Towards understanding what Dutch people in a socio-economically disadvantaged position need to enhance their living conditions

Sandra Schel

Colophon

For reasons of consistency within this thesis, some terms have been standardized throughout the text. As a consequence, the text may differ in this respect from the articles that have been published.

The work presented in this thesis was carried out within the Radboud Institute for Health Sciences. The research projects were conducted by Impuls - Netherlands Center for Social Care Research and funded by the Netherlands Organization for Health Research and Development (ZonMw) and the Academic Collaborative Center Impuls Participation and Social Care.

ISBN: 978-94-6473-336-5

Cover design and layout by Anke Muijsers, persoonlijkproefschrift.nl
Printed by Ipskamp Printing, proefschriften.net

Naar het begrijpen van wat Nederlandse mensen die sociaaleconomisch op achterstand staan nodig hebben om hun levensomstandigheden te verbeteren

Towards understanding what Dutch people in a socio-economically disadvantaged position need to enhance their living conditions

Proefschrift
ter verkrijging van de graad van doctor
aan de Radboud Universiteit Nijmegen
op gezag van de rector magnificus prof. dr. J.M. Sanders,
volgens besluit van het college voor promoties
in het openbaar te verdedigen op
vrijdag 22 maart 2024
om 10.30 uur precies

door

Sandra Helena Hendrika Schel
geboren op 17 februari 1984
te Nijmegen

Promotor:

Prof. dr. J.R.L.M. Wolf

Copromotor:

Dr. L. van den Dries

Manuscriptcommissie:

Prof. dr. A.F.A. Schellekens

Prof. dr. K. Hermans (Katholieke Universiteit Leuven, België)

Dr. C Akkermans (Hogeschool Leiden)

Contents

Chapter 1

General introduction

Homelessness and poverty are considered severe enduring public health problems and are inextricably linked (Bramley & Fitzpatrick, 2017; Fowler et al., 2019; Price et al., 2018). The association between poverty and homelessness is often bidirectional (Luchenski et al., 2018). Poverty can directly lead to homelessness, for example, as a result of an eviction due to the inability to pay rent. But it can also have a more indirect effect by leading to a range of stressors that precipitate homelessness (Fitzpatrick et al., 2011; McNaughton, 2008). Poverty is, for instance, associated with a poorer physical and mental health (Marmot & Bell, 2012; Ridley et al., 2020), which increases the chances of job loss and a consequent fall in income (Ridley et al., 2020). Or via the strain financial hardship has on family and other important social relationships, leading to a fragile social network (Johnsen & Watts, 2014; Pinderhughes et al., 2007), which diminishes the changes of receiving income support or shelter when needed (Johnsen & Watts, 2014). Poverty is seen as an important dimension of social exclusion (Horsell, 2006; Watson et al., 2016), with homelessness being its most extreme form. Social exclusion refers to the inability of people to fully participate in society, and is the result of multidimensional and mutually reinforcing processes of deprivation at different levels of society (Fazel, et al., 2014; Van Straaten et al., 2016; van Bergen et al., 2018). To tackle social exclusion, FEANTSA and the Foundation Abbé Pierre have been advocating for an integrated approach and underline the importance of early intervention and the implementation of policies that address the root causes of social exclusion (Foundation Abbé Pierre, & FEANTSA, 2018). Policy makers and service providers should be aware of the factors associated with poverty and homelessness. In the process of developing and implementing new policies and interventions, policy makers and service providers should include the perspectives of people actually experiencing high levels of social exclusion (e.g. experts by experience) in order to adequately match the needs of people living in poverty (Luchenski et al., 2018).

The aim of this thesis is to deepen our knowledge of what Dutch homeless people and people living in persistent poverty need in order to overcome their disadvantaged position, enhance their living conditions and participate in society. The knowledge from this thesis will contribute to the quality and professionalization of the services and support provided to people who experience grave forms of social exclusion. According to the Social Support Act (WMO, 2015) and the Social Participation Act (2015), municipalities have a broad responsibility to support the participation of people who (temporarily) are not able to hold their own in society. This dissertation provides important clues to policy makers and service providers as to what is needed to structurally enhance the constitutional conditions for 'a good life' and optimize the social inclusion of people living in vulnerable conditions.

The next sections of this introduction describe the main concepts that underly the studies included in this thesis. First, the definition, prevalence, profiles and consequences of homelessness and persistent poverty in the Netherlands are described. Subsequently, the Social Quality Approach (Van der Maesen & Walker, 2012; Wolf & Jonker, 2020) is introduced, as this approach offers a deeper understanding of factors and processes associated with social exclusion such as homelessness and persistent poverty and is applied in chapter 2 and 3 of this thesis. Then an overview of risk factors for homelessness is provided, as this is the main subject of chapter 2. Next, the central theme of chapter 3, which is the link between childhood abuse experiences and homeless people's quality of life is described. Then, the value of peer support for socially excluded populations is formulated, which is the main subject of chapter 4. Subsequently, the necessity to understand the wishes of people living in persistent poverty is discussed, as this is the subject of chapter 5. Furthermore, the research questions and research methods of this thesis are presented. Finally, the contents of this thesis are summarized per chapter.

Background

Definition, prevalence, profiles and consequences of homelessness in the Netherlands

Definition

Homelessness can be narrowly defined as not having a roof over one's head (Edgar et al., 2007). However, this definition does not take into account the various other forms of housing insecurity, and the fact that homelessness often is not a permanent situation. Many people experiencing homelessness transition recurrently between living on the streets, residing in shelters or institutions such as a hospital or jail, being housed, and atypical living situations such as staying in a hotel, in a squatted building, or with family or friends (Orwin et al., 2005; Van der Laan, 2020). Therefore, FEANTSA, the European Federation of National Organizations Working with the Homeless, introduced the European Typology of Homelessness and Housing Exclusion (ETHOS), a more comprehensive definition of homelessness that also includes individuals living in accommodations that are temporary, insecure, or inadequate (Edgar, 2012; Edgar & Meert, 2005). This typology comprises of thirteen living situations of homelessness divided over four categories: rooflessness, houselessness, insecure accommodation, and inadequate accommodation.

Internationally, the ETHOS-light definition (a shortened version of the ETHOS typology), is getting more and more support within research and policy (Hermans, 2020). The ETHOS-light typology was constructed to support the measurement of homelessness at European level and encompasses the following living situations: 1) people living rough; 2) people in emergency accommodation such as overnight shelters; 3) people living in accommodation for the homeless such as temporary accommodation, transitional supported accommodation, and women's shelters; 4) people living in institutions who stay longer than needed due to lack of housing, or for whom there is no housing available prior to release; 5) people living in non-conventional dwellings due to lack of housing, such as mobile homes and non-conventional buildings; and 6) homeless people living in conventional housing with family and friends due to lack of housing (FEANTSA, 2018). To better align with their mission to focus on prevention of homelessness and provision of stable housing, and to collect comprehensive data on homelessness that can accurately assist this policy, the Dutch national government recently committed to working towards using the ETHOS-light typology in the National Homelessness Action Plan: Housing First (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022).

Prevalence

During the last decade, the number of people experiencing homelessness has increased at an alarming rate in the majority of the EU countries (Foundation Abbé Pierre, & FEANTSA, 2019). According to FEANTSA and the Foundation Abbé Pierre (2019), on any given night, 700,000 people sleep rough or live in emergency or temporary accommodation across the EU, which is an increase of 70% in ten years. The estimates on the number of people experiencing homelessness in the Netherlands vary, depending on the definition of homelessness and the counting method. The estimated number of literally homeless people (i.e. rooflessness) in the Netherlands on January 1 2020 was 36,000 (Statistics Netherlands, 2021a) and 32,000 in January 1 2021 (Statistics Netherlands, 2021b). However, Dutch social relief facilities do not recognize the decrease in the number of homeless people reported by Statistics Netherlands, as they report a constant demand for their shelter facilities (Federation of shelters, 2021). Moreover, the figures reported by Statistics Netherlands do not take into account people under the age of eighteen, people aged sixty-five and older, women living in women's shelters and undocumented homeless people. According to the National Federation of Shelters in the Netherlands, around 100,000 people including both literally and residentially homeless people (i.e. rooflessness and houselessness), sought and received help from the social relief facilities in the Netherlands in 2019 (Federation of Shelters, 2019). It is unknown how many people are marginally housed (i.e. insecure and inadequate housing), in the Netherlands, nor are there reliable estimates on the number of people who run a high risk of becoming homeless or struggle to find adequate housing (Trimbos Institute, 2021).

Profiles and consequences

The profiles of people experiencing homelessness in the EU seem to change: vulnerable groups like young adults and children, women, people with a migration background and the working poor, are becoming increasingly numerous among the homeless population in Europe (Foundation Abbé Pierre, & FEANTSA, 2018; Baptista et al., 2017). This trend is also observed in the Netherlands. In addition to the existing group of mostly homeless single men who relatively often suffer from mental health problems, addictions, intellectual disabilities, and problems such as poverty or debt, an increase of 71% of so-called 'new homeless people' is being reported (Raad Volksgezondheid en Samenleving, 2020). New homeless people are defined as people who have serious problems in different areas, but without psychological problems or addiction problems (Raad Volksgezondheid en Samenleving, 2020). This group includes for example families who have been evicted because of rent arrears or nuisance, people who leave an institution (such as prison or a psychiatric hospital) and do not have a place to stay, or people who are unable to find housing after a divorce (Trimbos Institute, 2015; Vereniging Nederlandse Gemeenten, 2019).

Being homeless has detrimental consequences that also tend to accumulate rather than occur in isolation: it impedes people's capabilities, undermines their physical and mental health and quality of life and decreases their life expectancy with 30 years compared to the general population (Aldridge et al., 2018, Fazel et al., 2014). Correspondingly, people experiencing homelessness encounter all kinds of challenges in meeting their needs because of their harsh living conditions such as poverty, food insecurity, barriers to health care and other services, social isolation and risk of assault. Unsheltered and sheltered homeless people consistently report substantial unmet healthcare needs such as medical care, mental health care and dental care (Fleury et al., 2021; Van Straaten et al., 2017; Verheul et al., 2020). Unmet needs with regards to finances, housing, employment (Van Straaten et al., 2017; Fleury et al., 2021) and physical safety (Fleury et al., 2021) have also been reported. Homelessness is often accompanied by a lack of future perspective, feelings of hopelessness, shame and stigma, and isolation from mainstream society (Wolf, 2002).

Definition, prevalence, profiles and consequences of (persistent) poverty in the Netherlands

Definition

Poverty is often divided into absolute poverty and relative poverty (Iceland, 2005). Absolute poverty refers to a condition where the household income is below a required threshold to meet basic needs such as food, shelter, clothing and healthcare. Relative poverty is a condition where the household's living standards are comparatively below the minimum acceptable standard of living in that society or region. In Europe, for example, people are considered at risk of poverty when they live in a household with an income below the European poverty threshold, which is less than 60% of the national median (equivalised) disposable income (Eurostat, 2021a). Additionally, Eurostat, the statistical office of the European Union, also uses a broader indicator to measure the number of people who are at risk of poverty and/or social exclusion, named AROPE (At Risk Of Poverty and/or Social Exclusion). AROPE corresponds to "the sum of people who either have an income below the European poverty line, or are severely materially and socially deprived, or live in a household with a very low work intensity" (Eurostat, 2021b).

In the Netherlands, two other thresholds are used to measure poverty. Statistics Netherlands (Statistics Netherlands, 2021c) applies a low-income threshold, i.e. a fixed amount of income that is annually adjusted to price developments. Statistics Netherlands classifies households with an income below this threshold as low-income households or as households at risk of poverty, as opposed to poor households (Statistics Netherlands, 2021c), because views vary whether this threshold accurately defines poverty.

The Social and Cultural Planning Bureau (Sociaal en Cultureel Planbureau) uses a budget threshold, i.e. the 'not much but sufficient criterium' which is a standard amount based on the minimum required living expenses (Hoff et al., 2019). People are considered persistently poor when they have, according to the 'not much but sufficient criterium', insufficient financial resources to pay their monthly necessary costs for living and social participation for at least three years in a row (Goderis et al., 2019).

Prevalence

In 2021, according to the AROPE indictor, approximately 73.7 million people in the EU were living in poverty (at-risk-of-poverty rate, Eurostat, 2021a). This is over one-fifth of the population. In the Netherlands, the number of people living in poverty is estimated at 2.5 million according to this indicator, which is about 1 in 7 people (Eurostat, 2021b). According to the 'not much but sufficient criterium' 939.000 (5.7%) people in the Netherlands were living in poverty in 2017 (Hof et al., 2019). Compared to 2013, in which over 1.2 million people (7.6%) were living in poverty, the number of people living in poverty significantly decreased, which was mainly due to the improving economy. Within the total group of people living in poverty, the proportion of people living in *persistent* poverty remained the same at around 65% (508,000) between 2013 and 2017 (Van Hulst & Hoff, 2020).

Alarmingly, the number of people living in poverty is expected to increase significantly, due to the current rising inflation rates in general, and the sharp increase in energy prices in particular. The Dutch national institute for budget education (NIBUD) expects that currently as much as 1 in 3 households struggle to make ends meet (NIBUD, 2022).

Profiles and consequences

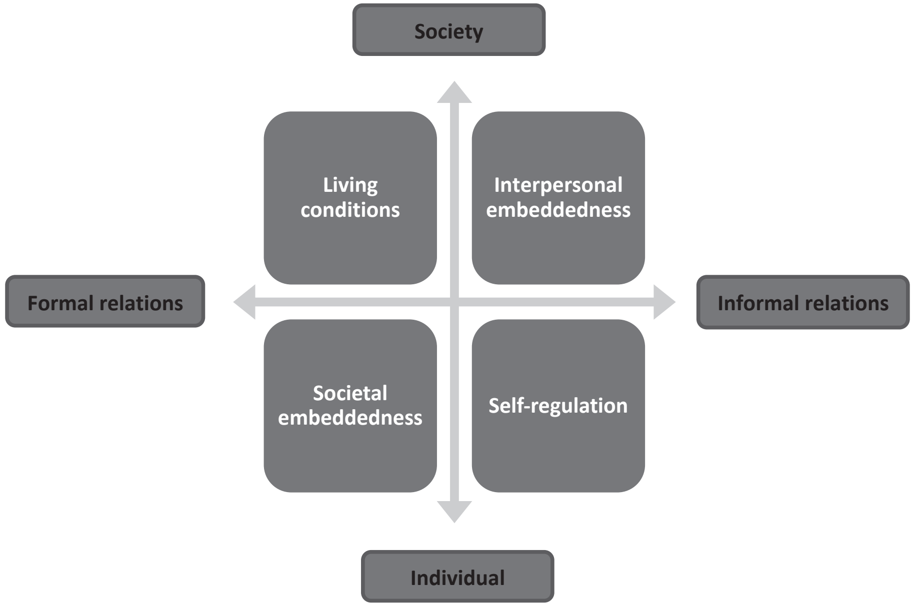
In the Netherlands, several groups have been identified that run a higher risk of living in poverty (Hoff et al., 2019). This concerns women, single-person households, single-parent families, people on benefits, people with a low level of education, people with a migration background, and people after a divorce or who had many housing transitions (including an eminent eviction or homelessness) (Hoff et al., 2019). Poverty can be passed on from generation to generation, named intergenerational poverty. These individuals and families are generally less healthy, less highly educated, have less language and numeracy skills, are less likely to have a job and are more isolated, compared to the general population (College for Human Rights, 2016; Coumans, 2012; Visser, 2019).

As has been described above, research has shown that living in poverty, and related factors such as unemployment and having a low income, are well known risk factors for becoming homeless (Barile et al., 2018; Benjaminsen, 2015; Bramley & Fitzpatrick, 2017; Doran et al., 2019; Tsai & Rosenheck, 2015). Furthermore, financial difficulties are associated with higher levels of stress (Haushofer & Fehr, 2014), lower levels of self-regulation and perceived control (Evans & Kim, 2012; Price et al., 2002), impaired cognitive functioning (Mani et al., 2013), more domestic violence (Levy & O'hara, 2010) and more posttraumatic stress disorder (Golin et al., 2016), compared to the general population. As with the detrimental consequences of homelessness, these stressors tend to accumulate rather than take place on their own (Marttila et al., 2013; Taylor & Barusch, 2004).

Social Quality

The Social Quality Approach (SQA) (Van der Maesen & Walker, 2012; Wolf & Jonker, 2020) offers a deeper understanding of factors and processes associated with various forms of social exclusion such as homelessness and persistent poverty. The SQA contains two dimensions: 1) macro level versus micro level or the (societal) structure and (human) agency (see also the vertical axis depicted in figure 1); and 2) formal relationships (institutions and organizations) versus informal relationships (communities, groups and individuals; see also the horizontal axis depicted in figure 1). Combining these two dimensions results in the four constitutional conditions that encourage or impede social participation: 1) living conditions; 2) interpersonal embeddedness; 3) societal embeddedness; and 4) self-regulation. Living conditions refer to the extent to which people acquire material and immaterial resources, thus enabling them to live a good life, such as being employed, having sufficient financial resources and having a safe place to live. Interpersonal embeddedness is the degree to which people experience meaningful, reciprocal positive relationships and develop a sense of connectedness with others (for example, with family and friends) based on shared values and identities. Societal embeddedness means the extent to which people are integrated (or able to participate) in their community or society and are able to access or make use of their basic rights (for instance the degree to which they can access professional care for physical or mental health problems). Finally, self-regulation is the degree to which people are in control of themselves and their lives and can alter their own internal states, processes and responses (thoughts, feelings and actions) in anticipation of future goals. Self-regulation is influenced, for example, by the degree to which people experience psychological distress or the extent to which they depend on drugs or alcohol to regulate their feelings and emotions (Van der Maesen & Walker, 2012; Wolf & Jonker, 2020). In chapter 2 and 3 of this thesis the SQA is applied to structure the variables used in these studies and to interpret the studies' findings.

Figure 1. Social Quality Approach (Wolf & Jonker, 2020)



Individual risk factors for homelessness

Homelessness is often perceived as the result of a complex interaction between structural factors and individual factors. Well-known structural risk factors for homelessness are, for example, the absence of low-cost housing, a lack of or insufficient income support, and insufficient accessibility of health services (Fazel et al., 2014). They are generally outside an individual's control and are related to broader socio-economic factors. These structural factors play an important role in the individual pathways to homelessness: research shows that individuals who are deprived of socio-economic resources (such as people living in poverty) or who lost socio-economic resources (for example, people who became unemployed), have a higher change of becoming homeless (Barile et al., 2018; Benjaminsen, 2015; Bramley & Fitzpatrick; Doran et al., 2019; Georgiades, 2015; Nilsson et al., 2019; Tsai & Rosenheck, 2015).

Individual risk factors refer to personal characteristics or circumstances that can make people more vulnerable to homelessness. Research regarding individual risk factors shows that physical and mental health issues and substance abuse may generate and reinforce exclusionary processes and may lead to homelessness (Barile et al., 2018; Benjaminsen, 2015; Doran et al., 2019; Georgiades, 2015; Nilsson, et al., 2019; Piat et al., 2015; Tsai & Rosenheck, 2015). Previous imprisonment (Barile et al., 2018; Nilsson, et al., 2019), and biographical characteristics, such as being male, being single and being a veteran (Nilsson et al., 2019; Tsai & Rosenheck, 2015) seem to be associated with a higher change of becoming homeless as well. At the individual level, relational risk factors for homelessness such as family conflicts, domestic violence and relationship breakups may also contribute to homelessness (Barile et al., 2018; Georgiades, 2015; Mabhala et al., 2017; Piat et al., 2015). Relational factors that go back as far as children's youth, known as adverse childhood experiences (Nilsson et al., 2019) correlate with current social isolation and the absence or fragility of social support networks (Tsai & Rosenheck, 2015; Bramley & Fitzpatrick, 2017), which in turn generates a higher risk of becoming homeless. As mentioned, the complexity of homelessness arises from the interplay of both individual and structural factors. Nevertheless, it's important to note that individual factors do not necessarily lead to homelessness, if structural elements are effectively addressed.

Trauma and Adverse Childhood Experiences

It is beyond dispute that homelessness should be prevented at all times, all the more because it is in itself a traumatizing experience. In addition, while being homeless, people are at increased risk of further traumatization because they are particularly vulnerable to injury, accident and assault (To et al., 2015; Calvo et al., 2022). In general, two types of trauma are discerned: Type 1 trauma refers to an experience that happens at a particular time and place, and is transitory, such as a car accident, sudden loss of a parent or a single sexual assault. Type 2 trauma represents experiences which are 'typically chronic, begin in early childhood and occur within family or social environment. They are usually repetitive and prolonged, involve direct or indirect (witnessing) harm or neglect by caregivers or other entrusted adults in an environment where escape is impossible' (Foundation Abbé Pierre & FEANTSA, 2017). Many homeless people have suffered both Type 1 and Type 2 trauma, which is known as complex or compound trauma (Maquire et al., 2009). Complex trauma frequently stems from adverse childhood experiences (ACE). These are traumatic events in childhood that include childhood abuse (psychological, physical and sexual), childhood neglect (emotional and physical), and exposure to household dysfunction (parental separation or divorce, exposure to substance abuse, mental illness, violent treatment of mother/stepmother and incarceration in the household) (Felitti et al., 1998; Van der Kolk, 2014).

It is increasingly recognized that many people who are at risk of or are experiencing long term homelessness have been a victim of ACE (Fondation Abbé Pierre, & FEANTSA, 2017). ACE such as childhood abuse, childhood neglect and exposure to household dysfunction have repeatedly been associated with an increased risk of becoming homeless in adult life (Nielssen et al., 2018; Patterson et al., 2014; Sundin & Baguley, 2015). A significant amount of studies have shown a high prevalence of all types of ACE among adult people experiencing homelessness compared to the general population (Nielssen et al., 2018; Patterson et al., 2014; Sundin & Baguley, 2015). ACE have also been associated with worse outcomes within homeless populations. Within homeless populations, ACE were found to be associated with poorer physical health (Patterson et al., 2014), poorer mental health (Brown et al., 2016; Lee et al., 2017; Liu et al., 2020; Patterson et al., 2014), higher levels of psychological distress (Keane et al., 2018) and problematic substance use (Brown et al., 2016; Patterson et al., 2014). Research investigating the adverse outcomes of ACE has predominantly focused on physical and mental health problems, while studies within the general population indicate that ACE are also related to adverse outcomes on a range of other factors that influence the quality of one's daily life, such as socioeconomic status and the ability to form healthy social relationships. Little is known about the degree to which ACE have a persisting influence on the quality of life of homeless people after accessing social relief facilities. More insight is needed into whether, and in which areas, homeless people with ACE need extra support to optimally benefit from the service system in order to enhance their self-direction and participation in society.

Chapter 3 examines the association between the degree to which experiences of childhood abuse, a sub-type of ACE, are associated with outcomes on the four constitutional conditions of social quality among homeless people at the moment they entered the social relief system and 2.5 years later. The results of this study can inform homeless services on which life domains homeless people with childhood abuse experiences might need additional support.

Peer support

It is more and more recognized that peer workers can offer a kind of support that other professionals cannot or do not provide. Because of their personal experiences, peer workers have the capacity to 'close the gap' between the client and the professional, and between the living world and the system world (Van der Kooij & Keuzenkamp, 2018). It is understood that peer workers can contribute to, for example, clients' resilience, personal development and self-direction (Van der Kooij & Keuzenkamp, 2018). Homeless services increasingly foster and develop peer support interventions, called intentional peer support (IPS). Dutch municipalities also started to involve peer workers in their social services, for example by letting them support people living in persistent poverty and include their experiences in the development and implementation of their social policy (Movisie, 2022). IPS exists in different forms, such as group interventions run by peers, peers providing mutual support or individual mentorship where the peer is clearly more advanced and is mentoring the client in an organized way, referred to as intentional unidirectional peer support (IUPS) (Barker & Maguire, 2017).

To date, the effectiveness of IUPS has mostly been investigated within populations with predominantly mental health problems, often utilising randomized controlled trials. However, research investigating the efficacy of IUPS within homeless populations is scarce and mostly overlooked the perspective of homeless people themselves (Barker & Maguire, 2017). In chapter 4 of this thesis, the outcomes and critical elements of IUPS for homeless people according to people experiencing homelessness and peer workers are examined, as well as the working mechanisms of IUPS derived therefrom.

Needs of people living in persistent poverty

Given the profound negative impact poverty has on people's quality of life and the extent to which they are able to participate in society, it is crucial to facilitate appropriate and effective support to people living in persistent poverty. To determine what appropriate and effective support for people living in persistent poverty entails, it is essential to consult people living in persistent poverty themselves on what they wish to see differently in their lives and what they need to achieve that, as they are experts by experience in their own situation.

To our knowledge, however, the wishes of people living in persistent poverty to improve their quality of life in general have not yet been empirically examined. The barriers people living in poverty perceive and their related support needs have been studied more extensively, but only regarding access to healthcare and public services. These barriers include, for example, feelings of shame, fear for being misunderstood and judged, complex administrative procedures, long waiting lists and high healthcare costs (Canvin et al., 2007; Loignon et al., 2015; Williamson et al., 2006). The identified support needs were an extension of these barriers, such as affordable healthcare, more flexible regulations for using support, and support by professionals who are empathic, caring and respectful (Gupta & Holloway, 2016; O'Donnell et al., 2016; Williamson et al., 2006).

The wishes, perceived barriers and support needs of people living in persistent poverty also have not yet been studied in relation to one another, despite their interconnectedness and the need for a broad and integrated perspective required to improve support for people living in persistent poverty and increase their quality of life (Luijben et al., 2019; Marttila et al., 2013; Taylor & Barusch, 2004). Chapter 5 fills this knowledge gap by exploring the wishes people living in persistent poverty have for their future, the barriers they perceive for realizing these wishes, and the support they need to fulfil these wishes, from the perspectives of people living in persistent poverty, peer workers and practitioners.

Aim and research questions

The general aim of this thesis is to deepen our knowledge of what Dutch homeless people and people living in persistent poverty need in order to overcome their disadvantaged position, enhance their living conditions and participate in society. The following research questions were examined:

Chapter 2. What is the prevalence of modifiable risk factors for homelessness at the individual level among homeless people at admission to the social relief system in Amsterdam and 5.5 years later, also considering their housing status, and does the prevalence of these risk factors for homelessness change 5.5 years after shelter entry?

Chapter 3. Do homeless people with and without childhood abuse experiences differ in the constitutional conditions of social quality when entering the Dutch social relief system and 2.5 years later, and are childhood abuse experiences predictive of the rate of change in these constitutional conditions in this period of 2.5 years?

Chapter 4. What are the outcomes of individual unidirectional peer support according to people experiencing homelessness and peer workers, which critical elements of IUPS do they distinguish and which working mechanisms of IUPS can be identified, based on the perceived outcomes and critical elements?

Chapter 5. What are the wishes people living in persistent poverty have for their future according people living in persistent poverty themselves, peer workers and practitioners, what kind of support do they need to fulfil their wishes, and what barriers do they perceive in realizing those wishes?

All research questions start from the perspectives of the people experiencing social exclusion themselves, i.e. Dutch homeless people and people living in persistent poverty. The research questions examined in chapter 4 and 5, the perspectives of peer workers are examined as well.

Summary of methods

To address the research questions in this dissertation, data were used from two studies on homeless adults and youth residing in or leaving the Dutch social relief system, and one study on people living in persistent poverty. The design of these three studies will be described below. Table 1 shows an overview of the research questions and study design per chapter of this thesis.

To answer research questions 1 and 2, data were used from an observational longitudinal multisite cohort study that followed over 500 homeless persons in the four major cities of the Netherlands for a period of 2.5 years (CODA-G4). The study involved a baseline interview and three follow-up interviews in Amsterdam, Rotterdam, Den Haag and Utrecht, using a questionnaire that consisted of seven life domains: housing and daily life, finance and daily activities, physical health (including substance use), mental health, safety and protection against violence, social relations and care use, and experience with services. Additionally, participants from Amsterdam were followed up with a fourth interview 5.5 years after their baseline interview. Data collection associated with research question 1 took place between January 2011 and June 2017, and data concerning research question 2 were gathered between January 2011 and June 2014. The cohort study complied with the criteria for studies that have to be approved by an accredited Medical Research Ethics Committee (aMREC) and was exempted from formal review by the local aMREC (CMO Region Arnhem-Nijmegen region of the Netherlands: registration number 2010/321). The cohort study was conducted according to the principles expressed in the Code of Conduct for health research with data (http://www.federa.org/). The participants, consisting of homeless adults (aged ≥ 23 years) and young adults (aged 18–22 years), all satisfied the criteria for entering the social relief system in 2011, including being ≥18 years of age, having abandoned the home situation, and being unable to function independently in society. All participants gave written informed consent.

To answer research question 3, data from a qualitative study on peer support in residential shelters in the Netherlands were used. This study examined the outcomes, critical elements and working mechanisms of peer support within homeless services from the perspective of both homeless people receiving peer support and peer workers providing peer support. For this study face-to-face interviews were held with people experiencing homelessness and receiving individual peer support (*n* = 10) and peer workers providing individual peer support (*n* = 10) in five residential shelter facilities across the Netherlands. This study was exempt from formal review by the accredited Medical Review Ethics Committee region Arnhem-Nijmegen (file number 2018-5007). All participants gave written informed consent.

To answer research question 4, data were used from a larger Community Based Participatory Research study investigating how the financial situation, stress-level, participation and health of people living in persistent poverty could be improved. This study examined the wishes people living in persistent poverty have for the future, the support they need to fulfil their wishes, and the barriers they perceive in realizing those wishes, from the perspective of people living in persistent poverty (*n* = 14), peer workers (*n* = 5) and practitioners (*n* = 5) in five municipalities across the Netherlands. For this study digital interviews were held instead of face-to-face interviews, due to contact restrictions related the Covid-19 pandemic. This study was exempt from formal review by the accredited Medical Review Ethics Committee region (file number 2020-7030). All participants gave verbal informed consent, which was audio-recorded.

Thesis outline

This dissertation continues with chapter 2 describing the housing status, the prevalence of a comprehensive set of modifiable risk factors for homelessness at the individual level, and changes in the prevalence of housing status and these risk factors among homeless people over a period of 5.5 years. Chapter 3 describes differences in the four constitutional conditions of social quality between homeless people with and without childhood abuse experiences at the moment they enter the social relief system and 2.5 years later. Chapter 4 describes the outcomes, critical elements and working mechanisms of individual unidirectional peer support according to people experiencing homelessness and peer workers. Chapter 5, describes the wishes that people living in persistent poverty have for the future, the support they need to fulfil their wishes, and the barriers they perceive in realizing those wishes. Lastly, chapter 6 summarizes and discusses the results of all studies and discusses strengths and limitations of this thesis as well as the implications for policy and practice.

Table 1. Overview of the chapters in this thesis

	Chapter 2	**Chapter 3**	**Chapter 4**	**Chapter 5**
Research questions	What is the prevalence of modifiable risk factors for homelessness at the individual level among homeless people at admission to the social relief system in Amsterdam and 5.5 years later, also considering their housing status? Does the prevalence of these risk factors for homelessness change 5.5 years after shelter entry?	Do homeless people with and without childhood abuse experiences differ in the constitutional conditions of social quality when entering the Dutch social relief system and 2.5 years later? Are childhood abuse experiences predictive of the rate of change in these constitutional conditions in this period of 2.5 years?	What are the outcomes of individual unidirectional peer support (IUPS) according to people experiencing homelessness and peer workers? Which critical elements of IUPS do they distinguish? Which working mechanisms of IUPS can be identified, based on the perceived outcomes and critical elements?	What whishes do people living in persistent poverty have for the future? What support do they need to fulfil their wishes? What barriers do they perceive in realizing those wishes?
Design	Quantitative & Longitudinal	Quantitative & Longitudinal	Qualitative & Cross-sectional	Qualitative, Cross-sectional & Collaborative Approach
Method	Face-to-face interviews	Face-to-face interviews	Face-to-face interviews	Digital interviews
Participants	Clients (*n*= 72)	Clients (*n*= 378)	Clients (*n* = 10) and peer workers (*n*= 10)	Clients (*n* = 14), peer workers (*n* = 5) and practitioners (*n* = 5)

References

Aldridge, R. W., Story, A., Hwang, S. W., Nordentoft, M., Luchenski, S. A., Hartwell, G., Tweed, E. J., Lewer, D., Katikireddi, S. V., & Hayward, A. C. (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The Lancet, 391*(10117), 241-250. doi: 10.1016/S0140-6736(17)31869-X

Baptista, I., Benjaminsen, L., Busch-Geertsema, V., & Pleace, N. (2017). *Family Homelessness in Europe. EOH Comparative Studies on Homelessness.* FEANTSA, retrieved from: https:// www.feantsaresearch.org/en/comparative-studies/2017/12/15/comparative-studies-on-homelessness?bcParent=763

Barile, J. P., Pruitt, A. S., & Parker, J. L. (2018). A latent class analysis of self-identified reasons for experiencing homelessness: Opportunities for prevention. *Journal of Community & Applied Social Psychology, 28*(2), 94-107. doi: 10.1002/casp.2343

Barker, S. L., & Maguire, N. J. (2017). Experts by experience: Peer support and its use with the homeless. *Community Mental Health Journal, 53*(5), 598–612. doi: 10.1007/s10597-017-0102-2

Benjaminsen, L. (2015). Homelessness in a scandinavian welfare state: The risk of shelter use in the Danish adult population. *Urban Studies, 53*(10), 2041-2063. doi: 10.1177/0042098015587818

Bramley, G., & Fitzpatrick, S. (2018). Homelessness in the UK: who is most at risk? *Housing Studies, 33* (1), 96-116. doi: 10.1080/02673037.2017.1344957

Brown, R.T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M.B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *PLoS ONE 11* (5), doi: 10.1371/journal.pone.0155065

Calvo, F., Watts, B., Panadero, S., Giralt, C., Rived-Ocaña, M., & Carbonell, X. (2022). The Prevalence and Nature of Violence Against Women Experiencing Homelessness: A Quantitative Study. *Violence against women, 28(6-7),* 1464–1482. doi: 10.1177/10778012211022780

Canvin, K., Jones, C., Marttila, A., Burström, B., & Whitehead, M. (2007). Can I risk using public services? Perceived consequences of seeking help and health care among households living in poverty: Qualitative study. *Journal of Epidemiology and Community Health, 61*, 984-989. doi: 10.1136/jech.2006.058404

College for Human Rights (2016). *Armoede, sociale uitsluiting en mensenrechten*. Utrecht, retrieved from: https://mensenrechten.nl/nl/publicatie/37645

Coumans, M. (2012). *Sociale uitsluiting, beschrijvende analyses*. Statistics Netherlands, Den Haag. Retrieved from: https://www.cbs.nl/nl-nl/achtergrond/2012/51/sociale-uitsluiting-beschrijvende-analyses

Curl, A., & Kearns, A. (2014). Financial difficulty and mental wellbeing in an age of austerity: The experience in deprived communities. *Social Policy & Society, 14*, 217-240. doi: 10.1017/S1474746414000475

Doran, K. M., Ran, Z., Castelblanco, D., Shelley, D., & Padgett, D. K. (2019). "It wasn't just one thing": A qualitative study of newly homeless emergency department patients. *Academic Emergency Medicine, 26*(9), 982-993. doi: 10.1111/acem.13677

Edgar, B. (2012). The ETHOS definition and classification of homelessness and housing exclusion. *European Journal of Homelessness, 6*, 219–226.

