordance with a lack of knowledge of recently homeless people, related to their pathways into homelessness and their social and medical problems [3,5,6,10].

Objectives of this study

Regarding the lack of assistance for evicted households in Amsterdam, and contributing to the knowledge on recently homeless people and the development of prevention practice, for this study we tried to identify recently homeless adults, to explore 1) the pathways into homelessness, 2) the social and medical problems before and after becoming homeless, and 3) the contacts with social and medical services before and after becoming homeless.

Methods

Study population

Included in our study were recently homeless adults defined as persons, 18 years and older, who lost their house for the first time during the last two years (between April 2002 and April 2004) and who were legally staying in the Netherlands. The choice of the length of homelessness up to two years was intended to enhance the reliability of the information reported and to overcome problems of memory. To find locations to meet recently homeless adults, data on rough sleepers and visitors of day centres in Amsterdam were studied [11,12]. Staff at one specific benefits provider for the homeless, at five day centres and at two emergency shelters were interviewed for information on their homeless visitors. After combining oral and written information, we decided to reach as many recently homeless adults as possible at locations recently homeless people tend to visit and where they could be approached for an interview. These were three gathering places for outreach soup distribution and popular street hangouts, one specific agency for benefits provision for the homeless, four emergency shelters and seven day centres with each over 450 visits a week. To keep a homogenous sample, shelters for adolescents and families were not included. The study design did not need a process of ethical approval according to the Dutch Act on Medical Research.

In April and May 2004, interviews were conducted by ten undergraduate social science students. The students were familiar with approaching and interviewing homeless people. Interviewers underwent three training sessions on the process and quality of data registration, and all questionnaires were reviewed after the interviews. For every completed questionnaire students received twenty euros. Interviews lasted on average 45 minutes.

During a total of 40 occasions, at fourteen locations, between 4 and 38 homeless people were present at any moment (on average 25), of whom 125 homeless adults were eligible and participated in the study, by giving written consent for an interview and anonymous data analysis. Specific encouragement or incentives for homeless people to participate were not applied. None of the respondents were too intoxicated or too confused to be able to participate. During the interviews, on a separate list, the questionnaire number, a coded name and date of birth of participants were recorded to exclude doubling. Two persons were interviewed twice and were excluded from analysis. Three questionnaires were excluded as the respondents were homeless for longer than two years. In total 120 questionnaires were included in the analysis.

Collected data

Questionnaires for this study consisted of author-generated items. In consultation with city sociologists at the...
To identify independent factors associated with the spec-
fic pathways, logistic regression analyses were performed
using backwards selection based on the loglikelihood
ratio. In addition, logistic regression analyses was per-
formed to study factors independently associated with the
main problems identified in each pathway.

Results

Housing setting and pathways into homelessness

In table 1 the self reported housing setting and pathways
into homelessness are shown. Before homelessness two
thirds were living in a rented house. Thirteen respondents,
out of the 120, mentioned never having lived independ-
ently; they had always been staying with family or friends.
More than half had rented a house a housing associa-
tion (53%) and one third had rented privately (32%). The
median rent price was 268 euros (range 0–1,000 euros),
and the median gross salary was 809 euros (range 0–
4,500 euros). Forty respondents had a rent/income ratio
up to 30%, 33 up to 60%, 7% more than 60% and for 40
respondents this was not known.

When asked how respondents lost their last housing,
answered by 109 respondents, the three main pathways
were evictions (38%), leaving one house or being send
away by others due to relationship problems (35%) and
other reasons (28%). Among 38 respondents who were
homeless due to relationship problems, (of whom one
third had a rent contract in their own name), 4 had left on
their own initiative and 34 were sent away by household
members (partner 22, parents 6 and roommates 6).

Among other reasons, 6 mentioned they had lost their
house while doing time in prison. Four out of five had
become homeless in Amsterdam. After loss of last hous-
ing, 57% reported immediate homelessness, and 86%
reported being on the streets within three months.
The median length of homelessness was six months (23
weeks).

