

## **Quantitative point in time analyses of homelessness in the Netherlands**

### **Short paper for the thematic workshop in CHUP**

**Madrid, 9-10 October, 2003**

#### **INTRODUCTION**

This paper consists of two parts. Part 1 gives a survey of the methods used in quantitative point in time analyses of homelessness.

In part 2 the results of point in time analyses will be presented. This part is written by Judith Wolf and Sarala Nicolas (Trimbos institute) and will be presented at the FEANTSA conference in November 2003.

## Part 1 MATTERS OF METHODOLOGY

Lia van Doorn

### Quantitative data gathering

In 1995 the leading institute the National Health Council published a report on the state of affairs of research into the population of homeless persons in the Netherlands. The institute stated that different definitions were being used, rendering it difficult to compare research results. On the one hand the National Health Council advocated a sounder methodological foundation of point in time studies in which the homeless are counted at a specific time and/or interviewed in order to recover their characteristics. And on the other hand it advocated longitudinal study. In this part we focus on methodological aspects of the point in time studies conducted so far. How were these studies conducted and what research methods, questionnaires and measuring instruments were used?

Since the National Health Council drew its conclusion in 1995, several large-scale studies have been conducted in which the homeless were counted and their demographical characteristics mapped out. Of the five main studies reviewed here, four have a regional scope and one has a nation-wide scope.

- a local study, conducted in 1989 in Utrecht among 150 roofless persons (Reinking et al.1998)
- a local study, conducted in 1999 in Amsterdam among 212 homeless persons, most of whom could be characterised as roofless (Korf et al. 1999)
- a local study conducted between 2000 to 2001 in The Hague, among 103 roofless persons and 100 houseless persons (Reinking et al. 2001)
- a local study conducted in 2001 in The Hague, among 112 homeless persons (both homeless and houseless)
- a national study conducted between 2001 and 2002 among 500 homeless persons (both roofless and houseless) in 20 towns (De Bruin et al. 2003)

(Source: J. Wolf, S. Nicholas 2003).

In addition a start was made with the combining of available research data in the Netherlands and with the continuous monitoring of the homeless population periodically and systematically by means of the national Monitor on Homelessness (MMO). In 1997 the Ministry of Health, Welfare and Sport (VWS) ordered the development of this monitor. The Ministry formulated the MMO's goal as follows: 'maintaining and acquiring insight into social shelter and care, specifically in the care need, the service provision and local policy, under responsibility of several co-operating agencies'. These agencies are the Trimbos Institute, the research and advice bureau of the VNG / SGBO (Association of Netherlands Municipalities), the Netherlands Institute for Care and Welfare / NIZW and the Central Statistical Office (CBS). The MMO has three functions: carrying out monitoring activities, co-ordinating activities and presenting and integrating data from the activities mentioned in reports to the national government, local councils, institutions and other agents, such as the Federation Shelter and the VNG. In 2000 MMO presented its first publication entitled Monitor Maatschappelijke Opvang (Monitor on Homelessness), by the Trimbos Institute (Wolf et al. 2000) (In addition the Socio-cultural Planning Agency paid attention to the financial positions of the homeless in another monitor study: the Poverty Monitor (SCP 2001)).

The Monitor Social Care and Shelter concluded –surveying the studies into the homeless that were carried out during the past decade- that an unequivocal set of concepts was still lacking. The monitor initiated its development. In addition it stated that there is little reliable quantitative information on homeless persons (Wolf et al. 2000). In this respect a number of methodological dilemmas occur that will be reviewed hereafter.

- *Client registration in the institutions*

In the majority of institutions for homeless persons registration data on clients are entered in computer systems. These registration data are gathered at the national level and included in the Monitor Social Care and Shelter. Thus a multitude of information is made available on ‘institutional homeless persons’. For example with regard to gender, age, nationality and town of birth, level of education, marital status and family composition, source of income and care need. In addition it provides insight into the number of applicants and the percentage of applicants turned down from lack of space.

However, some methodological comments should be made regarding the gathering and interpreting of these client registration data (Feijter 1999):

- Two very different digital registration systems are being used by the institutions, the data of which can only be compared in part. For that matter, at present both systems are being combined into one new national system that became operational in 2003.
- A considerable number of institutions, in particular the smaller organisations, does not have at its disposal one of the usual registration systems. They either register by means of lists filled in by hand or do not register at all.
- Due to amongst other things pressure of time in the institutions the registration data of clients are often incomplete, resulting in incomplete information.
- In the present system client data are not linked to the individual. Therefore homeless persons that turn to several institutions will be registered again and counted again. This flaw by the way will be overcome in the new system by allocating an individual registration number to every homeless person.

The main objection is that the data based on client registration only provide insight into homeless persons reached by the institutions. The potential target group –homeless persons not being reached- remains out of sight.

- *Street survey*

A similar methodological misrepresentation or bias can be observed in point of time analysis of homelessness. In the past the available studies would focus almost entirely on the homeless population staying in the institutions: on those that used the boarding houses, hostels, and walk-in services. This population of institutional homeless persons can be localised with relative ease. However, as a result of this other categories such as rough sleepers, the marginally housed, illegal immigrants (that will not be admitted to some of these institutions) and suspended homeless persons (denied access to the institutions) are paid too little attention.

By the middle of the nineties this bias was overcome to some extent. As of then point of time studies tended to involve these homeless persons rather more into the research population through street survey.

The street survey carried out by sociologists of the University of Amsterdam (UvA) among rough sleepers is the most advanced and the soundest as to its basis from a methodological perspective (Deben et al. 1997; Rensen et al. 2002). They made use of the so-called capture-recapture method derived from ecology. In a nutshell this implies that the researcher will

fish several times in the same pond, mark the fish he caught and then put them back. If the researcher catches different fish all the time, the total number of fish in the pond will exceed the number of fish caught. If the same fish are being caught over and over again, it can be assumed that only few uncaught fish remain. Thus by means of probability calculus the size of the total fish stock in the pond can be established.

By means of the capture-recapture method rough sleepers in Amsterdam were counted and interviewed. In the period between 1995 and 2001 on a set date every two years during the night counts were made and these were repeated in four different seasons. The research team was assisted by students who, on foot, armed with a torch and with police protection searched demarcated parts of the city to track down and interview rough sleepers in hidden nooks and crannies. The individual rough sleepers were identified by means of a name code and recognition by the researchers. The data gathered thus were then extrapolated to other parts of the city where no count had been carried out. By applying the very same research model during annual repeats the reliability of the research data was increased and a view was gained of the increase or decrease of the number of rough sleepers.