Edgar, W., & Meert, H. (2005) *Fourth Review of Statistics on Homelessness in Europe. The ETHOS Definition of Homelessness*. Brussels: FEANTSA.

Edgar, B., Harrison, M., Watson, P., & Busch-Geertsema, V. (2007). *Measurement of homelessness at European Union level*. Brussels, Belgium: European Commission. Retrieved from http://ec.europa.eu/employment_social/social_inclusion/docs/2007/study_homelessness_en.pdf

Eurostat (2021a). *Glossary: At risk of poverty rate*. Retrieved from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:At-risk-of-poverty_ rate

Eurostat (2021b). *At risk of poverty rate*. Retrieved from: https://ec.europa.eu/eurostat/databrowser/ view/tespm010/default/table?lang=en

Evans, G. W., & Kim, P. (2012). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives, 7*(1), 43-48. doi: 10.1111/cdep.12013

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet, 384(*9953), 1529-1540. doi: 10.1016/S0140-6736(14)61132-6

FEANTSA (2018). *ETHOS Light: European Typology of Homelessness and Housing Exclusion, Measurement of Homelessness at European Union Level.* Retrieved from: www.feantsa.org/download/fea-002-18-update-ethos-light-0032417441788687419154.pdf.

Federation of shelters (2021). *Dakloosheidcijfers roepen vragen op*. Vereniging Valente, retrieved from: https://www.valente.nl/nieuws/reactie-valente-cbs-cijfers-dakloosheid/

Federation of Shelters (2019). Jaarverslag Federatie Opvang & RIBW Alliantie 2019. Vereniging Valente, retrieved from: https://www.valente.nl/wp-content/uploads/2020/06/Jaarverslag-Federatie-Opvang-en-RIBW-Alliantie-Valente-2019-publieksversie-1.pdf

Fleury, M.J., Grenier, G., Sabetti, J., Bertrand, K., Clément, M., & Brochu, S. (2021). Met and unmet needs of homeless individuals at different stages of housing reintegration: A mixed-method investigation. PLOS ONE, 16(1). doi:10.1371/journal.pone.0245088

Foundation Abbé Pierre, & FEANTSA (2017). *Recognising the Link between Trauma and Homelessness.* Feantsa Position, retrieved from: https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf

Foundation Abbé Pierre, & FEANTSA (2018). Third overview of housing exclusion in Europe 2018. FEANTSA, retrieved from: https://www.feantsa.org/download/full-report-en1029873431323901915.pdf

Foundation Abbé Pierre, & FEANTSA, (2019). Fourth overview of housing exclusion in Europe 2019. FEANTSA, retrieved from: https://www.feantsa.org/public/user/Activities/events/OHEEU_2019_ENG _Web.pdf

Fowler, P.J., Hovmand, P., Marçal, K.E., & Das, S. (2019). Solving Homelessness from a Complex Systems Perspective: Insights for Prevention Responses. *Annual review of public health, 40*, 465-486. doi: 10.1146/annurev-publhealth-040617-013553

Georgiades, S. (2015). The dire straits of homelessness: Dramatic echoes and creative propositions from the field. *Journal of Human Behavior in the Social Environment, 25*(6), 630–642. doi: 10.1080/10911359.2015.1011254

Goderis, B., Van Hulst, B., & Hoff, S. (2019). *Waar ligt de armoedegrens?* Social and Cultural Planning Bureau, retrieved from: https://digitaal.scp.nl/armoedeinkaart2019/waar-ligt-de-armoedegrens/

Golin, C. E., Haley, D. F., Wang, J., Hughes, J. P., Kuo, I., Justman, J., Adimora, A. A., Soto-Torres, L., O'Leary, A., & Hodder, S. (2016). Post-traumatic Stress Disorder Symptoms and Mental Health over Time among Low-Income Women at Increased Risk of HIV in the U.S. *Journal of health care for the poor and underserved, 27*(2), 891–910. doi: 10.1353/hpu.2016.0093

Gupta, A., & Holloway, R. (2016). Giving poverty a voice: Families' experiences of social work practice in a risk-averse child protection system. *Families, Relationships and Societies, 5*(1), 163-172. doi: 10.1332/204674316X14540714620166

Haushofer, J., & Feher, E. (2014). On the psychology of poverty. *Science, 344*(6186), 862-867. doi: 10.1126/science.1232491

Hermans, K., (2020). Editorial: Measuring Homelessness in Europe. *European Journal of Homelessness, 14 (3*), 9-16.

Hoff, S., Van Hulst, B., Wildeboer Schut, J.M., & Goderis, B. (2019). *Armoede in Kaart 2019*. Social and Cultural Planning Bureau, retrieved from: https://www.scp.nl/publicaties/monitors/2019/09/03/armoede-in-kaart-2019

Horsell, C. (2006). Homelessness and social exclusion: A Foucauldian Perspective for Social Workers. *Australian Social Work, 59* (2), 213-225. doi: 10.1080/03124070600651911

Iceland, J. (2005). Measuring Poverty: Theoretical and Empirical Considerations. *Measurement: Interdisciplinary Research and Perspectives, 3 (4)*, 199-235. doi: 10.1207/s15366359mea0304_1

Johnsen, S., & Watts, B. (2014). *Homelessness and Poverty: Reviewing the Links*. Edinburgh: Heriot-Watt University.

Johnson, G., Scutella, R., Tseng, Y. P. & Wood, G. (2015) Entries and Exits from Homelessness: A Dynamic Analysis of the Relationship Between Structural Conditions and Individual Characteristics. *AHURI Final Report No 248*, Melbourne, AHURI.

Kahn, J. K., & Pearlin, L. I. (2006). Financial strain over the life course and health among older adults. *Journal of Health and Social Behavior, 47*, 17-31. doi: 10.1177/002214650604700102

Keane, C.A., Magee, C.A., & Kelly, P.J. (2018), Trajectories of Psychological Distress in Australians Living in Urban Poverty: The Impact of Interpersonal Trauma. *Journal of Traumatic Stress, 31*, 362-372. doi: 10.1002/jts.22297

Lee, C.M., Mangurian, C., Tieu, L., Ponath, C., Guzman, D., & Kushel, M. (2017). Childhood Adversities Associated with Poor Adult Mental Health Outcomes in Older Homeless Adults: Results From the HOPE HOME Study*. American Journal of Geriatric Psychiatry, 25*(2), 107-117. doi: 10.1016/j.jagp.2016.07.019

Levy, L.B., & O'Hara, M.W. (2010). Psychotherapeutic interventions for depressed, low-income women: A review of the literature. *Clinical Psychology Review, 30* (8), 934-950. doi.org/10.1016/j.cpr.2010.06.006.

Liu, M., Mejia-Lancheros, C., Lachaud, J., Nisenbaum, R., Stergiopoulos, V., & Hwang, S.W. (2020). Resilience and Adverse Childhood Experiences: Associations With Poor Mental Health Among Homeless Adults. *American Journal of Preventive Medicine, 58* (6), 807-816. doi: 10.1016/j.amepre.2019.12.017

Loignon, C., Hudon, C., Goulet, E., Boyer, S., De Laat, M., Fournier, N., Grabovschi, C., & Bush, P. (2015). Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project. *International Journal for Equity in Health, 14*(4). doi: 10.1186/s12939-015-0135-5

Luijben , G., Hertog , F., & van der Lucht, F. (2019). *Armoede, chronische stress en gezondheid in Den Haag, een verkenning op basis van group model building* (vol. 2019-0004). Bilthoven, The Netherlands: Rijksinstituut voor Volksgezondheid en Milieu RIVM, Ministerie van Volksgezondheid, Welzijn en Sport.

Luchenski, S., Maguire, N., Aldridge, R. W., Hayward, A., Story, A., Perri, P., ... Hewett, N. (2018). What works in inclusion health: Overview of effective interventions for marginalised and excluded populations. *The Lancet, 391*(10117), 266-280. doi:10.1016/s0140-6736(17)31959-1

Mabhala, M. A., Yohannes, A., & Griffith, M. (2017). Social conditions of becoming homelessness: qualitative analysis of life stories of homeless peoples. *International journal for equity in health, 16*(1), 1-16. doi: 10.1186/s12939-017-0646-3

Maguire, N.J., Johnson, R., Vostanis, P., Keats, H., & Remington, R.E. (2009). *Homelessness and complex trauma: a review of the literature*. Southampton, UK, University of Southampton. Retrieved from: http://eprints.soton.ac.uk/69749

Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013). Poverty impedes cognitive function. *Science, 341*, 976-980. doi: 10.1126/science.1238041

Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public Health, 126*, 4-10. doi: 10.1016/j.puhe.2012.05.014.

Marttila, A., Johansson, E., Whitehead, M. et al. (2013). Keep going in adversity – using a resilience perspective to understand the narratives of long-term social assistance recipients in Sweden*. International Journal for Equity in Health 12 (8).* doi:10.1186/1475-9276-12-8

Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport (2022). *Nationaal Actieplan Dakloosheid: Eerst een Thuis*. Retrieved from: https://open.overheid.nl/documenten/ronl-bb529bd58adc8061e5c058d2fe9671197ba6244f/pdf

Mood, C., & Jonsson, J.O. (2016). The Social Consequences of Poverty: An Empirical Test on Longitudinal Data. *Social Indicators Research, 127*(2), 633-652. doi: 10.1007/s11205-015-0983-9

Movisie (2022). *Inzetten van ervaringskennis- en deskundigheid werkt. Democratischer, passender, menselijker.* Retrieved from: https://www.movisie.nl/artikel/inzetten-ervaringskennis-deskundigheid-werkt

National Institute for Budget Education (2022). Retrieved from: https://www.nibud.nl/dossiers/koopkracht-betaalbaarheid/

Nielssen, O.B., Stone, W., Jones, N.M., Challis, S., Nielssen, A., Elliott, G., Burns, N., Rogoz, A., Cooper, L.E., & Large, M.M. (2018), Characteristics of people attending psychiatric clinics in inner Sydney homeless hostels. *Medical Journal of Australia, 208*, 169-173. doi: 10.5694/mja17.00858

Nilsson, S.F., Nordentoft, M., & Hjorthøj, C. (2019). Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis*. Journal of Urban Health, 96*(5), 741-750. doi: 10.1007/s11524-019-

O'Donnell, P., Tierney, E., O'Carroll, A., Nurse, D., & MacFarlane, A. (2016). Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *International Journal Equity in Health, 15*, 197. doi: 10.1186/s12939-016-0487-5

Orwin, R. G., Scott, C. K., & Arieira, C. (2005). Transitions through homelessness and factors that predict them: Three-year treatment outcomes. *Journal of Substance Abuse Treatment, 28*(2), S23–S39. doi: 10.1016/j.jsat.2004.10.011

Patterson, M.L., Moniruzzaman, A., & Somers, J.M. (2014). Setting the stage for chronic health problems: cumulative childhood adversity among homeless adults with mental illness in Vancouver, British Columbia. *BMC Public Health, 14*, 350. doi: 10.1186/1471-2458-14-350

Piat et al., (2015). Pathways into homelessness: Understanding how both individual and structural factors contribute to and sustain homelessness in Canada. Urban Studies, 52(13), 2366-2382. doi: 10.1177/0042098014548138

Price, R. H., Choi, J. N., & Vinokur, A. D. (2002). Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning, and poor health. *Journal of Occupational Health Psychology, 7*(4), 302-312. doi.org/10.1037//1076-8998.7.4.302

Price, J. H., Khubchandani, J., & Webb, F. J. (2018). Poverty and Health Disparities: What Can Public Health Professionals Do? *Health Promotion Practice, 19*(2), 170–174. doi: 10.1177/1524839918755143

Raad Volksgezondheid en Samenleving (2020). Herstel begint met een huis: Dakloosheid voorkomen en verminderen. Den Haag, retrieved from: https://www.raadrvs.nl/documenten/publicaties/2020/ 04/21/herstel-begint-met-een-huis---dakloosheid-voorkomen-en-verminderen

Ridley, M., Rao, G., Schilbach, F., & Patel, V. 2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science, 370, issue 6522*. doi: 10.1126/science.aay0214

Statistics Netherlands (2019). *The Netherlands on the European scale 2019.* Retrieved from: https://www.cbs.nl/en-gb/publication/2019/20/the-netherlands-on-the-european-scale-2019

Statistics Netherlands (2021a). *Stijging van het aantal daklozen tot stilstand gekomen*. Retrieved from: https://www.cbs.nl/nl-nl/nieuws/2021/13/stijging-van-het-aantal-daklozen-tot-stilstand-gekomen

Statistics Netherlands (2021b). *Daklozen 18 tot en met 65 jaar, persoonskenmerken*. Retrieved from: https://www.cbs.nl/nl-nl/cijfers/detail/84990NED

Statistics Netherlands (2021c). *Armoede en sociale uitsluiting.* Retrieved from: https://longreads.cbs.nl/armoede-en-sociale-uitsluiting-2021/

Sundin, E., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 50* (2), 183–194. doi: 10.1007/s00127-014-0937-6

Tabner, K. (2010) *Beyond Homelessness: Developing Positive Social Networks. Edinburgh*: Rock Trust.

Taylor, M.J., Barusch, A.S. (2004). Personal, family, and multiple barriers of long-term welfare recipients. *Social Work, 49*(2), 175-83. doi: 10.1093/sw/49.2.175

To, M. J., et al. (2015). Healthcare Utilization, Legal Incidents, and Victimization Following Traumatic Brain Injury in Homeless and Vulnerably Housed Individuals: A Prospective Cohort Study*. Journal of Head Trauma Rehabilitation 30(4),* 270-276. doi: 10.1097/HTR.0000000000000044

Trimbos Institute (2015). *Dakloze personen zonder OGGz-problematiek en hun ondersteuning*. Utrecht, retrieved from: https://www.trimbos.nl/wp-content/uploads/sites/31/2021/09/af1371-dakloze-personen-zonder-oggz-problematiek-en-hun-ondersteuning.pdf

Trimbos institute (2021). Maatschappelijke opvang: feiten en cijfers. Utrecht, retrieved from: https://www.trimbos.nl/kennis/maatschappelijke-opvang/feiten-en-cijfers/

Tsai, J., & Rosenheck, R. A. (2015). Risk factors for homelessness among US veterans. *Epidemiologic reviews, 37*(1), 177-195. doi: 10.1093/epirev/mxu004

Van der Kooij, A., & Keuzenkamp, S. (2018). *Ervaringsdeskundigen in het sociaal domein: wie zijn dat en wat doen ze?* Movisie, retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2019-11/Startnotitie-Ervaringsdeskundigen-in-het-sociaal-domein.pdf

Van der Laan, J. (2020). *Giving Voice to Homeless People: homeless people's personal goals, care needs, and quality of life in the Dutch social relief system* (Doctoral thesis). Radboud University, Nijmegen.

Van der Maesen, L. J. G., & Walker, A. (Eds.) (2012). *Social quality: From theory to indicators*. Basingstoke, United Kingdom: Palgrave Macmillan. doi: 10.1057/9780230361096

Van Hulst, B., & Hoff, S. (2020). *Hoeveel mensen zijn langdurig arm?*. In: Armoede in kaart: 2019. Geraadpleegd op [datum] via https://digitaal.scp.nl/armoedeinkaart2019/hoeveel-mensen-zijn-langdurig-arm

Van Straaten, B., Van der Laan, J., Rodenburg, G., Boersma, S.N., Wolf, J.R., & Van de Mheen, D. (2017). Dutch homeless people 2.5 years after shelter admission: what are predictors of housing stability and housing satisfaction? *Health and Social Care in the Community, 25* (2), 710-722. doi: 10.1111/hsc.12361.

Vereniging Nederlandse Gemeenten (2019) *Halt aan dak- en thuisloosheid*. Retrieved from: https://vng.nl/sites/default/files/2019-11/brandbrief_toename_daklozen.pdf

Verheul, M., Laere, I. V., Muijsenbergh, D. M., & Genugtenc, W. V. (2020). Self-perceived health problems and unmet care needs of homeless people in The Netherlands : The need for pro-active integrated care. *Journal of Social Intervention: Theory and Practice, 29*(1), 21-40. doi:10.18352/jsi.610

Visser, S. (2019). *Mechanismen van en interventies bij intergenerationele armoede: Een literatuur-onderzoek*. Rijksuniversiteit Groningen.

Watson, J., Crawley, J., & Kane, D. (2016). Social exclusion, health and hidden homelessness. *Public Health, 139*, 96-102. doi: 10.1016/j.puhe.2016.05.017

Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy, 76*(1), 106-121. doi: 10.1016/j.healthpol.2005.05.005

Wolf, J.R.L.M., & Jonker, I.E. (2020). Pathways to empowerment: The social quality approach as a foundation for person-centered interventions. *International Journal of Social Quality, 10* (1), 29-56. doi: 10.3167/IJSQ.2020.100103

Wolf, J. R., Zwikker, M., Nicholas, S., Bakel, H. van, Reinking, D., & van Leiden, I. (2002). *Op achterstand: een onderzoek naar mensen in de marge van Den Haag [On backlog: a study of people in the fringe of society in the Hague*]. Netherlands Institute of Mental Health and Addiction. http:// docplayer.nl/15781424-J-wolf-m-zwikker-s-nicholas-h-van-bakel-d-reinking-i-van-leiden-op-achterstand-een-onderzoek-naar-mensen-in-de-marge-van-den-haag.html

Chapter 2

Initially homeless people in the Netherlands: housing status, prevalence of risk factors and changes in this prevalence 5.5 years after shelter entry

Schel, S.H.H., Van den Dries, L., Van der Laan, J., Van de Mheen, D., & Wolf, J.R.L.M.
Initially homeless people in the Netherlands: Housing status, prevalence of risk factors and changes in this prevalence 5.5 years after shelter entry. (Revision submitted)

Abstract

This observational longitudinal cohort study examines housing status, the prevalence of a comprehensive set of modifiable risk factors for homelessness at the individual level, and changes in the prevalence of housing status and these risk factors among initially homeless people from Amsterdam over a period of 5.5 years. The four constitutional conditions of the Social Quality Approach (namely living conditions, interpersonal embeddedness, societal embeddedness and self-regulation), were used to cluster the risk factors included in this study. Data were collected with a quantitative questionnaire that was orally administered at two time points; at baseline (at shelter entry), and at follow-up (5.5 years after shelter entry). At baseline (n=172), as expected, the participants were seriously disadvantaged regarding all four constitutional conditions of social quality. At the 5.5 year follow-up (n=72), 69% of the participants were stably housed, and, although for all four constitutional conditions of social quality significant improvements were found, the prevalence of the majority of risk factors had not decreased after 5.5 years. Findings indicate that, even 5.5 years after shelter entry, Dutch initially homeless people still experienced high levels of social exclusion, which leaves them particularly vulnerable for recurrent homelessness. Implications for policy and practice are discussed.

Introduction

Homelessness is a serious and widespread public health problem, affecting the quality of daily life of increasing numbers of people in Europe (Fondation Abbé Pierre – FEANTSA, 2018; Fondation Abbé Pierre – FEANTSA, 2019). Homelessness can be narrowly defined as not having a roof over one's head (Edgar et al., 2007), but this definition fails to take into account that homelessness is not a permanent state (De Vet, 2020). Many homeless persons transition repeatedly between living on the streets, residing in shelters or institutions such as a hospital or jail, being housed, and atypical living situations such as staying in a hotel, in a squatted building, or with family or friends (Orwin et al., 2005; Van der Laan, 2020).

Homelessness is often perceived as the result of a complex interaction between structural factors and individual factors. Well-known structural risk factors for homelessness are, for example, the absence of low-cost housing and a lack of or insufficient income support (Fazel et al., 2014). These structural factors play an important role in the individual pathways to homelessness: research shows that individuals who are deprived of socio-economic resources (such as people living in poverty) or who lost socio-economic resources (for example, people who became unemployed), have a higher change of becoming homeless (Barile et al., 2018; Benjaminsen, 2015; Bramley & Fitzpatrick; Doran et al., 2019; Georgiades, 2015; Nilsson et al., 2019; Tsai & Rosenheck, 2015). Well-known individual risk factors are, for instance, a poor physical health (Nilsson, et al., 2019), mental health issues (Nilsson, et al., 2019), and the absence of a social support system (Bramley & Fitzpatrick, 2017). Besides governments investing in improving societies' structural factors, insight into modifiable risk factors for homelessness at the individual level and the extent to which their prevalence changes over time is also needed. Homeless services can use this knowledge to prevent people from recurrent homelessness. The Social Quality Approach (SQA; Van der Maesen & Walker, 2012; Wolf & Jonker, 2020) offers a deeper understanding of factors and processes associated with social exclusion; because, in essence, social quality is concerned with risk factors for societal participation. According to the SQA there are four conditions that constitute the quality of daily life: 1) living conditions; 2) interpersonal embeddedness; 3) societal embeddedness; and 4) self-regulation. Living conditions refer to the extent to which people acquire material and immaterial resources, thus enabling them to live a good life, such as being employed, having sufficient financial resources and having a safe place to live. Interpersonal embeddedness is the degree to which people experience meaningful, reciprocal positive relationships and develop a sense of connectedness with others (for example, with family and friends) based on shared values and identities. Societal embeddedness means the extent to which people are integrated (or able to participate) in their community or society and are able to access or make use of their basic rights (for instance the degree to which they can access professional care for physical or mental health problems). Finally, self-regulation is the degree to which people are in control of themselves and their lives and can alter their own internal states, processes and responses (thoughts, feelings and actions) in anticipation of future goals. Self-regulation is influenced, for example, by the degree to which people experience psychological distress or the extent to which they depend on drugs or alcohol to regulate their feelings and emotions. A more extensive elaboration of the SQA is described elsewhere (Wolf & Jonker, 2020)

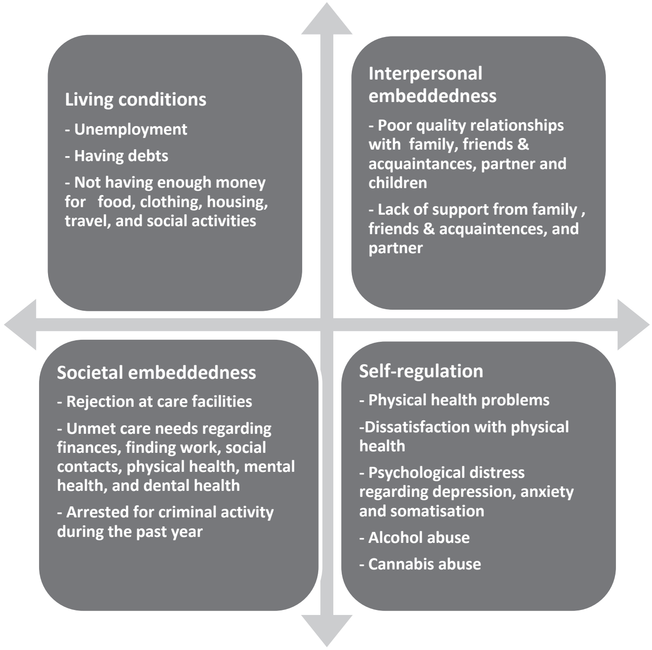
Studies on modifiable risk factors for homelessness at the individual level reveal risk factors in all four constitutional conditions for 'a good life'. Regarding living conditions, a low educational level (Benjaminsen, 2015; Nilsson et al., 2019), unemployment (Doran et al., 2019; Nilsson et al., 2019), financial hardship such as having a low income (Georgiades, 2015; Tsai & Rosenheck, 2015), and living in poverty (Bramley & Fitzpatrick, 2017; Doran et al., 2019) were found to be risk factors for homelessness. Risk factors for homelessness relating to interpersonal embeddedness were found to be a frail social support system, such as relationship and family conflicts (Mabhala et al. 2017; Piat et al., 2015), relationship breakups (Georgiades, 2015), social isolation (Tsai & Rosenheck, 2015), lacking social support networks (Bramley & Fitzpatrick, 2017), and even going back as far as a person's youth, known as adverse childhood experiences (Nilsson et al., 2019). Where societal embeddedness is concerned; a previous imprisonment (Benjaminsen, 2015; Nilsson et al., 2019), being a veteran (Nilsson et al., 2019; Tsai & Rosenheck, 2015), and major life transitions such as release from rehab, an eviction, and a release from jail (Barile et al., 2018) were identified as risk factors for becoming homeless. Risk factors for homelessness relating to self-regulation were found to be physical health issues (Barile et al., 2018; Doran et al., 2019), mental health problems (Barile et al., 2018; Nilsson, et al., 2019;) and substance abuse (Doran et al., 2019; Nilsson et al., 2019). Studies specifically investigating risk factors for recurrent homelessness after the transition from homelessness to housing are scarce, but mostly reveal the same modifiable risk factors at the individual level as for first-time homelessness (De Vet, 2019).

Present study

Although research over the last decades has accumulated considerable knowledge on risk factors for homelessness, we still know little about changes in the prevalence of these risk factors over time. This information is essential for preventing recurrent homelessness. Therefore, this present study longitudinally assesses the prevalence of a comprehensive set of modifiable risk factors for (recurrent) homelessness in the lives of initially homeless people over a 5.5 year period. Because service providers within the social relief system are only able to address issues that can be changed over time, the current study focuses on modifiable risk factors at the individual level. This exploratory study addresses the following research questions: 1) what is the prevalence of modifiable risk factors for homelessness at the individual level among homeless people at admission to the social relief system in Amsterdam and 5.5 years later, also considering their housing status?; and 2) does the prevalence of these risk factors for homelessness change 5.5 years after shelter entry? The risk factors assessed in this study, grouped in the four conditions of the SQA, are shown in Figure 1.

Findings of this study may raise awareness of the extent to which homeless people are at high risk of recurrent homelessness, and may provide important clues to service providers and policy makers as to what is needed to structurally enhance the four constitutional conditions for 'a good life' in order to prevent recurrent homelessness.

Figure 1. Study variables, grouped in the four constitutional conditions of the Social Quality Approach (Wolf & Jonker, 2020).



Methods

Study design

This study is part of a longitudinal multi-site cohort study following 513 initially homeless people for a period of 2.5 years, starting from the moment they reported at a central access point for social relief in 2011 in one of the four major cities in the Netherlands (G4: Amsterdam, The Hague, Rotterdam and Utrecht). Participants from one of these cities, Amsterdam, were followed up for a period of 5.5 years (Van den Dries et al, 2018). Data for this sample were collected by means of a quantitative questionnaire that was administered face-to-face at two time points: at baseline (T0) between January 2011 and December 2011, and at follow-up (T1) between July 2016 and June 2017. This study was exempt from formal review by the accredited Medical Review Ethics Committee - Arnhem-Nijmegen (file number 2010-321).

Participants

In the Netherlands it is obligatory for homeless persons to report at a central access point and to be accepted for an individual program plan, in order to get access to social relief facilities, such as night shelters. To be accepted for an individual program plan, participants had to meet the following criteria: being at least 18 years of age, having legal residence in the Netherlands, having resided in the region of application for at least 2 of the preceding 3 years, having abandoned the home situation, and being unable to hold one's own in society.

At baseline (T0) 172 participants from Amsterdam completed the face-to-face administered questionnaire. At follow-up (T1) all former 172 participants were contacted, of whom 72 participants (42%) took part in the interview and were included in the analyses. Reasons for attrition were: inability to contact the participant (*n* = 56), unwillingness to participate (*n* = 15), no show at the scheduled interview (*n*=13), inability to participate due to private circumstances such as health problems (*n* = 5), death (*n* = 4) or emigration (*n* = 3). Two participants had moved to another G4 city within the first two years of the study and were therefore followed within another cohort. Additionally, two participants who completed the interview were excluded from the study because the researcher questioned the reliability of their answers.

To investigate selective loss to follow-up, we compared respondents on the final interview (*n* = 72) with non-respondents of the Amsterdam cohort (*n* = 100) on demographic variables as reported at the first measurement. No differences were found between participants who only completed the questionnaire at baseline compared to participants who completed the questionnaire at baseline and follow-up after 5,5 years regarding age, gender, level of education, physical- and mental health complaints, and cannabis- and alcohol use (Van den Dries et al, 2018).

Procedure

At the start of the study in January 2011 (T0), potential participants were approached, either at a central access point for social relief in Amsterdam by an employee of the access point, or at temporary accommodation where they stayed shortly after entering the social relief system, by the researchers or interviewers. Potential participants were informed about the study by means of leaflets, posters and face-to-face information provision. When a potential participant expressed interest in taking part in the study, the researchers contacted that person to explain the study aims, the interview procedure and the informed consent. When the participant then agreed to participate based on the terms explained to them, an interview appointment was scheduled. At follow-up (T1), participants were contacted by letter, telephone, e-mail, their social contacts, their (former) caregiver/institution and/or private messages via social media. At both measurements (mean duration of 1.5 hours) participants gave written informed consent and received €15 for their participation.

Problems that may occur when using questionnaires designed for the general population among people with an intellectual disability were anticipated, e.g. acquiescence, not understanding the question, getting tired during the interview (Finlay & Lyons, 2001). Participants were for example told that they could take a break during the interview and that they were allowed to have missing answers.

Measures

Demographics

The following demographic characteristics were assessed at the follow-up measurement: age, gender, having a partner, having one or more children, and educational level. Education was categorized as 'lowest' when the participant completed primary education at the most, as 'low' when the participant completed prevocational education, lower technical education, assistant training or basic labor-oriented education, as 'intermediate' when the participant completed secondary vocational education, senior general secondary education or pre-university education, and categorized as 'high' when the participant completed higher professional education or university education.

Housing status

Stable housing was assessed at baseline and at follow-up, and the median duration of lifetime homelessness was assessed at baseline. Stable housing was defined as being at least 90 consecutive days independently housed or living in supportive housing at the 5.5 year follow-up interview. Supportive housing is a combination of independent housing and support services, in which the house is generally owned by a care organisation.

Risk factors for (recurrent) homelessness

The risk factors for homelessness, grouped in the four conditions of the SQA, were collected at baseline and at follow-up after 5.5 years.

Living conditions

This condition was assessed with seven factors: unemployment, having debts, and not having enough money for: food, clothing, housing, travel, and social activities. All factors were assessed with questions from the Dutch abbreviated version of the Lehman Quality of Life Interview (QoLI; Wolf et al. 2002). The answer options were yes or no.

Unemployment was assessed with the question: ‘Are you working now or have you worked during the past year?’. Having debts, not including mortgages, was assessed with the question: ‘Do you currently have debts?’. Not having enough money was measured with five items: ‘During the past month, did you generally have enough money to cover (1) food, (2) clothing, (3) housing, (4) travel around the city for things like shopping, medical appointments, or visiting friends and relatives and (5) social activities like movies or eating in restaurants?’

Interpersonal embeddedness

This condition encompasses seven factors: quality of relationships with a) family members, b) friends and acquaintances, c) partner, and d) child(ren), and lack of support from a) family members, b) friends and acquaintances, and c) partner.

The quality of relationships was assessed with questions from the QoLI (Wolf et al. 2002). The answer options ranged from terrible (1) to delighted (7), where a score below 4 was considered as poor quality relationships. The quality of relationships with family members was measured with two questions: ‘How do you feel about (1) the way you and your family act toward each other?, and (2) the way things are in general between you and your family?. A score was constructed by averaging responses. Cronbach’s α of this sub-scale was 0.92 at baseline and 0.97 at follow-up. The quality of relationships with friends and acquaintances was assessed with one question: ‘How do you feel about the people you see socially?’. The quality of relationships with a partner and children were measured with one question each, consecutively: ‘How do you feel about the way things are in general between you and your partner?’ and ‘How do you feel about the way things are in general between you and your child(ren)?’. Lack of support from family members was assessed with five items derived from scales developed for the Medical Outcome Study (MOS) Social Support (Sherbourne & Stewart, 1991). Participants were asked to indicate how often their family members are there for them to (1) have fun with, (2) offer you meals or a place to stay, (3) listen to you talking about yourself or your problems (4) offer you moral support by accompanying you with appointments and (5) show you that they care about you or love you? A score was constructed by averaging responses, which ranged from none of the time (1) to all of the time (5). A score of 3 or lower was considered as representing a lack of support. Cronbach’s α of this sub-scale was 0.90 at baseline and 0.94 at follow-up. Lack of support from friends and acquaintances and lack of support from a partner were measured with the same items and cutoff point. Cronbach’s α for these sub-scales were subsequently 0.88 at baseline and 0.94 at follow-up for friends and acquaintances and 0.76 at baseline and 0.79 at follow-up for partner.

Societal embeddedness

This condition includes eight factors: rejection at care facilities, being arrested or picked up for criminal activity during the past year, and unmet care needs regarding: finances, finding work, social contacts, physical health, mental health and dental health. Rejection at care facilities was assessed at the follow-up interview with the following question: ‘Have you ever been rejected at a care facility?’. Being arrested or picked-up for criminal activity during the past year was measured with one item: ‘Have you been arrested or picked-up for any crimes in the past year?’. Unmet needs were assessed per domain (e.g. finances, finding work, social contacts, physical health, mental health, and dental health) with the questions: ‘Do you want help with…?’ and ‘Do you receive help with…?’. Participants who indicated they wanted but did not receive help were considered to have an unmet need.