Table 1: Self reported setting and pathways into homelessness

<table>
<thead>
<tr>
<th>Type of housing</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>own house</td>
<td>75</td>
<td>65</td>
</tr>
<tr>
<td>stay with family, friends or other</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>prison</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>abroad</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>hospital</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>hostel</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Pathways, how last housing lost? (n = 109)

<table>
<thead>
<tr>
<th>Pathways</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>eviction</td>
<td>41</td>
<td>38</td>
</tr>
<tr>
<td>relationship problems (left or sent away)</td>
<td>38</td>
<td>35</td>
</tr>
<tr>
<td>after prison</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>other reasons</td>
<td>24</td>
<td>22</td>
</tr>
</tbody>
</table>

Pathways and problems

To find out pathways into homelessness, respondents
were asked about their last housing condition and included
composition of the household, type of housing, type of
lesser, rent agreement and rent/income ratio. Demograph-
ics included sex, age and country of birth. For information
on the social and medical problems before and after becom-
ing homeless the following items were asked. Social prob-
lars were domestic conflicts (with household members,
neighbours, landlords and/or services) and financial
problems. Medical problems included addiction to alcohol,
drugs and gambling, mental health problems and physical
health problems. Alcohol use could be scored as normal,
escalation, 57% reported immediate homelessness, and 86%
reported being on the streets within three months. The
median length of homelessness was six months (23
weeks).

Table 2: Demographics and household composition related to pathways into homelessness

<table>
<thead>
<tr>
<th>Demographics</th>
<th>total (n = 120)</th>
<th>eviction (n = 41)</th>
<th>relationship (n = 38)</th>
<th>other (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>105</td>
<td>88</td>
<td>38</td>
<td>15</td>
</tr>
<tr>
<td>female</td>
<td>15</td>
<td>12</td>
<td>93</td>
<td>13</td>
</tr>
<tr>
<td>gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>120</td>
<td>41</td>
<td>38</td>
<td>33</td>
</tr>
<tr>
<td>age in years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>39</td>
<td>33</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>30-39</td>
<td>30</td>
<td>25</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>40-49</td>
<td>26</td>
<td>22</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>50-64</td>
<td>14</td>
<td>12</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>65-74</td>
<td>10</td>
<td>9</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>country of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>58</td>
<td>48</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>Suriname/Kit/Morocco</td>
<td>24</td>
<td>20</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>composition of household</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>single</td>
<td>46</td>
<td>44</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>with partner</td>
<td>22</td>
<td>21</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>with partner and children</td>
<td>18</td>
<td>17</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>with other adult</td>
<td>10</td>
<td>9</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

* p = 0.025; ** p = 0.000
those between 18–29 years and those 60 years and older, and among respondents not born in the Netherlands. Underlying social or medical problems were not significantly associated with domestic conflicts.

Regarding pathways and medical problems, the eviction group reported more alcohol problems than the relationship group (p = 0.048). Drug problems, mainly cocaine use, tended to be more common in the relationship group compared to the eviction group, although not significantly. In all groups more than half reported mental health problems.