However, in this street survey a number of difficulties occurred.

- The researchers were faced with the dilemma whether to restrict themselves to counting people that were actually found lying down and/or asleep, of whether 'rough walkers' should be included, such as homeless persons that have turned around their day and night rhythm and sleep during the day, or drug addicts that stay awake at night for hours on end. Eventually they opted for the latter variation.
- It appeared to be impossible to find all potential sleeping-places, for example in inaccessible parts of private buildings.
- The risk of double counting could not be excluded completely.
- The recently homeless -as yet unable to find their way to shelter and care provisions- appeared to be relatively overrepresented.
- It was difficult to distinguish accidental, once-only rough sleepers from the regulars that slept rough frequently.
- *Fundamental demographical data*

In the available point in time analyses it is not always possible to compare demographical data of homeless persons. The questionnaires used are not consistent. As a rule the studies contain the same core questions regarding demographical data such as the question about gender, age, marital status and nationality. Comparison of results is simple, as a rule. However, with regard to less easily quantifiable demographical characteristics, the results are not quite so unequivocal. We will illustrate this with three examples.

- The level of education of homeless persons. Some studies merely enquire after actually completed education, others also include education not completed, and some do not distinguish between completed or not completed education.
- Assessment of the income of homeless persons is not carried out in an unequivocal manner either. Some studies merely enquire after a registered (legal) income. Others also enquire after income from illegal sources. Often the research account does not state how income levels of the homeless have been calculated precisely. In addition, for the larger part street economy is based on barter, mutual exchange of goods and services. It is hardly possible to quantify this.
- From data on the duration of homelessness it is often impossible to establish whether the research data refer to one long uninterrupted period of homelessness or whether it is the sum total of several episodes of homelessness.

Such methodological inconsistencies hamper comparison of available studies.

- *Psychological functioning and psychiatric illness*

How is the mental health situation of homeless persons in the Netherlands assessed? On the basis of available studies it is not possible to provide reliable estimations of the prevalence of mental disorders. Not even by means of the current DSM classification system. Neither can an indication be given about a supposed in- or decrease of the number of people with psychological problems, living on the streets. Media coverage of a great increase of the number of psychiatric patients on the streets, usually attributed to the effects of de-institutionalisation in mental health care, cannot be verified. The methodological problems that occur when assessing the prevalence of mental problems and disorders among the homeless, can be summarised as follows (Wolf c.s. 2000):

- There is conceptual ambiguity with regard to what exactly has been studied: such diverse concepts as mental complaints, mental disorders, psychiatric clinical picture and psycho-social problems are mixed;
- There is conceptual ambiguity with regard to the target group on who exactly have been studied: roofless persons, homeless persons or roof- and homeless persons;
- Not always a differentiation is made between an actual diagnosis (the disorder at the time of the interview) and a 'life-time' diagnosis (a disorder that occurred in someone's life at a certain time);
- It is hardly possible to distinguish between psychiatric disorders and deviant behaviour that can be related to adaptation mechanisms of the stress of a life on the streets;
- We lack instruments to establish cause-effect relations; it is not clear whether people became homeless due to a psychiatric disorder or the other way round, that people developed a psychiatric clinical picture in reaction to being homeless;
- In genuine addicts it is usually impossible to establish whether mental problems are hidden behind the addictive behaviour. Neither can it be established to what extent an addiction is the cause or the effect of a psychiatric disorder;
- Finally the prevalence of psychiatric disorders is usually based on self-reporting of homeless persons and rarely on diagnostics of clinically schooled scientists;
- Standardised and validated measuring instruments are rarely used.

In the Netherlands three studies availed themselves of standardised instruments to measure psychiatric disorders among homeless persons. The first and second are a study among the homeless in Utrecht (Reinking et al. 1998) and a study among homeless in Den Haag (Reinking et al. 2001). In both studies the following instruments are being used: Composite International Diagnostic Interview (CIDI, version 1.0) and the European version of the Addiction Severity Index (Europ-ASI, version III).

The third is a small-scale study (N=48) in which the prevalence of depression among the homeless in the city of Nijmegen was scored by means of the Selfrating Depression Scale (SDS) of W.W.K. Zung (1965) and of the Montgomery-Asberg Depression Scale (MADRS) by S.A. Montgomery and M. Asberg (1979). (Pham 1998).

- *Substance dependence*

Methodological snags in recovering data on substance use by the homeless are that once more the data are primarily based on self-reporting by the homeless and as a result of this possibly less reliable. In addition different criteria are used in determining the extent of substance dependence. Usually this is expressed by means of a scale in which the frequency of substance use is indicated. Two variations become apparent here.

In the first variation homeless persons are asked to give an objective assessment of the frequency of substance use. For example by means of response categories that vary from 'each day, almost every day, several times a week, no more than once a week, less than once a week' to 'never' (Korf et al. 1999).

In the second variation the frequency of substance use is established by asking homeless persons to assess their substance use subjectively. For example by using response categories that vary from 'moderate use', 'excessive use' to 'problematic use'.

In other studies homeless persons are simply asked whether they consider themselves as addicts, by means of response categories 'yes' and 'no' or 'don't know' (Rensen et al. 2002).

Due to these different ways of data gathering it is hardly at all possible to compare established research data on substance use.

### *Physical health*

In point of time analysis once again the medical situation is based on self-reporting by homeless persons. In some studies they were asked to list their complaints. This provides detailed information on their medical complaints. However, as a rule this is restricted to a questionnaire question in which homeless persons are asked to give report marks to themselves expressing their overall health, or lack of it.

Two authors have conducted a more thorough and methodologically substantiated study of the medical situation of homeless persons. We refer to the physician-researcher Laere (2001) who systematically gathered and noted his findings on homeless persons that come to surgery in Amsterdam. In addition physician-researcher Leemans (1999) gathered quantitative data on cognitive decline among homeless men, regarding the prevalence of senile dementia, alcohol dementia and Korsakoff's syndrome, in a very small-scale study (N = 5), by means of validated score instruments. Use was made of two diagnosis instruments, to wit the Cognitive Screening Test (CST nr. 14), the Amsterdam Dementia Screening Test (ADS nr 6). In addition use was made of an instrument for assessing the extent of invalidity: Beoordeling Oudere Patiënten BOB (Assessing older patients).