Self-regulation

This condition was assessed with seven factors: physical health problems, dissatisfaction with physical health, psychological distress regarding: depression, anxiety and somatisation, excessive alcohol use and excessive cannabis use. To measure physical health problems, the number of self-reported physical complaints over the last 30 days was assessed on 20 categories of complaints. This included 14 categories based on the International Classification of Diseases (ICD; World Health Organisation, 1994), five categories of common complaints (visual problems, auditory problems, dental problems, foot problems, fractures) (Levy & O’Connell 2004) and a final category ‘health-related complaints not previously mentioned’. Because the mean number of physical health problems within the total cohort of the larger observational longitudinal cohort study was around 3 (Van Straaten et al., 2017), a score of 4 and above was considered high physical complaints and a score below 4 was considered low physical complaints. Dissatisfaction with physical health was measured with one item from the QoLI: ‘How do you feel about your physical condition?’. Responses ranged from terrible (1) to delighted (7). A score below 4 was considered as dissatisfaction with physical health. Psychological distress was measured with three symptom scales (i.e., depression, anxiety and somatisation) of the Dutch translation of the Brief Symptom Inventory 18 (BSI-18; De Beurs, 2011; Derogatis, 2001). Participants rated 18 items like ‘Nervousness or shakiness inside’ and ‘Feelings of worthlessness’ from 0 (never experience symptom) to 4 (very often experience symptom). Cronbach’s α for the sub-scale depression was 0.84 at baseline and 0.78 at follow-up, for the sub-scale anxiety 0.90 at baseline and 0.78 at follow-up, and for the sub-scale somatisation 0.83 both at baseline and at follow-up. Participants were divided into two groups based on norm scores for the Dutch population (De Beurs, 2011). Participants were categorised as having a high level if they scored in the upper 20th percentile on the sub-scales compared with a Dutch community sample (De Beurs, 2011). Excessive alcohol use was assessed with 2 items: How many days during the past 30 days did you drink (1) at least 1 unit of alcohol? and (2) at least 5 units of alcohol? From these two items a score was deduced indicating the minimum alcohol intake during the past 30 days. Note, because of this deduced calculation, the number of alcohol units consumed will most probably be an underestimation. Participant’s alcohol intake was considered as excessive at 60 units or more for women and 90 units or more for men, following the guidelines of the Dutch Trimbos Institute (2018). Excessive cannabis use was measured with one item: ‘How many days did you use cannabis during the past 30 days?'. Participants who used cannabis for at least 20 days during the past month were considered to excessively use cannabis. No other substances were taken into account due to the low prevalence rates (<5%) in this population (Van Straaten et al., 2016).

Data analysis

All statistical analyses were performed with IBM SPSS Statistics for Windows, Version 25.0. Missing values on items of a scale were substituted with the mean score of the other items on that scale for the participant when missing variables did not exceed 30% of the scale. If a scale consisted of five items or less, we used 20% as the cutoff point. Descriptive analyses were performed to describe the socio-demographic characteristics and the prevalence of the risk factors for homelessness at baseline and the follow-up after 5.5 years.

To analyse changes in the prevalence of risk factors for homelessness between the baseline measurement and the 5.5-year follow-up, a McNemar test was used.

Results

Demographics

At follow-up (T1, *n* = 72), participants' age ranged from 18 to 71 years old (*M* = 43.6, SD = 13.1), most participants were male (79.2%), single (62.5%), had one or more children (60.3%), and 65.6% reported completing at most the equivalent of high school education (see Table 1).

Housing status

The median duration of lifetime homelessness was 32 months (ranging from 1.5 month to 324 months). At baseline, none of the participants were stably housed. At 5.5 year follow-up, 50 participants (69.4%) were stably housed. The unstably housed participants (*n* = 22) were residing in an institution (20.8%, e.g. residential shelters), were marginally housed (4.2%; e.g. staying temporarily with friends, relatives or acquaintances), were homeless (4.2%; e.g. staying in a night shelter, transitional accommodation or sleeping rough) or staying in a psychiatric hospital (1.4%).

Table 1. Socio-demographic characteristics of all participants at T1 (*n*=67-72)

	***M* (SD) / Range**
Years of age	43.60 (13.12) / 24-74
	Mdn / Range
Life time duration of homelessness (months, at T0)	32.00 / 1.50 – 324.00
	***n* (%)**
Gender (being male)	57 (79.2)
Stable housing	50 (69.4)
Having a partner	27 (37.5)
One or more children	41 (60.3)
Education level	
Lowest education level	22 (32.8)
Low education level	22 (32.8)
Intermediate education level	16 (23.9)
High education level	7 (10.4)

Risk factors for homelessness at shelter entry

Table 2 shows the prevalence of risk factors for homelessness at shelter entry (T0) and 5.5 years later (T1), clustered in the four constitutional conditions of the SQA.

Regarding living conditions, at T0, most participants were unemployed (75.0%), almost all participants had debts (91.7%) and between one third (33.8%) to two thirds (66.2%) of the participants did not have enough money for basic needs such as food and clothing.

Concerning interpersonal embeddedness, at T0, more than half of the participants experienced poor quality in their relationships with family members (52.2%), almost one fifth reported poor relationships with friends and acquaintances (18.2%) and more than one third experienced poor relationships with their child(ren) (35.7%). The majority of participants lacked support from family members (70.0%), over half lacked support from friends and acquaintances (51.4%), and a small group (12.9%) lacked support from their partner.

Regarding societal embeddedness, at T0, around one in ten participants reported an unmet care need regarding finances (11.3%) and social contacts (9.9%), almost one fifth reported an unmet care need regarding mental health (19.4%), a quarter of the participants reported an unmet care need regarding physical health (25.0%), and around one third reported an unmet care need regarding finding work (32.4%) and dental health (38.9%). More than half of the participants had been arrested or picked-up for criminal activity during the preceding year (52.8%).

Concerning self-regulation, at T0, over one third of the participants reported four or more physical health problems (35.2%), a quarter was dissatisfied with their physical health (25.0%), and between one third and a half of the participants experienced high levels of depression (45.8%), anxiety (37.5%) and somatisation (45.8%). A small (9.7%), but probably underestimated group, was considered to be using alcohol excessively and over one third of the participants used cannabis excessively (38.0%).

Table 2. Prevalence of risk factors for homelessness and changes in this prevalence between shelter entry (T0) and 5.5 years later (T1) among the initially homeless people

Constitutional conditions of social quality	***n***	**T0 (%)**	**T1 (%)**	p^a
Living conditions				
Unemployment	72	75.0%	76.4%	1.0
Having debts	71	91.7%	57.7%	.00***
Not having enough money for...: (during past month)				
Food	71	33.8%	23.6%	.28
Clothing	71	64.8%	61.1%	.84
Housing	70	38.6%	15.3%	.01**
Travel	72	43.1%	44.4%	1.0
Social activities	71	66.2%	52.8%	.14
Interpersonal embeddedness				
Poor quality of relationships with:				
Family members	66	52.2%	24.6%	.00***
Friends and acquaintances	63	18.2%	11.9%	.45
Partner	26	-	15.4%	-
Child(ren)	26	35.7%	22.2%	.22
Lack of support from:				
Family members	70	70.0%	47.2%	.01**
Friends and acquaintances	72	51.4%	40.3%	.17
Partner	15	12.9%	7.4%	1.0
Societal embeddedness				
Rejected at care facilities	72	-	19.4%	-
Unmet care needs:				
Finances	71	11.3%	9.7%	1.0
Finding work	70	32.4%	22.5%	.33
Social contacts	70	9.9%	4.2%	.34
Physical health	72	25.0%	12.5%	.05*
Mental health	72	19.4%	9.7%	.17
Dental health	72	38.9%	16.7%	.00***
Arrested for criminal activity during past year	72	52.8%	12.5%	.00***
Self-regulation				
Physical health problems (≥4)	71	35.2%	30.6.%	0.05*
Dissatisfaction with physical health	72	25.0%	26.4%	1.00
Psychological distress:				
High level of depression	72	45.8%	43.1%	.85
High level of anxiety	72	37.5%	26.4%	.15
High level of somatisation	72	45.8%	34.7%	.13
Excessive alcohol use	72	9.7%	8.3%	1.0
Excessive cannabis use	69	38.0%	34.4%	.80

$p \leq .05$; $**p \leq .01$; $***p \leq .00$ ^{a}McNemar test

Changes in prevalence of risk factors for homelessness

The prevalence of the majority of risk factors did not significantly change in all four constitutional conditions of social quality between shelter entry and 5.5 years later (see Table 2). Regarding living conditions, this concerns unemployment (75.0% versus 76.4%, $p = 1.0$), not having enough money for basic needs such as food (33.8% versus 23.6%, $p = .28$), travel (43.1% versus 44.4%, $p = 1.0$), clothing (64.8% versus 61.1%, $p = .84$) and social activities (66.2% versus 52.8%, $p = .14$). With regard to interpersonal embeddedness, this applies to poor relationships with and lack of support from friends and acquaintances (18.2% versus 11.9%, $p = .45$ and 51.4% versus 40.3%, $p = .17$), poor relationships with children (35.7% versus 22.2%, $p = .22$) and lack of support from partner (12.9% versus 7.4%, $p = 1.0$). Regarding societal embeddedness, the prevalence of unmet care needs regarding finances (11.3% versus 9.7%, $p = 1.0$, finding work (32.4% versus 22.5%, $p = .33$), social contacts (9.9% versus 4.2%, $p = .34$) and mental health (19.4% versus 9.7%, $p = .17$) did not significantly decrease between T0 and T1. Concerning self-regulation, the prevalence of the following risk factors did not decrease significantly: symptoms of depression (45.8% versus 43.1%, $p = .85$), anxiety (37.5% versus 26.4%, $p = .15$) and somatisation (45.8% versus 34.7%, $p = .13$), and excessive cannabis use (38.0% versus 34.4%, $p = .8$).

However, significant improvements did take place in all four constitutional conditions of social quality (see Table 2). Regarding living conditions, there was a significant decrease in the number of people with debts (91.7% versus 57.7%, $p = .00$) and with insufficient money for housing (38.6% versus 15.3%, $p = .01$). Concerning interpersonal embeddedness there was a significant decrease in the number of people with poor quality relationships with and lack of support from family members (52.2% versus 24.6%, $p = .00$ and 70.0% versus 47.2%, $p = .01$). Regarding societal embeddedness, fewer people were arrested for criminal activity (52.8%

versus 12.5%, *p* = .00) and fewer people reported an unmet care need regarding physical health (25.0% versus 12.5%, *p* = .05) and dental health (38.9% versus 16.7%, *p* = .00). Concerning self-regulation, fewer people reported four or more physical complaints (35.2% versus 30.6%, *p* = .05). Nevertheless, some of the risk factors that did decrease significantly over time, were still highly present among the participants 5.5 years after shelter entry. For example, after 5.5 years, 57.7% of the participants still had debts, 47.2% still reported a lack of support from family members, and 30.6% reported four or more physical health problems.

Discussion

This study examined the prevalence of risk factors for homelessness at shelter entry and changes in the prevalence of these risk factors among homeless people over a period of 5.5 years. At baseline, none of the participants were stably housed and, as expected, were seriously disadvantaged regarding all four constitutional conditions of social quality. As described in the introduction, the variables included in this study were based on current knowledge on modifiable risk factors for homelessness at the individual level. By demonstrating poor outcomes on those risk factors at baseline, the results of this study further validate the knowledge on modifiable risk factors for homelessness at the individual level.

At the 5.5 year follow-up, the results of this study show both substantial improvements as well as persistent challenges within the lives of the participants. After, 5.5 years, most participants were stably housed, which is an important accomplishment, as it signifies not only a roof over their heads but also a foundation for stability and progress. Furthermore, for all four constitutional conditions of social quality improvements were found, which sheds light on the progress that has been achieved. We found a statistically significant decrease in the number of people with debts, insufficient money for housing, and a poor quality of relationships with and lack of support from family members. Significantly fewer people were arrested for criminal activity, fewer people reported four or more physical complaints and unmet care need with regard to physical and dental health.

The results also provide important insights into the ongoing hurdles participants faced over the course of 5.5 years. Because, despite the mentioned improvements, the prevalence of the majority of risk factors did not significantly change after 5.5 years, such as unemployment, not having enough money for basic needs such as food and clothing, lack of support from friends and acquaintances, unmet care needs regarding finding work, and symptoms of depression, anxiety and somatisation. In addition, some of the risk factors that did decrease significantly over time, were still frequently reported by the participants. For example, after 5.5 years, more than half of the participants still had debts, almost half still reported a lack of support from family members, and almost one third reported four or more physical health problems.

To our knowledge, this is the first study that longitudinally assessed the prevalence of modifiable risk factors for homelessness at the individual level. Figures on the general adult population in the Netherlands show that, even 5.5 years after shelter entry, the participants were substantially worse off regarding the quality of their daily lives. Compared to the general population, they were much more likely to, for instance, be unemployed (76% versus 33%; CBS Statistics, 2017), have insufficient money for food (24% versus 3%; CBS Statistics, 2017) and clothing (61% versus 16%; CBS Statistics, 2017), experience high levels of depression (43% versus 20%; De Beurs, 2011), and excessively use cannabis (34% versus 1%; Trimbos Instituut, 2016).

Implications for practice

Although significant improvements took place 5.5 years after shelter entry, the majority of the participants are still disadvantaged on all four constitutional conditions of social quality, and therefore remain relatively vulnerable for recurrent homelessness. Policy makers should be more aware of the persistent vulnerability regarding the living circumstances formerly homeless people find themselves in. They should, for example, enable service providers to support this group for as long as necessary to ensure they achieve and retain stable housing and ensure they can fully participate in society. Although previous research has identified quite a few risk factors for recurrent homelessness, it remains very difficult to accurately predict who will become homeless again after being housed at an individual level (De Vet, 2019; Volk et al., 2016). Therefore, providing appropriate services to all individuals who make the transition from a homeless shelter to independent housing remains the most viable strategy.

Furthermore, the results of this study urge service providers and policy makers to structurally enhance the constitutional conditions for 'a good life' in order to prevent recurrent homelessness. Findings indicate that more and specific attention should be paid to improving formerly homeless people's socio-economic security, for example via sufficient income support, adequate debt relief programs, and support in finding a job. More awareness for the need to improve formerly homeless people's poorer health seems to be essential, for example by ensuring proper access to appropriate mental health care and physical health care. Particular attention should also be paid to improve the quality of their social relations, for example through support programs to strengthen family ties.

Strengths and limitations

The present study has a number of strengths. First of all, to our knowledge, this is the first study that longitudinally assesses the prevalence of a comprehensive set of modifiable risk factors for homelessness in the lives of homeless people. Also, the participants were followed for a relatively long period of time (5.5 years), which is a challenge within homeless populations, because of tracking difficulties such as frequent moves and changing contact details (Stefancic et al., 2004).

This study also has several limitations. First, despite the tracking strategies described in the method's section, participant loss at follow-up was high (58%). Although no differences were found regarding various variables between participants who only completed the questionnaire at baseline compared to participants who completed both questionnaires, it is unknown whether and how the loss of participants may have biased our findings, as we lack information on the change variables of the non-respondents. Furthermore, some results are likely to underestimate the prevalence of certain risk factors. For example, the use of the mean number of physical complaints from data regarding an already vulnerable group as a cutoff score, probably led to an under-representation of people with a high level of physical complaints. And, as already mentioned in the method's section, the way the number of alcohol units consumed was measured, probably led to an underestimation of the prevalence of excessive alcohol use. Another limitation related to the design of the study concerns the effect of 'regression to the mean'. The baseline interviews were conducted shortly after a period of literal homelessness. Therefore, it can be expected that most participants would have improved on most outcome measures by the time of the follow-up interviews. This implies that we should be hesitant to attribute improvements in the four constitutional conditions of social quality to professional support or policies.

Another methodological issue concerns the external validity of the results. The criteria for entering the social relief system in the G4 in the Netherlands in 2011 were used as inclusion criteria for this study. Therefore, a substantial part of the homeless population is covered by this selection criterion. Subgroups not included in this study were undocumented homeless people and homeless people who do not make use of social relief facilities. The prevalence of risk factors may differ for those subgroups that were not allowed to enter the social relief system. Also, the study sample was primary male (79.2%), and thus does not equally represent the prevalence of risk factors for homelessness for women. Previous research found that women who were about to move from shelter to (independent) supported housing were disadvantaged regarding many factors of social quality, compared to men (de Vet et al., 2019). Based on this previous research, the results of the current study might, for example, underestimate the prevalence of risk factors for women. However, due to the small sample size we were unable to statistically test this.

Last, it is worth mentioning that the data analyzed within this study were collected between 2011 and 2017. However, as the number of homeless people in The Netherlands has only increased during the last years (Statistics Netherlands, 2019; Statistics Netherlands, 2016) due to changes in social policy, the social relief system and the housing market, the results of this study may even be more relevant in the present-day.

Conclusion

This study shows that, although significant improvements took place 5.5 years after shelter entry, the personal situation of Dutch people who were initially homeless lagged behind, especially compared to the general Dutch population. This shows that they are exposed to high levels of social exclusion, leaving them particularly vulnerable for a new episode of homelessness. Flexible and accessible support aimed at long term housing stability and a good quality of daily life should be made available as long as necessary.

References

Barile, J. P., Pruitt, A. S., & Parker, J. L. (2018). A latent class analysis of self-identified reasons for experiencing homelessness: Opportunities for prevention. *Journal of Community & Applied Social Psychology, 28*(2), 94-107. doi: 10.1002/casp.2343

Benjaminsen, L. (2015). Homelessness in a scandinavian welfare state: The risk of shelter use in the Danish adult population. *Urban Studies, 53*(10), 2041-2063. doi: 10.1177/0042098015587818

Bramley, G., & Fitzpatrick, S. (2018). Homelessness in the UK: who is most at risk? *Housing Studies, 33* (1), 96-116. doi: 10.1080/02673037.2017.1344957

De Beurs E. (2011). Brief Symptom Inventory/ Brief Symptom Inventory 18 Handleiding. Leiden: PITS B.V.

Derogatis, L. R. (2001). *Brief Symptom Inventory (BSI)-18. Administration, scoring and procedures manual*. Minneapolis: NCS Pearson Inc.

De Vet, R. (2019). *Effectiveness of critical time intervention for homeless people: a randomized controlled trial to enhance continuity of care during the transition from shelter to community living* [Doctoral dissertation, Radboud University Nijmegen]. Available at: https://repository.ubn.ru.nl/bitstream/handle/2066/213934/213934.pdf

De Vet, R., Beijersbergen, M.D., Lako, D.A., van Hemert, A.M., Herman, D.B., & Wolf, J.R. (2019). Differences between homeless women and men before and after the transition from shelter to community living: A longitudinal analysis. *Health & Social Care in the Community, 27*, 1193 - 1203. doi: 10.1111/hsc.12752

Doran, K. M., Ran, Z., Castelblanco, D., Shelley, D., & Padgett, D. K. (2019). "It wasn't just one thing": A qualitative study of newly homeless emergency department patients. *Academic Emergency Medicine, 26*(9), 982-993. doi: 10.1111/acem.13677

Edgar, B., Harrison, M., Watson, P., & Busch-Geertsema, V. (2007). *Measurement of Homelessness at European Union Level* (Brussels: European Commission), available at: http://ec.europa.eu/employment_social/social_inclusion/docs/2007/study_homelessness_en.pdf.

Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet (London, England), 384*(9953), 1529-1540. doi: 10.1016/S0140-6736(14)61132-6

Fondation Abbé Pierre – FEANTSA (2018). *Third Overview of Housing Exclusion in Europe 2018*. Retrieved from https://www.feantsa.org/download/full-report-en1029873431323901915.pdf

Fondation Abbé Pierre - FEANTSA (2019*). Fourth Overview of Housing Exclusion in Europe 2019*. Retrieved from https://www.feantsa.org/download/oheeu_2019_eng_ web 512064608 n79 93915253.pdf

Finlay, W. M. L., & Lyons, E. (2001). Methodological Issues in Interviewing and Using Self-Report Questionnaires With People With Mental Retardation. *Psychological Assessment, 13*(3), 319–335. doi: 10.1037//1040-3590.13.3.319

Georgiades, S. (2015). The dire straits of homelessness: Dramatic echoes and creative propositions from the field. *Journal of Human Behavior in the Social Environment, 25*(6), 630–642. Doi: 10.1080/10911359.2015.1011254

Levy, B. D., & O'Connell, J. J. (2004). Health Care for Homeless Persons. *The New England Journal of Medicine, 350*(23), 2329–2332. doi: 10.1056/NEJMp038222

Mabhala, M. A., Yohannes, A., & Griffith, M. (2017). Social conditions of becoming homelessness: qualitative analysis of life stories of homeless peoples. *International journal for equity in health, 16*(1), 1-16. doi: 10.1186/s12939-017-0646-3

Nilsson, S.F., Nordentoft, M., & Hjorthøj, C. (2019). Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis. *Journal of Urban Health, 96*(5), 741-750. doi: 10.1007/s11524-019-

Orwin, R. G., Scott, C. K., & Arieira, C. (2005). Transitions through homelessness and factors that predict them: Three-year treatment outcomes. *Journal of Substance Abuse Treatment, 28*(2 SUPPL.), S23–S39. https://doi.org/10.1016/j.jsat.2004.10.011

Piat et al., (2015). Pathways into homelessness: Understanding how both individual and structural factors contribute to and sustain homelessness in Canada. *Urban Studies, 52*(13), 2366-2382. doi: 10.1177/0042098014548138

Sherbourne C.D. & Stewart A.L. (1991) The MOS social support survey. *Social Science and Medicine 32*, 705–714. doi: 10.1016/0277-9536(91)90150-B

Statistics Netherlands [Centraal Bureau voor de Statistiek], (2016). Aantal daklozen in zes jaar met driekwart toegenomen [Number of homeless people increased by three quarters in six years]. Retrieved April 30, 2017, https://www.cbs.nl/nl-nl/nieuws/2016/09/aantal-daklozen-in-zes-jaarmet-driekwart-toegenomen

Statistics Netherlands [Centraal Bureau voor de Statistiek], (2017). CBS Statistics, www.cbs.nl/statline

Statistics Netherlands [Centraal Bureau voor de Statistiek], (2019). Aantal daklozen sinds 2009 meerdan verdubbeld [Number of homeless people more than doubled since 2009]. Retrieved March 20, 2020, https://www.cbs.nl/nl-nl/nieuws/2019/34/aantal-daklozen-sinds-2009-meer-danverdubbeld

Stefancic, A., Schaefer-McDaniel, N. J., Davis, A. C., & Tsemberis, S. (2004). Maximizing follow-up of adults with histories of homelessness and psychiatric disabilities. *Evaluation and Program Planning, 27*(4), 433–442. doi: 10.1016/j.evalprogplan.2004.07.006

Trimbos Instituut (2018). Factsheet riskant alcoholgebruik in Nederland. Utrecht: Trimbos Instituut.

Tsai, J., & Rosenheck, R. A. (2015). Risk factors for homelessness among US veterans. *Epidemiologic reviews, 37*(1), 177-195. doi: 10.1093/epirev/mxu004

Van den Dries, L., Peters, Y., Al Shamma, S., & Wolf, J. (2018*). Dakloze mensen in Amsterdam: veranderingen in 5,5 jaar na instroom in de opvang. Resultaten uit de vervolgmeting Coda-G4 in Amsterdam*. Nijmegen: Impuls Onderzoekscentrum maatschappelijke zorg, RadboudUmc.

Van der Laan, J. (2020). *Giving Voice to Homeless People: homeless people's personal goals, care needs, and quality of life in the Dutch social relief system* (Doctoral thesis). Radboud University, Nijmegen.

Van der Maesen, L. J. G., & Walker, A. (Eds.) (2012). *Social quality: From theory to indicators*. Basingstoke, United Kingdom: Palgrave Macmillan. doi: 10.1057/9780230361096

Van Straaten, B., Rodenburg, G., Van der Laan, J., Boersma, S. N., Wolf, J. R. L. M., & Van de Mheen, D. (2016). Substance use among Dutch homeless people, a follow-up study: prevalence, pattern and housing status. *European Journal of Public Health, 26*(1), 111-116. doi: 10.1093/eurpub/ckv142

Van Straaten, B., Van der Laan, J., Rodenburg, G., Boersma, S.N., Wolf, J.R., & Van de Mheen, D. (2017). Dutch homeless people 2.5 years after shelter admission: what are predictors of housing stability and housing satisfaction? Health and Social Care in the Community, 25 (2), 710-722. doi: 10.1111/hsc.12361

Volk, J.S., Aubry, T., Goering, P., Adair, C.E., Distasio, J., Jette, J., . . . Tsemberis, S. (2016). Tenants with additional needs: When housing first does not solve homelessness. *Journal of Mental Health, 25*, 169–175. doi:10.3109/09638237.2015.1101416

Wolf, R.L.M., & Jonker, I. E. (2020). Pathways to empowerment: The Social Quality Approach as a foundation for person-centered interventions. *International Journal of Social Quality, 10* (1), 29-56. doi: 10.3167/IJSQ.2020.100103

Wolf J., Zwikker M., Nicholas S., Van Bakel, H., Reinking, D., & Van Leiden, I. (2002). *Op achterstand. Een onderzoek naar mensen in de marge van Den Haag*. Utrecht: Trimbos-Instituut.

World Health Organisation (1994). *International Classification of Diseases (ICD)*. WHO, Geneva.

Chapter 3

The link between childhood abuse experiences and homeless people’s quality of life: a longitudinal study

Schel, S.H.H., Van den Dries, L., Van der Laan, J., Van Straaten, B., Van de Mheen, D., Al Shamma, S., & Wolf, J.R.L.M. (2023).
The link between childhood abuse experiences and homeless people’s quality of life:
A longitudinal study. *Journal of Child & Adoloscent Trauma. doi: 10.1007/s40653-023-00582-6*

Abstract

Purpose: Studies report a relatively high prevalence of childhood abuse experiences (CAE) among adult homeless people. Within homeless populations, people with CAE appear to be worse off than homeless people without such experiences. This study compares a broad set of factors influencing the quality of the daily lives of Dutch homeless people with and without CAE. It also examines the extent to which CAE are predictive of the rate of change in these factors 2.5 years after entering the social relief system.

Methods: Data were used from an observational longitudinal multi-site cohort study following Dutch homeless people 2.5 years after entering the social relief system. The 4 constitutional conditions of the Social Quality Approach (living conditions, interpersonal embeddedness, societal embeddedness and self-regulation) were used to cluster the factors included in this study. Participants were interviewed twice, at baseline (N=513) and at follow up (N= 378), using a quantitative questionnaire.

Results: At baseline and follow-up participants with CAE were more disadvantaged in each of the 4 conditions of social quality, except for societal embeddedness at follow-up. After 2.5 years, on average, all participants improved more or less at a similar rate on almost all factors, with a few exceptions: Significant differential changes over time were found regarding employment status, quality of relationships with family members and symptoms of depression and anxiety.

Conclusions: Findings corroborate the broad, detrimental and persistent impact of CAE on the quality of daily lives of homeless people and the need for homelessness services to apply trauma-informed care.

Introduction

Are homeless people who report childhood abuse experiences (CAE) worse off regarding constitutional conditions influencing the quality of daily life compared to homeless people without such experiences? And, are CAE predictive of the rate of change in these constitutional conditions over a period of 2.5 years after entering the social relief system? This longitudinal multi-site cohort study aims to answer these questions. CAE have been found to be among the strongest risk factors for becoming homeless (Nilsson et al, 2019). Studies investigating CAE among homeless people are limited; in this population more research has been conducted on the broader concept of adverse childhood experiences. The latter is an umbrella concept often discerning three types of experiences: childhood abuse (psychological, physical and sexual), childhood neglect (emotional and physical), and exposure to household dysfunction (parental separation or divorce, exposure to substance abuse, mental illness, violent treatment of mother/stepmother and incarceration in the household) (Felitti et al, 1998; Van der Kolk, 2014). Studies among homeless people have found CAE to correlate significantly with childhood neglect and exposure to household dysfunction (Bellis et al, 2015; Larkin & Park, 2012).

A significant number of studies have shown a high prevalence of CAE (Sundin & Baguley, 2015) and adverse childhood experiences (Liu et al, 2021) among adult homeless people compared to the general population. For example, a systematic review study on the prevalence of CAE among homeless populations in the USA, Australia and the UK found that the mean prevalence of physical childhood abuse among homeless populations was estimated at 37%, compared to rates between 4% and 16% within the general population (Sundin & Baguley, 2015). The Welsh Adverse Childhood Experience and Resilience Study found that those who reported four or more adverse childhood experiences were sixteen times more likely to have experienced homelessness in their adult lives (Grey & Woodfine, 2019).

Within the general population, it is well established that childhood abuse experiences have devastating consequences (Lippard & Nemeroff, 2020). Research has shown long lasting detrimental impacts of adverse childhood experiences as well. Adverse childhood experiences have, for example, been found to disrupt children’s neurological, immunological and hormonal development (Anda et al, 2006; Danese & McEwen, 2012; Van der Kolk, 2014) and negatively affect children’s attachment system (Kalmakis & Chandler, 2015; Van der Kolk, 2014). They have also been found to impair the ability to have healthy social relationships in adulthood (Van der Kolk, 2014), negatively affect people’s socio-economic status (Metzler et al, 2017) and lead to poorer physical and mental health (Bellis et al, 2019; Hughes et al, 2017; Kalmakis & Chandler, 2015; Van der Kolk, 2014).

Within homeless populations, people with CAE appear to be worse off than homeless people without such experiences. Studies have found CAE among homeless people to be associated with a higher suicide risk (Torchalla et al, 2012), lower self-esteem, more victimization, more depression, and chronic homelessness (Stein et al, 2002). Among homeless women, research has found that childhood experiences of physical abuse were associated with a sparse and risky social network, meaning a network with, for example, members misusing alcohol and drugs and displaying more risky sexual behavior (Green et al, 2012). Studies investigating the role of adverse childhood experiences among homeless people have shown that such experiences were associated with poorer physical health (for example, were more likely to have three or more chronic physical conditions; Patterson et al, 2014), poorer mental health (for instance, were more likely to meet the criteria of a severe mental disorder; Brown et al, 2016; Lee et al, 2017; Liu et al, 2020; Patterson et al, 2014), higher levels of psychological distress in general (Keane et al, 2018), and more problematic substance abuse (Brown et al, 2016; Patterson et al, 2014; Tam et al, 2003).

While research within the general population has shown long lasting impacts of CAE (Lippard & Nemeroff, 2020) and adverse childhood experiences (Anda et al, 2006; Danese & McEwen, 2012; Van der Kolk, 2014), little is known about the degree to which they have a persisting influence on the quality of life of homeless people after accessing social relief facilities. For homeless service providers it would be very helpful to know whether, and in which areas, homeless people with CAE need extra support to thrive in the service system. Also, apart from the above-mentioned study of Green and colleagues (2012) and Stein and colleagues (2002), research investigating the adverse outcomes of adverse childhood experiences or CAE within homeless populations has predominantly focused on physical and mental health problems. However, based on the aforementioned studies on adverse childhood experiences or CAE in the general population, we know that CAE are also related to adverse outcomes on a range of factors that influence the quality of one's daily life, such as socioeconomic status and the ability to form healthy social relationships. The Social Quality Approach provides a framework for the conditions that constitute the quality of daily life (Van der Maesen & Walker, 2012; Wolf & Jonker, 2020). According to the Social Quality Approach these conditions are fourfold: 1) living conditions; 2) interpersonal embeddedness; 3) societal embeddedness; and 4) self-regulation (see Box 1 for a more comprehensive description of these four conditions).

The purpose of the present study is to extend the previous studies on CAE in homeless populations with a longitudinal study that compares the four constitutional conditions influencing the quality of the daily lives of homeless people with and without CAE. The research questions of this study are twofold: 1) Do homeless people with and without CAE differ in the constitutional conditions of social quality when entering the Dutch social relief system and 2.5 years later?; and 2) Are CAE predictive of the rate of change in these constitutional conditions in this period of 2.5 years? Based on the findings of studies on CAE and adverse childhood experiences in the general population (Bellis et al, 2019; Hughes et al, 2017; Kalmakis & Chandler, 2015; Lippard & Nemeroff, 2020; Metzler et al, 2017; Van der Kolk, 2014), this study hypothesizes that homeless people reporting CAE encounter worse outcomes on all four constitutional conditions of the Social Quality Approach compared to homeless people without such experiences, when entering the Dutch social relief system and 2.5 years later.

Findings of this study may raise awareness of the impact of CAE on the quality of the daily lives of homeless people, and changes therein after entering the social relief system. The results might, for example, provide insight into the extent to which homeless people with CAE are able to catch up their hypothesized disadvantages regarding their quality of life after entering the social relief system. These insights may give service providers valuable information on how to optimize their support provision. Furthermore, they may provide important clues for service providers and policy makers on what is needed to structurally enhance the four constitutional conditions for 'a good life' in order to allow formerly homeless people with CAE to participate within society.

Box 1. Description of Social Quality Approach

According to the Social Quality Approach there are four conditions that constitute the quality of daily life: 1) living conditions; 2) interpersonal embeddedness; 3) societal embeddedness; and 4) self-regulation. Living conditions refer to the extent to which people acquire material and immaterial resources which enables them to live a good life, such as being employed, having sufficient financial resources and having a safe place to live. Interpersonal embeddedness is the degree to which people experience meaningful, reciprocal positive relationships and develop a sense of connectedness with others (for example, with family and friends) based on shared values and identities. Societal embeddedness means the extent to which people are integrated (or are able to participate) in their community or society and are able to access or make use of their basic rights (for instance the degree to which they can access professional care for physical or mental health problems). Finally, self-regulation is the degree to which people are in control of themselves and their lives and can alter their own internal states, processes and responses (thoughts, feelings and actions) in anticipation of future goals. Self-regulation is influenced, for example, by the degree to which people experience psychological distress or the extent to which they depend on drugs or alcohol to regulate their feelings and emotions.

Methods

Study design

Data are used from an observational longitudinal multi-site cohort study following homeless people for a period of 2.5 years, starting from the moment they reported themselves at a central access point for social relief in 2011 in one of the four major cities in the Netherlands (Amsterdam, The Hague, Rotterdam and Utrecht) and were accepted for an individual program plan provided by local care agencies. Data were collected with a quantitative questionnaire that was orally administered at two time points; at baseline (T0) from January 2011 to December 2011 and at follow up (T1) 2.5 years later, from July 2013 to June 2014. This study was exempt from formal review by the accredited Medical Review Ethics Committee region Medical Review Ethics Committee - Arnhem-Nijmegen (file number 2010-321).

Participants

In the Netherlands it is obligatory for homeless persons to report at a central access point for social relief to get access to social relief facilities, such as a night shelter. After being accepted for an individual program plan at the central access point, care and living accommodation are provided by local care agencies. The municipalities act as policy coordinators. Case managers monitor the execution of individual program plans. In 2011 (T0), over 1,800 adults and 1,100 young adults reported themselves at the central access point for social relief in one of the four major cities (G4) in The Netherlands and were accepted for an individual program plan (Tuynman & Planije, 2012). This implies that they met the criteria set by the G4 for starting an individual program plan, i.e., being at least 18 years of age, having legal residence in the Netherlands, residing in the region of application for at least 2 years of the preceding 3 years, having abandoned the home situation, and being unable to hold one's own in society. All these persons were potential participants for this study.

At baseline (T0) 513 participants completed the orally administered questionnaire. No data were available on how many of the total 2,900 potential participants were approached and how many refused to participate. Therefore, in order to obtain information about the representativeness of the study participants, the total population of homeless adults who reported themselves at a central access point for social relief in the four major cities in 2011 were compared with the study participants. Adult participants (aged ≥23 years; n = 410) were representative in terms of age and gender. Young adult participants (aged 18–22 years; n = 103) were representative in terms of age but, in our sample, males were overrepresented (60.2% younger males in the cohort vs. 49.2% younger males in the total group).