### Table 3: Self reported problems before homelessness related to pathways into homelessness

<table>
<thead>
<tr>
<th>Reported problems before homelessness</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social problems (n = 120)</td>
<td>88</td>
<td>81</td>
<td>85</td>
<td>82</td>
<td>80</td>
<td>81</td>
<td>87</td>
<td>85</td>
</tr>
<tr>
<td>financial debts</td>
<td>73</td>
<td>66</td>
<td>68</td>
<td>64</td>
<td>63</td>
<td>64</td>
<td>66</td>
<td>65</td>
</tr>
<tr>
<td>domestic conflicts</td>
<td>55</td>
<td>48</td>
<td>78</td>
<td>70</td>
<td>79</td>
<td>72</td>
<td>96</td>
<td>78</td>
</tr>
<tr>
<td>Medical Problems (n = 41)</td>
<td>57</td>
<td>48</td>
<td>59</td>
<td>77</td>
<td>50</td>
<td>61</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Addiction total</td>
<td>37</td>
<td>31</td>
<td>12</td>
<td>9</td>
<td>37</td>
<td>31</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>alcohol</td>
<td>26</td>
<td>22</td>
<td>12*</td>
<td>10</td>
<td>26</td>
<td>22</td>
<td>12*</td>
<td>10</td>
</tr>
<tr>
<td>drugs</td>
<td>20</td>
<td>18</td>
<td>12</td>
<td>12</td>
<td>20</td>
<td>18</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>cocaine</td>
<td>13</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>13</td>
<td>11</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>heroin</td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>gambling</td>
<td>22</td>
<td>19</td>
<td>24</td>
<td>19</td>
<td>22</td>
<td>19</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Mental problems</td>
<td>67</td>
<td>56</td>
<td>63</td>
<td>53</td>
<td>67</td>
<td>56</td>
<td>63</td>
<td>53</td>
</tr>
<tr>
<td>depressed</td>
<td>61</td>
<td>51</td>
<td>54</td>
<td>48</td>
<td>61</td>
<td>51</td>
<td>54</td>
<td>48</td>
</tr>
<tr>
<td>confused</td>
<td>29</td>
<td>24</td>
<td>19</td>
<td>16</td>
<td>29</td>
<td>24</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Physical problems</td>
<td>26</td>
<td>22</td>
<td>7</td>
<td>6</td>
<td>26</td>
<td>22</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

The self reported gambling rate decreased from 48% before to 20% after becoming homeless, due to less excessive and medical services even lower. Among the contacts with medical services the general practitioner played a minor role.

Regarding pathways and social problems, the eviction group reported more contacts with debt control services than the relationship group (33/41 = 81% versus 18/38 = 47%; p = 0.009, not in table). Despite these contacts they did not keep their house. Regarding pathways and medical problems no significant differences in service use between pathway groups were found. Before homelessness, of 86 respondents who reported a medical problem, 47 did look for some sort of medical service and 39 did not feel the need. Reasons mentioned for not perceiving the need for medical support were e.g. “I don’t need help”, “I solve my own problems”, “I don’t have an addiction problem”, “I don’t see how they can help me”, “I don’t know where to go”, “they ask too many questions” and “services are slow”.

How recently homeless people envision better services and their biggest dream

We asked recently homeless people about their ideas how to improve assistance. In general, the majority of respondents mentioned that they wished that the city provides a one stop comprehensive service for social and medical problems, active assistance for red tape and financial management, and fast tracking towards (guided) housing and jobs. Respondents said e.g. “you need to be verbally strong to succeed at services”, “social and financial support should be much faster”, “I wish clear information where to go for what problem”, “services should work together”. Other answers were “If I had help before I became homeless...”, “I try to be nice, but they are rude”, and “they should offer help for normal homeless people”.

What is your biggest dream? Almost all wanted a house, a normal life with family contacts and/or a job. Respondents said e.g. “I hope they give me benefits in the future”, “to see my daughter”, “a safe place”, “a house within a few months, and decorate Christmas with friends at home”. Other answers were “that they do more for homeless people who do not take drugs”, “I do not have dreams, I gave up hope a long time ago” and “one man was dreaming of a ”shower and clean clothes”.

Discussion

For the homelessness prevention practice, we aimed to discover the sources of homelessness; defined as the factual pathway that leads to an (official) forced or voluntary displacement from one home or facility. Therefore, we explored the pathways people took into homelessness and compared the characteristics, problems and service use per pathway taken. In our approach, we focus on the detection of underlying problems, that services should respond to, rather than examining why the underlying problems exist. Knowledge of the characteristics and problems of people who follow different pathways into homelessness should contribute to timely detection of vulnerable people who might step into homelessness.