### **Summary**

All in all we may state that in addition to conceptual ambiguity regarding definitions of homelessness, there is also conceptual ambiguity in the Netherlands with regard to research methods used. In particular the lack of standardised questionnaires and unequivocal score instruments is detrimental to comparing research results.

## PART 2. RESULTS OF POINT IN TIME ANALYSIS

Judith Wolf, Sarala Nicholas

### - *Introduction*

In this section we will describe what is known from the literature and research about the characteristics and circumstances of the homeless population in the Netherlands with regard to several areas of living: housing, work- and daily activities, financial situation, social network, physical functioning, mental functioning and drug and alcohol dependency. The information needs to be read with certain caution keeping the following remarks in mind:

- Almost all of the information comes from research at the local level. This implies that there may be problems in terms of the comparability of the information (use of different concepts and definitions of the target group, different variables and categories, different sampling methods, et cetera). The data that have been collected often concern a relatively small group of homeless people at only one or a few locations, which ensures at most that the local population of homeless people are represented.
- The information on homeless people has been collected at one specific point in time. It is known that cross-sectional research, especially in comparison with longitudinal research, leads to an overrepresentation of the so-called "long-term" roofless people, the hard core of the homeless population. The chance of including "incidental/short-term" roofless people is small because of the short period of data collection. Therefore, there is a chance that the picture/idea we have of the population may differ from the real population, which may also influence our idea of the phenomenon of homelessness (Snel & Engelbersen, 1997)

The review draws data from several studies undertaken on homelessness in the Netherlands and Table 2 gives an overview of the main studies included in the review; four are city based (Amsterdam, Rotterdam, Utrecht and The Hague) and one is a national study covering 20 cities. Respondents for the city surveys were approached and interviewed at day and night shelter facilities, whereas with the national study performed a street survey of homeless people.

Each study surveyed a various combinations of subgroups of the homeless population. These subgroups are those that were formulated by the National Health Council (Gezondheidsraad1995), where a distinction was made between the roofless, the houseless and the marginally housed. In detail: -

- Roofless: people who over a long period of time, don't have accommodation at their own disposal. This refers to those that sleep 1) outdoors or in public covered spaces such as shops, stations, (2) in emergency refuge or night shelters.
- Houseless: Residents of semi-permanent hostels or boarding houses for the homeless.
- Marginally Housed: People who in the near future have a good chance of becoming roofless or houseless.

The review does not present data of the marginally housed and in the following text respondents that are either roofless and or houseless are termed as the homeless.

The studies were selected primarily as they were current (interviews were carried out between January 1998 and May 2002) and they interviewed similar groups of homeless (ie. those attending day and night shelters).

Table 2 Overview of research on homelessness in the Netherlands

Reference	Locality	Homeless Criteria	Time Period
Reinking et al. 2001	The Hague	<i>DH - Roofless</i> (n=103): Adults (18 years or older) who have spent at least one night in the preceding 30 days either sleeping (1) outdoors or in public covered spaces such as shops, stations, (2) in emergency refuge or night shelters, (3) at the house of a relative or a friend and being uncertain of whether they can continue to live there for more than that particular night.  <i>DH - Houseless</i> (n=100): Adults (18 years or more) who do not meet the criteria mentioned above but who were currently living in semi-permanent hostels or boarding houses for the homeless.	Oct 00 - Mar 01
Reinking et al. 1998	Utrecht	<i>UTR-Roofless</i> (n=150): Adults (18 years or older) who have spent at least one night in the preceding 30 days either sleeping (1) outdoors or in public covered spaces such as shops, stations, (2) in emergency refuge or night shelters, (3) at the house of a relative or a friend and being uncertain of whether they can continue to live there for more than that particular night.	Jan 98
Korf et al. 1999	Amsterdam	<i>AMS Homeless*</i> (n=212): Adults (18 years or older) that had no place to live of their own disposal for an extended period of time or were likely to become homeless. The majority of the sample (n=190) consisted of people fitting the above definition of roofless.	Feb-Mar 99
Jansen et al. 2002	Rotterdam	<i>ROT Homeless*</i> : (n=112) People who had spent one or more nights in a night shelter for the homeless during 2001	01
De Bruin et al. 2003	20 Cities in Nederland	<i>NED Homeless*</i> (n=500) People who live mainly on the streets and call themselves roofless and houseless.	Nov 01 – May 02

Homeless\* refers to both roofless and houseless respondents

#### - Social demographics

The majority of the Dutch homeless is male, in their late 30's, had never married and lives alone. The picture is coherent both nationally and locally. In the national sample of homeless respondents (NED), 87% was male, 70% had never married and a further 24% were divorced (Table 3). The average age was 39 years for men and 37 years for women, and the majority (85%) was between 25 and 55 years. The average age and sex of the respondents in the other samples namely Rotterdam (ROT), Amsterdam (AMS), Utrecht (UTR) and The Hague (DH) were very similar (respectively 42, 40, 38 and 37 years old, and 90%, 88%, 92% and 80% male).

Table 3 Social demographic characteristics

	The Hague Roofless	Utrecht Roofless	Amsterdam Homeless	Rotterdam Homeless	National Homeless
	N=103	N=150	N=212	N=112	N=500
<b>Gender</b>					
Male (%)	80%	92%	88%	90%	87%
<b>Age</b>					
Mean (SD)	37 (9,8)	38 (10,4)	40	42	39 (Men) 37 (Women)
Range	18 – 66		18-80	-	-

<b>Ethnic Background</b>		N=148			
Dutch <sup>1</sup> (%)	48%	60%	41%	46%	59%
Moroccan(%)	-	12%	-	8%	-
Suriname(%)	-	9%	-	8%	-
<b>Marital Status</b>		N=140			
Married (%)	4%	4%	-	6%	2%
Divorced or separated (%)	33%	36%	-	41%	24%
Never married (%)	63%	62%	-	43%	70%
<b>Living Situation</b>		N=140			
	<i>Current</i>	<i>Past 3 years</i>		<i>Last month</i>	<i>Current</i>
Alone(%)	94%	59% <sup>2</sup>	-	82%	-
With Partner(%)	-	14% <sup>2</sup>	-	8%	17%

1 Dutch Origin – Both the respondent and his/her parents were born in the Netherlands.

2 Refers to Living situation past 3 years

Marital status of the Utrecht and The Hague roofless survey was comparable with the national survey, as almost two-thirds had never married, and approximately a third were divorced or separated. However, marital status of the Rotterdam homeless does differ from the national figures. The group of people who never married or cohabited was smaller (43%) and the percentage of divorced or separated people was bigger (43%). This data was not collected in the Amsterdam research.