At follow up (T1) all former 513 participants were contacted, of whom 378 participants participated in the second interview (73.7%). Although we do not have information about

the reasons for attrition of most the 135 non-respondents, we know that some no longer wished to participate in the study and that one participant had died. To investigate selective loss to follow-up, we compared respondents on the second measurement (n = 378) with non-respondents (n = 135) on demographic variables as reported at the first measurement. Compared to respondents on the final interview, non-respondents were on average younger (33.8 vs. 37.2 years), were more often male (83.0% vs. 74.3%) and more often had the lowest level of education (44.4% vs. 30.2%).

Procedure

At the start of the study (T0), potential participants were approached either at a central access point for social relief by an employee of the access point, or by the researcher or interviewers at a temporary accommodation where they stayed shortly after entering the social relief system. Potential participants were informed about the study by means of leaflets, posters and face-to-face information provision. When a potential participant expressed interest in taking part in the study, the researchers contacted that person to explain the study aims, the interview procedure and the informed consent. When the participant agreed to take part based on the terms explained to them, an interview appointment was scheduled. A trained interviewer met them at the participant's location of choice (generally a shelter facility, public library or the researcher's office). All participants gave written informed consent. Participants were interviewed face-to-face using a structured questionnaire (mean duration of 1.5 hours) and received €15 for their participation. The interviews were held in Dutch, English, Spanish or Arabic.

Problems that may occur when using questionnaires designed for the general population among people with an intellectual disability (e.g., acquiescence, not understanding the question, getting tired during the interview) were anticipated. Participants were told at the start of the interview that they could take a break during the interview whenever they wanted to. Also, they did not have to supply an answer when either they did not know what to say or they did not want to answer ('Don't know' and 'No answer' options were available and were regarded as missing answers); this procedure is recommended for the use of questionnaires among people with an intellectual disability (Finlay & Lyons, 2001). The questionnaires were administered orally combined with cards visually displaying the answering categories to take into consideration participants who may have trouble with reading.

At follow up (T1), from July 2013 to June 2014, participants were contacted for the follow-up measurement 2.5 years after the first measurement by letter, telephone, e-mail, their social contacts, their (former) caregiver/institution or private messages via social media. Participants were interviewed in the same way as during the first measurement, i.e., face-to-face, with a structured questionnaire (mean duration of 1.5 hours), and with the same support options (optional break during the interview, cards with answering categories, etc.). The participants received €30 for participation in this interview.

Measures

Demographic characteristics including gender, age, educational level, having a partner, having children and duration of homelessness were assessed at baseline. Education was categorized as *lowest* when the participant completed primary education at the most, as *low* when the participant completed prevocational education, lower technical education, assistant training or basic labor-oriented education, as *intermediate* when the participant completed secondary vocational education, senior general secondary education or pre-university education, and categorized as *high* when the participant completed higher professional education or university education.

Childhood abuse experiences (CAE)

CAE were measured with three questions: (1) Were you emotionally abused at home: for example, by threatening, insulting or humiliating you or forbidding you to leave the house?, (2) Were you physically abused at home: for example, by slapping, kicking or by throwing things at you? and (3) Were you sexually abused: for example, by touching / fondling you in a sexual way when you did not want to or by unwanted sexual intercourse? Participants received a positive score if they responded *yes* to one or more of these questions.

Social quality

The factors of the four constitutional conditions of the Social Quality Approach were collected both at baseline and follow-up, with a few exceptions. Factors assessed only at follow-up were: having independent housing, being rejected at care facilities, the item 'ever served sentence in detention' (part of the factor involvement in criminal activity) and satisfaction with relationship with partner.

Living conditions

This condition was assessed with seven factors: Satisfaction with financial resources, having debts, current employment status, independent housing, satisfaction with housing, satisfaction with personal safety, and victimization. **Satisfaction with financial resources** was measured with Lehman's abbreviated Quality of Life Interview (QoLI; Lehman, 1983): 'How do you feel about (1) the amount of money you get, (2) how comfortable are you with the amount of money you have (saved), and (3) the amount of money you have available to spend for fun?'. A score was constructed by averaging responses, which ranged from *terrible* (1) to *delighted* (7). Cronbach's α of this subscale was .80 at baseline and .85 at follow-up. **Having debts,** not including mortgages, was assessed with one question from the QoLI: 'Do you currently have debts?'. We assessed whether participants were **currently employed**, or had been employed within the last year, with another question from the QoLI: 'Are you working now or have you worked during the past year?'. **Independent housing** was measured by asking participants whether they were independently housed either with or without support. **Housing satisfaction** was measured with three items from the QoLI: 'How do you feel about (1) the living arrangements where you live, (2) the privacy you have there, and (3) the prospect of staying where you currently live for a long period of time?'. A score was constructed by averaging responses, which ranged from *terrible* (1) to *delighted* (7). Cronbach's α of this scale was .82 at baseline and .83 at follow-up. **Satisfaction with personal safety** was assessed with three items from the QoLI: 'How do you feel about (1) how safe you are on the streets in your neighborhood, (2) how safe you are where you live, and (3) the protection you have against being robbed or attacked?'. A score was constructed by averaging responses, which ranged from *terrible* (1) to *delighted* (7). Cronbach's α was .64 at baseline and .79 at follow-up. Lastly, participants were asked the following question from the QoLI about **victimization**: 'In the past year, were you a victim of any violent crime such as assault, rape, mugging or robbery?

Interpersonal Embeddedness

This condition was measured with eight factors: Subjective social functioning, quality of relationships with a) family members, b) friends and acquaintances, c) partner, d) child(ren), and support from a) family members, b) friends and acquaintances and c) partner. **Subjective social functioning** was assessed with one item from the QoLI: 'Overall, how would you rate your functioning in home, social, school, and work settings at the present time?'. Responses ranged from *terrible* (1) to *delighted* (7). **Quality of the relationships with family members** were measured with two items from the QoLI: 'How do you feel about (1) the way you and your family act toward each other? and (2) the way things are in general between you and your family?. A score was constructed by averaging responses, which ranged from *terrible* (1) to *delighted* (7). Cronbach's α of this subscale was 0.91 at baseline and 0.94 at follow-up. **Quality of the relationships with friends and acquaintances** was assessed with one item from the QoLI: 'How do you feel about the friends and acquaintances you see socially?', with scores ranging from *terrible* (1) to *delighted* (7).**The quality of relationships with a partner and children** were measured with one item each, consecutively: 'How do you feel about the way things are in general between you and your partner?' and 'How do you feel about the way things are in general between you and your child(ren)?'. Responses also ranged from *terrible* (1) to *delighted* (7). **Support from family members** was assessed with five items: 'Please indicate how often your family members are there for you to (1) have fun with, (2) offer you meals or a place to stay, (3) listen to you talking about yourself or your problems (4) offer you moral support by accompanying you with appointments and (5) show you that he/she cares about you or loves you? A score was constructed by averaging responses, which ranged from *none of the time* (1) to *all of the time* (5). Cronbach's α of this subscale was 0.91 at baseline and 0.95 at follow-up. The same five questions were used to measure **support from friends and acquaintances and support from partner.** Cronbach's α for these subscales were respectively 0.89 at baseline and 0.94 at follow-up and 0.85 at baseline and 0.81 at follow-up.

Societal Embeddedness
This condition encompassed three factors: Number of unmet care needs, rejection at care facilities and involvement in criminal activity. **The number of unmet care needs** participants experienced was measured with a questionnaire developed by Impuls – Netherland Center for Social Care Research (Lako et al., 2013), with responses from the Short-Form Quality of Life and Care questionnaire (Wennink & van Wijngaarden, 2004). Participants were asked 'Do you want help with...?' and 'Do you receive help with...?' for six domains (finding housing, finances, mental health, physical health, daytime activities and social contacts). Participants who indicated they wanted but did not receive help were considered to have an unmet need. All unmet care needs were added up to achieve a total number of unmet needs, ranging from 0 to 6. **Rejection at care facilities** was assessed at the follow-up interview with the following question: 'Have you ever been rejected at a care facility?'. **Involvement in criminal activity** was measured with two separate items: (a) 'Have you been arrested or picked-up for any crimes in the past year?' and (b) 'Have you ever served a sentence in detention?'.

Self-Regulation
This condition included five factors: Satisfaction with physical health, satisfaction with mental health, psychological distress, alcohol use and cannabis use. **Satisfaction with physical health and mental health** were measured with one item each from the QoLI, consecutively: (1) 'How do you feel about your physical condition?' and (2) 'How do you feel about your emotional well-being?' Responses ranged from *terrible* (1) to *delighted* (7). **Psychological distress** was measured with the Brief Symptom Inventory 18 (BSI-18; Derogatis, 2001). The BSI-18 assesses three symptom scales (i.e., depression, anxiety and somatization), which are also included in a total score as an indication of general psychological distress. Participants rated 18 items like 'Nervousness or shakiness inside' and 'Feelings of worthlessness' from 0 (*never experience symptom*) to 4 (*very often experience symptom*). Cronbach's α for the total score was 0.96 at baseline and 0.90 at follow-up, for depression 0.85 at baseline and 0.87 at follow-up and for anxiety and somatization both 0.83 at baseline and at follow-up. **Alcohol use** was assessed with one item: 'How many units of alcohol did you have during the past 30 days?'. **Cannabis use** was measured with one item: 'Did you use cannabis during the past 30 days?'.

Data analysis
All statistical analyses were performed with IBM SPSS Statistics for Windows, Version 25.0. Missing values on items of a scale were substituted with the mean score of the other items on that scale for the participant when missing variables did not exceed 30% of the scale. If a scale consisted of five items or less, we used 20% as the cutoff point. Descriptive analyses were performed to describe the socio-demographic characteristics for participants who reported CAE and participants who did not report CAE at baseline. Relationships between CAE and socio-demographic characteristics were analyzed using chi- square tests for categorical data and one-way analyses of variance tests for continuous variables.

To assess the differences in constitutional conditions influencing the quality of daily life between participants with and without CAE at entering the social relief system and at follow-up, 2.5 years later (research question 1) we also applied chi-square tests and one-way analyzes of variance tests. Then, to assess differences in constitutional conditions in the 2.5 years after entering the social relief system for all participants, repeated linear regression analysis were used for continuous variables and repeated logistic regression analysis for categorical data. To examine whether CAE are predictive of the rate of change of constitutional conditions in the 2.5 years after entering the social relief system (research question 2), the same repeated regression analysis were used with a model which included an interaction between group (yes /no CAE) and time to test this effect.

Results

Descriptives
Out of the 513 participants at baseline, 203 participants (39.6%) reported one or more forms of childhood abuse. Emotional abuse was reported by 164 participants (32%), 135 (26.3%) participants reported physical abuse and 38 (7.4%) reported sexual abuse. Baseline differences in socio-demographic characteristics between participants with CAE and participants without CAE are presented in Table 1. Participants who reported CAE were significantly younger than participants who did not report CAE, they were more likely to be female and had been homeless significantly longer during their life.

Differences in constitutional conditions influencing the quality of daily life between participants with and without CAE when entering the Dutch social relief system and 2.5 years later

At baseline, significant differences between the two groups were found for all four conditions of social quality (see Table 2). Participants with CAE were more likely to report having debts ($\chi 2 = 8.18$, $p = .00$) and were more often victim of a violent offense during the past year ($\chi 2 = 37.79$, $p = .00$) compared to participants without these experiences. They reported significantly lower levels of social functioning ($F(1, 507)$ 4.63, $p = .03$), experienced less support from their family members ($F(1, 494)$ 24.62, $p = .00$), and reported a poorer quality of relationships with family members ($F(1, 481)$ 65.03, $p = .00$), friends and acquaintances ($F(1, 489)$ 6.92, $p = .01$) and their children ($F(1, 193)$ 3.77, $p = .05$). They also reported more unmet care needs (F(1, 509) 12.99, p = .00), were less satisfied with their physical health ($F(1, 511)$ 6.84, $p = .01$) and mental health ($F(1, 511)$ 20.46, $p = .00$), experienced more psychological distress in general ($F(1, 474)$ 24.62, $p = .00$), reported significantly higher levels of depression ($F(1, 503)$ 23.82, $p = .00$), anxiety ($F(1, 504)$ 23.39, $p = .00$) and somatization ($F(1, 504)$ 14.45, $p = .00$) and were more likely to be using cannabis ($\chi 2 = 17.37$, $p = .00$).

Table 1. Baseline differences in socio-demographic characteristics between participants with CAE compared to participants without CAE

	CAE (*N*=203)	No CAE (*N*=310)		
	M (SD)	*M* (SD)	F (df)	*p*-value[a]
Years of age	32.84 (11.3)	38.56 (13.6)	24.68 (1,511)	.00
Duration of homelessness (months)	36.15 (49.1)	27.40 (36.8)	5.25 (1,503)	.02
	CAE (*N*=203)	No CAE (*N*=310)		
	n (%)	*n* (%)	Pearson chi-square	*p*-value[b]
Gender (being female)	62 (30.5)	58 (18.7)	9.58	.002
Married or in civil partnership	70 (34.5)	91 (29.6)	1.33	.25
One or more children	91 (44.8)	148 (47.9)	.46	.50
Education level				
Lowest education level	79 (38.9)	94 (30.7)	4.75	.19
Low education level	83 (40.9)	132 (43.1)	4.75	.19
Intermediate education level	29 (14.3)	52 (17.0)	4.75	.19
High education level	12 (5.9)	28 (9.2)	4.75	.19

[a] One-way analyses of variance, [b] χ^2 test

At follow-up, significant differences between the two groups were found in three of the four conditions of social quality, namely: living conditions, interpersonal embeddedness and self-regulation. Participants who reported CAE still had been a victim of a violent offense more often during the past year ($\chi2$ = 7.57, *p* = .01) compared to participants who did not report CAE, but they no longer reported having debts significantly more often ($\chi2$ = 1.88, *p* = .17). However, as opposed to baseline, they did report being unemployed during the past year more often ($\chi2$ = 7.2, *p* = .01). Participants who reported CAE still reported significantly lower levels of social functioning (*F*(1, 375) 5.32, *p* = .02), experienced less support from family (*F*(1, 376) 10.72, *p* = .00) and a poorer quality of relationships with family members (*F*(1, 363) 20.01, *p* = .00). In contrast with baseline, they did not report a significantly lower quality of their relationships with friends and acquaintances (*F*(1, 365) 1.96, *p* = .16) and with their children anymore (*F*(1, 160) .83, *p* = .36), but they did experience less support from friends and acquaintances compared to participants without CAE (*F*(1, 376) 3.75, *p* = .05). As opposed to baseline, participants with CAE did not report more unmet care needs compared to participants without such experiences (*F*(1, 376) 2.82, *p* = .09). They were still significantly less satisfied with their physical health (*F*(1, 376) 5.77, *p* = .02), but not anymore with their mental health (*F*(1, 370) 3.67, *p* = .06); they still reported significantly higher levels of depression (*F*(1, 373) 6.77, *p* = .01), anxiety (*F*(1, 376) 8.02, *p* = .01) and somatization (*F*(1, 376) 8.33, *p* = .00) and were still more likely to be using cannabis ($\chi2$ = 13.39, *p* = .00).

Table 2. Differences in constitutional conditions influencing the quality of daily life at baseline and follow-up for participants with CAE compared to participants without CAE

	Baseline						Follow-up					
	CAE		No CAE				CAE		No CAE			
Continuous factors	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	*p*[a]	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	*p*[a]
Living conditions												
Satisfaction with financial resources	191	2.70 (1.45)	273	2.93 (1.58)	2.53 (1,462)	.11	141	3.16 (1.52)	225	3.32 (1.62)	.87 (1,364)	.35
Satisfaction with housing	199	3.98 (1.76)	303	3.90 (1.70)	.25 (1,500)	.62	142	5.10 (1.39)	229	5.23 (1.47)	.66 (1,369)	.42
Satisfaction with personal safety	195	4.84 (1.28)	291	5.03 (1.22)	2.74 (1,484)	.1	137	5.39 (1.13)	220	5.57 (1.14)	2.16 (1.355)	.14
Interpersonal embeddedness												
Subjective social functioning	202	5.07 (1.55)	307	5.35 (1.35)	4.63 (1,507)	.03*	145	5.45 (1.32)	232	5.73 (1.03)	5.32 (1,375)	.02*
Quality of relationships with:												
Family members	196	3.60 (1.80)	287	4.88 (1.66)	65.03 (1,481)	.00**	141	4.64 (1.71)	224	5.37 (1.40)	20.01 (1, 363)	.00**
Friends and acquaintances	199	5.14 (1.50)	292	5.46 (1.24)	6.92 (1,489)	.01**	142	5.40 (1.39)	225	5.59 (1.15)	1.96 (1,365)	.16
Partner	-						59	6.03 (1.05)	83	5.88 (1.20)	.63 (1,140)	.43
Child(ren)	68	4.94 (2.08)	127	5.50 (1.80)	3.77 (1,193)	.05*	62	5.63 (1.56)	100	5.85 (1.47)	.83 (1,160)	.36
Support from:												
Family members	200	2.43 (1.24)	296	3.01 (1.32)	24.62 (1,494)	.00**	145	3.31 (1.52)	233	3.79 (1.30)	10.72 (1,376)	.00**
Friends and acquaintances	203	3.01 (1.04)	310	3.12 (1.14)	1.13 (1,511)	.29	145	3.45 (1.23)	233	3.69 (1.60)	3.75 (1,376)	.05*
Partner	70	4.24 (.90)	91	4.13 (1.0)	.58 (1,159)	.45	59	4.51 (.71)	83	4.59 (.62)	.51 (1,140)	.48
Societal embeddedness												
Number of unmet care needs	203	1.65 (1.36)	308	1.23 (1.22)	12.99 (1,509)	.00**	145	.99 (1.23)	233	.79 (1.13)	2.82 (1,376)	.09

Table 2. *Continued.*

	Baseline						Follow-up					
	CAE		No CAE				CAE		No CAE			
Continuous factors	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	p^a	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	p^a
Self-regulation												
Satisfaction with physical health	203	4.64 (1.73)	310	5.04 (1.70)	6.84 (1,511)	.01**	145	4.79 (1.65)	233	5.18 (1.47)	5.77 (1,376)	.02*
Satisfaction with mental health	203	3.98 (1.79)	310	4.69 (1.71)	20.46 (1,511)	.00**	145	4.92 (1.52)	227	5.23 (1.48)	3.67 (1,370)	.06
Psychological distress:												
General psychological distress	189	.90 (.71)	287	.53 (.54)	41.11 (1,474)	.00**	-					
BSI depression	201	1.08 (.99)	304	.69 (.81)	23.82 (1,503)	.00**	145	.60 (.78)	230	.41 (.65)	6.77 (1,373)	.01**
BSI anxiety	201	.87 (.83)	305	.53 (.74)	23.39 (1,504)	.00**	145	.56 (.71)	233	.37 (.57)	8.02 (1,376)	.01**
BSI somatization	200	.66 (.75)	306	.42 (.64)	14.45 (1,504)	.00**	145	.49 (.64)	233	.31 (.54)	8.33 (1,376)	.00**
Alcohol use (number of units during past 30 days)	135	8.95 (10.20)	177	9.81 (10.42)	.53 (1,310)	.47	79	10.14 (10.6)	123	10.11 (10.2)	0.00 (1,200)	.99

	Baseline						Follow-up					
	CAE		No CAE				CAE		No CAE			
Dichotomous factors	N	n (%)	N	n (%)	Pearson's χ^2	p^b	N	n (%)	N	n (%)	Pearson's χ^2	p^b
Living conditions												
Having debts	203	188 (92.6)	307	258 (84.0)	8.18	.00**	144	120 (83.3)	231	179 (77.5)	1.88	.17
Employed (currently or within the past year)	203	124 (61.1)	310	186 (60.0)	.06	.81	145	66 (45.5)	233	139 (59.7)	7.20	.01**
Independently housed at follow-up	-						142	64 (45.1)	230	123 (53.5)	2.4	.12
Victimized	203	61 (30.0)	310	28 (9.0)	37.79	.00**	145	20 (13.8)	233	13 (5.6)	7.57	.01**

Table 2. *Continued.*

	Baseline						Follow-up					
	CAE		No CAE				CAE		No CAE			
Continuous factors	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	p^a	*n*	*M (SD)*	*n*	*M (SD)*	*F (df)*	p^a
Societal embeddedness												
Rejected at care facilities	-						145	2 (1.4)	233	2 (0.9)	.23	.63
Involved in criminal activity:												
Arrested in the past year	199	64 (32.2)	303	97 (32.0)	.00	.97	144	18 (12,5)	233	16 (6.9)	3.44	.06
Ever served sentence detention	-						145	64 (44.1)	232	94 (40.5)	.48	.49
Self-regulation												
Cannabis used during past 30 days	203	118 (58.1)	310	122 (39.4)	17.37	.00**	145	70 (48.3)	233	69 (29.6)	13.39	.00**

[a] One-way analyses of variance. [b] χ^2 test. *$p \leq .05$. **$p \leq .01$.

Changes in constitutional conditions influencing the quality of daily life over time between participants with and without CAE

First, significant time effects were found for all four conditions of social quality when all participants, with and without CAE, were combined (see Table 3 and Table 4). Participants improved over time on all factors except for quality of relationships with friends and acquaintances (F(1, 349) 3.18, $p = .08$, $\eta_p^2 = .01$), satisfaction with physical health (F(1, 376) 5.21, $p = .11$, $\eta_p^2 = .00$) and alcohol use (F(1, 154) .63, $p = .43$, $\eta_p^2 = .00$).

Additionally, significant differential changes over time were found between participants with and without CAE regarding employment status ($B = -.61$, $Wald\ \chi 2 = 5.62$, $p < .05$), quality of relationships with family members (F(1, 347) 5.21, $p = .02$, $\eta_p^2 = .02$) and symptoms of depression (F(1, 368) 6.05, $p = .01$, $\eta_p^2 = 0.02$) and anxiety (F(1, 372) 5.16, $p = .02$, $\eta_p^2 = .01$). At baseline, participants with and without CAE reported being employed just as often, while at follow-up less participants with CAE reported being employed during the past year, and the number of employed participants without CAE remained the same. Also, participants with CAE reported a larger increase in satisfaction with the quality of their relationships with family members and reported a larger decline in symptoms of depression and anxiety compared to participants without CAE.

Table 3. Differences in continuous constitutional conditions influencing the quality of daily life over time for all participants and differences in changes over time between participants with CAE compared to participants without CAE

	time			time * CAE		
Continuous factors	***F* (1,371)**	η_p^2	p^a	***F* (1,371)**	η_p^2	p^a
Living conditions						
Satisfaction with financial resources	8.29 (1, 328)	.03	.00**	.36 (1, 328)	.00	.55
Satisfaction with housing	95.91 (1,361)	.21	.00**	1.44 (1,361)	.00	.23
Satisfaction with personal safety	43.44 (1,340)	.11	.00**	.06 (1,340)	.00	.82
Interpersonal embeddedness						
Subjective social functioning	11.51 (1,372)	.03	.00**	.26 (1,372)	.00	.61
Quality of relationships with:						
Family members	36.37 (1,347)	.10	.00**	5.21 (1,347)	.02	.02*
Friends and acquaintances	3.18 (1,349)	.01	.08	.12 (1,349)	.00	.73
Partner						
Child(ren)	7.82 (1,130)	.06	.01**	1.85 (1,130)	.01	.18
Support from:						
Family members	115.90 (1,364)	.24	.00**	.51 (1,364)	.00	.48
Friends and acquaintances	42.88 (1,376)	.10	.00**	.63 (1,376)	.00	.43
Partner	8.26 (1,69)	.11	.01**	2.06 (1,69)	.03	.16
Societal embeddedness						
Number of unmet care needs	49.61 (1,374)	.12	.00**	.88 (1,374)	.00	.35
Self-regulation						
Satisfaction with physical health	2.54 (1,376)	.01	.11	.04 (1,376)	.00	.84
Satisfaction with mental health	38.68 (1,369)	.10	.00**	3.40 (1,369)	.01	.07
Psychological distress:						
General psychological distress						
BSI depression	68.03 (1,368)	.16	.00**	6.05 (1,368)	.02	.01**
BSI anxiety	37.56 (1,372)	.09	.00**	5.16 (1,372)	.01	.02*
BSI somatization	20.10 (1,371)	.05	.00**	.41 (1,371)	.00	.52
Alcohol use (number of units during past 30 days)	.63 (1,154)	.00	.43	.00 (1,154)	.00	.98

[a] Repeated linear regression analysis. *$p \leq .05$. **$p \leq .01$

Table 4. Differences in dichotomous constitutional conditions influencing the quality of daily life over time for all participants and differences in changes over time between participants with CAE compared to participants without CAE.

	Time				Time * CAE			
Dichotomous factors	**B**	**OR**	**95% CI**	**Wald χ^2**	**B**	**OR**	**95% CI**	**Wald χ^2**
Living conditions								
Having debts	-.55	.58	[.43, .79]	11.84 **	.45	1.57	[.74, 3.35]	1.37
Employed (currently or within the past year)	.24	1.28	[1.0, 1.63]	3.73*	-.61	.54	[.33, .90]	5.62*
Victimized	.75	2.12	[1.43, 3.14]	14.24**	-.47	.63	[.27, 1.44]	1.22
Societal embeddedness								
Arrested in the past year	1.55	4.72	[3.30, 6.77]	71.79**	.66	1.93	[.94, 3.97]	3.23
Self-regulation								
Cannabis use during past 30 days	-.43	.65	[.55, .77]	25.75**	-.08	.92	[.65, 1.32]	.19

*$p \leq .05$. **$p \leq .01$. Logistic regression analyses

Discussion

This study indicates that homeless people with CAE were significantly younger when entering the social relief system, were more often female and had a longer duration of lifetime homelessness, which is in line with findings in previous studies (Liu et al, 2020; Sundin & Baguley, 2015). Our findings confirm our hypotheses, that at time of entering the social relief system, homeless people with CAE were more disadvantaged compared to people without such experiences on all four constitutional conditions of social quality. In particular, homeless people with CAE reported poorer living conditions, experienced a lower level of interpersonal embeddedness, reported poorer societal embeddedness and experienced a lower level of self-regulation. Most differences between homeless people with and without CAE still existed 2.5 years after entering the social relief system. These findings are in line with previous research among the general population indicating that adverse childhood experiences are related to negative outcomes in various life domains, such as health, socio-economic status and the ability to form healthy social relationships (Bellis et al, 2019; Hughes et al, 2017; Kalmakis & Chandler, 2015; .Lippard & Nemeroff, 2020; Metzler et al, 2017; Van der Kolk, 2014). The findings are also in line with previous studies among homeless people that have shown that adverse childhood experiences are related to poorer physical and psychological health (Brown et al, 2016; Lee et al, 2017; Liu et al, 2020 Patterson et al, 2014; Stein et al, 2002), more victimization (Stein et al, 2002) and a poorer social network (Green et al, 2012). In addition to previous research, our findings also show that, among a homeless population, people with CAE experienced worse outcomes on societal embeddedness (more unmet care needs) and additional poorer outcomes regarding living conditions (more debts and more unemployment). In conclusion, within this population of homeless people, many people have CAE, which have a persistent impact on a broad range of factors influencing their quality of life after entering the social relief system.

In addition, findings also show that, after 2.5 years homeless people improved on the majority of factors of the four constitutional conditions of social quality, regardless of having reported CAE. This finding might by explained to the effect of 'regression to the mean'. The baseline interviews were conducted shortly after the time that participants were literally homeless, while the follow-up interviews were conducted 2.5 years after this stressful and often traumatic circumstance. Therefore, it is probable that most participants would have improved on most outcome measures by the time of the follow-up interviews. Additionally, all factors changed at a similar rate for people with and without CAE, except for employment status, quality of relationships with family members and symptoms of depression and anxiety. At baseline, participants with and without CAE reported being employed just as often, then at follow-up less participants with CAE reported being employed while the number of employed participants without CAE remained the same. Furthermore, while still being less satisfied with the quality of their relationships with family members, participants with CAE showed a larger increase in satisfaction with the quality of those relationships, compared to participants without CAE. And, while still experiencing higher levels of symptoms of depression and anxiety, participants with CAE reported a larger decline in these symptoms compared to participants without CAE.

Implications for practice

Our finding, that people with CAE improve over time at a similar rate, and sometimes even at a greater rate, compared to people without CAE, seems to indicate that people with CAE possess at least the same potential for growth and self-realization. However, as homeless people with CAE were generally still worse off 2.5 years after shelter entry, trauma- informed approaches seem to be essential within current homelessness services. Trauma-informed approaches recognize the link between traumatic experiences and behavior that prevents people from having their needs met, such as problematic drug and alcohol use, personality disorders, suicide attempts, and family instability (Feantsa, 2017). The need for trauma-informed approaches is in line with previous research wherein homeless people described early trauma, family instability, mental health, substance misuse and homelessness as co-dependent variables all of which must be addressed together in order to match service provision to their needs (Mc Conalogue et al., 2019). Trauma Informed Care (TIC; Hopper et al, 2010) and Psychologically Informed Environments (PIE; Keats et al, 2012) provide a framework that can assist homelessness services to understand and address the specific problems of people with CAE and adverse childhood experiences in general more successfully.

Furthermore, policy makers should be more aware of the extensive and persistent additional vulnerability of formerly homeless people with CAE, and enable service providers to support this group for as long as necessary. Furthermore, the results of this study urge service providers and policy makers to structurally enhance the four constitutional conditions for 'a good life' in order to enable formerly homeless people with CAE to overcome their disadvantaged situation, specifically regarding access to mental health care and physical health care, and support programs to strengthen family ties.

Strengths and limitations

To our knowledge, this is the first longitudinal study on differences between homeless people with and without CAE assessing a wide range of constitutional conditions influencing the quality of their daily lives, and therefore addresses an important knowledge gap. The present study has a number of strengths. The theoretical framework of the Social Quality Approach allowed us a comprehensive insight into the factors that can influence the quality of daily lives of homeless people, with and without CAE. Longitudinal data were available for a relatively large cohort of homeless people with a high response rate at the follow-up measure, 2.5 years after entering the Dutch social relief system (73.7%). Also, using longitudinal data to investigate factors of social quality over time, this study provided insight into the persistence of the additional disadvantaged situation of homeless people with CAE. It would be interesting to examine whether the disadvantaged position of individuals with ACE persists over an extended period of time. A longitudinal study with a duration of more than 2.5 years could offer more insight into this matter.

This study also has several limitations that should be noted. First, this study only examined the impact of CAE and did not include the two other types of adverse childhood experiences (childhood neglect and exposure to household dysfunction) (Felitti et al, 1998). However, as studies among homeless people have found the prevalence of these three types of adverse childhood experiences to be significantly correlated with one another (Bellis et al, 2015; Larkin & Park, 2012), we expect that many of the respondents in our sample also experienced neglect and/ or have been exposed to household dysfunction. Another limitation of this study is that CAE were not assessed with a standardized questionnaire. Future research should include a more comprehensive and standardized assessment of adverse childhood experiences such as the widely used Adverse Childhood Experience Questionnaire (Felitti et al, 1998).

Furthermore, it is worth mentioning that the data analyzed within this study were collected between 2011 and 2014. In the meantime, due to changes in social policy, the social relief system and the housing market, the number of homeless people in The Netherlands has increased (Statistics Netherlands, 2019; Statistics Netherlands, 2016). However, as the prevalence of child abuse and the characteristics that make families vulnerable to child maltreatment seem to be considerably stable over time (Van Berkel et al, 2020), we expect that the number of homeless people with CAE experiences in The Netherlands is still significant. Therefore, the results of this study should be applicable in present-day.

Another issue is the higher loss of follow-up of participants who were younger, male, and had a low level of education. However, it is unknown whether and in which direction this selective loss to follow-up may have biased our findings as we lack information on the study variables of these non-respondents. A final methodological issue concerns the external validity of the results. The criteria for entering the social relief system in the four major cities in the Netherlands (G4) in 2011 were used as inclusion criteria for this study. Homeless people who did not meet these criteria such as undocumented homeless people, were excluded from this study. The prevalence of CAE as well as the situation and change in the constitutional social quality factors may differ from the group allowed to enter the social relief system.

Overall conclusion

Homeless people with CAE are, compared to people without CAE, more disadvantaged regarding a broad range of factors influencing the quality of their daily lives when entering the Dutch social relief system and are still worse off 2.5 years later. Homeless services should be aware of the broad and persistent impact of CAE on the quality of the daily lives of homeless people. They should be more attuned to the needs of people with CAE, specifically regarding their interpersonal relationships, mental health and physical health. Findings corroborate the need for homelessness services to apply trauma-informed care.

References

Anda, R.F., Felitti, V.J., Bremner, J.D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*,174–86. doi: 10.1007/s00406-005-0624-4

Bellis, M., Ashton, K., Hughes, K., Ford, K., Bishop, J., & Paranjothy, S. (2015). *Adverse Childhood Experiences and their impact on health harming behaviours in the Welsh adult population.* Public Health Wales NHS Trust.

Bellis, M.A., Hughes, K., Ford, K., Ramos Rodriguez, G., Sethi, D., & Passmore, J. (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis. *Lancet Public Health*, *4(10),* 517-528. doi: 10.1016/S2468-2667(19)30145-8

Brown, R.T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M.B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *PLoS ONE 11 (5)*, e0155065. doi: 10.1371/journal.pone.0155065

Danese, A., & McEwen, B.S. (2012). Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiology and Behaviour, 37*, 389-96. doi: 10.1016/j.physbeh.2011.08.019

Derogatis, L.R. (2001). Brief symptom inventory (BSI). Administration, scoring, and procedures manual, 3rd edn. NCS Pearson, Inc, Minneapolis

Feantsa (2017). Recognising the Link between Trauma and Homelessness. Feantsa Position, retrieved from: https://www.feantsa.org/download/feantsa_traumaandhomelessness030 7347121905294681073 8.pdf

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258. doi: 10.1016/s0749-3797(98)00017-8

Finlay, W.M.L., & Lyons, E. (2001). Methodological issues in interviewing and using self-report questionnaires with people with mental retardation. *Psychological Assessment 13 (3*), 319–335. doi: 10.1037//1040-3590.13.3.319

Green, H.D., Tucker, J.S., Wenzel, S.L., Golinelli, D., Kennedy, D.P., Ryan, G.W., & Zhou, A.J. (2012). Association of childhood abuse with homeless women's social networks. *Child Abuse & Neglect, 36 (1)*, 21-31. doi: 10.1016/j.chiabu.2011.07.005

Grey, C.N.B., & Woodfine, L. (2019). *Voices of those with lived experiences of homelessness and adversity in Wales: informing prevention and response*. Cardiff: Public Health Wales NHS Trust.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal*, *3*(1), 80–100. doi: 10.2174/1874924001003020080

Hughes, K., Bellis, M.A., Hardcastle, K.A., Sethi, D., Butchart, A., Mikton, C., et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health,* 2(8), 356–66. doi: 10.1016/S2468-2667(17)30118-4

Kalmakis, K.A., & Chandler, G.E. (2015). Health consequences of adverse childhood experiences: a systematic review. *Journal of the American Association of Nurse Practitioners, 27(8),* 457-465. doi: 10.1002/2327-6924.12215

Keane, C.A., Magee, C.A., & Kelly, P.J. (2018), Trajectories of Psychological Distress in Australians Living in Urban Poverty: The Impact of Interpersonal Trauma. *Journal of Traumatic Stress, 31*, 362-372. doi: 10.1002/jts.22297

Keats, H., Maguire, N., Johnson, R., & Cockersell, P. (2012) *Psychologically informed services for homeless people.* Southampton, GB, Communities and Local Government (Good Practice Guide).