We identified 120 recently homeless people in Amsterdam to explore their pathways into homelessness, problems and service use, before and after becoming homeless. The main pathways into homelessness reported were evictions from one home (38%), relationship problems that lead to leaving a home or being sent away by household members (35%), leaving prison (6%) and various other reasons (22%). These pathways into homelessness are consistent with those known in the literature [4-10, 15, 16]. However, the figures in this sample can not be compared with those found by others due to varying settings, definitions and methodology. For comparison, the factual pathways into homelessness, the key causes, underlying contextual factors and triggers need to be disentangled [45,9].

Not surprisingly, the characteristics of the recently homeless people in our study show more similarities than differences with those found among the majority of...
households at risk of eviction (due to rent arrears and sui-
cidal threats), shelter users and homeless adults visit-
ing outreach medical care facilities in Amsterdam [6,11,17-19]. The profile of the majority of the homeless in Amsterdam is comparable with those cities abroad [10,20-22].

In all pathway groups almost two thirds reported a com-
nbination of social and medical problems. Those who were homeless after eviction did belong to a major migrant group more often, were slightly older, were more often living single, had more financial problems and more alcohol problems, than the other groups. Those who were home-
less due to relationship problems were slightly younger, had more domestic conflicts and tended to report more drug (cannabis use) problems, than the others groups.

Gambling, as a known source of debts and financial diffi-
culties, was reported by 24% among those evicted and 13% among those who had lived with others. In Mel-
bourne, Australia, before homelessness, among 93 older homeless men, gambling was reported by 46% among those who were living alone and 28% among those living with others [4,16]. In Amsterdam, gambling was hardly mentioned by employees of housing associations han-
dling rent arrears and by employees in nuisance control care networks handling nuisances when asked to report problems among households at risk of eviction [6]. Serv-
Ice providers should be alert for gambling problems among mostly single men at the brink of homelessness due to financial difficulties.

Furthermore, regarding medical support before homeless-
nes, for all pathways, the general practitioner, as a gate-
keeper for addiction, mental and physical health problems, played a marginal role in providing care, which was also found among households at risk of eviction in Amsterdam [7]. For those at risk of homelessness with silent and/or non-self perceived health needs, 39 out of 86 who reported a medical problem, a sharp decrease of possible patient contacts with social and medical services might be unfa-
vourable [8,23]. Specifically, if no alternative social medical care at home is provided, and lessons how to integrate care for those in highest need have to be learned, many previously home-
less people staying in the same shelters and day centres together with the long-term homeless might have a numbing effect on a positive attitude towards rehabil-
itation [26,27].

The strength of this study is that we had good access to key informants and the locations where recently homeless people tend to gather. We obtained a high response rate among the recently homeless people who were approached for an interview. This study involved two principal limitations. First, our data regarding medical problems were based on self-reported information. Spe-
cifically for psychiatric problems diagnostic or clinical instruments were not used, therefore data can not be com-
pared with other studies. Furthermore, some respondents mentioned having trouble remembering the number of services they had used over time. Second, a random sam-
ples of the recently homeless could not be drawn since the duration of homelessness is not registered at day centres and shelters, and not for those using these facilities. Following our experience with homeless care, we believe that the data are valid and can be generalised for the total recently homeless population in Amsterdam.

Homelessness prevention strategies

Scholars in Australia, England and the US have described mul-
tiple obstacles for homelessness prevention strategies and the evaluation of prevention programs [3-5]. Regard-
ging causes of homelessness, most cases involved personal problems and incapacities, policy gaps and service deliv-
ery defects. Crenan et al. found that vulnerable people were being excluded because health and welfare services did not have the responsibility or resources to search for peo-
ple with untreated or untreated support needs [4,5]. Further-
more, evaluation of homelessness prevention programs are hampered e.g. by fragmented and provision driven data registration [3].