With regards to ethnicity, the homeless majority is of Dutch origin with a range from 41% in the Amsterdam homeless sample to 60% in The Utrecht roofless sample. The remainder was of non-Dutch origin. In the national study, this figure was 41% and more than three-quarters were first generation (person and parents are not born in the Netherlands), and a quarter second generation (respondent born in the Netherlands with at least one parent not born in the Netherlands). The two largest single groups in the non-Dutch homeless samples across all surveys were people of Surinam or Moroccan descent; in The Hague the figures were 27% and 15% respectively; in Utrecht it was 20% and 30% and in Rotterdam it was 15% for both. Out of the Amsterdam group of homeless people, 59% was migrant, mostly from a Surinam background.

#### - *Living situation and homelessness history*

Up till now, few of the homeless people in the Netherlands literally lived without 'a roof over their head' over a long period time of time. The group of people sleeping outdoors is relatively small. A somewhat older assessment mentions between 1000 and 3000 people (Feijter & Radstaak, 1994). A sizeable part of this group however make use of shelter facilities and vary their sleeping locations between an indoor and outdoor setting. (NRV, 1993; Van Doorn 1994; Polstra, 1998; Wolf ea., 2002).

The studies reviewed reflect very much this pattern (Table 4). There was a 60/40 split between sleeping outdoors and elsewhere in both the Utrecht and The Hague roofless sample; as approximately 40% had slept mainly outdoors in the previous month (UTR 42%; DH 41%). The remainder had made use of night shelters (UTR 35%; DH 23%), or stayed temporarily with friends (UTR 5%; DH 22%) or elsewhere (UTR15%, DH, 10%). In Rotterdam, only 14% of the homeless sample had spent a significant part of the month on the streets. The rest had made use of mainly shelters, semi-permanent hostels or boarding houses for the homeless (37%) or other locations (26%). The picture was similar amongst the Amsterdam homeless: 26% had slept outdoors and 33% had used night shelters. The national data confirms the picture from research on local groups: 46% had slept outdoors during the past month, which they did on average seven nights. Further in Rotterdam, one-fifth of the sample had made use of semi-permanent residence for homeless people over 13 or more days in the past month. This percentage was much higher than what was reported in The Hague.

Changing and unstable housing is possibly more typical for homeless people than literally being without accommodation (Van Doorn, 1994; Deben et al., 1997; Greshof, 1997; Jansen et al., 2002). In Amsterdam, almost half of the homeless had a fixed place to sleep, either outdoors, or in a shelter or with people they know. The others change sleeping locations. In Utrecht, two thirds of the roofless changed their sleeping location regularly during the past month. Also in Rotterdam homeless people were found to have unstable and mobile lives. In the past month almost half of the people stayed shorter than one week at one sleeping place and during the past year 70% of the interviewed homeless group had stayed in three or more different sleeping locations.

Duration of homelessness varied on average from three and a half to six years. The shortest duration was amongst the Rotterdam homeless sample, followed by The Hague roofless (4.9 years), the Utrecht roofless (5.6 years) and the national homeless sample (6.0 years). Not surprisingly then, that the vast majority of the homeless in these five studies were the long term homeless. The percentage of short-term homeless (duration of less than 1 year) are approximately one fifth to a third.

**Table 4 Living situation and homelessness history**

	The Hague Roofless	Utrecht Roofless	Amsterdam Homeless	Rotterdam Homeless	National Homeless
	N=103	N=150	N=212	N=112	N=500
<b>Duration of Homelessness</b>	N=102	N=137		N=111	
Less than 1 year	20%	26%	33%	21%	18%
1 and up to 5 years	44%	74% (>=1yr)	33%	47%	42%
5 and up to 10 years	20%	-	13%	33% (>=5yrs)	18%
10 years or more	17%	-	12%	-	22%
Mean (SD)	4,9 (5,7)	5,6 (6,4)	-	-	6
<b>Age at first homelessness</b>	N=101				
Mean (SD)	28,9 (10,4)	-	-	-	31
Range	11 - 56	-	-	50% (>=30 years)	-
<b>Sleeping locations</b>	N=102	N=139		N=112	-
<i>Number of nights</i>	<i>15+ nights last month</i>	<i>15+ nights last month</i>	<i>1+ Nights last month</i>	<i>13+ Nights last month</i>	<i>1+ Nights last 3 mnths</i>
Street (%)	41%	42%	26%	14%	55%
Night Shelter s (%)	22%	35%	33%	37%	72%
Semi permanent residence for homeless people (%)	3%	-	-	18%	-
With friends or family (%)	22%	5%	-	3%	-
Other (%)	10%	15%	42% <sup>1</sup>	26%	-
<b>Mobility past month</b>					-
Remained Within City (all 30 nights)	-	60%	-	-	-
Remained within city (<30 nights)	-	40%	20%	-	-

<sup>1</sup> includes staying over at family and friends

Reintegration in society appears to be more difficult the longer a person is homeless. Van Doorn (1994) found that out of the 60 homeless people in her research, 67% had been in the street for at least one year in total, and 15% for over ten years. Almost half of the respondents lived at a fixed place for a brief or longer period, but did get back in the scene. Out of the Utrecht group of roofless people more than half had been homeless more than once in their lives.

- *Education and Employment*

Many sources ascertain that the majority of the homeless in the Netherlands do not have a job (Gezondheidsraad, 1995; Nuy, 1998; Deben & Greshof, 1995). It is indicated that a substantial part of the group used to do unskilled labour and most of them were not very successful in school or dropped out early (Van Doorn, 1994; Van Der Ham ea. 1995; Roorda-Honeé & Heydendael, 1997; Reinking & Kroon, 1998; Polstra, 1998; Lohuis ea. 1998). This is very much evident in the studies reviewed. Of the national sample, 26% had finished elementary school and a 3% did not finish elementary school (Table 5). A quarter had completed secondary education, and almost 40% had completed studies relating to a profession. Only 6% had done higher education (University, HBO).