Lako D.A., de Vet R., Beijersbergen M.D., Herman D.B., van Hemert A.M. & Wolf J.R.L.M. (2013) The effectiveness of critical time intervention for abused women and homeless people leaving Dutch shelters: study protocol of two randomized controlled trials. *BMC Public Health, 13* (1), 555. doi: 10.1186/1471-2458-13-555

Larkin, H., & Park, J. (2012). Adverse Childhood Experiences (ACEs), Service Use, and Service Helpfulness among People Experiencing Homelessness. *Families in Society*, *93*(2), 85–93. doi: 10.1606/1044-3894.41

Lee, C.M., Mangurian, C., Tieu, L., Ponath, C., Guzman, D., & Kushel, M. (2017). Childhood Adversities Associated with Poor Adult Mental Health Outcomes in Older Homeless Adults: Results From the HOPE HOME Study. *American Journal of Geriatric Psychiatry, 25(2),* 107-117. doi: 10.1016/j.jagp.2016.07.019

Lehman, A. F. (1983). The well-being of chronic mental patients. *Archives of General Psychiatry*, *40*, 369–373. doi: 10.1001/archpsyc.1983.01790040023003

Lippard, E., & Nemeroff, C. B. (2020). The Devastating Clinical Consequences of Child Abuse and Neglect: Increased Disease Vulnerability and Poor Treatment Response in Mood Disorders. *The American journal of psychiatry, 177*(1), 20–36. doi: 10.1176/appi.ajp.2019.19010020

Liu, M., Luong, L., Lachaud, J., Edalati, H., Reeves, A., & Hwang, S.W (2021). Adverse childhood experiences and related outcomes among adults experiencing homelessness: a systematic review and meta-analysis. *Lancet Public Health, 6(11)*, 836-847. doi: 10.1016/S2468-2667(21)00189-4

Liu, M., Mejia-Lancheros, C., Lachaud, J., Nisenbaum, R., Stergiopoulos, V., & Hwang, S.W. (2020). Resilience and Adverse Childhood Experiences: Associations With Poor Mental Health Among Homeless Adults. *American Journal of Preventive Medicine, 58 (6),* 807-816. doi: 10.1016/j.amepre.2019.12.017

Mc Conalogue, D., Maunder, N., Areington, A., Martin, K., Clarke, V., & Scott, S. (2019). Homeless people and health: a qualitative enquiry into their practices and perceptions. *Journal of Public Health*, 1-8. doi: 10.1093/pubmed/fdz104

Metzler, M., Merrick, M.T., Klevens, J., & Ports, K.A. (2017). Adverse childhood experiences and life opportunities: shifting the narrative. *Children and Youth Services Review, 72,* 141–49. doi: 10.1016/j.childyouth.2016.10.021

Nielssen, O.B., Stone, W., Jones, N.M., Challis, S., Nielssen, A., Elliott, G., Burns, N., Rogoz, A., Cooper, L.E., & Large, M.M. (2018), Characteristics of people attending psychiatric clinics in inner Sydney homeless hostels. *Medical Journal of Australia, 208*, 169-173. doi: 10.5694/mja17.00858

Nilsson, S.F., Nordentoft, M., & Hjorthøj, C. (2019). Individual-Level Predictors for Becoming Homeless and Exiting Homelessness: a Systematic Review and Meta-analysis. Journal of Urban Health, 96(5), 741-750. doi: 10.1007/s11524-019-

Patterson, M.L., Moniruzzaman, A., & Somers, J.M. (2014). Setting the stage for chronic health problems: cumulative childhood adversity among homeless adults with mental illness in Vancouver, British Columbia. *BMC Public Health, 14*, 350. doi: 10.1186/1471-2458-14-350

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American journal of public health*, *103 Suppl 2*(Suppl 2), S275–S281. doi: 10.2105/AJPH.2013.301323

Statistics Netherlands [Centraal Bureau voor de Statistiek], (2016). Aantal daklozen in zes jaar met driekwart toegenomen [Number of homeless people increased by three quarters in six years]. Retrieved April 30, 2017, https://www.cbs.nl/nl-nl/nieuws/2016/09/aantal-daklozen-in-zes-jaarmet-driekwart-toegenomen

Statistics Netherlands [Centraal Bureau voor de Statistiek], (2019). Aantal daklozen sinds 2009 meerdan verdubbeld [Number of homeless people more than doubled since 2009]. Retrieved March 20, 2020, https://www.cbs.nl/nl-nl/nieuws/2019/34/aantal-daklozen-sinds-2009-meer-danverdubbeld

Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26 (10)*, 1011–1027. doi: 10.1016/s0145-2134(02)00382-4

Sundin, E., & Baguley, T. (2015). Prevalence of childhood abuse among people who are homeless in Western countries: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 50 (2)*, 183–194. doi: 10.1007/s00127-014-0937-6

Tam, T.W., Zlotnick, C., & Robertson, M.J. (2003). Longitudinal Perspective: Adverse Childhood Events, Substance Use, and Labor Force Participation Among Homeless Adults. *The American Journal of Drug and Alcohol Abuse, 29 (4)*, 829-846. doi: 10.1081/ada-120026263

Torchalla, I., Strehlau, V., Li, K., Schuetz, C., & Krausz, M. (2012). The association between childhood maltreatment subtypes and current suicide risk among homeless men and women. *Child Maltreatment, 17(2)*, 132–143. doi: 10.1177/1077559512439350

Tuynman, M., & Planije, M. (2012). Monitor Plan van Aanpak Maatschappelijke Opvang. Rapportage 2011: Amsterdam, Rotterdam, Den Haag en Utrecht.

Van Berkel, S.H., Prevoo, M.J.L., Linting, M., Pannebakker, F.D., & Alink, L.R.A. (2020). Prevalence of child maltreatment in the Netherlands: An update and cross-time comparison. *Child Abuse & Neglect, 103*, 104439. doi: 10.1016/j.chiabu.2020.104439

Van der Kolk, B.A. (2014). The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. New York, USA: Viking Books.

Van der Maesen, L. J. G., & Walker, A. (Eds.) (2012). *Social quality: From theory to indicators*. Basingstoke, United Kingdom: Palgrave Macmillan.

Wennink, J., & Wijngaarden, B.V. (2004) Quality of life and care (QoLC). Kwaliteit van leven en vervulling zorgwensen [Quality of Life and Care (QoLC). Quality of Life and Fulfilling of Care Needs]. Trimbos-instituut, Utrecht.

Wolf, R.L.M., & Jonker, I. E. (2020). Pathways to empowerment: The Social Quality Approach as a foundation for person-centered interventions. *International Journal of Social Quality, 10* (1), 29-56. doi: 10.3167/IJSQ.2020.100103

Chapter 4

What Makes Intentional Unidirectional Peer Support for Homeless People Work? An Exploratory Analysis Based on Clients' and Peer Workers' Perceptions

Schel, S. H. H., van den Dries, L., & Wolf, J. R. L. M. (2022).
What Makes Intentional Unidirectional Peer Support for Homeless People Work? An Exploratory Analysis Based on Clients' and Peer Workers' Perceptions. Qualitative Health Research. doi: 10.1177/10497323221083356

Abstract

Homeless people are increasingly supported by peer workers in one-on-one mentorship relations called intentional unidirectional peer support (IUPS). Insight is therefore needed into the application and outcome of IUPS for this vulnerable population. This study examined the outcomes, critical elements, and working mechanisms of IUPS within homeless services from the perspective of both clients receiving IUPS and peer workers providing IUPS. Semi-structured face-to-face interviews were held with ten homeless clients and ten peer workers. According to participants, IUPS enhances clients' self-image, advances their personal growth, and results in better engagement with needed services. Rapport and empathy, a trustworthy and empowering relationship, as well as support, guidance, and mediation are what makes IUPS work according to the participants. The inclusion of both perspectives has led to a deeper understanding of what makes IUPS work for homeless people. Implications for practice are discussed.

Introduction

Homeless people are increasingly supported by peer workers in one-on-one mentorship relations, called intentional unidirectional peer support (IUPS). Intentional unidirectional peer support refers to "a formalized mentorship type of peer intervention where the peer is clearly more advanced and is mentoring the client in an organized fashion" (Barker et al., 2020). Research investigating the effectiveness of IUPS within homeless populations is scarce (Barker & Maguire, 2017; Faulkner & Basset, 2012). Insight is therefore needed into the application and outcomes of IUPS for this vulnerable population.

Although IUPS in the homeless population is an under-researched area, in this population, several studies on intentional peer support (IPS) in general, have been conducted. Intentional peer support is peer support that is fostered and developed by organizations and can be divided into IUPS and intentional bidirectional peer support (IBPS) which involves reciprocal and mutual types of peer interventions (Barker et al., 2020). One review study assessing all research published between 1995 and 2014 that quantitatively examined the effectiveness of IPS within homeless populations reported that IPS has significant positive impacts on participants' overall quality of life, drug and alcohol use, mental and physical health, and social support (Barker & Maguire, 2017). However, the results were considered inconclusive, because most studies had substantial methodological limitations, such as a lack of randomization, no control group, or limited power. Until now, the effectiveness of IUPS within homeless populations has only been examined in two qualitive studies, mainly from the peer worker's perspective. One study assessed the motivation and outcomes experienced by peer workers providing IUPS (Croft et al., 2013). The other study explored the perspective of peer workers and clients with regard to the critical elements that underpin IUPS and also reported outcomes experienced by peer workers (Barker et al., 2018). The two studies reported that the peer workers themselves benefited from helping clients: they experienced empowerment, identity integration, enhanced self-esteem, and confidence as valuable outcomes of IUPS. Outcomes of IUPS for clients were not examined in these studies.

Within populations with mental health problems the effectiveness of IPS has been investigated more often. Intentional peer support has been associated with positive recovery related outcomes, such as hope, empowerment, self-esteem, self-efficacy, self-management, and social inclusion, but these outcomes also need to be interpreted with caution due to the low quality of the research methodologies (Chien et al., 2019; King et al., 2018; Lloyd-Evans et al., 2014; Pitt et al., 2013; Repper & Carter, 2011). Those studies, mostly being randomized controlled trials (RCT, Chien et al., 2019; Lloyd-Evans et al., 2014; Pitt et al., 2013), also generally lack comparability, because the way IPS was provided (for example IUPS vs. IBPS) and the outcomes that were measured varied widely between studies (King et al., 2018). A review assessing qualitative studies on the outcomes of IPS for people with mental health problems, revealed that the majority of outcomes were examined from a peer worker's perspective (Repper & Carter, 2011). Two qualitative studies that have investigated the outcomes of IPS for people with mental health problems from the clients' perspective, reported that clients felt better understood by their peer worker than by other professionals (Coatsworth-Puspokey et al., 2006) and noted an increase in community involvement (Trainor et al., 1997).

Besides the notion that the effectiveness of IUPS within homeless populations is still an under-researched area, the utilization of RCTs is being questioned within the field as an appropriate method to investigate peer support (Walker & Peterson, 2021). Outcomes relating to the participant's long term personal recovery, such as empowerment and resilience, are difficult to grasp with a quantitative questionnaire, and were thus generally not included in previous RCT studies (Walker & Peterson, 2021). By focusing on clients' and peer workers' experiences and narratives, qualitative interviews with both these groups can provide this essential in-depth information from each of their perspectives. Qualitative interviews are also useful to comprehend the mechanisms that make IUPS, a complex intervention, work, and induce change (e.g., getting into the "black box" of the intervention) (Greenhalgh & Papoutsi, 2018; Mannell & Davis, 2019; Walker & Peterson, 2021). Through qualitative interviews clients and peer workers can provide insight into the elements that define and are considered critical for IUPS, called critical elements, and the mechanisms establishing a link between these critical elements and the outcomes, shedding light on what makes IUPS work. To the best of our knowledge, there is only one model describing critical elements and potential change mechanisms of IUPS for homeless people (Barker, 2018). This model clarifies three critical elements: (1) The peer-client relationship, referring to the peer worker's ability to understand the client (e.g., positive regard), the peer worker helping the client to understand that their reactions to oppressive systems are normal (e.g., normalization), the use of experiential knowledge, and empowerment; (2) Role modeling, whereby clients learn from peer workers' coping techniques and strengths-based approach, where peers advocate for clients and highlight their lived experience as a strength and in which clients evaluate themselves through social comparison with the peer workers; (3) Experience-based social support, whereby peer workers offer different types of support, such as informational support (guiding clients through social services in which the peer worker has already found their way), instrumental support, emotional support, companionship, and appraisal (Barker, 2018; Barker et al., 2019).

Regarding people with mental health problems, studies examining the critical elements and working mechanisms of IPS are less scarce. They do, however, also represent a range of peer roles applied within various mental health care settings, and predominantly involve the perspective of peer workers (Watson, 2019). To our knowledge, only one study within mental health care included the perspective of clients (Gidugu et al., 2015). This study examined the nature and processes of IUPS and what makes IUPS work. It showed that clients particularly benefited from practical, emotional, and social support, valued "having someone to rely on, a friend, and someone to socialize with" and esteemed having a non–treatment-based, normalizing relationship with peer workers. These findings are fairly in line with the critical elements discerned in IUPS for homeless people (Barker, 2018; Barker et al., 2019). Nonetheless, it is evident that homeless people experience additional problems compared to people "only" experiencing mental health problems. Besides physical and mental health problems, homeless people often experience high levels of social exclusion resulting in deprivation in areas such as social relations, material resources, access to health services and housing as well as a lack of future perspective. Therefore, the experiences of homeless people regarding the outcomes, critical elements, and working mechanisms of IUPS should be explicitly assessed.

The purpose of the current study is to extend the previous studies on outcomes, critical elements, and working mechanisms of IUPS with a study that examines those aspects within homeless services from the perspective of both clients receiving IUPS and peer workers providing IUPS. The research questions of this study are threefold: (1) What are the outcomes of IUPS according to homeless people and peer workers? (2) Which critical elements of IUPS do they distinguish? and, (3) Which working mechanisms of IUPS can be identified, based on the perceived outcomes and critical elements for both groups? The results of this study will contribute to the development of an experience-based foundation for IUPS for homeless people and may give clues for the development and maintenance of IUPS.

Methods

Design

This study applied a qualitative design, utilizing semi-structured interviews, to examine the outcomes, critical elements, and working mechanisms of IUPS within homeless services, from the perspective of both clients receiving IUPS and peer workers providing IUPS. Face-to-face interviews were held with ten homeless people and ten peer workers.

Ethical Approval, Quality Criteria, and Research Team

This study was exempt from formal review by the accredited Medical Review Ethics Committee region Arnhem-Nijmegen (file number 2018–5007). All participants gave written informed consent and received verbal and written information about the aim and process of the study, and their right to withdraw at any time, without giving any reason. Participants were aware that their participation was voluntary. At the start of the study, all participants were assigned a research number, ensuring anonymity during the process of data collection, data analysis, and data storage. Only the research team had access to data that could lead to the identification of the participants. The research team consisted of a researcher, a senior researcher, two interviewers, an expert in peer support, and a professor of social care. All were experienced in conducting research and interviewing vulnerable citizens, ensuring the presence of important skills that are required by qualitative health researchers, such as the ability to modify the research methods to fit the contextual and participants limitations, and the understanding of the participants' situation (Morse, 2010). The interviewers were two psychologists who had not met the participants prior to the start of the study.

Setting and Participants

In this study, all member organizations of the institution named "Academic Collaborative Center Impulse: Participation and Social Care" that provide ambulant and residential care to homeless people were contacted by the researcher and asked whether they provided IUPS to homeless people and wanted to participate in the study. All five organizations that provided IUPS to homeless people were willing to participate and were included in the study. Four organizations formally employed peer workers and one organization employed peer workers on a voluntary basis. Within two organizations peer workers worked in a team with other peer workers in a special "peer workers department" that was accessible to all clients, for all kinds of support. In the other three organizations, the peer workers worked in a team with a mix of professionals and peer workers where they supported clients alongside the other professionals. Besides IUPS, all five organizations had implemented the strengths-based approach of "Pathways to Empowerment" (Krachtwerk in Dutch; Wolf, 2016) by training and coaching professional staff throughout their ambulant and residential care services. Peer workers were included in this study when they provided support to homeless people in one-on-one relationships. The homeless people were currently receiving this support or had been receiving this assistance within the preceding year. They either lived in transitional or residential care accommodation or had recently moved from such an accommodation to independent (supported) housing in the community.

Recruitment

Participants were recruited via purposeful sampling. Only Dutch speaking participants were included in this study. Candidate participants who, according to the manager or daily staff, were not able to provide reliable information, for example due to an active psychotic episode, were excluded from this study. Candidate participants received an information letter containing details of the study; peer workers received this letter via their manager and clients via their peer workers. Peer workers who expressed interest in participating were contacted by telephone by the researcher, who provided additional information, answered remaining questions and scheduled the interview. Clients who expressed interest in participating were contacted by their peer worker, who scheduled a face-to-face meeting with the interviewers. Prior to the start of the interview the interviewer provided further information and answered remaining questions. Participants received a twenty-euro gift card as compensation for their time.

Interview guide and data collection

The interviews were conducted using an interview guide developed by the research team. This guide was based on two sources: expert opinions from the research team and knowledge from scientific literature about IUPS and recovery. After conducting the first two interviews, the interviewers noticed that a few specific questions led to some confusion with the interviewees about the purpose of these questions. This was discussed with the researcher and led to a slight simplification of the interview questions to make them easier to understand. Each interview consisted of two parts: (1) questions about the perceived outcomes of IUPS and (2) questions about the critical elements of IUPS. To examine the perceived outcomes of IUPS, clients were asked whether and how their lives had changed due to the peer support (e.g.,: "How has the peer support affected your life?"). In order to gain insight into the critical elements of IUPS, clients were asked: "What was valuable or important about the support you received from the peer worker?" To help clients talk about their experiences and elaborate on what they perceived as critical elements of IUPS, additional questions were asked, for instance: "What part/element of the peer worker's support was most helpful to you?" For the peer workers, the questions were adjusted to their role, for example: "What was valuable or important about your support for your clients?" and "How has your support affected your clients' lives?"

The interviews were held at the location of the participant's choice, to make participants more comfortable. In the majority of cases, this was a quiet room within the participating organization, to make sure the interviewer and interviewee were not disturbed and to ensure confidentiality. On two occasions, the interview took place at the client's home or outdoors close to the organization, because the interviewee either had to look after her children or felt uncomfortable being in the allocated room. The interviewer made field notes during and immediately after the interviews. After each interview, the interviewers discussed the findings with the researcher (e.g., peer debriefing) in order to ensure a consistent performance of the interviews, but also to check whether the focus of the interviews was sufficient or should be altered. This did not lead to any changes. Furthermore, after each interview the interviewers reported their observations regarding aspects that could have affected the reliability of the interviews, such as the participants' functioning, mood, ability to focus and the context in which the interview took place (e.g., location, presence of others). All interviews were considered reliable. The interviews were held between March and July 2019. They took approximately one hour and were recorded with an audio recorder. Audio recordings were transcribed verbatim. To protect participants' identities, research ID numbers were applied in all transcripts.

Data Analysis

Data analysis was supported using a qualitative data analysis software program (Atlas.ti version 7). The transcripts of clients and peer workers were independently analyzed using an inductive ("conventional thematic content analysis") and a deductive ("directed content analysis”) approach as described by Braun and Clarke (2006). To minimize subjectivity of findings, two researchers independently coded the interview transcripts line-by-line, describing the data using initial codes for both the outcomes as well as the critical elements of IUPS. After coding four transcripts, the two researchers met to review and discuss the meaning and uniqueness of the initial codes and agreed upon the initial coding schemes. Then a meeting with a third researcher was organized, during which the initial coding schemes were discussed and consensus about the initial coding schemes was reached. The initial coding schemes formed the basis for the subsequent (selective) coding process. After coding eight, twelve, sixteen, and twenty interviews, the above-mentioned review and consensus process was repeated. After seventeen interviews the transcripts did not generate new codes or modifications to the coding schemes, indicating that code saturation was reached. Interviews eighteen, nineteen, and twenty helped all codes to reach or approach meaning saturation (Hennick et al., 2017). Then, the three researchers discussed and established the final coding schemes of the outcomes and critical elements of IUPS. Next, the researchers extracted, identified and developed possible working mechanisms. During two additional meetings these working mechanisms were discussed and further adjusted.

Results

The results of this study are reported in terms of outcomes and critical elements of IUPS as experienced and reported by clients and peer workers. Although the interviews with clients and peer workers were independently examined, the results of the analyses were almost identical for these two groups. In this results section, the outcomes and critical elements that were reported by both groups will therefore be referred to as perceived by “participants Regarding the outcomes and critical elements that were mentioned by one group only, this specific group will be indicated in the description of the results and in the Tables. Based on an exploration of the interaction between the perceived outcomes and critical elements this section will also present the working mechanisms of IUPS. First, the characteristics of the participants are described.

Characteristics of Participants

Of the ten participating clients, five were female, and the average age was 46 years, ranging from 31 years to 56 years, with 50% having a lower and 50% having an intermediate educational level. All clients were single, one person was living with her children. The average duration of lifetime homelessness was 42 months, ranging from 7 months to 10 years. On average, clients had been receiving IUPS for 23 months, ranging from 2 months to 7 years. Eight clients lived in a transitional or residential care accommodation and two clients had recently moved from such an accommodation to independent (supported) housing in the community.

Of the ten peer workers, five were female, and the average age was 42 years, ranging from 26 to 59 years, with 20% having a lower, 70% an intermediate, and 10% a higher educational level. In addition, all peer workers received higher or intermediate professional training in peer support work or had almost finished this training. All peer workers had personal experiences of being homeless at some point during their lives. On average, the peer workers had been supporting (formerly) homeless people for 39 months, ranging from 7 months to almost 10 years. Peer workers were currently providing IUPS to clients at various stages of their recovery process.

Perceived Outcomes of IUPS

The three perceived outcomes of IUPS were: Positive self-image, Personal growth and Engagement with services, consisting of a total of eight aspects (see Table 1). Below these outcomes are presented, together with participant quotes to give meaning to each outcome.

Positive Self-Image

Due to IUPS, many participants reported clients experiencing more self-worth, having more self-esteem, feeling more confident, having more self-respect and being more proud of themselves. A client expressed this by saying: “*Until two years ago I had no self-esteem at all and I had completely lost my self-confidence. My psychologist and peer worker have given me strength again, because of them I regained my self-esteem and self-confidence.*” Peer workers made clients experience that they have a lot to offer, that just being themselves is enough, that they are worthy and can rely on themselves. Peer workers were fully aware of the positive influence their support had on their clients’ self-image. They highly valued this aspect of their profession and considered this the core of what they have to offer their clients.

Table 1. Overview of outcomes of intentional unidirectional peer support for homeless people perceived by clients and peer workers.

Outcomes	Aspects
Positive self-image	• Increased self-worth • Increased self-esteem • Increased self-respect
Personal growth	• Increased acceptance of self and own situation[1] • Progressing in recovery process • Feeling more resilient[1] • Feeling more positive about the future[2]
Engagement with services	• Engaging with necessary services

[1] Clients only; [2] Peer workers only

Personal Growth

Participants described that, because of IUPS, clients were able to progress in their recovery process. Clients were taking up things again like looking for a job, starting an internship or following a financial care trajectory. A peer worker exemplified: "*That older man who is off the streets again, has a decent allowance and is able to take part in a debt relief trajectory. He basically has got his whole life back on track and he feels safe and being taken seriously.*" Clients whose daily life used to revolve around drug use for example, developed a more positive perspective on the future due to IUPS and tried to spend their evenings and weekends in a meaningful way. Clients also stated that they felt more resilient and were more able to accept themselves, their current situation and their past due to IUPS.

Engagement with Services

Due to IUPS, clients had become engaged with the services they needed. Peer workers helped clients to identify their physical and mental health problems, and to get in touch with the help they needed, for example, from a general practitioner or specialized care. Peer workers also motivated clients to seek, for instance, treatment for their addiction problems, for which the client until then lacked motivation.

Critical Elements of IUPS

The analysis of the interviews revealed ten critical elements of IUPS, namely: Being there, Understanding, Being accessible and available, Providing comfort and a personal connection, Having an equal relationship, Role modeling, Stimulating and empowering, Providing practical support and developing better life circumstances, Supporting client-professional relationship, and Supporting clients with care trajectories. The elements and aspects—thirty-four in total (see Table 2)—are formulated in terms of actions performed by peer workers. All critical elements are presented below with participant quotes used to give context to elements.

Being There

Peer workers reported that they established rapport with clients and showed genuine interest in them. This was highly valued by clients, because due to their history of homelessness, not all clients are used to "*someone wanting to have a conversation with them.*" Nearly all participants described the peer worker as providing a listening ear and sincerely caring for clients' well-being, which made clients feel that they are worthy. This was experienced as a very important aspect of IUPS. Several participants also described that peer workers, unlike some other professionals, had plenty of time to really be there for their clients, which was highly valued. A peer worker exemplified: "*It is just that sometimes, they have to blow off steam and they can do that here… the workload for staff working at the wards often is so high that they do not have time to 'receive' that steam from a client. We have a somewhat different set of tasks, so if someone comes to me, or when I go to them, I do have time to 'receive' their steam.*"

Understanding

According to many participants, clients highly appreciated the peer worker's deep understanding of the client's situation because of their shared experiences. Clients sensed that peer workers really know what it is like to have lost everything and to live in a homeless shelter: "*With him it is just like, when I tell him something, he just knows how it is. Because he has experienced it himself.*" Alongside the peer worker's deep understanding, clients also appreciated peer workers explicitly expressing their understanding and acknowledging the difficult situation clients find themselves in. A client exemplified this: "*And then yes…then I feel down again. But then my peer worker says: 'Hey, I understand, you don't want to be here, you don't belong here. You want to have your own place. Of course, we all see that, and we think you deserve it'.*"

Being Accessible and Available

Almost all participants described that clients felt really supported by the fact that the peer worker was available for them when they need him/her: "*It feels like a sort of backup to me, if I have a hard time with something he is always there for me. That you just know from the back of your mind: okay, whatever I run into, there is always someone I can rely on, you know.*" Many participants described that the peer worker was even accessible for clients outside office hours, which reinforced client's belief that they could truly rely on their peer worker. While it's not always allowed to keep in touch with clients after they exited the shelter, the peer worker often did so, for example, by sending them WhatsApp messages and visiting them. As a peer worker pointed out: "*I don't think I'm officially allowed to do that, and I don't need to do it, but I want to. I want them to know that I am just there when things are not going well.*"

Providing Comfort and a Personal Connection

Nearly all participants reported that clients had a special connection or bond with the peer worker and perceived the peer worker as trustworthy because of shared experiences. Peer workers are able to build a trusting relationship fairly quickly, because they know what they are talking about, due to their own experiences. Peer workers also reported that clients experienced them as keeping less professional distance compared to other professionals, and clients keeping less distance to the peer worker: "*So it's not only that professionals keep a distance from clients, clients also keep a distance from professionals too, because 'you never know', it's not like the old boys' network on the street…and I notice that they rather tell their troubles to me.*" Peer workers reported that they were aware of the importance of a safe, trusting and comfortable working relationship with their clients and mentioned that they consciously and actively tried to create such a relationship or bond.

Having an Equal Relationship

Participants described that clients appreciated being accepted for who they are and felt the peer worker treated them as equal without judging them, and treated them as a person instead of a number or "just another client." Participants stated that within this equal and respectful relationship, the needs, and goals of clients were considered as most important by peer workers and were put first. A peer worker elucidated: "*I don't know what it is, just equality. I always say: you are the boss, it is your life.*" Another peer worker mentioned: "*I always said to him that it is very important that you do what is helpful for you...What works for you, that is what you have to do.*"

Role Modeling

According to many participants, peer workers served as role models and induced hope in their clients, by showing them that they can get out of their current situation, just like the peer worker did. As a peer worker exemplified: "*I think hope arises, say, at the moment I tell them that I once sat at that table and now everything turned out well...Many people are looking for something to hold onto, especially in times when they feel lost.*" Peer workers also shared their own experiences with clients, for example, of how they handled a specific situation, so clients can learn from them. Peer workers usually shared their experiences only when they thought it would be helpful for their clients. Peer workers elucidated that they consciously and carefully choose what kind of experiences they shared with whom and when. They, for example, tried to pick out the positive things when they told about their recovery and only shared the negative parts over time, when their client was doing better and if it was of added value.

Table 2. Overview of critical elements of intentional unidirectional peer support for homeless people perceived by clients and peer workers.

Critical elements	**Aspects**
Being there	• Making contact and show interest in client [2] • Providing a listening ear • Having plenty of time for client • Sincerely caring for client's well-being
Understanding	• Expressing understanding of client's situation • Deeply understanding the client's situation, based on shared experiences • Acknowledging client's difficult situation
Being accessible and available	• Being available when client needs it • Being accessible after office hours • Keeping in touch after client's trajectory ends
Providing comfort and a personal connection	• Having a special connection with client • Keeping less distance (compared to other professionals)[2] • Being trustworthy for client, because of shared experiences • Actively building a trusting relationship with client [2]
Having an equal relationship	• Accepting client for who he/she is, without being judgmental • Treating client as a person and not as a number • Putting needs and goals of client first
Role modeling	• Sharing own experiences to help clients [2] • Being a role model
Stimulating and empowering	• Validating and reinforcing client's behavior • Expressing to clients that they matter • Motivating clients to work on their recovery • Providing client with informational support about recovery • Expressing to client that he/she is responsible for his/her own recovery • Confronting client with his/her nonconstructive behavior
Providing practical support and developing better life circumstances	• Providing tips and advice for everyday problems • Providing practical support [2] • Supporting client with establishing meaningful daily activities • Supporting client with forming and strengthening social network
Supporting client-professional relationship	• Mediating between client and professional
Supporting clients with care trajectories	• Supporting client with care trajectories within and outside the organization • Supporting client with problems within care trajectories • Aiding client by working together with professionals on client's trajectory [2] • Educating professionals about client's problems [2]

[2] Peer workers only

Stimulating and Empowering

Many participants described how clients valued the way peer workers validated and reinforced clients throughout their recovery process, by saying things that increased their self-esteem, and providing encouragement to work through their difficulties. Various participants mentioned that peer workers also provided informational support about recovery by advising them, for example, to formulate specific and achievable recovery goals, and to not look too far ahead. Furthermore, participants described that peer workers helped clients to persist and stick with their recovery goals, like a client mentioned: "*Then he says like: 'Hey, your time will come, you'll have to bite the bullet just a little bit longer. And stick to your goal, go for it.' Because well, I'm actually not at the right place now. For me this is actually more of a transitional step to real life again.*" Occasionally peer workers were asked by other professionals in their organization or team to help persuade clients to participate in essential parts of their care trajectory. Participants also described that peer workers tried to activate clients by expressing to the client that they are responsible for their own recovery. Also, some participants mentioned that the peer worker confronted or corrected clients when their behaviors had a negative influence on their well-being and recovery process, as a peer worker stated: "*At a certain point I just confront them and say: 'Ok, these are the steps you should take, I also made these steps.' Sometimes you have got to be honest, that's all part of the game, they're going to have to bite the bullet.*"

Providing Practical Support and Developing Better Life Circumstances

Several participants described that the peer worker advised clients with everyday problems, peer workers also mentioned that they offered clients practical support if needed, such as assistance with their administration. This practical support was still provided after clients had exited the shelter, as a peer worker exemplified: "*I recently helped someone move out. Yes, those things, these are also just part of my work, right… He was standing there obviously with all his belongings and he had to get from A to B.*" Some participants described that the peer worker helped clients establish meaningful daily activities, by exploring their capabilities and preferences regarding hobbies, work or other activities. Some participants mentioned that peer workers also supported clients with forming and strengthening their social network.

Supporting Client-Professional Relationship

Several participants mentioned that the peer worker acted as a liaison and mediator between the client and his professional caregiver, for instance, by trying to explain to a colleague how a client sees something or vice versa. When problems arose within the relationship between the client and his professional caregiver, peer workers often helped clients to solve these problems: "*We receive a lot of complaints from clients about professionals. So, when we receive a complaint, first we look at what is exactly going on and then we try to mediate between both parties. This usually results in the complaints being settled.*"

Supporting Clients with Care Trajectories

Most participants felt that peer workers supported clients with all kinds of issues associated with their care trajectories within and outside their organization. They helped clients for example with navigating the social care and mental health system to get them the services they needed, finding treatment for physical problems or applying for housing. Many participants reported that peer workers helped clients to solve problems that arose within their care trajectories and that they aided clients by working together with other professionals on a clients' trajectory: "*When regular professionals run into a problem with their client, they ask us (peer workers) to assist within the client's care trajectory or to work alongside them when this problem is being discussed within a team meeting.*" Peer workers described that they were actively involved in educating professionals about certain difficulties or mental health problems that clients experience, such as addiction or self-mutilation, in order to create a greater understanding among professionals of how to effectively support clients with these problems.

Working Mechanisms of IUPS

Based on an exploration of the interaction between the above-mentioned outcomes and critical elements of IUPS as perceived by homeless people and peer workers, three mechanisms were identified that make IUPS work for homeless people: Rapport and empathy, Trusting and empowering relationship and Support, guidance and mediation (Figure 1).

Rapport and Empathy

Because peer workers build rapport, offer a listening ear and sincerely care for clients' well-being, the clients feel they are being taken seriously and appreciated, and that an effort is being made for them. These feelings are reinforced by the fact that peer workers often have ample time for clients and are available outside office hours. Peer workers deeply understand the difficult situation the clients are in, and by sharing their experiences with clients consciously and carefully they validate and empower clients' experiences and needs. Explicitly acknowledging the client's difficult situation and the challenges in their process of recovery further validates their experiences. The genuine and reciprocal interaction between the two increases clients' self-esteem, self-worth and self-respect, which also leads to more self-acceptance and acceptance of their own situation.