In Amsterdam, several strategies to prevent and reduce homelessness have been implemented, since our study was executed in 2004. The Amsterdam Welfare and Care department promotes an integrated approach by housing, social and medical services to take responsibility in actively assisting vulnerable citizens with support needs. This strategy is in accordance with the wishes and dreams of the majority of the recently homeless in our study. Since 2007 service providers are being trained for this approach. They learn how to expand the activities. More guided living options in the social housing sector (75% of the total housing stock in Amsterdam) are being offered, more integrated on call medical services will be build, and the number of beds in shelters, addiction and mental health care facilities are being increased [28].

Regarding the three pathways into homelessness of the recently homeless people in our study, we reflect and comment on the existing strategies in Amsterdam.

1) Eviction from one home was the main source of home-
lessness. Per year more than 1,400 households are being evicted in Amsterdam [6]. To decrease the numbers of evic-
tions, existing outreach networks respond to persistent rent arrears and nuisance, as signals to be picked up by housing associations and landlords, to be shared with social services. In response, during a house visit underly-
ings, such as gambling and medical problems, and unmet support needs are being explored [6,7,28]. Based on our previous studies on evictions and current findings, we suggest that assistance should explicitly be applied to low income single men, with underlying finan-
cial problems, addiction and/or mental and/or physical health problems. As among these high risk a mix of social and medical problems is to be expected, social and medical workers should be trained to systematically approach and guide the underlying problems to keep these men at home [6,7,25].

2) Relationship problems that lead to leaving a house was the second source of homelessness. Prevention strategies might be difficult to design. However, underlying prob-
lems and service use are also prevalent among this high-
risk group. Alertness of social and medical services could be the way to identify this high risk group for preventive activities. Social services should know their clients and should be trained to be sensitive for signals of vulnerability. These signals should be detected with a few additional questions related to a person's coping with daily living, house-
hold management, income and debts (alcohol, cocaine and gambling), and should actively be shared among dis-
ciplines [4,5,21]. In health care settings medical profes-
sionals, and the general practitioner in particular, do have the opportunity and responsibility to diagnose social dis-
 ease (such as poverty and imminent homelessness), that intrinsically interacts with medical disease, and actively ask for social assistance in response [5,29].

3) Leaving prison was the third source of homelessness, among various other reasons. In the Netherlands, when people stay in prison for a certain period of time welfare benefits are terminated. Data on the number of peo-
ple that did pay rent off welfare benefits before they went to prison are not being collected. Nor data on the number of people that lost their house during time in prison because nobody assisted in paying the rent at home, and, as a consequence, became homeless after leaving prison. However, in Amsterdam, vulnerable inmates and multi-
ple offenders are actively being followed up and assisted to anticipate housing, income and care after prison [28].

Furthermore, to prevent long term homelessness, new arrivals in the homeless circuit, at places the homeless tend to gather, are actively being identified and fast tracked along social and medical services, as the motivation to turn their situation around is expected to be a crucial entry point towards rehabilitation. For this strategy, social and shelter services aim to converge their intake procedures in a cen-
tral shelter unit, where (recently) homeless people can undergo a social medical assessment and be guided towards problem oriented housing and care. Among the services for the poor and underserved, the GGD Municipal Public Health Service is operating as the central field director to monitor strategies to further prevent and reduce homelessness in Amsterdam [28]. New evalua-
tions should demonstrate whether the present situation has improved compared to our findings in 2004.

Conclusion

Among recently homeless adults in Amsterdam, the main pathways into homelessness reported were evictions, rela-
tionship problems and leaving prison. In all pathways the recently homeless fit the profile of the majority of the total homeless population in Amsterdam: single men, around 40 years old, with a mixed history of drug addiction and mental health problems. During homelessness only con-
tacts with social and/or medical services that did not prevent homelessness. During homelessness only con-
tacts with social work and benefit agencies increased, con-
tacts with medical services remained low. For homelessness prevention, systematic and integrated social medical care before and during homelessness should be T

Competing interests

The authors declare they have no competing interests. No external funding was provided for this research.

Authors' contributions

All authors contributed to the conceptualisation of the paper. J.V contributed to the study design and implemen-
tation, and wrote the manuscript. M.W contributed to the study design and implementation, analysed the data and
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