Educational levels were much lower in the Hague and Utrecht roofless sample; almost half had a basic education or none, and a third had completed secondary education or studies relating to a profession. Forty percent of the Rotterdam homeless people solely finished elementary school and another 40% had completed studies relating to a profession (that is VMBO level in the Dutch system). This level of education does correspond more or less with the level of the Amsterdam homeless people. Of them only one third didn't finish secondary education. Another third of the people had completed studies relating to a profession (VMBO level).

**Table 5 Education, Income & financial situation**

	The Hague Roofless	Utrecht Roofless	Amsterdam Homeless	Rotterdam Homeless	National Homeless
	N=103	N=150	N=212	N=100	N=500
<b>Highest Educational Level</b>	-	N=141	-	-	-
Basic or no education (%)	51%	51%	37%	40%	29%
Secondary Education (%)	33%	34%	38%	53%	53%
Higher Education (%)	15%	15%	17%	7%	18%
<b>Years of Education</b>	-	-	-	-	-
Average years (SD)	-	9,9 (3.5)	-	-	-
<b>Sources of Income</b>	N=94	-	-	-	-
<i>Time Period</i>	<i>Past year</i>	<i>Last month</i>	<i>Past 7 days</i>	<i>Past year</i>	<i>Not Specified</i>
Work <sup>3</sup>	36%	25%	-	19% <sup>9</sup>	27%
Welfare Benefits <sup>4</sup>	84%	70%	65%	72% <sup>9</sup>	76%
Illegal Activities <sup>5</sup>	52%	33% <sup>7</sup>	-	2% <sup>9</sup>	19%
Other <sup>6</sup>	33%	25% <sup>8</sup>	-	7% <sup>9</sup>	10%
<b>Debts</b>		N=137	-	-	-
Any		58%		44%	
>10,000 Euro		24%		21%	

3 Work includes both legal and semi-legal work

4 Unemployment and other benefits, disability allowance, pension

5 Stealing, burglary, prostitution, begging, receiving stolen goods etc.

6 Income from partners/family, gifts, grants

7 Excludes prostitution

8 Includes prostitution

9 Refers to only main income past year

Current employment or employment history are not directly reported in any of the studies, except in The Hague. Here 36% of the roofless sample was reported to have worked in the past year and 5% were working at time of interview. Other data on employment were derived from information on income or daily activities. More than half of the roofless sample in Utrecht had been unemployed most of the time in the last three years and 80% had been unemployed the past month. The figures were similar amongst the Rotterdam homeless, where almost 70% were currently unemployed. A bare 5% of homeless visitors to a social services centre (n=309) had a paid job. The majority (85%) had no (structured) day activities (Van Erp & Wolf, 1997). None of the 90 homeless visitors to a surgery for the homeless in Groningen had work or structured daytime activities (Lohuis ea. 1998). Another study showed that most of the interviewed homeless people were unemployed for three years. The cause of dismissal was often alcohol- or drug abuse. They passed the time reading, watching television and walking around (to avoid growing cold). Half of them said they sometimes or even often felt bored (Polstra, 1998). Many of the interviewed homeless (n=19) living in institutions for the homeless in Amsterdam pass the time playing chess or at cards, watching television, cleaning, listening to music etc. Other activities are going out to fish, for a walk, have a pint and go to the market (Greshof & Wevers, 1999).

A homeless person from Groningen: "At ten o'clock in the morning I go out into the streets. When I have to do something or have to arrange something, I do it in the morning, before 12 o'clock. At 12 o'clock I go most of the time to this place (meant is: the day shelter) to drink coffee and eat a sandwich. The rest of the day is waiting for something to happen. Sometimes you meet somebody, sometimes not."

Polstra, 1998:26

- *Income & financial situation*

The financial situation of the homeless are bad (Gezondheidsraad, 1995; Snel & Engbersen, 1996). Although many receive welfare benefits<sup>1</sup>, many homeless people encounter problems obtaining them (Deben & Greshof, 1995; Broër & van Waveren, 1997; Broër, 1997). Many also have to hand over a part of their allowance because of outstanding fines or debts, for instance to the social insurance institute, housing corporations or the National Health Service. Living in the street is not cheap and an addiction to alcohol or drugs does give many homeless people further financial difficulties. The situation is one of chronic shortage of money of real poverty (Snel & Engbersen, 1996; Roorda-Honée, 1997). The obligatory customer fee charged for a stay in a residential shelter facility ensures that some homeless people do not make use of the services. The costs of staying in such a facility would, in combination with paying off debts and fines, reduce their disposable income to only a few tenners per week. Besides that, quite a few facilities oblige clients to have their budget and expenses supervised (Greshof & Wevers, 1999).

Almost three quarters of all homeless people in Utrecht lives under the poverty line, with is a monthly income less than 1300 Dutch guilders (± 590 Euro). Half of the homeless receiving welfare benefits get less than 800 Dutch guilders (±365 Euro), because of punitive reductions and terms of repayment. People remain vague about their debts. They don't know or don't want to know the amount of money they are in debt with. Some state they do not have any, as they do not consider long overdue fines or claims related to unpaid rent or fraud regarding welfare benefits as debts. It is estimated that 58% has debts of a somewhat known proportion; for a quarter of these that is at least 10.000 Dutch guilders (4545 Euro).

Reinking & Kroon, 1998

<sup>1</sup> Since the 1st of July 1998, homeless people have a right to claim welfare benefits providing that they are registered with the local council for social shelter care and possess a mailing address. Local social services are obliged to provide people with a mailing address if they don't have one.

Because they have to live with a lack of money, homeless people use so-called survival strategies: look as often as possible for free food, clothes and shelter, travel without a permit, ask for charity and sell the local street journal. A small part of the population takes to theft, housebreaking, fencing and drug dealing (Van Doorn, 1994; Reinking & Kroon, 1998). Most try to borrow money from each other, but not everybody has the social network that is necessary for this (Snel & Engbersen, 1996).

Man of 23 years of age, seven years homeless

"Look, if you don't have money you have to see how to get it (...). When you see people walking in the street: you know how they act, what they look like, you just pay attention. You get a feel of human nature, uh. So you know where to get something. You become smart."

Van Doorn, 1997: 262

Results from the studies reviewed show that the majority of homeless respondent's main source of income was welfare benefits (Table 5). The figures from the national homeless sample showed that three quarters of the group were on welfare benefits; and across the various cities this percentage ranged from 65% to 84%.