Trusting and Empowering Relationship

Because peer workers actively work on establishing a trusting and secure relationship and keep less "distance" from clients compared to other professionals, clients tend to confide in peer workers rather quickly, open themselves up and share their experiences with peer workers. Being treated as an equal person without being judged and not being treated as "a number" underpins this trusting and secure relationship as well. This relationship encourages clients to regain hope, set small goals, and work towards realizing them. Their trust in the peer worker, based on having shared experiences, also makes clients take on the peer workers' advice quickly. They accept peer workers being critical and addressing and confronting their nonconstructive behavior. Peer workers also express to clients that they matter, they actively motivate clients to work on their recovery and further empower them by providing clients with informational support about recovery. This comforting and nurturing relationship also provides possibilities for self-reflection and learning, and stimulates and motivates clients to grow and progress in their recovery process step by step and day by day. The fact that peer workers put clients' needs and goals first helps herein as well. Peer workers also function as role models providing clues as to how to go about certain challenges and showing that things could actually turn out well in the end, generating a more positive perspective on the future.

Support, Guidance and Mediation

In order to develop better life circumstances for clients and to let them progress in their recovery process, peer workers provide clients with all sorts of practical support, such as tips and advice for everyday problems, support with establishing meaningful daily activities and support with strengthening their social network. The knowledge that they are no longer alone in life and that they can turn to the peer worker for help and advice with all sorts of problems, eases the difficulties they face during their recovery process, and makes clients feel more resilient, more self-confident, and more positive about their future. Supporting clients with their care trajectories and with their relationships with other professionals, also makes clients engage with services they need. The peer workers' own experiences with and knowledge of care trajectories enables them to provide clients with useful advice and support as regards their contact with professionals and organizations. When clients experience problems within care trajectories or with other professionals, peer workers act as mediators between clients and professionals, making sure that clients obtain and maintain the right care. In order to maintain and improve the quality of care for clients, peer workers also educate other professionals about clients' problems and advice and assist other professionals in working on clients' care trajectory.

Figure 1. Outcomes, critical elements, and working mechanisms of intentional unidirectional peer support in homeless services, based on clients and peer workers experiences.

Discussion

This is the first study to qualitatively examine the outcomes, critical elements and working mechanisms of IUPS for homeless people from the perspective of both clients and peer workers. Both groups mentioned the same outcomes and critical elements of IUPS. However, certain aspects of outcomes and critical elements were only mentioned by a single group. The inclusion of both perspectives has therefore provided a more complete understanding of the identified outcomes and critical elements of IUPS.

Regarding the outcomes of IUPS, the findings of this explorative study show that homeless people and peer workers perceive a more positive self-image, personal growth and better engagement with services as valued outcomes of IUPS. For the outcome personal growth, the aspects increased acceptance of self and own situation and feeling more resilient were only mentioned by clients and the aspect feeling more positive about the future was only pointed out by peer workers. Until now, there was insufficient knowledge about the outcomes of IUPS for homeless people, because, as was mentioned in the introduction, most previously conducted quantitative studies described various types of IPS and had substantial methodological limitations (Barker & Maguire, 2017). Furthermore, the few qualitative studies that have been carried out did examine the outcomes of IUPS (Barker et al., 2018; Croft et al., 2013), but only from the peer worker's perspective and did not, as in this study, examine the outcomes for clients and from both perspectives. Nevertheless, the aspects of the outcomes of IUPS for homeless people that we identified in our study are much in line with the outcomes found for peer workers in homeless settings, namely, perceived empowerment, identity integration, enhanced self-esteem, and confidence (Barker et al., 2018; Croft et al., 2013). The findings also compare well with the positive recovery related outcomes found among people with mental health problems, such as increased hope, empowerment, self-esteem, self-efficacy, self-management, and feeling better understood by the peer worker but differ from the reported outcomes regarding increased social inclusion and increase in community involvement (Chien et al., 2019; King et al., 2018; Lloyd-Evans et al., 2014; Pitt et al., 2013; Repper & Carter, 2011).

This study also identified critical elements of IUPS: Being there, Understanding, Being accessible and available, Providing comfort and a personal connection, Having an equal relationship, Role modeling, Stimulating and empowering, Providing practical support and developing better life circumstances, Supporting client-professional relationship and Supporting client with care trajectories. For the critical elements, Being there, Providing comfort and a personal connection, Role modeling, Providing practical support and developing better life circumstances, and Supporting client with care trajectories certain aspects were only mentioned by peer workers. Regarding Providing comfort and a personal connection for example, the aspects Keeping less distance (compared to other professionals) and Actively building a trusting relationship with client were solely described by peer workers. Concerning the critical element Supporting client with care trajectories for instance, peer workers only mentioned the aspects Aiding client by working together with professionals on client's trajectory and Educating professionals about client's problems.

The critical elements found in our study seem to coincide with critical elements revealed by peer workers providing IUPS within homeless services as studied by Barker (2018) who used slightly different terms and categorizations: (1) Peer-client relationship; (2) Role modeling; and (3) Experiences based support (Barker, 2018; Barker et al., 2019). In addition to this earlier research, the current study found that participants explicitly, and highly, valued peer workers being present—Being there—and within easy reach—Being accessible and available. The fact that those elements seem rather obvious and basic in providing support to clients, might have been a factor that could explain why Barker (2018) did not identify these elements as separate critical elements of IUPS.

By combining the three outcomes and the ten critical elements as perceived by clients and peer workers, three working mechanisms of IUPS emerged: Rapport and Empathy, Trusting and Empowering Relationship and Support, Guidance and Mediation. The results demonstrate in particular that the quality of the relationship between clients and peer workers is vital to make IUPS work. These results are much in line with previous research about the processes of IUPS within mental health care, showing that clients particularly benefited from practical, emotional, and social support, valued "having someone to rely on, a friend, and someone to socialize with" and esteemed having a non–treatment-based, normalizing relationship (Gidugu et al., 2015). The findings of this study also underline the importance of applying strengths-based approaches such as "Pathways to Empowerment" (Wolf, 2016) that emphasize, for example, the importance of focusing on the client's strengths and assets, building a trusting relationship with them, supporting the client in her/his process of recovery, and taking the client's needs and goals as a starting point for the support provided.

Strengths and Limitations

This study has several strengths. First, to our knowledge, this is the first study that examined the outcomes and the critical elements of IUPS for homeless people from the perspective of the clients as well as the perspective of the peer worker and compared both insights. Additionally, the interaction between the outcomes and critical elements of IUPS were explored, resulting in three mechanisms that make IUPS work for homeless people. These findings contribute to the still under-researched area of IUPS within homeless populations and provide an experience-based grounding for IUPS with clues for its development and improvement. Another strength of this study is the rigor of the data collection and data analysis. For example, the following procedures were applied: anonymous transcription of each interview, making field notes after each interview, thick description, in-depth and independent data analysis by two researchers and peer review and debriefing with the senior researcher and the professor. This significantly increased the reliability of our findings.

This study has several limitations as well. First, we conducted a fixed number of interviews (ten clients and ten peer workers) and did not have the possibility to interview more people, which is not ideal reaching code and meaning saturation. In this study, code saturation was reached at seventeen interviews, but it was not always clear whether meaning saturation was reached. Previous research found that high prevalence codes generally reach meaning saturation at around nine interviews and that low prevalence codes mostly require between sixteen and twenty-four interviews (Hennick et al., 2017). This implies that the twenty interviews performed in this study should have been sufficient in reaching meaning saturation for most codes. In order to be sure of meaning saturation, future research should not start the study with a fixed number of interviews but should leave the number of interviews open until this has been reached for all codes. Second, clients were recruited by their peer worker. This might have led to some selection bias, for example resulting in a more positive perspective on IUPS when clients with high appreciation for their peer worker or clients who have benefited relatively much from IUPS may have been more willing to participate. Also, clients who, from the viewpoint of the peer worker, were considered to be less able to reflect on their personal experiences may not have been asked to participate in this study. It is unknown if selection bias, perhaps also for other reasons, have occurred. Despite these potential limitations, the rigor of the data collection and data analysis strengthen the credibility and value of the results.

To increase the transferability of the findings, a variety of residential care services throughout The Netherlands were included, such as generic residential care services for homeless people and residential care services specifically aimed at homeless people with addiction problems and severe mental health problems. However, the results of this study might not be entirely applicable to IUPS provided in other types of homeless services, such as emergency shelters or night shelters, as homeless people residing in such accommodations might have other or additional support needs. Also, because this study specifically examined IUPS, the findings are not expected to fully match other forms of peer support within homelessness services, such as peer support groups led by peer workers. Moreover, all peer workers included in this study had received higher or intermediate professional training in peer support work or had almost finished this training. This implies that IUPS examined in this study was of a certain quality that is not necessarily comparable with other forms of IUPS, such as IUPS provided by peer workers who had not received professional training in peer support work or peers providing mutual support.

Implications for Practice

The findings of this study could help homeless services to optimize IUPS in order to make it work for homeless people. This study shows IUPS for homeless people is greatly valued by clients and peer workers, indicating that IUPS could be considered an important addition to the spectrum of care provided by professionals. Implementing IUPS as standard care thus would further advance care provision within homeless services, provided that organizations will ensure that IUPS is effectively implemented within their services. Organizations should for example use a clear job description with relevant competencies for peer workers providing IUPS and ensure that they are able to use these competencies (which they have obtained through their life experiences and training), instead of being assigned tasks that other professionals are too busy to perform (such as providing clients with transportation when they move out; Davidson et al., 2012). Furthermore, the results of this study suggest that organizations should make sure that peer workers have and retain ample time to “be there” for clients, for instance by preventing high caseloads for peer workers. Organizations should also formally allow and support peer workers being available for clients after office hours or after clients have exited a shelter, if they think this could benefit clients. At the same time, organizations should assist peer workers in maintaining a sound work-life balance, as research shows that role and time boundaries can be a concern for peer workers providing and clients receiving peer support (Gidugu et al., 2015; Miyamoto & Sono, 2012). Additionally, reducing caseloads for other professionals might be beneficial for clients as well, as our results show that the clients feel that other professionals are often too busy to just be there for them and therefore highly value peer workers having ample time for them. When other professionals have more time available for their clients, this could lead to clients feeling listened to and valued as a human being.

The results of this study also suggest that clients could benefit from grounding service provision within homeless services more on an equal footing. Organizations could for example make all professionals aware of the importance of a trusting and equal working relationship and could specifically encourage other professionals to act in a less reserved way when it comes to sharing their personal experiences with clients. This approach, however, is still quite unlike current daily practice within care services for homeless people. During their professional training and in the workplace, professionals are taught to not disclose their personal experiences to clients, while sharing these experiences could in fact be beneficial for clients (Weerman, 2016). However, like peer workers in the current study already indicated, professionals should only share their personal experiences when they think this would be beneficial for clients.

This study showed that peer workers are involved in educating professionals about certain challenges that clients face in their process of recovery and are asked to inform and aid other professionals in dealing with these challenges. This suggests the value of experience-driven service provision and the need among other professionals to learn more about what it takes to recover and what challenges clients are confronted with within this process.

Conclusion

Homeless people and peer workers greatly value the outcomes and workings of IUPS. Rapport and empathy, a trustworthy and empowering relationship, and support, guidance and mediation are what makes IUPS work. Intentional unidirectional peer support in homeless services enhances client's self-image, advances their personal growth and results in better engagement with needed services. Intentional unidirectional peer support should therefore be considered standard support in service provision for the homeless.

References

Barker, S. L., (2018). *Peer Support and Homelessness*. (Doctoral dissertation, University of Southampton, United Kingdom). Retrieved from: https://eprints.soton.ac.uk/429021/1/Barker_PhD_Thesis_Final.pdf. doi:10.5258/SOTON /D0649

Barker, S. L., & Maguire, N. J. (2017). Experts by experience: Peer support and its use with the homeless. *Community Mental Health Journal, 53(5),* 598–612. doi: 10.1007/s10597-017-0102-2

Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. (2018). Peer support critical elements and experiences in supporting the homeless: A qualitative study. *Journal of Community & Applied Social Psychology, 28*(4), 213-229. doi: 10.1002/casp.2353

Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. L. (2019). Expert viewpoints of peer support for people experiencing homelessness: A Q sort study. *Psychological Services, 16*(3), 402–414. doi: 10.1037/ser0000258

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. doi: 10.1191/1478088706qp063oa

Chien, W.T., Clifton, A.V., Zhao, S., & Lui, S. (2019). Peer support for people with schizophrenia or other serious mental illness. *Cochrane Database of Systematic Reviews 2019, 4*. doi: 10.1002/14651858.CD010880.pub2

Coatsworth-Puspoky, R., Forchuk, C., & Ward Griffin, C. (2006). Peer support relationships: An unexplored interpersonal process in mental health. *Journal of Psychiatric and Mental Health Nursing, 13*, 490–497. doi: 10.1111/j.1365-2850.2006.00970.x

Croft, L. A., Hayward, A. C., & Story, A. (2013). Tuberculosis peer educators: personal experiences of working with socially excluded communities in London. *International Journal of Tuberculosis and Lung Disease, 17*(10 Suppl 1), 36-40. doi: 10.5588/ijtld. 13.0309

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry, 11(2),* 123-128. doi: 10.1016/j.wpsyc.2012.05.009

Gidugu , V., Rogers, E.S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal, 51*, 445-452. doi: 10.1007/s10597-014-9801-0

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: desperately seeking an overdue paradigm shift. *BMC Medicine, 16,* 95. doi: 10.1186/s12916-018-1089-4

Hennick, M.M., Kaiser, B.N., & Marconi, V.C. (2017). Code saturation vs. meaning saturation: How many interviews are enough? *Qualitative Health Research, 27*, 591-608. doi: 10.1177/1049732316665344

King, A.J., Thy, B.O., & Simmons, M.B., (2018). A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions. *Psychiatric Services, 69*, 961–977. doi: 10.1176/appi.ps.201700564

Lloyd-Evans et al. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry, 14*:39. doi: 10.1186/1471-244X-14-39

Mannell, J., & Davis, K. (2019). Evaluating complex health interventions with randomized controlled trials: How do we improve the use of qualitative methods? *Qualitative Health Research, 29*(5), 623–631. doi 10.1177/1049732319831032

Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature. *Clinical Practice and Epidemiology in Mental Health, 8*, 22–29. doi: 10.2174/1745017901208010022

Morse, J. M. (2010). How Different is Qualitative Health Research From Qualitative Research? Do We Have a Subdiscipline? *Qualitative Health Research, 20*(11), 1459–1464. doi:10.1177/1049732310379116

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends,_L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews 2013,3*. doi: 10.1002/14651858.CD004807. pub2

Rapp, C. & Goscha, R. (2012). *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services*. New York: Oxford University Press. doi: 10.1080/15487768.201 3.818884

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20 (4)*, 392-411.doi: 10.3109/09638237.2011.583947

Trainor, J., Shepherd, M., Boydell, K.M., Leff, A., & Crawford, E. (1997). Beyond the service paradigm: The impact and implications of consumer/survivor initiatives. *Psychiatric Rehabilitation Journal, 21*, 132–140. doi: 10.1037/h0095328

Walker, C., & Peterson, C. L. (2021). Where does value lie in peer support? An exploratory discussion of the theories and methods underpinning effective research in peer support. *Qualitative Health Research, 31*(2), 218–227. doi: 10.1177/1049732320964173

Watson, E. (2019). The mechanisms underpinning peer support: a literature review. *Journal of Mental Health, 28*, 677-688. doi: 10.1080/09638237.2017.1417559

Weerman, A. (2016). *Ervaringsdeskundige zorg- en dienstverleners: Stigma, verslaving & existentiële transformatie.* (Doctoral dissertation, Vrije Universiteit Amsterdam, The Netherlands). Retrieved from https://research.vu.nl/ws/portalfiles/portal/42162914/complete+dissertation.pdf.

Wolf, J. (2016). *Krachtwerk, methodisch werken aan participatie en zelfregie.* Bussum: Uitgeverij Coutinho.

Chapter 5

The wishes, perceived barriers, and support needs of people living in persistent poverty

Schel, S.H,H.†, Scholten, L.†, Van den Dries, L., Fransen-Kuppens, G.A.J., De Vet, R., & Wolf, J.R.L.M. †These authors contributed equally to the study
The wishes, perceived barriers, and support needs of people living in persistent poverty.
(Submitted)

Abstract

This study explores the wishes of people living in persistent poverty, the barriers they perceive and the support they need for realizing these wishes. A comprehensive understanding of these wishes, barriers and support needs is absent, whereas this is essential for developing appropriate and effective support for this group. Between March and July 2021, digital semi-structured interviews were conducted with people living in persistent poverty (n=14), peer workers (n=5) and practitioners (n=5) in five municipalities in the Netherlands. A combination of inductive and deductive data analyses showed that wishes centered around improving socio-economic security (i.e., financial security, adequate housing, labor market participation and social participation), improving the well-being of oneself and of loved ones (i.e., physical health, psychological well-being, well-being of children), and improving relatedness (i.e., to matter, being heard and seen, being trusted, social contacts and social support). The realization of these wishes is hindered by socio-economic barriers (e.g., lack of financial means), support structures (e.g., non-structural support, limited availability and accessibility of support and healthcare, welfare laws, institutional distrust), a reality gap, and psychological processes (e.g., chronic stress, trauma, lack of energy, hopelessness, fear, feelings of inferiority). Participants therefore advocated for structural changes in policy and practice. These include increasing the income of people living in poverty, focusing on poverty prevention, improving easy access to and use of support, offering tailor-made support, adopting institutional trust, and reducing the gap between the realities of people living in poverty, and the realities of policy makers and practitioners. In addition, service provision for people living in persistent poverty should engage peer workers, be holistic, be based on self-direction, and prioritize the quality of the working alliance between clients and practitioners (e.g., based on trust, equality, empathy).

Introduction

In 2021, approximately 73.7 million people in the EU were living in poverty (at-risk-of-poverty rate, Eurostat, 2021a). In the Netherlands, the number of people living in poverty is estimated at 2.5 million, which is about 1 in 7 people (Eurostat, 2021b). In over half of these cases, poverty is persistent for at least three consecutive years (Van Hulst & Hoff, 2020). Living in poverty has detrimental consequences for the quality of one's daily life. Poverty, especially when persistent, is related to worse physical and mental health outcomes (Kahn & Pearlin, 2006; Richardson et al., 2013), higher stress-levels (Haushofer & Fehr, 2014), and lower levels of self-regulation and perceived control (Evans & Kim, 2012; Price et al., 2002). Poverty has also been associated with impaired cognitive functioning (Mani et al., 2013), weaker social relationships (Mood & Jonsson, 2016), feelings of social exclusion (Marttila et al., 2010), and domestic violence (Marttila et al., 2013; Taylor & Barusch, 2004). These disadvantages tend to accumulate (Marttila et al., 2013; Taylor & Barusch, 2004), and shape the opportunities of future generations, as growing up in poverty predicts a lower well-being in adulthood (Crouch et al, 2020). Poverty is consequently considered both a widespread and enduring public health problem (Price et al., 2018) and an extreme form of social exclusion (Watson et al., 2016). It is therefore crucial to facilitate appropriate and effective support to improve the quality of life of people living in persistent poverty (next: PLPP).

The question of what appropriate and effective support for PLPP entails, has resulted in valuable studies into the impact of interventions on PLPP's well-being (e.g., experiments with more autonomy and trust-based social assistance, cash transfer experiments, and service provision interventions such as Mobility Mentoring®; Betkó, 2023; McGuire et al., 2022; Thomson et al., 2022; Washington State, Department of Children, Youth, and Families, 2018). With this study, however, we aim to take a step back and first explore what it is that PLPP wish to see differently in their lives, irrespective of such interventions. Founding support for PLPP on their wishes is imperative, because wishes function as key motivators in the recovery process of individuals in vulnerable conditions (Lai et al., 2021; Wolf & Jonker, 2020). In addition, the ability and opportunity to pursue one's own wishes has been associated with better well-being and performance (Deci & Ryan, 2000; Sheldon et al., 2004; Vansteenkiste et al., 2004).

The wishes of PLPP, however, remain largely unknown. Wishes refer to individuals' needs (i.e., that what is essential for survival) and their wants (i.e., individual desires). In contrast to the concept of wishes, the concept of needs has received much academic attention over the years. Maslow (1943) for instance developed a hierarchy of needs, Doyal and Gough (1984) coined a theory of human need deeming health the most basic of needs, Deci and Ryan (2000) discerned basic psychological needs of competence, autonomy and relatedness, and Nussbaum (2000) created a list of basic capabilities. These theories are nevertheless considered to reflect universal needs, and hence do not provide the in-depth insight into the wishes of the group of PLPP that is essential for developing appropriate support.

The extent to which PLPP can realize their wishes is strongly affected by various individual and environmental barriers. Such barriers have been mapped for PLPP regarding their access to healthcare and public services, and include for instance feelings of shame, fear of losing custody of their children, fear for being misunderstood and judged, perceptions that support does not match their individual needs, complex administrative procedures, and high costs (Canvin et al., 2007; Loignon et al., 2015; Williamson et al., 2006). The identified support needs of PLPP – i.e., the support they need to overcome these barriers and realize their wishes – are mostly an extension of these barriers (e.g., affordable healthcare, tailor-made support, more flexible rules for using support) (Gupta & Holloway, 2016; O'Donnell et al., 2016; Williamson et al., 2006). In addition, support needs of PLPP have been addressed in evaluation studies. These for instance show that PLPP value practitioners who are empathic and caring, who listen and respect them, and who show them that they matter (O'Donnell et al., 2016; Williamson et al., 2006).

To our knowledge, the wishes of PLPP have not yet been systematically explored, nor have they been linked to their perceived barriers and support needs. This study aims to fill this knowledge gap by exploring (1) the wishes of PLPP, (2) the barriers they perceive for realizing these wishes, and (3) the support they need to fulfil these wishes, from the perspectives of PLPP, peer workers and practitioners. Combining these perspectives facilitates the broad and integrated approach needed to improve support for PLPP and increase their quality of life (Marttila et al., 2013; Taylor & Barusch, 2004).

Methods

Design

This study was part of a larger research project investigating the constituents of appropriate support for PLPP and its impact on PLPP's quality of life. The current qualitative study applied a collaborative approach by involving peer workers throughout the research process (i.e., developing information letters and data collection tools, data collection). Semi-structured interviews were conducted to examine the perspectives of PLPP (n=14), peer workers (n=5) and practitioners (n=5) regarding the wishes, perceived barriers, and support needs of PLPP.

Ethical approval, quality criteria and research team

This study was exempted from formal review by the accredited Medical Review Ethics Committee region Arnhem-Nijmegen (file number 2020-7030). All participants received written and verbal information about the study's aim and procedure, and their right to withdraw at any time, without giving any reason. Participants were aware that their participation was voluntary and they gave audio-recorded verbal informed consent.

At the start of the study, participants were assigned a research ID, ensuring anonymity during the process of data collection, analysis and storage. Only the research team had access to the data and key file, which were stored separately. The research team consisted of two peer workers, two researchers, three senior researchers, and a professor of social care (Principal Investigator). The interviewers were experienced in interviewing people living in vulnerable conditions, ensuring the presence of important skills required for qualitative health researchers (Morse, 2010).

Participants and setting

PLPP could participate if they were at least 18 years old, had legal residence in the Netherlands, were fluent in Dutch, and living in persistent poverty. The latter was defined as having had insufficient financial resources to pay for monthly necessary expenses for living and social participation for at least three consecutive years between 2016 and 2020 ('not-much-but-sufficient' criterium, see Goderis et al., 2019). Potential participants who were unable to provide reliable information according to the recruiting practitioner (e.g., due to an active psychotic episode) were excluded from this study. Eligible peer workers had personal experience with living in persistent poverty, and had received professional training in peer support work. Practitioners (either with or without personal experience with persistent poverty) were required to be professionally trained and have a paid job in service provision to PLPP.

Participants were recruited in the five Dutch municipalities that participated in the larger research project (Groningen, Meppel, Midden-Groningen, Nieuwegein, Nijmegen), and in surrounding municipalities.

Recruitment

Participants were recruited via purposeful sampling. In each municipality, a gatekeeper (i.e., a contact with access to the target population) recruited participants from various sites (e.g., social work team, financial support organization). Peer workers and practitioners were recruited by gatekeepers and research team members; PLPP were approached by practitioners selected by gatekeepers. Potential participants were verbally informed about the study and received an information letter. If potential participants expressed interest to participate, their contact details were shared with the researchers. A researcher then contacted them to explain the study aims and interview procedure again, and to answer any questions. An interview appointment was scheduled with those who agreed to participate.

Interview guide and data collection

Interviews took place between March and July 2021 via video call, as face-to-face interviews were not feasible due to restrictions following the COVID-19 pandemic. The interviews covered the following topics: wishes, perceived barriers, and support needs. Interviews with PLPP were conducted both by a researcher and peer worker. To explore their wishes, PLPP were asked: "What are your wishes for the future? What do you want to change or achieve in your life?" and "why do you want to change this?". Perceived barriers were examined by asking: "What makes it difficult for you to fulfill your wishes? What do you perceive as major bumps in the road?". Support needs were investigated by asking: "What do you think is needed to fulfill your wishes for the future? What would help you to realize them?". For peer workers and practitioners, the questions were adjusted to their role, for example: "What do you think are the wishes of your clients living in persistent poverty?".

After each interview, the researcher and peer worker discussed the interview (i.e., peer debriefing) to ensure consistent performance across interviews, to check whether the interview questions should be altered, and to assess the reliability of the interview. This did not lead to any changes in the interview guide or procedure, or to exclusion of interviews. The audio-recorded interviews took, on average, 100 minutes (range: 75-125 minutes) for PLPP and 90 minutes (range: 74-100 minutes) for peer workers and practitioners. Interviews were transcribed verbatim and anonymized. To thank participants, PLPP received a fifty-euro gift card. Peer workers and practitioners received a twenty-five-euro gift card.

Data analysis

Data analyses ware supported using a qualitative data analysis software program (Atlas.ti version 7). The transcripts were analyzed using both an inductive ('conventional thematic content analysis') and deductive ('directed content analysis') approach, as described by Braun and Clarke (2006). More specifically, we used open, axial and thematic coding to identify the wishes, perceived barriers and support needs of PLPP. In order to minimize the subjectivity of our findings, two researchers independently coded the first four transcripts line-by-line (two with PLPP, one with a peer worker and one with a practitioner). Next, they reviewed the meaning and uniqueness of the initial codes and agreed upon an initial coding scheme. This coding scheme was then discussed with a third researcher and the principal investigator, and adapted until consensus was reached. In each of the subsequent two analysis rounds, the two researchers coded five different interviews and repeated the review and adaption process described above. This resulted in a final coding scheme describing the wishes, perceived barriers and support needs of PLPP on three themes, which were identified during the coding process. A member check with two peer workers took place to validate the final coding scheme.

Results

Characteristics of participants

Participants living in persistent poverty (*n*=14) were mostly female (*n*=10), born in the Netherlands (*n*=10), and had an average age of 46 years (range: 33-63 years). Our sample included singles (*n*=5), single parents (*n*=5), participants living with a partner (*n*=1), and participants living with a partner and children (*n*=3). They completed lower education (*n*=5), intermediate education (*n*=6) or higher education (*n*=3). Some participants had a paid job (*n*=2) or volunteered (*n*=6). Most had been living in poverty for much longer than 3 years – even up to approximately 25 years. Self-reported causes include intergenerational poverty and life events such as job loss, illness and divorce.

Peer workers (*n*=5) were mostly female (*n*=4), completed lower education (*n*=2), intermediate education (*n*=2) or higher education (*n*=1), and had an average age of 58 years (range: 50-63 years). They worked as experts by experience, social workers and public servants to improve support for PLPP.

All practitioners (*n*=5) were female, received professional training in social work or a related professional area, and were, on average, 40 years old (range: 29-51 years). Practitioners supported PLPP as counsellors, consultants and coaches, for instance with legal issues, debt and finances. One practitioner also had experienced persistent poverty at some point in her life.

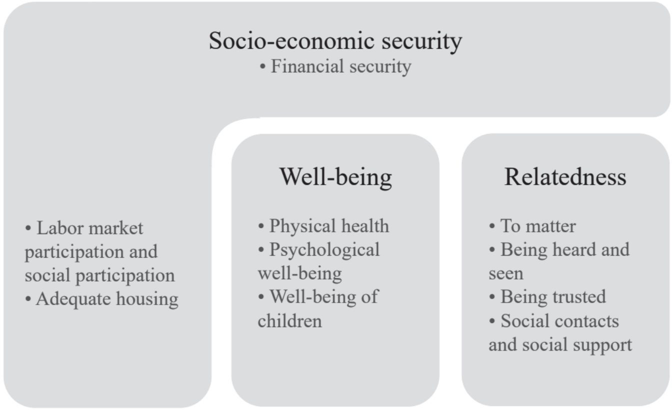
Themes regarding wishes, barriers and support needs

Initially, multiple PLPP found it difficult to express their wishes. Some indicated they had never really thought about their wishes for the future, which peer workers and practitioners explained was a result of having no cognitive space. Others deliberately chose not to dream as a form of self-preservation, explaining that daring to have wishes would only cause disappointment when they could not be fulfilled. However, as the interviews progressed, all PLPP managed to formulate at least one wish.

> *You don't have the freedom to dream because – yes, that's very scary. Then you dream about something you cannot make come true, something that is unattainable. That becomes very painful. You may do that for a while in your younger years, but you quickly learn to stop dreaming, because it's just not achievable when you have little money and don't count.* (Peer worker, 02601)

From the wishes expressed by PLPP, peer workers and practitioners, three overarching themes emerged. These themes concern socio-economic security, well-being, and relatedness, which are visualized in Figure 1. Socio-economic security refers to wishes regarding individuals' financial security, living conditions and participation; well-being indicates wishes regarding physical and psychological well-being of oneself and of loved ones; and relatedness specifies wishes regarding individuals' relationships with themselves and their environment, including network members, (governmental) organizations and society at large. These wishes are discussed in relation to the barriers that obstruct them and the support they need for realizing these wishes.

Figure 1. Themes and subthemes regarding the wishes of PLPP.



Socio-economic security

Wishes

Almost all participants expressed that PLPP wished for financial security. This means they wished to experience peace of mind regarding their finances, and to have enough money to fulfill their basic needs, including paying their bills, buying food, using necessary healthcare, and supporting their children's needs.

> *Still, all I want is just a job and sufficient income to live a normal life, without having to use the calculator ten times to see: 'oh, what do I still have to pay?', and 'oh, what do I have left? Can I get a winter coat or shoes this month? Just that you're always preoccupied with money. Money, money, money, money.* (PLPP, 01401)

Financial security was considered one of the most important wishes of PLPP, as it was mentioned to be a prerequisite for realizing their other wishes:

> *You always need to have income if you want to move forward. If you don't have money, you won't survive. That's what it always comes down to. If I don't have money, I can't live a healthy life, I can't buy expensive vegetables. If I don't have money, I can't use healthcare, because I can't pay my health insurance. I can't exercise, I can't... I could list everything. I can't go to my family and friends by car, because they live 170 kilometers away. I can't afford gas. My partner – well, you don't feel like having a relationship because your situation is already so terrible at home, so to speak. Children – yeah, they're great, but I don't have time for them because my head is full. So I take it all out on my children. [...] If there is no income, you can't do anything.* (PLPP, 01501)

In addition, participants often indicated they wanted to be (self-)employed, do volunteer work or follow a study program or training course. These wishes for labor market participation and social participation were most often described as means to achieve financial security, but also served to fulfill wishes for psychological well-being and relatedness, including having structure in their daily lives, feeling useful, having a purpose, stimulating personal development, being a role model for their children, feeling of value, and having social interactions. In addition, participants expressed they wished to participate in hobbies, sports, and social activities.

> Interviewer: Why is having a routine [...] so important to you?
> *Participant: [...] I think I've have been working since I was 15. And I've never been without work for this long, and I also notice that, yeah, then I stay in bed until 11 am or 4 pm, because there's nothing else to do. And you have no reason to get up and you feel bad about everything. You worry. So, in order to have motivation again, to have work and to get up on time and get into that routine. To do it for something again.* (PLPP, 01502)

Furthermore, some participants mentioned they wanted to improve the livability of their homes (e.g., adding necessary furniture, painting walls), to be able to cohabitate with their partner, and to move to another house, for instance to better fit their family or regain a sense of safety.

Barriers

Firstly, participants explained that PLPP are hindered from realizing financial security, because their income (i.e., minimum wage, welfare benefits, weekly allowances) is simply too low to pay the basic costs of living. In addition, while some participants mentioned their strong budgeting skills and creative financial solutions, others discussed the trouble they had in handling the little amount of money they had. They, for instance, made financial decisions that were beneficial in the moment (e.g., to feel good or pay off a debt while having insufficient funds) but not in the long run, or did not do their financial administration out of fear of failing or facing their financial situation.

Another barrier for realizing financial security pertains to the type of available financial support as well as the limited offer of, access to and use of financial support. Some commented that certain measures, like the possibility to request a laptop when needed, were merely seen as poverty management, and were insufficient to structurally improve individuals' financial situation. Others shared they 'fell through the cracks', as those who live on or just above the official poverty line did not qualify for any form of financial support, or because initiatives were available for children only. Moreover, participants often did not use available financial support. Some were not aware of all the measures they were entitled to; others were discouraged by the amount and complexity of administrative work it took to apply. In addition, long processing times before support is granted, geographical remoteness of support organizations, participants' wish to be self-reliant, to maintain a sense of pride and autonomy, feelings of shame about their financial situation, and feelings of distrust and disappointment towards local authorities and support organizations, also hindered them in using available support.

> *Right at the beginning when I was on welfare, I once requested exemption from municipal taxes and things like that. Let me tell you, that is a lot of work. Paperwork. I understand that they don't make it too easy, but it takes a really long time and it's a lot of work. And in the end, it's rejected. So, on the one hand, I'm fortunate enough to be familiar with the Internet and I do read up on things [on the available support options]. I can imagine that people who are less educated, may not know about many of the rules. And on the other hand, the rules that do exist, are so complicated that at some point, you just think: never mind.*
> (PLPP, 01101)

Another barrier in achieving financial security is participants' limited access to the labor market. One practitioner described welfare benefits as an uncomfortable yet predictable zone. Some welfare recipients have reached a state of acceptance and resignation and have given up their wish to leave this zone. Some still wish for employment, but are unable to motivate themselves to search for jobs or are unsure where and how to start. One participant, discussing why she needed help with starting her own business, explained: "Because in your head you have so many plans of action, right, so many things that need to be dealt with, that you don't even know where to begin" (PLPP, 01202). For others, finding a job is hindered by a sense of fear; fear of doing things they are not used to doing, fear of failing, fear of complex rules and procedures they do not understand, and fear of financial insecurity. Peer workers and practitioners explained that having a job implies that participants lose sight of exactly how much monthly income they will receive, and that some will even experience a decline in income (i.e., the poverty trap). Participants also mentioned that rejections from potential employers, discrimination (ageism in particular), physical and psychological health problems (e.g., lack of energy, chronic pain), and the task of taking care of children and/or ill relatives hindered them in finding a job.

> *Afraid of what is to come. You see, if you've been on welfare for four years, it's also very predictable what you'll get every month. The moment you start working, yes, what can you expect? You are less entitled to benefits, you are expected to show up at work. So it's also very scary to take the next step.* (Practitioner, 02101)

Other wishes for social participation (i.e., education, volunteering, sports, hobbies, social activities) and for adequate housing were mainly hindered by participants' lack of financial means. Participants also mentioned that certain welfare laws – especially for cost sharing, which entails that households receive lower allowances the more cost sharers it counts – obstructed their housing wishes. One participant, for instance, was forced to live separately from her partner, as lower allowances made cohabitating financially unfeasible.

Support needs

Firstly, participants stressed the urgency of structural solutions to ensure financial security. Most importantly, they suggested raising individuals' income, for instance by increasing the minimum wage and welfare benefits, increasing the weekly allowance of individuals in debt settlements or introducing a universal basic income. A practitioner also proposed that fixed expenses should be subtracted from social welfare benefits to ensure clarity and financial security.

In addition, participants pointed out the importance of preventative support in realizing financial security. This for instance implies that municipalities should reach out to individuals with arrears, and that educational programs should teach minors about healthy financial behavior, their rights and obligations. Furthermore, they argued that support should be tailor-made – i.e., adapted to the needs of each individual – to realize more durable solutions to financial insecurity. This may, for instance, include reimbursing a scooter so individuals are able to commute, or providing more opportunities to pursue education and follow courses.

> *At the moment, I have a client [...] who's currently in debt restructuring. She's on sick leave now and needs physiotherapy to recover. But physiotherapy isn't covered [by her basic health insurance]. If it were covered, she could return to work more quickly and generate more income to pay off her debts. But because it isn't covered, it's likely that she'll be on sick leave long-term and so less [money] goes to creditors. This type of story you hear every day.*
> (Practitioner, 02201)

Participants also underlined the importance of improving access to existing support structures. Some advocated for national coordination of support – as opposed to the current municipal coordination – in order to create equality in and clarity about the support participants are entitled to. They also emphasized support should be easily accessible, visible and understandable, for instance by creating an overview of all existing forms of support and regulations, and by ensuring access does not require any or only minimal administrative work. Furthermore, the coordination between support organizations should be improved. Participants for instance stated that practitioners should refer participants to relevant forms of (financial) support, that one practitioner must be appointed to coordinate all supporting practitioners when participants receive assistance from multiple organizations, and that participants should have a single continuous file that is shared between organizations so participants do not have to start over each time they receive support.

Well-being

Wishes

Many participants expressed that PLPP wished for an improvement in their physical health, for instance to experience less pain, quit smoking, exercise more, and have better dental health. Participants also wished for a better psychological well-being, including more peace of mind, more structure and purpose in life, more opportunities for personal development, as well as more autonomy and mastery. Regarding the latter, participants for instance shared they wanted freedom to make their own choices, more mobility, and be (financially) independent. Moreover, some wished for a better ability to control their behavior (e.g., regarding smoking), and expressed the need for PLPP to regain a sense of hope and perspective, often referred to as a 'light at the end of the tunnel'.

> *A lot of people don't see a future, especially when they have been living in poverty for a long time. They just don't see any positive future prospects anymore. [...] So it's very important to figure out how we can create some future perspective for them.* (Practitioner, 02201)

In addition, participants wished for their children's well-being, explaining they wanted their children to grow up healthily and happily, without being hindered in their development or being excluded from activities because of their financial situation.

Barriers

Firstly, well-being wishes are hindered by a lack of financial resources. This obstructs access to healthy food and to healthcare that is not included in basic health insurance (e.g., physiotherapy, dental care), and impedes individuals' peace of mind, hope for the future, independence and autonomy, and the opportunities they can offer their children.

> *Many families, both single-parent and two-parent households, want to provide for their children and give them the best opportunities possible. However, when you have limited financial resources, you don't have the choice to make the best decisions for your children. You can't choose the best school, for example, because you may not be able to afford transportation costs. This lack of choice affects all areas of life.* (Peer worker, 02601)

Furthermore, the interviews highlighted that the well-being wishes were interrelated: An unfulfilled well-being wish was often considered an important barrier to realize other well-being wishes. Participants for instance shared that chronic stress, caused by the accumulation of stressors (e.g., having too little money, health problems of oneself and loved ones, relational problems, behavioral problems), induced unhealthy habits (e.g., stress eating, smoking), physical problems (e.g., pain), and/or psychological problems (e.g., 'a heavy mental burden', burn-out). Moreover, the majority of participants mentioned that chronic stress and trauma, feelings of hopelessness and being stuck, and fear and expectance of setbacks and disappointment consumed all of their energy. Participants were consequently unable to turn their ideas into action and to do the things that would make them feel better, varying from taking a walk to getting much needed support.

> *Due to all the stress and persevering all these years. And thinking: 'Oh, next year will be better. Maybe .... You'll make progress'. [...] And eventually you get tired and don't take any initiative anymore to do things, because you don't believe in it anymore.* (PLPP, 01401)

> *I'm tired and exhausted from everything that happened lately. Just tired. And I also don't feel like doing anything anymore. It's not going to be okay.* (PLPP, 01302)

Support needs

To realize the well-being wishes of PLPP, participants called for structural solutions, emphasizing that PLPP should receive more income, and that healthy food, physical and psychological healthcare, and healthcare insurance should be more affordable and accessible for everyone, regardless of income.

> *You have to ensure that people can live a decent life. That things are affordable. Because if you, let's see, if you have to pay €200 per month for health insurance. Your income is say, €1100, and you have to pay say, €650, in rent, [...] then you've already [almost] used up your entire income. You've [almost] used up your income on just two fixed expenses, and you haven't even paid for your home insurance or other things yet.* (Practitioner, 02401)

Moreover, they advocated for improving the quality of service provision. Multiple participants indicated that, in order to improve the well-being of PLPP, support should be holistic and based on self-direction. Practitioners should gain insight into how participants are doing on each area of life, ask participants what they want and need, support participants towards realizing those wishes and needs, and let participants make decisions themselves. It was noted, moreover, that in most cases, support would have to start with creating peace of mind and cognitive space. Participants shared that getting an overview of their income and expenses, help with their financial administration, and debt restructuring procedures where a debt counsellor completely took over their financial affairs, really helped them in this regard.

> *Self-direction. That they can make their own choices and that they always have a choice. Even if as professionals we sometimes seem to know what is best for our clients and we tend to present them with ready-made plans, and tell them that this is what they should do. But people just really want to have agency and want to have a choice.* (Practitioner, 02201)

Relatedness

Wishes

PLPP wished to feel that they matter, meaning they want to be valued just as much as anyone else, and to have more self-confidence. They also expressed the wish to be heard and seen, and to be trusted by others, specifically by local and national authorities and by care organizations.

> *I think people who live in poverty often […] feel like they're a criminal because they receive welfare benefits. So, [PLPP wish] that they matter, that they are not just a number, but a person with needs and wishes and dreams.* (Practitioner, 02101)

Moreover, whereas some people living in poverty were content with their social network and social support, others articulated they wanted to interact with individuals outside their inner circle, to have more friends, or just have someone to talk to.

> Interviewer: Are there any other things that come to mind that you want to change or attain?
> *Participant: Yes, I miss… Yes, I'm just sitting at home, alone. And that's it. Once a week I go visit my wife [who is in a nursing home]. Once a week I go grocery shopping. And the rest of the time I'm at home […]. So yeah, that's it. […] What I miss, is just… Being able to share my thoughts and feelings.* (PLPP, 01302)

Barriers

Participants indicated that feelings of mattering were affected by their upbringing, as some PLPP had never learned to love themselves during their childhood. Insufficient financial resources also posed an important barrier for realizing relatedness wishes. Participants shared that having a low income in itself, as well as the resulting necessity to wear cheap or second-hand clothes and depend on (financial) support, made them feel 'like beggars', 'discarded' and as lesser human beings.

> *We went out for dinner. Not so posh, because all three of us were tight on money. And I thought: well, I don't have to dress up as much. And then they wore glamorous dresses while I wore a denim skirt and second-hand boots. I felt so scrutinized. Especially because one of them [my sisters] looked at me with so much disdain. […] It made me feel so small that I thought: 'Just give me money, so I can have a nice wardrobe again and look good'.*
> (PLPP, 01101)

Participants' stories also reveal that the (internalized) negative societal sentiment towards unemployment and poverty, and more direct experiences of stigmatization hindered their feelings of mattering. Multiple participants for instance experienced a sense of failing regarding expectations set by themselves and by society (e.g., "Why can't I find a job"?), in comparison to others (e.g., other parents are able to pay for their child's birthday party) and in comparison to their past selves (e.g., "I was good and now I am nothing"), inducing feelings of inferiority and shame. A practitioner summarized these psychological consequences of living in poverty as follows:

> *Look, poverty is not just a lack of money, but it also affects you internally. You experience social exclusion [and] stigmatization from others, and you also start treating yourself that way. So you grow up [in poverty] feeling like you're worthless. And if you're on welfare for a long time, you're in a situation where you don't feel like you have any right to exist, and there can be a lot of shame involved.* (Practitioner, 02102)

Feelings of mattering were also hindered by the offer and provision of support. Specifically by the limited availability of support options for PLPP, and by the distrust ingrained in financial support. Participants for instance referred to the authoritarian and threatening tone of letters from local authorities; the requirement that social assistance recipients should justify the what and why for every bank statement; and the bulletproof glass in some meeting rooms, separating practitioners from (potentially aggressive) clients.

According to some peer workers, the barriers mentioned above are the result of a gap between the worlds of those living in poverty and those not living in poverty. They explained that society, policy makers and practitioners have a limited understanding of the lived experience of poverty, and that PLPP have limited knowledge to navigate the world of policy makers, fueling stigma and distrust.

> *Professionals just don't know what it's like to live in persistent poverty. You don't experience it yourself. […] And you may try to empathize, but you don't know what it's like to go through it every day.* (Practitioner, 02201)

Lastly, participants' wish for more social connectedness is mostly hindered by their lack of financial means. Participants described that PLPP tend to have insufficient financial means to attend and travel to social activities (e.g., birthdays, family activities), making it harder for them to have and maintain social contacts with family, friends, and acquaintances.

Support needs

To realize these relatedness wishes, participants highlighted several support needs regarding the approach of PLPP by institutions, practitioners, local authorities and society at large. Firstly, they emphasized the importance of establishing institutional trust, for instance by creating more lenient laws about receiving gifts and earning additional income. For this to be realized, participants argued, the gap between the poor and non-poor should be closed. They suggested that knowledge about the impact of (chronic) stress and poverty on individuals' lives should be more broadly disseminated to society – citizens, institutions, practitioners and policy makers included – to facilitate an understanding of the lived experience of poverty and reduce poverty stigma. Participants also suggested using peer workers in this regard, who were considered well-equipped to share their own story of poverty as well as collective poverty experiences, and to voice the needs of PLPP in policy making processes.

> *I want to advocate for more experts by experience at policy tables. Use that knowledge and expertise that are present there. How does a measure work out? What can be improved? [...] In an advisory board... There are people who absolutely have no experience with poverty. They ask me: 'what are you talking about?', and then they're baffled. And later, at the coffee machine, they say: 'could you explain that again?'. You know. Yes, and that's... Yes, that's all well and good, but these are the people who... If you don't have experience in the field, how can you give advice about it?* (PLPP, 01202)

Secondly, they pointed out the importance of establishing a trust-based working alliance between practitioners and clients. This was considered crucial for realizing participants' wish of being trusted in particular, as well as for participants to accept help. Establishing trust requires practitioners to take time for their clients, be patient and transparent, keep agreements, be easy to contact, and share some of their personal struggles. It also implies that practitioners need to give clients a sense of being heard and seen, by letting them share their story and their struggles, listening with interest and understanding, recognizing their hardship and treating them as an equal, without prejudice. Contacts at local authorities, too, should adopt such an open and unprejudiced attitude towards PLPP. In addition, participants vouched for using peer workers in service provision for PLPP, too, as they were thought to be easy to trust and confide in, served as a beacon of hope, and showed PLPP they were not alone.

Discussion

This study is the first to examine the wishes, perceived barriers and support needs of PLPP in relation to one another. We drew on the perspectives of PLPP, peer workers, and practitioners to gain a better understanding of what appropriate support for improving the quality of life of PLPP entails.

We found that PLPP's wishes centered around improving socio-economic security (i.e., financial security, labor market participation and social participation, adequate housing), improving the well-being of oneself and of loved ones (i.e., physical health, psychological well-being, well-being of children), and improving relatedness (i.e., to matter, being heard and seen, being trusted, social contacts and social support). These wishes reflect multiple of the basic (psychological) needs that are considered vital for human well-being and growth (e.g., Nussbaum, 2002). This highlights that even in a prosperous state as the Netherlands, these universal basic needs are unattainable for PLPP.

One of the most important barriers for PLPP to fulfill their wishes for socio-economic security, well-being and relatedness, concerns their lack of money. Most wishes require money to be realized; the associated stress negatively affects individuals' well-being and drains the energy needed for pursuing wishes; and a lack of money affects one's view of self, both directly and indirectly via one's appearance (e.g., second-hand clothes). The impact of financial hardship on well-being has been widely documented (e.g., Frankham et al, 2020; Marttila et al., 2013; Richardson et al., 2013). Consequently, PLPP, peer workers and professionals advocated for structural solutions to reduce financial insecurity, including a focus on preventative support, a price reduction for healthy food, and a nation-wide raise of the minimum wage and welfare benefits. Previous research in both low-, middle- and high-income countries accordingly demonstrate that experiments with basic income and cash transfers are associated with an increase in subjective well-being and mental health (Gibson et al., 2020; McGuire et al., 2022).

Other barriers regarding the existing support structures that prevent PLPP from realizing their wishes, include financial support aimed at poverty management rather than poverty eradication; financial support grounded in distrust towards the receiver; welfare laws that serve as additional stressors; and unavailable and insufficiently accessible service provision and healthcare for PLPP. In line with the literature, it was therefore argued that the so-called 'administrative burden' of support should be minimized (Moynihan et al., 2015). This includes national coordination of support, a simple and clear overview of the available services, and easy access to service provision.

Furthermore, it was argued that PLPP would be helped by institutional trust. Public policies, legislation and services, in other words, should depart from the premise that PLPP wish to improve their situation, and should be tailored to the individuals' situation and wishes. Wishes are key motivators (Lai et al., 2021; Wolf & Jonker, 2020), and associated with better well-being and performance (Deci & Ryan, 2000; Sen, 1999; Sheldon et al., 2004; Vansteenkiste et al., 2004). Recent findings of a social experiment in the municipality of Nijmegen, the Netherlands, demonstrate that the most vulnerable social assistance recipients in particular tend to benefit from a more trust-based social assistance in terms of their experienced health and participation (Betkó, 2023).

In addition, for practitioners, our findings highlight the importance of adopting a holistic approach, of offering self-direction to clients, and of establishing a high-quality working alliance between practitioners and clients for realizing the wishes of PLPP. Practitioners should be empathic and open minded, listen to and respect the wishes of their clients, and establish a relationship of trust and equality (O'Donnell et al., 2016; Williamson et al., 2006). Consistently, strengths-based approaches, which accentuate self-direction, a focus on strengths and assets, and a trust-based relationship, have been related to various positive outcomes for individuals in vulnerable positions (Fukui et al., 2012; Krabbenborg et al., 2017).

The hinder PLPP experience from the existing support structures, seem to be the result of a gap between the realities and experiences of PLPP compared to those who have no personal experience of living in poverty, including many policy makers, practitioners, and the general public. To close this gap, individuals with lived experiences of poverty should be actively involved in policy development and in the daily practice of service provision. This concurs with the growing awareness of the importance of listening to the voices of lived experience, as an integral part of evidence-based policy development (Smith-Merry, 2020). Also within the daily practice of service provision, it is increasingly recognized that peer workers can offer a kind of support that other practitioners cannot or do not provide, and have the ability to 'close the gap' between the reality of clients and that of practitioners (Van der Kooij & Keuzenkamp, 2018).

Lastly, PLPP were hindered by psychological barriers in realizing their wishes. Our results showed that the various stressors and setbacks in the lives of PLPP drained their energy, hope and motivation to have and pursue wishes. PLPP were also reportedly hindered by trauma, feelings of inferiority and failure, and by a strong sense of fear. These findings emphasize the importance of establishing a trust-based working alliance between PLPP and practitioners, and providing support that is tailored to the emotional needs of recipients (e.g., trauma-informed and stress-sensitive support).

To fundamentally improve the quality of life of PLPP, it is essential that the abovementioned recommendations are implemented together instead of separately.

Strengths and limitations

This study has several limitations that should be noted. First, we conducted a fixed number of interviews and analyzed the data subsequent to, rather than simultaneous with, data collection. As a result, relevant findings that emerged during data analysis were not systematically probed during data collection. Second, we adopted a strategy of purposeful sampling, likely resulting in a biased sample of PLPP. Participants, for instance, all spoke Dutch, most were involved in some kind of support trajectory, and none lived in one of the four largest cities of the Netherlands. We attempted to grasp the perspectives of a broader range of individuals by including interviews with practitioners and peer workers, but we may nevertheless have missed some perspectives (e.g., the wish to learn the Dutch language). Also, our sampling strategy could have led to a biased sample of practitioners. Gatekeepers may have selected practitioners known for their empathetic engagement with clients, or such practitioners may have been more willing to participate. This may also clarify the discrepancy between the reported reality gap between clients and practitioners on the one hand, and the overlap in wishes, barriers and support needs discerned by clients and practitioners on the other.

Despite these limitations, this study provides a unique insight into the wishes of PLPP and what PLPP, peer workers and practitioners think is needed to overcome perceived barriers and realize these wishes. As a result, this study provides a wide range of clues to local and national policy makers and practitioners for optimizing appropriate and effective support to improve the quality of life of PLPP. Another strength of this study lies in our close collaboration with peer workers, who were involved in the development of information letters, interview guides and data collection. The reason for this was to start from the views of people living in poverty as much as possible, and to examine their reality, challenges, and their understanding of solutions as closely as possible.

Conclusion

Our study showed that structural changes in policy and practice are needed for PLPP to fulfill their wishes for socio-economic security, well-being, and relatedness. These structural changes should provide PLPP with more financial security, with better access to appropriate support and healthcare, and should close the reality gap between PLPP on the one hand, and policy makers, practitioners, and the general public on the other. In addition, the quality of the working alliance between practitioners and PLPP should have a central role in service provision (e.g., based on trust, equality, empathy and open-mindedness). These changes should be implemented together in order to effectively support PLPP in improving their quality of life.

References

Betkó, J. (2023). *Effects of welfare policies based on autonomy and unconditionality: A social experiment with social assistance recipients* [Dissertation]. Radboud University: Nijmegen, the Netherlands.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. doi: 10.1191/1478088706qp063oa

Canvin, K., Jones, C., Marttila, A., Burström, B., & Whitehead, M. (2007). Can I risk using public services? Perceived consequences of seeking help and health care among households living in poverty: Qualitative study. *Journal of Epidemiology and Community Health, 61*, 984-989. doi: 10.1136/jech.2006.058404

Crouch, E., Jones, J., Strompolis, M., & Merrick, M. (2020). Examining the association between ACEs, childhood poverty and neglect, and physical and mental health: Data from two state samples. *Children and Youth Services Review, 116*, 105-155. doi: 10.1016/j.childyouth.2020.105155.

Deci, E. L., & Ryan, R. M. (2000). The 'what' and 'why' of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inguiry, 11*(4), 227-268. doi: 10.1207/S15327965PLI1104_01

Doyal, L., & Gough, I. (1991). A theory of human need. *Critical Social Policy, 4*(10), 6-38. doi: 10.1177/026101838400401002

Eurostat (2021a). *Glossary: At risk of poverty*. Retrieved from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:At-risk-of-poverty_rate

Eurostat (2021b). *At risk of poverty rate.* Retrieved from: https://ec.europa.eu/eurostat/databrowser/view/tespm010/default/table?lang=en

Evans, G. W., & Kim, P. (2012). Childhood poverty, chronic stress, self-regulation, and coping. *Child Development Perspectives, 7*(1), 43-48. doi: 10.1111/cdep.12013

Frankham, C., Richardson, T., & Maguire, N. (2020). Do locus of control, self-esteem, hope and shame mediate the relationship between financial hardship and mental health? *Community Mental Health Journal, 56*, 404-415. doi: 10.1007/s10597-019-00467-9

Fukui, S., Goscha, R., Rapp, C., Mabry, A., Liddy, P. & Marty, D. (2012). Strenghts model case management fidelity scores and client outcomes. *Psychiatric Services, 63*(7), 708-710. doi: 10.1176/appi.ps.201100373

Gibson, M., Hearty, W., & Craigh, P. (2020). The public health effects of interventions similar to basic income: A scoping review. *The Lancet Public Health, 5*(3), E165-E176. doi: 10.1016/S2468-2667(20)30005-0

Goderis, B., Van Hulst, B., & Hoff, S. (2019). *Waar ligt de armoedegrens?* Retrieved from: https://digitaal.scp.nl/armoedeinkaart2019/waar-ligt-de-armoedegrens/

Government of The Netherlands (2022). *Minimumloon in een keer met 10,15% omhoog*. Retrieved from: https://www.rijksoverheid.nl/actueel/nieuws/2022/09/23/minimumloon-in-een-keer-met-1015-omhoog

Gupta, A., & Holloway, R. (2016). Giving poverty a voice: Families' experiences of social work practice in a risk-averse child protection system. *Families, Relationships and Societies, 5*(1), 163-172. doi: 10.1332/204674316X14540714620166

Haushofer, J., & Feher, E. (2014). On the psychology of poverty. *Science, 344*(6186), 862-867. doi: 10.1126/science.1232491

Krabbenborg, M., Boersma, S., Van der Veld, W., Van Hulst, B., Vollebergh, W., & Wolf, J. (2017). A cluster randomized controlled trial testing the effectiveness of Houvast: A strengths-based intervention for homeless young adults. *Research on Social Work Practice, 27*(6), 639-652. doi: 10.1177/1049731515622263

Inglis, G., McHardy, F., Sosu, E., McAteer, J., Biggs, H. (2019). Health inequality implications from a qualitative study of experiences of poverty stigma in Scotland. *Social Science & Medicine, 232*, 43-49. doi: 10.1016/j.socscimed.2019.04.033

Kahn, J. K., & Pearlin, L. I. (2006). Financial strain over the life course and health among older adults. *Journal of Health and Social Behavior, 47*, 17-31. doi: 10.1177/002214650604700102

Lai, D. W. L., Chan, K. C., Daoust, G. D., & Xie, X. J. (2021). Hopes and wishes of clients with mentally illness in Hong Kong. *Community Mental Health Journal, 57*, 1556-1565. doi: 10.1007/s10597-021-00779-9

Loignon, C., Hudon, C., Goulet, E., Boyer, S., De Laat, M., Fournier, N., Grabovschi, C., & Bush, P. (2015). Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project. *International Journal for Equity in Health, 14*(4). doi: 10.1186/s12939-015-0135-5

Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013). Poverty impedes cognitive function. *Science, 341*, 976-980. doi: 10.1126/science.1238041

Marttila, A., Johansson, E., Whitehead, M., & Burström, B. (2013). Keep going in adversity – using a resilience perspective to understand the narratives of long-term social assistance recipients in Sweden. *International Journal for Equity in Health, 12*(8). doi: 10.1186/1475-9276-12-8

Marttila, A., Whitehead. M., Canvin, K., & Burström, B. (2010). Controlled and dependent: Experiences of living on social assistance in Sweden. *International Journal of Social Welfare, 19*(2), 142-151. doi: 10.1111/j.1468-2397.2009.00638.x

McGuire, J., Kaiser, C., & Bach-Mortensen, A.M. (2022). A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries. *Nature Human Behaviour, 6,* 359-370. doi: 10.1038/s41562-021-01252-z.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. doi: 10.1037/h0054346

Mood, C., & Jonsson, J. O. (2016). The social consequences of poverty: An empirical test of longitudinal data*. Social Indicators Research, 127*, 633-652. doi: 10.1007/s11205-015-0983-9

Morse, J. M. (2010). How different is qualitative health research from qualitative research? Do we have a subdiscipline? *Qualitative Health Research, 20*(11), 1459–1464. doi: 10.1177/1049732310379116

Moynihan, D., Herd, P., & Harvey, H. (2015). Administrative burden: Learning, psychological, and compliance costs in citizen-state interactions. *Journal of Public Administration Research and Theory, 25* (1), 43–69. doi: 10.1093/jopart/muu009

Nussbaum, M. (2000). *Women and human development: A study in human capabilities.* Cambridge: Cambridge University Press.

O'Donnell, P., Tierney, E., O'Carroll, A., Nurse, D., & MacFarlane, A. (2016). Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *International Journal Equity in Health, 15*, 197. doi: 10.1186/s12939-016-0487-5

Price, R. H., Choi, J. N., & Vinokur, A. D. (2002). Links in the chain of adversity following job loss: How financial strain and loss of personal control lead to depression, impaired functioning, and poor health*. Journal of Occupational Health Psychology, 7*(4), 302-312. doi: 10.1037//1076-8998.7.4.302

Price, J.H., Khubchandani, J., & Webb, F.J. (2018). Poverty and health disparities: What can public health professionals do? *Health Promotion Practice, 19*, 170-174. doi: 10.1177/1524839918755143

Richardson, T., Elliott, P., & Roberts, R. (2013). The relationship between personal unsecured debt and mental and physical health: A systematic review and meta-analysis. *Clin. Psychol. Rev., 33*(8), 1148-1162. doi: 10.1016/j.cpr.2013.08.009

Ridley, M., Rao, G., Schilbach, F., & Patel, V. (2020). Poverty, depression, and anxiety: causal evidence and mechanisms. *Science, 370*(6522). doi: 10.1126/science.aay0214

Sen, A. (1999). *Development as freedom.* Anchor Books.

Sheldon, K. M., Ryan, R. M., Deci, E. L., & Kasser, T. (2004). The independent effects of goal contents and motives on well-being: It's both what you pursue and why your pursue it. *Journal of Personality and Social Psychology, 87*(2), 246-260. doi: 10.1037/0022-3514.87.2.246

Smith-Merry, J. (2020). Evidence-based policy, knowledge from experience and validity. *Evidence & Policy, 16(2)*, 305-316. doi: 10.1332/174426419X15700265131524

Taylor, M.J., Barusch, A.S. (2004). Personal, family, and multiple barriers of long-term welfare recipients. *Social Work, 49*(2), 175-83. doi: 10.1093/sw/49.2.175

Thomson, R. M., Igelström, E., Purba, A. K., Shimonovich, M., Thomson, H., McCartney, G., Reeves, A., Leyland, A., Pearce, A., & Katikireddi, S. V. (2022). How do income changes impact on mental health and wellbeing for working-age adults? A systematic review and meta-analysis. *The Lancet. Public health, 7*(6), e515–e528. doi: 10.1016/S2468-2667(22)00058-5

Van der Kooij, A., & Keuzenkamp, S. (2018). Ervaringsdeskundigen in het sociaal domein: wie zijn dat en wat doen ze? Movisie, retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2019-11/Startnotitie-Ervaringsdeskundigen-in-het-sociaal-domein.pdf

Van Hulst, B., & Hoff, S. (2020). Hoeveel mensen zijn langdurig arm? In: Armoede in kaart: 2019. Retrieved from: https://digitaal.scp.nl/armoedeinkaart2019/hoeveel-mensen-zijn-langdurig-arm

Vansteenkiste, M., Simons, J., Lens, W., Sheldon, K. M., & Deci, E. L. (2004). Motivating learning, performance, and persistence: The synergistic effects of intrinsic goal contents and autonomy-supportive contexts. *Journal of Personality and Social Psychology, 87*(2), 246-260. doi: 10.1037/0022-3514.87.2.246

Washington State, Department of Children, Youth, and Families. (2018). *Mobility Mentoring® outcomes report 2017-2018*. Retrieved from https://www.dcyf.wa.gov/services/early-learning-providers/eceap/reports

Watson, J., Crawley, J., & Kane, D. (2016). Social exclusion, health and hidden homelessness. *Public Health, 139*, 96-102. doi: 10.1016/j.puhe.2016.05.017

Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy, 76*(1), 106-121. doi: 10.1016/j.healthpol.2005.05.005

Wolf, J. R. L. M., & Jonker, I. E. (2020). Pathways to Empowerment: The Social Quality Approach as a foundation for person-centered interventions. *International Journal of Social Quality, 19*(1), 29-56. doi: 10.3167/IJSQ.2020.100103

Chapter 6

Summary and general discussion

The aim of this thesis was to deepen our knowledge of what Dutch homeless people and people living in persistent poverty need in order to overcome their disadvantaged position, enhance their living conditions and participate in society. In this final chapter I will summarize and discuss the empirical findings of the four studies that have been performed, critically reflect on the studies' strengths and limitations, provide recommendations for policy and practice, provide suggestions for future research, and end with a conclusion.

Summary of the main findings

Prevalence and persistence of risk factors for homelessness (chapter 2)

This observational longitudinal cohort study provided insight into the housing status and the prevalence of a comprehensive set of modifiable risk factors for homelessness at the individual level among homeless people from Amsterdam at shelter entry and 5.5 years later. Face-to-face administered questionnaires were conducted at baseline (n=172), and at the 5.5 year follow-up (n=72). The four constitutional conditions of the Social Quality Approach (SQA) were used to cluster the risk factors included in this study. At shelter entry, the participants were seriously disadvantaged regarding all four constitutional conditions of social quality, and, as expected, none of the participants were stably housed. At the 5.5 year follow-up, substantial improvements were reported: 69% of the participants were stably housed, and for all four constitutional conditions of social quality improvements were found, which was expected because of the dire situation of the participants at shelter entry. Despite these improvements, the prevalence of the majority of risk factors for homelessness did not change, and some of the risk factors that did decrease significantly over time, were still frequently reported by the participants. After 5.5 years, for example, almost sixty percent of the participants still had debts, three quarters were unemployed (76%), and many people did not have enough money for basic needs such as food (24%), travel (44%), clothing (61%) and social activities (53%). A quarter of the participants had poor quality relationships with family members (25%), nearly half lacked support from family members (47%), and four tenth lacked support from friends and acquaintances (40%). Regarding their physical health, almost one third (31%) reported four or more physical health problems, a quarter (26%) reported being dissatisfied with their physical health. Moreover, high levels of anxiety, depression and somatization were reported compared to the general population: over four tenth reported high levels of depression (43%), a quarter reported high levels of anxiety (26%), and over one third reported high levels of somatization (35%). Excessive cannabis use was reported by just over one third of the participants (34%). This means that, besides important improvements, the personal situation of Dutch people who were initially homeless seriously lagged behind, especially compared to the general Dutch population. 5.5 years after shelter entry the participants were still exposed to high levels of social exclusion, which negatively affects their quality of life and also leaves them particularly vulnerable for a new episode of homelessness.

The impact of childhood abuse experiences on the quality of daily life of homeless people (chapter 3)

This study compared homeless people with and without childhood abuse experiences (CAE) on a comprehensive set of factors influencing the quality of their daily lives. Data were used from an observational longitudinal multi-site cohort study, and the factors influencing the quality of daily life included in this study were clustered in the four constitutional conditions of the SQA. Out of the 513 participants, 203 participants (40%) reported one or more forms of childhood abuse.

At baseline (i.e. at shelter entry) and follow-up (n =378), 2.5 years later, participants with CAE were more disadvantaged in each of the four conditions of social quality, namely living conditions, interpersonal embeddedness, societal embeddedness and self-regulation, except for societal embeddedness at follow-up. At baseline, regarding living conditions, participants with CAE were more likely to have debts, and were more often victim of a violent offense during the past year. Regarding Interpersonal embeddedness, they reported significantly lower levels of social functioning, experienced less support from their family members, and reported a poorer quality of relationships with family members, friends and acquaintances and their children. Concerning societal embeddedness, they reported more unmet care needs, and regarding self-regulation, they were less satisfied with their physical health and mental health, experienced more psychological distress in general, reported significantly higher levels of depression, anxiety and somatization and were more likely to be using cannabis.

At follow-up participants with CAE no longer had debts more often, they did not report a significantly lower quality of their relationships with friends and acquaintances and with their children anymore, they did not report more unmet care needs and were not less satisfied with their mental health anymore, compared to participants without such experiences. As opposed to baseline, they did report being unemployed during the past year more often. However, participants with CAE still reported significantly lower levels of social functioning, experienced less support from family, friends and acquaintances and a poorer quality of relationships with family members, and still had been a victim of a violent offense more often during the past year. They were also still significantly less satisfied with their physical health, they still reported significantly higher levels of depression, anxiety and somatization and were still more likely to be using cannabis.

With regard to the rate of change after 2.5 years, on average, participants with and without CAE had mostly improved in a similar rate on almost all factors. Differential changes over time were found for employment status, quality of relationships with family members and symptoms of depression and anxiety. At baseline, participants with and without CAE were employed just as often, while at follow-up less participants with CAE reported being employed during the past year, and the number of employed participants without CAE remained the same. Also, while still being worse off at follow-up, participants with CAE reported a larger increase in satisfaction with the quality of their relationships with family members and reported a larger decline in symptoms of depression and anxiety compared to participants without CAE. These findings seem to indicate that people with CAE possess at least the same potential for growth and self-realization, compared to people without CAE, which is important information for services that support homeless people.

To our knowledge, this is the first study assessing differences between adult homeless people with and without CAE on a wide range of constitutional conditions influencing the quality of their daily lives during adulthood. This was also the first study that examined the degree to which CAE had a persisting influence on the quality of life of homeless people after accessing social relief facilities. In conclusion, homeless people with CAE were worse off at baseline and generally remained worse off 2.5 years after shelter entry, compared to homeless people without CAE. Homeless services need to recognize the extensive and enduring impact of CAE on the daily lives of homeless people, especially concerning their interpersonal relationships, mental health, and physical well-being. The findings of this study support the importance of homeless services adopting trauma-informed care.