However, income from illegal activities showed wide variation across the studies. Approximately 1 in 5 of the national homeless sample had income from illegal activities compared to 1 in 3 in the Utrecht roofless sample and 1 in 2 in the Hague roofless sample. The variation in the percent reporting could well be a direct result to the varying time periods of reporting. The Hague study asked respondents to report income in the past year whereas the national sample covered only the current period.

Income was also generated through work and other sources. Almost one tenth (14%) of the national homeless sample had a regular paid job and 13% sold a street journal. Of the Amsterdam homeless the majority earned money out of legal activities like selling street journals or making music. A third of the roofless respondents in The Hague worked to earn an income (36%). Another third had income from other sources.

Income data on the Rotterdam sample is not directly comparable with the other surveys, as questions relate to main income as apposed to sources of income. Therefore, the percent of respondents reporting other sources except income from welfare is relatively low: 9% black market, 7% regular work and 12% other activities like supported jobs, prostitution, begging or drug dealing.

Not much information was available on debts from the studies reviewed. Half of the Rotterdam homeless people had debts, which on average was €12.000. Likewise, 58% of the Utrecht roofless sample had debts and a quarter had debts greater than 5.000 Euro.

#### - *Social network*

Social networks are generally weak amongst homeless people (Gezondheidsraad, 1995; Reinking & Kroon, 1998; Reijerse & Reinking, 1998; Van Erp & Wolf, 1997). An unflattering portrayal of the homeless is that of a 'socially handicapped loner' (NRV, 1993). It is a fact though that relationships with family, relatives and friends seem in the long run to be replaced by contacts in the homeless scene. The longer the situation of homelessness exists, the more difficult it seems to have relationships with people outside the homeless group (Van der Gaag, 1999).

Data on contacts with relatives and friends are, however, contradictory. Van Doorn (1994) interpreted the lack of contact with relatives of homeless people as their desire/wish to maintain their independence, but also as an indication that they are

sometimes ashamed of their situation. According to Deben et al. (1992) only 8% of the homeless people in their sample (n=220) maintained contacts outside the homeless scene: they visited relatives or acquaintances once in a while or stayed with them overnight. Research on homeless people in Groningen confirmed the lack of contact (Polstra, 1998). However, the study in Amsterdam found that the majority did have contact with friends or relatives outside the homeless scene during the past month. Similarly in The Hague, roofless respondents reported that they on average in the past year had monthly or less than monthly contact with family and friends. The national survey also showed that 60% of the sample was still in touch with relatives: parents, brothers and sisters, although 40% had lost contact. In their research on the Rotterdam homeless, Jansen et al. (2002) found the same percentage of people (60%) maintaining contacts with close relatives.

Having contacts does obviously not say much about the quality of these relationships. Out of 90 visitors to a drop in medical facility, one quarter had family problems, and one out of ten people had relationship problems (Lohuis et al., 1998). Also visitors of a **Dienstencentrum** had serious relationship and family problems (Van Erp & Wolf, 1997). Often the relationship with relatives and old friends is a very sensitive issue (Van Doorn, 1994).

Contacts with mates within the scene are vulnerable, superficial, little stable, and primarily directed at survival in daily life. Important functions of these contacts are moral support, safety, company and passing time together. Standard of life and available survival strategies influence the position of people in these relationships. People with mental health problems are usually outliners and are generally socially strongly isolated (Van Doorn, 1994; Van der Ham et al., 1995).

"People miss exactly those things that are so important to maintain functional and social relationships: housing, work and money."

Health Council (Gezondheidsraad in Dutch), 1995: 67

With regard to relationships, 17% of the national sample reported having a current fixed partner. Likewise 14% of the roofless in Utrecht had had a partner and 8% of the Rotterdam sample reported having a partner in the last month. These partner relationships amongst homeless are believed not to be very sustainable/stable. The insecurities of homelessness do not offer a stable base for long term relationships according to Van Doorn (1994). Many feel the lack of intimacy and sexuality as an important deprivation. The feeling of solitude is remarkably present (Polstra, 1998). Homeless people support each other as much as they can in order to survive, but they do not support each other in terms of trying to build a new life. Contacts in the scene can even have a negative effect on building a new life (Van Doorn, 1994; Greshof, 1994; Greshof & Wevers, 1999).

As to children, almost half of the national homeless sample had them, but half of this group did not have further contact with them. Also in Rotterdam half of the homeless people with children did not see them anymore.

- *Health*

#### *Physical health*

The physical condition of homeless people is bad, and that of the roofless people is worse than that of the average population using shelter facilities (NRV, 1993; Gezondheidsraad, 1995).

Homeless people have more often health problems like bronchial tubes disorders, dermatological problems (scabies, infected wounds on the feet, complaints related to the locomotor apparatus, gastro-intestinal problems, neurological disorders and infectious diseases than does the general population have (Gezondheidsraad, 1995; Roorda-Honée &

Heydendael, 1997; Dekker e.a. 1994; Reinking & Kroon, 1998). Use of medicine is very high (Roorda-Honée & Heydendael, 1997).

Causes of the relatively bad state of health are: bad food, alcohol and drugs use, excessive smoking, a bad body care and neglected health problems (Deben, 1993; Dekker e.a., 1994; Gezondheidsraad, 1995).

Infectious diseases get a chance because of lacking hygiene in combination with sometimes close physical contact at for instance drop in or community centres and hospices. The prevalence of tuberculosis amongst homeless people in Amsterdam and in some other regions was higher than amongst the general population (Gezondheidsraad, 1995). No assessment has been made yet of the number of homeless people who have HIV or Aids. It is also not clear what risk of infection with the virus this group has (Roorda-Honée & Heydendael, 1997). Homeless people with a hard drug addiction and/or a double diagnose are being mentioned as risk groups.

The studies reviewed were not consistent in the way they reported physical health problems. Some reported symptoms whilst others reported problems with specific body systems (e.g. heart, circulatory system). The Rotterdam homeless sample was asked to report on symptoms and more than half of the respondents mentioned being tired or having a lack of energy once in a while or more often. A lack of appetite and painful muscles are mentioned by almost half of them. On average, people answered to have three to four health complaints out of a list of ten. The way the Rotterdam homeless rate their own general health does not correspond with the above data. About half of them defined their health as being good to very good, 40% indicated that their general health was "fairly good" and 13% said it was "bad". Compared to the Rotterdam general population, homeless do view their own health situation significantly worse. Out of the general population 68% viewed their health as "good" or "very good". Only 3% stated to have a bad health. In the Utrecht and The Hague studies respondents reported physical problems relating to body systems. Most common complaints were relating to musculoskeletal system (UTR 18%, DH 26%), followed by the airways (UTR 13%, DH 16%). In The Hague, dental problems were also recorded and these were found to be the biggest complaints, as almost half the roofless sample experienced problems with their teeth.

Not all homeless have health insurance and access to medical care. Some of them do not receive welfare benefits and therefore cannot obtain health insurance. The ones that do receive welfare benefits have often-outstanding debts and therefore are not registered at a health insurance company. Of the studies reviewed, around 25% to 30% of the homeless does not have insurance (Van Waveren e.a., 1990; Dekker e.a., 1994; Roorda-Honée & Heydendael, 1997; Reinking & Kroon, 1998; Korf e.a., 1999).

### *Psychiatric problems*

With the data available, it is impossible to give a reliable estimation of the prevalence of psychiatric disorders amongst the homeless population in the Netherlands, that is to say, according to usual classification systems like the DSM. Two of the research projects did however report two mental health disorders (depression and schizophrenic disorders) using standardised measurement instruments. The Utrecht and The Hague sample were screened for depression using an instrument devised by Schrijvers et al (1997) which is based on the Composite International Diagnostic Interview (CIDI). The specific instrument asks the respondent to state whether they experienced in the past 6 months, a narrow range of 4 depressive symptoms. The maximum score is 4 and in the studies respondents with a score of 3 or 4 were diagnosed as depressed. For schizophrenia, a selection was made of the CIDI with additional questions from the Structured Clinical Interview for DSM-III-R (SCID-R). The data reports the prevalence of schizophrenia and other non-affective psychotic disorders in the past 6 months (DSM-III-R codes 295.00-295.70).

Thus in Utrecht (Table 6), one third of the homeless sample were reported to have depression and 15% had a schizophrenic disorder. In The Hague, amongst the homeless sample the 6-month prevalence of depression was 29% and a much lower prevalence of 5% of schizophrenia. Dual diagnosis (psychiatric disorders in combination with an alcohol- or drug addiction) was 24% in The Hague and 26% of the Utrecht sample. Percentages of homeless people with dual diagnose in other studies varied from 25% to 30% (Van Doorn, 1994; Reinking & Kroon, 1998; Korf e.a., 1999).

**Table 6: 6 month prevalence of psychiatric problem**

	The Hague Roofless	Utrecht Roofless	Amsterdam Homeless	Rotterdam Homeless	National Homeless
	N=103	N=150	N=212	N=112	N=500
<b>Disorders</b>	N=99	N=138			
Depression (%)	29%	32%	-	-	-
Schizophrenia (%)	5%	15%	-	-	-
<b>Dual Diagnosis</b>	N=93	N=138	-	-	-
Psychotic disorder (%)	6%	-	-	-	-
Substance dependence (%)	43%	-	-	-	-
Substance dependence & psychotic disorder (%)	24%	26%	-	-	-

In the national sample, instead of diagnosing respondents, respondents were asked to give their own mental health a rating from a scale from 0 to 10. One fifth evaluated their own mental health as "unsatisfactory" (a mark of five or lower). Out of all Amsterdam homeless, a quarter said to have 'quite some' or '(very) many' mental health problems. In Rotterdam, 42% of them reported depressive complaints during the past month, one third mentioned concentration and memory problems and a quarter of them had problems controlling their aggression. On average, they mentioned four mental health complaints in the past month.

#### *Addiction*

In Utrecht, Reinking & Kroon (1998) found the percentage of hard drugs use to be 58% in the homeless population (Table 7). They found a relationship between drug use and relatively young age, sleeping outdoors, little inner city mobility, judicial problems and an anti-social personality disorder. In the Groningen research, Lohuis et al. (1998) found that addiction problems were more often present than absent. A remarkable finding was that drinkers did not get along very well with hard drug users and vice versa. According to Korf et al. (1999), addiction was one of the largest problems for people sleeping in the street in Amsterdam. Amongst the visitors of facilities for homeless people, 57% appeared to be addicted to alcohol and/or drugs, and one third was addicted only to drugs. The criteria for alcohol addiction in this study were a daily use of at least eight glasses of alcoholic drinks. The criteria for drug addiction were a daily use of heroine, cocaine, methadone or a combination of these.

Table 7: Substance Use

	The Hague Roofless	Utrecht Roofless	Amsterdam Homeless	Rotterdam Homeless	National Homeless
	N=103	N=139	N=212	N=112	N=500
<b>Ever Use</b>	N=97	N=131			
Alcohol (%)	64% <sup>1</sup>	78% <sup>1</sup>	-	-	86%
Alcohol - 5 or more glasses (%)	49% <sup>1</sup>	59% <sup>1</sup>	-	-	-
Cannabis (%)	56% <sup>1</sup>	63% <sup>1</sup>	70%	-	74%
Heroin	-	48% <sup>1</sup>	39%	-	59%
Cocaine	-	45% <sup>1</sup>	56%	-	63% <sup>5</sup>
Methadone	-	36% <sup>1</sup>	30%	-	45%
Cocaine, Heroin or Methadone (%)	72% <sup>1</sup>	-	56%	-	-
Other (%)	51% <sup>1</sup>	-	-	-	-
<b>Age of first use</b>					
Alcohol (Mean <sup>2</sup> ,N)	17 (55)	16 (102)	-	-	-
Alcohol (5 or more glasses) (Mean <sup>2</sup> ,N)	19 (45)	20 (77)	-	-	-
Heroin (Mean <sup>2</sup> ,N)	21 (54)	22 (63)	-	-	-
Methadone (Mean <sup>2</sup> ,N)	27 (42)	27 (47)	-	-	-
Cocaine (Mean <sup>2</sup> ,N)	24 (56)	24 (59)	-	-	-
Cannabis (Mean <sup>2</sup> ,N)	16 (47)	18 (82)	-	-	-
<b>Use Past 30 days</b>	N=97	N=131		N=112	-
Alcohol (%)	35% <sup>1</sup>	52% <sup>1</sup>	-	53%	63%
Alcohol 5 or more glasses (%)	26% <sup>1</sup>	31% <sup>1</sup>	-	-	-
Cannabis (%)	35% <sup>1</sup>	50% <sup>1</sup>	-	29%	52%
Heroin	-	35% <sup>1</sup>	-	23%	40%
Cocaine	-	34% <sup>1</sup>	-	34%	47% <sup>5</sup>
Methadone	-	27% <sup>1</sup>	-	32%	29%
Cocaine, Heroin or Methadone (%)	59% <sup>1</sup>	-	-	-	53% <sup>6</sup>
Other (%)	31% <sup>1</sup>	-	-	-	-
<b>Drug and Alcohol dependence (Lifetime)</b>	N=97	N=131	N=211		
Alcohol dependance <sup>3</sup> (%)	47% <sup>3</sup>	59% <sup>3</sup>	-	-	-
Drugs dependance <sup>4</sup> (%)	68% <sup>3</sup>	76% <sup>3</sup>	-	-	-
Alcohol and / or drugs (%)	78% <sup>3</sup>	88% <sup>3</sup>	-	-	-
<b>Drug and Alcohol dependence (Last month)</b>					
Alcohol dependance <sup>3</sup> (%)	22% <sup>4</sup>	22% <sup>4</sup>	22%	-	17%
Drugs dependance <sup>3</sup> (%)	53% <sup>4</sup>	54% <sup>4</sup>	24%	-	35%
Alcohol and /or drugs (%)	65% <sup>4</sup>	64% <sup>4</sup>	11%	-	19%

1 Regular Use: - consumption 1) at least 3 days a week regardless of dosage or 2) binges when normal activities (such as work, school, family life, and other daily activities such as driving) are severely affected for at least two subsequent days after the binge in a week.

2 Mean Age

3 Translation of EUROPASI into DSM-Diagnosis according to Svikić e.a. (1996)

4 Translation of EUROPASI into DSM-Diagnosis according to Lehman e.a. (1996)

5 Base Coke

6 Heroin and or base coke

In Rotterdam, a quarter of the homeless drank alcohol daily and one out of six respondents used approximately every day hard drugs such as heroin and/or cocaine. One out of five used methadone almost on a daily basis, without other hard drugs. If we take methadone as a hard drug, then more than one third of the homeless people uses hard drugs (almost) daily. This percentage is the same as that of the Amsterdam percentage hard drugs addicted homeless people.

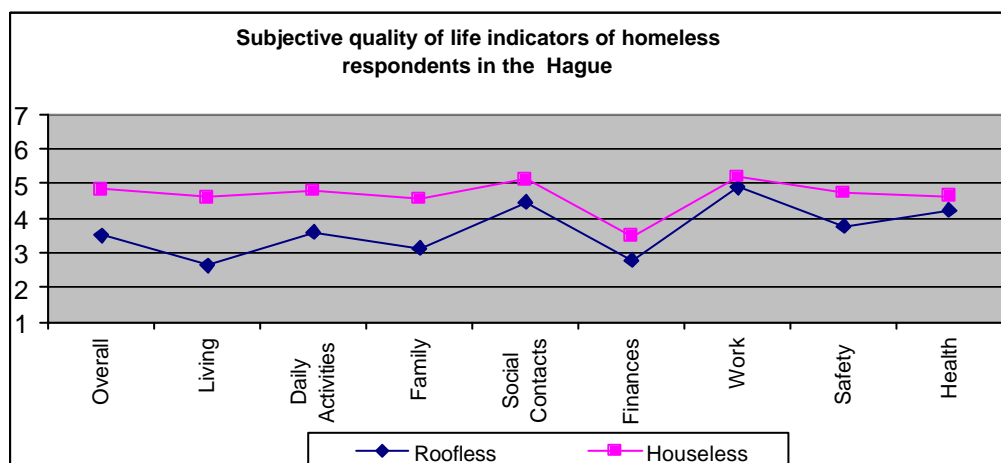
In The Hague amongst the homeless sample hard drug use was highly prevalent. 71% had used heroine, cocaine or methadone in the past on a regular basis and 59% had used them in the past 30 days. The average age when respondents first began using these drugs on a regular basis was 21 years for heroine, 24 years for cocaine and 27 years for methadone. Cannabis was also significantly more widely used in the homeless sample: ever use: 55%, current use: 32%). The average age of first use was 16 years. Ever-regular use of other drugs was 50%.

Heroine was identified by 20% of the homeless respondents as their main drug problem and a further 18% named cocaine. 15% had problems with several drugs and 31% said they had no problems at all. Almost half of the homeless population in The Hague had lifetime dependence (47%) and a fifth had current dependence (22%). There were significantly higher levels of drug dependence in the homeless sample both lifetime (68%) and current (53%).

Out of the national homeless people, one tenth used neither hard drugs, nor did they consume excessive alcohol. More than one third used hard drugs but no excessive alcohol. Almost one fifth (18%) used alcohol next to hard drugs. And 17% used excessive alcohol exclusively.

#### - *Quality of Life*

Quality of life (QOL) information was only available on the Hague sample. Overall scores on quality of life were significantly different across the two groups surveyed namely the roofless and the houseless. On a seven point scale from terrible (1) to delighted (7), the life satisfaction of the roofless was 3,5 indicating that they were in general somewhere between mostly dissatisfied or neutral with their overall feelings of wellbeing. Whereas with the houseless, the overall score was 4.8, showing that the houseless were on average mostly satisfied with life in general.



Across all other subjective QOL domains, the scores of the roofless respondents were lower than those of the houseless sample. These differences were significant with the exception of the work domain, as only the 31 people currently in work answered this item. For the houseless, the average score was close to 5 on 7 of the 8 items, indicating satisfaction across most domains. For this group the exception was finance (Mean Score=3,5). The roofless on the other hand showed much greater variation. They were least satisfied with housing (Mean=2,6) and finances (Mean=2,8) and most satisfied with work (Mean=4,9) and social relations (mean 4.4). Difference in ratings on each item varied from 0,3 (work) and 0,4 (health) to 2.0 (housing).

The objective QOL scores on domains relating to family, social relations, daily activities and functioning were similar in both groups. Both groups in the past year had on average monthly or less than monthly contact with family and friends and reported that they on average participated in 3 or 4 daily activities (out of a list of 8). However on other items, the scores of the roofless sample were significantly lower in comparison to the houseless sample. The roofless had less money in the past month to spend on basic items such as food, clothing, living, travelling and social activities. (Roofless 1.6 items, houseless 3,7 items). Fewer roofless worked the past month (5% vs. 26%); more were arrested (48% Vs 7%) and more were likely to be a victim of a crime (44% vs. 18%).

- *Conclusions and Limitations*

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