The value and working mechanisms of individual unidirectional peer support for homeless people (chapter 4)

Although the application of individual unidirectional peer support (IUPS) within homeless services is growing, research investigating its effectiveness is scarce and mainly overlooks the perspective of people experiencing homelessness. To our knowledge, this was the first study that examined the outcomes and critical elements of IUPS for homeless people, from the perspective of people experiencing homelessness as well as peer workers. Semi-structured interviews were conducted with people experiencing homelessness (n =10) and peer workers (n =10). According to the participants, IUPS enhances clients' self-image, advances their personal growth and results in better engagement with needed services. Regarding the critical elements of IUPS, the analysis of the interviews revealed ten separate elements, namely: being there, understanding, being accessible and available, providing comfort and a personal connection, having an equal relationship, role modeling, stimulating and empowering, providing practical support and developing better life circumstances, supporting client-professional relationship and supporting clients with care trajectories. Although all outcomes and critical elements were mentioned by both the peer workers and the people experiencing homelessness, certain aspects of outcomes and critical elements were only mentioned by a single group. The inclusion of both perspectives has therefore provided a more complete understanding of the identified outcomes and critical elements of IUPS. By combining the outcomes and the critical elements, three working mechanisms of IUPS emerged: Rapport and empathy, Trusting and empowering relationship, and Support, guidance and mediation. As these working mechanisms all refer to the quality of the relationship between homeless people and peer workers, the results of this study reveal that this quality is what makes IUPS work. The findings also show that homeless people and peer workers ascribed great value to the outcomes and workings of IUPS, which implies that IUPS should be considered standard support in service provision for homeless people.

Wishes and associated barriers and support needs of people living in persistent poverty (chapter 5)

While the perspectives of field experts on the wishes, barriers, and support needs of people living in persistent poverty are crucial for developing effective and appropriate support that can enhance their quality of life, they – and their interrelations - have been relatively understudied in research on poverty reduction. This study examined the wishes people living in persistent poverty have, the barriers they perceive for realizing these wishes, and the support they need to fulfill these wishes, from the perspectives of people living in persistent poverty themselves, peer workers and regular professionals.

Digital semi-structured interviews were conducted with people living in poverty (n=14), peer workers (n=5), and regular professionals (n=5) in five municipalities in the Netherlands. Data were analyzed using a combination of inductive and deductive methods. The analysis showed that wishes centered around improving socio-economic security (i.e., financial security, adequate housing, labor market participation and social participation), improving the well-being of oneself and of loved ones (i.e., physical health, psychological well-being, well-being of children), and improving relatedness (i.e., to matter, being heard and seen, being trusted, social contacts and social support).

The realization of these wishes is impeded by socio-economic barriers (e.g., lack of financial means), support structures (e.g., non-structural support, limited availability and accessibility of support and healthcare, welfare laws, institutional distrust), a reality gap, and psychological processes (e.g., chronic stress, trauma, lack of energy, hopelessness, fear, feelings of inferiority). The lack of financial means was found to be the primary reason why people living in persistent poverty are unable to fulfill their wishes for socio-economic security, well-being and relatedness.

Regarding their support needs, participants expressed the need for significant changes in policy and practice. These changes encompass raising the income of people living in poverty, prioritizing poverty prevention, enhancing accessibility and utilization of support services, providing personalized assistance, promoting institutional trust, and bridging the gap between the experiences of people living in poverty and the perspectives of policymakers and professionals. Moreover, they highlighted the importance of involving peer workers in service provision for people living in persistent poverty. They emphasized the significance of a holistic approach, self-directed support, and a strong emphasis on the quality of the working relationship between clients and professionals, characterized by trust, equality, and empathy. And, to effectively enhance the quality of life for people living in persistent poverty, it is crucial to implement these changes collectively.

Interpretation of the findings

Socio-economic security

Chapter 2 shows that, after 5.5 years, besides the reported substantial improvements, the majority of the risk factors related to socio-economic security were still present. For example, most participants were unemployed, many had debts and insufficient resources for basic needs. Moreover, one third of the participants remained unstably housed. These weak socio-economic conditions were accompanied by a poorer quality of one's daily life, 5.5 years after shelter entry: participants experienced a poor quality of the relationship with family members, often lacked support from family and friends, and had a poor physical and mental health. As limited financial means, a limited social support network, and a lack of meaningful daily activities have been identified as risk factors for recurring homelessness, many participants are living under circumstances that make them at risk to fall back into homelessness (Boesveldt et al., 2019; Boesveldt et al., 2021).

The results described in chapter 5 also emphasize the negative impact socio-economic insecurity has on the quality of one's daily life. The lack of financial resources and the absence of the means to acquire socio-economic security (i.e. not having a paid job, having debts) substantially undermined the realization of wishes of people living in persistent poverty in all life domains. Many people stressed the importance of having sufficient income to be able to participate in society, for instance to be able to pay for transportation for social visits, health care, healthy foods, and their children's basic needs. Other people mentioned the deteriorating influence financial stress had on their social relations, their parenting capacities and their physical and mental health.

Structural factors

The study in chapter 5 provides insight into the structural barriers that hinder people in obtaining socio-economic security. Participants of this study stated that issues such as a too low minimum wage, too low benefits, the high costs of the mandatory basic health insurance, and the exclusion of various forms of health care from the basic health insurance, prevented them from attaining socio-economic security.

Additionally, the complexity of regulations for attaining socio-economic support, and the bureaucratization of service delivery impeded participants to access social support services, both being detrimental for their quality of life and participation in society. For example, due to the complexity of regulations, one participant avoided to seek support in finding a job, because of fear for the financial uncertainty employment may bring. Another participant could not even live together with her partner and children, as social welfare regulations make cohabitation financially unfeasible for them.

That abovementioned structural factors hinder people in obtaining socio-economic security was also found in previous research (Gupta & Holloway, 2016; Loignon et al., 2015; Movisie, 2022; O'Donnell et al., 2016; Williamson et al., 2006). Feelings of shame, the lack of a human approach and the disrespectful way people are sometimes treated by social service professionals, also make that people do not always seek and receive the support they need (Pharos, 2023; Pharos, 2022).

The findings that weak socio-economic conditions are associated with a poorer quality of life coincide with previous research findings as well. Prior studies have shown a link between socio-economic insecurity and, for example, worse physical and mental health (Curl & Kearns, 2014; Marmot & Bell, 2012; Ridley et al., 2020), higher levels of stress (Haushofer & Fehr, 2014), lower levels of self-regulation and perceived control (Evans & Kim, 2012; Price et al., 2002), impaired cognitive functioning (Mani et al., 2013), and more strain on family and other important social relationships (Johnsen & Watts, 2014; Mood & Jonsson, 2016). Chronic stress due to long term poverty has been found to be associated with less rational decision making, which can lead to a (further) deterioration of mental and physical health (Beenackers et al., 2016; Jungman et al., 2020; Schiffrin & Nelson, 2010; Wolf, 2016).

The results of our studies underline the importance of a structural and adequate socio-economic safety net for people in disadvantaged circumstances. Attaining and maintaining socio-economic security is currently difficult in the Dutch society. During recent years, more and more people have been confronted with socio-economic insecurity, demonstrated by, for example, the growing number of people that is forced to use food banks (135.00 in 2016 versus 160.500 in 2020). Due to rising inflation rates and particularly the sharply rising energy prices, this number is expected to increase even further. Currently 1 in 3 households struggle to make ends meet (NIBUD, 2022), showing that, in addition to households who were already living in poverty before the energy crisis, middle class households currently are also financially struggling.

Adverse childhood experiences and trauma

Findings reported in chapter 3 show that, while going through the traumatizing experience of being homeless, homeless people with CAE were more disadvantaged compared to homeless people without CAE. These results are in line with research among homeless people on the association between adverse childhood experiences (ACE) and negative outcomes related to physical and psychological health (Brown et al., 2016; Lee et al., 2017; Liu et al., 2020; Patterson et al., 2014), the quality of social networks (Green et al., 2012) and victimization (Stein et al., 2002). In addition to previous research, our findings show that homeless people with CAE also experience more unmet care needs, more unemployment (at follow-up), and more debts (at baseline). These findings corroborate with the great body of literature that CAE and ACE in general deteriorate social support systems and instigate psychological and physical health problems which, as described in the former section, are risk factors for homelessness.

When being homeless, people have an increased risk of further traumatization because they are particularly vulnerable to injury, accident and assault (Feantsa, 2017), which is also demonstrated in chapter 3. Compared to the general population, in which 3% reported being victim of a violent offense in 2012 (year of the study's data collection, Statistics Netherlands, 2020) the participants without CAE were victim of a violent offense in the past year more often (9%), and participants with CAE even more so (30%). This points to the vicious circle between trauma and homelessness: traumatic experiences make people vulnerable to become homeless and homelessness can increase exposure to traumatic experiences (Feantsa, 2017).

Our finding, that factors influencing the quality of life of homeless people with CAE generally improve over time at a similar rate, and sometimes even at a greater rate, compared to people without CAE, seems to indicate that people with CAE possess at least the same potential for growth and self-realization. However, the results also show that, 2.5 years after shelter entry, participants with CAE were generally still worse off than participants without such experiences. Service providers should be aware of this to be able to address the specific problems of people who have experienced trauma more successfully, for instance via trauma-informed approaches.

More recently, a growing number of studies on childhood abuse applied a broader set of ACE, also including exposure to violence outside of the home, living in unsafe neighborhoods, homelessness, bullying, discrimination based on race or ethnicity, and experience of income insecurity (Bethell et al., 2017). This broader set is believed to better capture the diverse experiences of children from different backgrounds, especially children living in poverty and children of color, and should be taken into account by service providers when applying trauma-informed care.

Peer support, experiential expertise and including the client perspective

The results described in chapter 4 show that IUPS helps homeless people to overcome their disadvantaged position, by establishing rapport and showing true empathy, by creating a trusting and empowering relationship, and by providing support, guidance and mediation. Because these working mechanisms all concern the quality of the relationship between homeless people and peer workers, the results of this study indicate that this quality is what makes IUPS work.

Regarding the identified outcomes of IUPS for homeless people, our results compare well with the positive outcomes of intentional peer support in general (encompassing IUPS and intentional bidirectional peer support involving reciprocal and mutual types of peer interventions) found among people with mental health problems, such as increased hope, empowerment, self-esteem, self-efficacy, self-management and feeling understood by the peer worker (Chien et al., 2019; King, Thy & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al, 2013; Repper & Carter, 2012). Previous findings regarding increased social inclusion and increase in community involvement (Chien et al., 2019; King, Thy & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al, 2013; Repper & Carter, 2012) were not supported by our study. The latter could be explained by the fact that homeless people experience a more extreme form of social exclusion compared to people experiencing mental health problems. In addition to mental health problems, homeless individuals frequently face more disadvantages in various other areas, such as social relations, physical health, access to material resources and healthcare, housing, vulnerability to trauma and victimization, as well as the experience of stigma and discrimination.

As with the outcomes of IUPS, the critical elements found in our study coincide with results found in previous research on critical elements among peer workers providing IUPS within homeless services (Barker, 2018). Although this study used slightly different terms and categorizations:, namely: 1) peer-client relationship (e.g. positive regard, normalization, empowerment); 2) role modelling (e.g. positive self-evaluation through social comparison, learn from coping techniques); and 3) experiences based support (informational support regarding care trajectories, emotional support) (Barker, 2018; Barker, Maguire, Bishop & Stopa, 2019). In addition to this earlier research, our study found that participants explicitly and highly valued peer workers being present by being there and being within easy reach, and being accessible and available. Comparing the results of our study with research examining the working mechanisms of IUPS within the more frequently examined field of mental health services is complicated, as these studies represent a wide range of mental health care settings, peer roles and qualifications and mainly involve the perspective of peer workers instead of clients (Watson, 2017). To our knowledge, only one study examined the working mechanisms of IPS within mental health care from the perspective of clients (Gidugu et al., 2015). This study found similar results, showing that clients particularly benefitted from practical, emotional and social support, valued "having someone to rely on, a friend, and someone to socialize" and esteemed having a non-treatment based, normalizing relationship. These findings underline the importance of applying strengths-based approaches such as 'Pathways to Empowerment' (Wolf, 2016). 'Pathways to Empowerment' emphasizes, for example, building a trusting relationship with clients, supporting them in their process of recovery by focusing on their strengths, talents and possibilities, and taking their needs, future wishes and goals as the starting point for the support provided.

In line with the results of chapter 4, the participants of the study described in chapter 5 reported that people living in persistent poverty also ascribe great importance to a trusting and equal working relationship. They want to be heard and seen, without prejudice, and to feel that they matter. Building such a bond is seen as a crucial prerequisite for people living in persistent poverty to ask for and accept help from a professional, and to make progress. It requires professionals to take time for their clients, to be patient and transparent, to keep agreements and also share some of their personal struggles if it will contribute to their clients recovery. They significance of a trusting and equal working relationship has also been demonstrated in other populations benefiting from support in their recovery journeys, such as homeless young adults using shelter facilities (Altena, 2019) and probationers being supervised by probation officers (Sturm, 2022).

The results of chapter 4 and 5 also point to the need for professional support, social policies and regulations to be based on the needs and wishes of clients instead of being a "one size fits all" -approach. Such a person-centred approach honours homeless people's and people living in persistent poverty's strong wish for a greater sense of autonomy and mastery and would boost their self-esteem. A person-centred approach is also one of the core principles of the Housing First approach, which is a well-researched and proven effective strategy to combat homelessness (Aubry et al., 2015; Baxter et al., 2019).

The findings described in chapter 4 and 5 also cater to the general need within social support services and the social relief system for more in-depth knowledge about the added value of peer workers and experiential knowledge and expertise, their effective mechanisms, and the required conditions to successfully integrate this expertise and experience within teams, organizations and policy development (Movisie, 2018; Keuzenkamp, 2022). As chapter 5 has shown, people living in persistent poverty have highlighted the importance of the involvement of peer workers in the development and execution of policy-making processes.

Methodological considerations

Strengths

This thesis adds to the existing knowledge on the societal position of people experiencing homelessness and people living in persistent poverty, the risk factors present in their lives and their wishes for the future. The results provide important directions for appropriate social policies and further improvement of the working methodology of social professionals and peer workers. The overall strengths of the studies performed entail the use of strong research designs, such as the longitudinal studies employed in chapter 2 and chapter 3. These longitudinal designs allowed us to monitor changes in participants' living circumstances over time instead of assessing these changes in retrospect. Furthermore, regarding the study reported in chapter 3, longitudinal data were available for a relatively large cohort of homeless people (n = 513) with a high response rate (74%) at the follow-up measure, 2.5 years later. To yield a high response rate, efforts were made to thoroughly track the participants, for example by providing participants a compensation for their participation (increasing from €15 for the first interview to €30 for the follow-up after 2.5 years), interviewing them at the participant's location of choice and in their language of choice when Dutch was not feasible (e.g., English, Spanish, or Arabic), by collecting participants' contact information and information on their social networks via whom the participant could be contacted if direct contact with the participant was not feasible, by assigning each participant to the same interviewer for all interviews, and assuring them that their information would remain confidential.

Another strength of this thesis is the involvement of peer workers in different phases of the research process in the study described in chapter 5. Peer workers were involved in developing information letters, developing data collection tools, data gathering and a member check. This design helped to enhance the researchers' understanding of the living circumstances and daily hassles of people living in persistent poverty and made the study more responsive to the needs of the participants, which helped to bridge the gap between research and practice. Additionally, all studies included in this thesis explicitly examined the client perspective, which in crucial in accurately understanding their needs and circumstances. The study outlined in chapter 4 was actually the first to qualitatively assess the outcomes and the critical elements of IUPS for people experiencing homelessness from their own perspective.

Limitations

Some limitations of the studies in this thesis should also be noted. The first limitation concerns the extent to which our findings can be generalized to the total population of homeless people in the Netherlands. The study populations described in chapter 2 and 3 comprise of homeless people who met the criteria for entering the social relief system (SRS) in the four largest cities in the Netherlands (G4) in 2011. These criteria were: having abandoned the home situation, being unable to hold their own in society, legally residing in the Netherlands, and having regional ties (regiobinding) or living in the region of entry for two years or more (Tuynman & Planije, 2012). Homeless people who did not meet these criteria, such as people without identity documents or legal permits (mostly unaccepted asylum seekers), and labor migrants (mostly from for example Central and Eastern European countries) with less than two years of labor history, were excluded from the SRS. Homeless people who did meet the criteria for entering the SRS but did not make use of these services are also not represented in these studies. The prevalence of risk factors, the prevalence of CAE as well as the situation regarding the constitutional social quality factors may differ between the homeless people allowed to enter the social relief system and those who, for the aforementioned reasons, did not make use of the services. We also take note of the possibility that the results described in chapter 4, derived from a study performed in residential shelters, might not be entirely transferrable to IUPS provided in other types of homeless services (such as emergency shelters or night shelters), or other forms of peer support provided within homeless services (such as peer support groups led by peer workers or informal peer support).

The second limitation relates to the extent to which the study populations described in chapter 2 and 3 were representative of the total population of homeless people in the SRS in the G4 in 2011. Regarding the study population described in chapter 3, roughly 20% of the 2,084 homeless adults (aged 23 years and older, n = 410) and 11% of the 976 homeless young adults (aged 18–22 years, n = 103) entering the SRS in the G4 in 2011 were interviewed at baseline (Tuynman & Planije, 2012). In order to obtain information regarding the representativeness of the study population, van der Laan (2020) compared the total population of homeless (young) adults who entered the SRS in the G4 in 2011 with the study participants. This showed that the adult participants were representative in terms of gender and age. The young adults were representative regarding age, but young males were overrepresented (60%) compared to the total population of homeless young adults who entered the SRS in the G4 (49%). Data on other characteristics of the total population were unavailable. Furthermore, the recruitment procedures applied in chapter 4 and 5 might have led to some selection bias. For example, clients who, from the viewpoint of the recruiter (e.g. a peer worker, the daily staff, the manager, gatekeeper) were considered to be less able to reflect on their personal experiences may not have been selected by them to participate in this study. It is unknown if this selection bias, perhaps also for other reasons, has occurred and whether it influenced the results. Also, in the study described in chapter 4, clients with high appreciation for their peer worker or clients who have benefited relatively much from IUPS may have been more willing to participate, resulting in a more positive perspective on IUPS. In the study described in chapter 5, gatekeepers could, for example, have chosen professionals known for their empathetic involvement with clients, or those professionals were more willing to take part, leading to a biased sample of professionals.

Furthermore, loss to follow-up was examined regarding the studies described in chapter 2 and 3. As to chapter 2, participant loss at follow-up was high (58%). To investigate selective loss to follow-up we compared respondents on the final interview (n = 72) with non-respondents of the Amsterdam cohort (n = 100) on demographic variables as reported at the first measurement. No differences were found between participants who only completed the questionnaire at baseline compared to participants who completed the questionnaire at baseline and follow-up after 5,5 years regarding age, gender, level of education, physical and mental health complaints, and cannabis and alcohol use (Van den Dries et al., 2018). Regarding chapter 3, participant loss to follow-up was fairly low (26%) but this study reported a higher loss to follow-up of participants who were younger, male, and had a low level of education. It is unknown whether and in which direction this selective loss to follow-up may have biased our findings as we lack information on the scores on the study variables of these non-respondents.

Another limitation related to the study design in chapter 2 and 3 pertains to the effect of 'regression to the mean'. The baseline interviews were conducted shortly after the time that participants were literally homeless, while the follow-up interviews were conducted 2.5 years or 5.5 years after this stressful and often traumatic circumstance. Therefore, it is probable that most participants would have improved on most outcome measures by the time of the follow-up interviews. It is also worth mentioning that the data analyzed within chapter 2 and 3 were collected between 2011 and 2017. Statistics Netherlands (SN) estimates that the number of homeless people has significantly increased in the past decade (Statistics Netherlands, 2019a; Statistics Netherlands, 2016), and recent research indicates that these SN-figures are likely even an underestimation of the actual number of homeless people (Wewerinke et al., 2023). This indicates that the results of this study may even be more relevant in the present-day.

Recommendations

Implications for policy and practice

Based on the results of this thesis, a number of issues should be given priority to enhance the living conditions of homeless people and people living in persistent poverty, and to prevent people from succumbing to these vulnerable conditions:

- Strengthening socio-economic security
- Providing accessible, integrated support and continuity of care
- Including peer workers in practice and policy
- Interacting with a human approach
- Trauma-informed approaches
- Preventing ACE

Strengthening socio-economic security

Given the results of this thesis, high priority should be given to strengthening socio-economic security. According to article 25 of the Universal Declaration of Human Rights, everyone has the right to live in socio-economic security: '*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*' (College voor de Rechten van de Mens, 2016, blz. 8). According to the Dutch constitution (Article 20), the government is responsible for the socio-economic security of its citizens.

In order to strengthen these resources for people living in the margins of society, the national and local government should firstly address the structural factors that drive socio-economic insecurity. Based on the results of our studies, strong structural measures are needed that focus on housing security, sufficient and secure income and access to and quality of social support services. In solving the current housing crisis, they could for example prioritize to increase the amount of affordable housing. Also, three quarters of people living on benefits live in poverty, indicating that the benefits are too low to live a socio-economically secure life (Statistics Netherlands, 2019b). Therefore the amount of benefits should not only cover the minimum required living expenses, but should also enable people to build up some savings to cope with financial setbacks, and allow people to socially participate. This also applies to the minimum wage: it should be sufficient for people to attain socio-economic security and social participation. The national government could also further lower the costs of basic health insurance for people with a low income and give them access to various forms of health care that are currently excluded from the basic health insurance.

Among policy makers, there is growing awareness of the association between socio-economic security, poverty and homelessness and the need for action. The Association of Dutch Municipalities (VNG) and the Association of Municipal Directors in the Social Domain (Divosa) already called for strengthening the social domain (VNG & Divosa, 2021). Also, three Dutch ministries recently launched the National Action Plan on Homelessness: Housing First with many proposals for structural solutions to end homelessness (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022). This plan also emphasizes the importance of strengthening financial security. And it highlights the significance of enhancing housing security by means of implementing Housing First as a system approach, which means that this intervention is not only available for homeless people with the most intensive care needs but for all people in a situation of homelessness.

Providing accessible, integrated support and continuity of care

The results of this thesis also indicate that more and specific attention should be paid to optimize access to socio-economic support, access to mental health care and physical health care, and support programs to strengthen family ties. For example, the complexity of regulations regarding accessing and maintaining socio-economic support should be simplified. Chapter 5 points to the importance of support that is accessible, visible and understandable. Services should promote this by, for instance, providing a proper overview of all existing forms of support and regulations, facilitate that access to support is simple and does not require any or much administrative work, and enable professionals to be easy to contact and focus on what people really need. Additionally, service providers should be aware of the detrimental impact that socio-economic insecurity has on people's quality of daily life, and support people in dealing with this insecurity and assist people in strengthening their socio-economic situation. Socio-economic insecurity is often interrelated with other problems such as physical problems, mental health problems, and family instability. Given this interrelatedness, governmental institutions and care organizations should view people holistically and provide integrated, cross-domain support, instead of providing fragmented support (Luijben et al., 2019; Marttila et al., 2013). The National Action Plan on Homelessness: Housing First also addresses this issue by describing the need for tailor-made support that is offered quickly and integrally (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022).

Due to the complexity and persistence of the problems homeless people and people living in persistent poverty encounter, support should be provided as long as necessary to achieve and retain stable housing and socio-economic security in general. This is at odds with the current Dutch social support system that tends to overlook this complexity, imposes short-term support trajectories and requires concrete and measurable results (Hofs, 2017; Van der Tier et al, 2022).

Including peer workers in practice and policy

This thesis has highlighted the importance of including peer workers in daily practice and developing policy. The study described in chapter 4 showed that, in addition to providing direct support to clients, peer workers are also involved in educating professionals about certain challenges that clients face in their daily lives and in their process of recovery. Peer workers are also regularly asked to inform and assist other professionals in dealing with these challenges. This underlines the value of experience-driven service provision. Implementing peer support as an addition to standard care would further advance care provision within homeless services and social support services for people living in poverty, provided that organizations will ensure that the position of peer support is effectively implemented within their services. Organizations should for example use a clear job description with relevant competencies for peer workers and ensure that they are able to use these competencies (which they have obtained through their life experiences and training), instead of being assigned tasks that other professionals are too busy to perform (such as providing clients with transportation when they move out; Davidson et al., 2012). Furthermore, the results of this study suggest that organizations should make sure that peer workers have and retain ample time to 'be there' for clients, for instance by preventing high caseloads for peer workers. Organizations should also formally allow and support peer workers being available for clients after office hours or after clients have exited a shelter or support program, if they think this could benefit clients. At the same time, organizations should assist peer workers in maintaining a sound work-life balance, as research shows that role and time boundaries can be a concern for peer workers providing peer support (Gidugu et al., 2015; Miyamoto & Sono, 2012). The recently published 'Quality System for Experts by Experience' can support organizations with implementing the position of peer support within their services (Association for Experts by Experience, 2022; Daniels, 2022)

For policy to effectively address the needs of homeless people and people living in poverty, knowledge about the impact of homelessness and living in poverty on people's lives is paramount. It is argued that many policy makers lack personal experience with homelessness or poverty, leading to adverse effects on the effectiveness of social policies and interventions ('S Jongers, 2022). This underscores the critical need to explicitly incorporate the voices of individuals with lived experiences. The results of this thesis indicate that peer workers can play an important role in voicing the needs of homeless people and people living in poverty in ensuring that policy is relevant to those who are subject to it. Including the voices of people with lived experiences is very important: it helps policy makers to better understand these experiences and to create policies that fit the context in which it will be put into practice (Meriluoto, 2018). In The Netherlands there is growing awareness among policy makers regarding the necessity of the inclusion of lived experiences in policy making processes. The National Action Plan on Homelessness: Housing First was actually created together with people with lived experiences, and the necessity of cocreation is explicitly emphasized within this action plan (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022). However, there is no certainty that only because people with lived experience are represented in policy making processes, they will automatically be heard or be capable to communicate in such a way that their experiential knowledge is effectively received (Blume, 2017; Lancaster et al 2017; Meriluoto, 2018). So, it is essential that lived experiences are communicated in a way that is interpretable by policymakers (Smith-Merry, 2020). Samen Thuis 2030, a collective of individuals with experiential knowledge and independent advocates, also emphasizes that this process does not happen automatically and advocates for meaningful participation. Recently, they developed a guide for policymakers on how to meaningfully collaborate with people with experiential knowledge regarding homelessness (Samen Thuis 2030, 2023).

Interacting with a human approach

Chapter 4 and 5 have advocated for services to apply a more human-to-human approach, for example by providing ample time and patience to really listen, and offering open, transparent services based on trust and equality, which is in line with previous research (Luchenski et al., 2018). First of all, this requires regular professionals and peer workers to have enough time available for their clients. Therefore, organizations need to critically reflect on the case loads of their professionals and reduce these caseloads if necessary. This would give regular professionals and peer workers the opportunity to treat their clients as human beings instead of numbers. However, implementing this change depends on municipalities or other governmental funders recognizing the importance of this issue and offering additional funding where required.

The results of this thesis also suggest that clients would benefit from grounding service provision more on an equal footing. Organizations could for example educate all professionals on the importance of a working relationship that is based on trust and equality and could specifically encourage professionals to act in a less reserved way when it comes to sharing their personal experiences with clients. While sharing personal experiences with clients is still quite uncommon in social support services, homeless services and mental health services, sharing these experiences is argued to be beneficial for clients (Weerman, 2016). However, as peer workers in chapter 4 already indicated, they should only share their personal experiences when they think this would be beneficial for clients.

In addition to the working relationship between the client and the professional, equality should also be promoted in the processes and policies of the government and care organizations as well. Policies such as governmental letters with an authoritarian tone, the requirement for social assistance recipients to justify the what and why for every bank statement, and the bulletproof glass in some meeting rooms, make people feel like criminals and should, logically, be avoided (Jungmann et al., 2020). A trust-based relationship actually would benefit from more leniency in regulations, and a government and organizations who trust instead of control.

Furthermore, findings of chapter 4 and 5 also underline the importance of applying strengths-based approaches such as "Pathways to Empowerment" (Wolf, 2016) that emphasize, for example, the importance of focusing on the client's strengths and assets, building a trusting relationship with them, supporting the client in her/his process of recovery, and taking the client's needs and goals as a starting point for the support provided.

Trauma-informed approaches

As described in chapter 3, participants with CAE generally remained disadvantaged 2.5 years after shelter entry compared to participants without CAE, particularly regarding their socio-economic situation, their mental and physical health, and their relationships with other people.

These results indicate that homeless people with CAE might benefit from extra support in those areas. Trauma-informed approaches seem essential to address the long-term consequences of trauma and to prevent further traumatization through homelessness (Feantsa, 2017). Trauma-informed approaches identify the relationship between traumatic experiences and their consequences, such as problematic drug and alcohol use, personality disorders, suicide attempts, and family instability. These consequences often prevent traumatized people from having their needs met and enhance their living conditions (Feantsa, 2017). Trauma Informed Care (TIC; Hopper et al, 2010) and Psychologically Informed Environments (PIE; Keats et al, 2012) provide frameworks that can help homeless services optimize their support for people living with the burden of trauma. For example, homeless services should be client-driven, create a physically safe environment and ensure that their services do not retraumatize service users, for example by using strict or authoritarian rules. Staff should be trained in trauma-informed care and in creating therapeutic relationships. They should be encouraged, for example, to offer reliable, caring and long-term relationships with their clients. They should also apply a strengths-based approach. Homeless services and their staff should also acknowledge that traumatized service users will be managing the effects of their traumas by for example, substance abuse, self-harm or 'difficult' social interactions. Simultaneously, staff should be supported with emotional stress stemming from working with people who experienced trauma, to avoid burnout. Furthermore, trauma affects men and women differently, so a gendered approach within homeless services seems important. Previous research also argues that service providers should integrally address early trauma, family instability, mental health, substance misuse and homelessness, as they are co-dependent elements (Mc Conalogue et al., 2019).

Special attention should be paid to children living in homeless services. For these children their homelessness is a current ACE, hence homeless services should strive to reduce the traumatic stress as much as possible. Policymakers and housing corporations could, for instance, prioritize children when providing housing for homeless people.

Preventing ACE

Whereas trauma-informed approaches seem to be essential within homeless service provision, it would be even more worthwhile to prevent trauma and ACE. The prevention of ACE, evidently, should take place in childhood. Research has shown an association between childhood poverty and ACE. Children living in poverty experience additional ACE more often and more severe (Anda, Butchart, Felitti, & Brown, 2010). Poverty in childhood has been associated with poorer mental and physical health in adult life, and, even after accounting for other ACE, with more physical distress (Crouch et al, 2020). Research has also shown that the most effective method of preventing ACE is to reduce material poverty and deprivation (Luchenski, 2018). This would lower parental stress, and can therefore help reducing the chance of child maltreatment and children's exposure to violence at home (Fortson, et al., 2016; Niolon et al., 2017). To enhance the living conditions of families living in socio-economically insecure conditions, decrease the prevalence of ACE and reduce the additional negative effect child poverty has on their adult lives, structural measures are needed.

In addition to strengthening families' socio-economic security, The American Centers for Disease Control and Prevention (2019) outlines that the prevention of ACE requires a broad and comprehensive set of strategies. These strategies cover all four constitutional conditions of the Social Quality Approach. In short, they include the abovementioned strengthening of economic support for families (living conditions), ensuring a strong start for children (living conditions and societal embeddedness), promoting social norms that protect against violence and adversity (societal embeddedness), connecting youth to caring adults and activities (interpersonal embeddedness), teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges and intervening to lessen immediate and long-term harms (self-regulation).

Future research

Given the result that homeless people with CAE were worse off compared to homeless people without CAE regarding a wide range of constitutional conditions influencing the quality of their daily lives, it would be useful to research the application of trauma-informed approaches within Dutch homeless services. Such a study might be able to identify whether and on which conditions trauma-informed approaches have an effect in the lives of homeless people making use of homeless services.

Because of the limited generalizability of the findings described in chapter 2, 3 and 4 to the total population of homeless people in the Netherlands, future research should strive to include a broader and more inclusive representation of people who experience homelessness in the Netherlands. For example, people who are excluded from the SRS, such as people without identity documents or legal permits, or people with insecure and inadequate housing. This could provide further insight into what homeless people need to enhance their living conditions and participate in society.

Findings of this thesis underline the necessity of including the views of people experiencing social exclusion and peer workers in conducting research and formulating research agendas. This approach requires real collaboration, that needs researchers to listen and learn from the people they want to conduct their research for, instead of researchers trying to impose their norms (for example regarding healthy behavior or coping styles) on others via their research (Breed & Van Marle, 2022). Researchers who aim to improve the living situation of people experiencing social exclusion should, for example, collect research questions from the people themselves, focus their research thereon, and examine together how this research could best be conducted. In this regard, much can be learned from community-based participatory research (Jagosh et al., 2015).

Finally, (further) research should never be a reason to postpone policy measures that improve the living conditions and social support for people living in vulnerable conditions.

Conclusions

This thesis has increased our knowledge of the needs of homeless people using shelter facilities in the Netherlands and of the needs and wishes of people living in persistent poverty. It provides guidance for policy and further professionalization and quality improvements to the services and support provided to homeless people and people living in persistent poverty. The results underscore the importance of broad and integrated policy measures to strengthen socio-economic security, and emphasize the need for including the views of clients and experts by experience in the development of policy. Our research also stresses the need for services to employ peer workers to support homeless people and people living in persistent poverty and to apply a more human-to-human approach.

References

Altena, A.M. (2019). *Homeless young adults using shelter facilities: Their needs and the effectiveness and appropriateness of interventions and services* [Doctoral dissertation]. Radboud University Medical Center. Retrieved from: https://repository.ubn.ru.nl/bitstream/handle/2066/203564/203564.pdf?sequence=1

Association for Experts by Experience (2022). *Kwaliteitssysteem voor Ervaringsdeskundigen*. Retrieved from: https://vved.org/kve/

Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the At Home-Chez soi Demonstration Project. *Canadian Journal of Psychiatry, 60*(11):467-74. doi: 10.1177/070674 371506001102

Barker, S. L. (2018*). Peer support and homelessness* [Doctoral dissertation]. University of Southampton. Retrieved from: https://eprints.soton.ac.uk/429021/1/Barker_PhD_Thesis_ Final.pdf. doi: 10.5258/SOTON/D0649

Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. L. (2019). Expert viewpoints of peer support for people experiencing homelessness: A Q sort study. *Psychological Services, 16*(3), 402–414. doi: 10.1037/ser0000258

Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology & Community Health, 73*(5), 379-387. doi: 10.1136/jech-2018-210981

Beenackers, M. A., Groeniger, J. O., Kamphuis, C. B. M., & van Lenthe, F. J. (2016). The role of financial strain and self-control in explaining income inequalities in health behaviors. *European Journal of Public Health, 26*. doi: 10.1093/eurpub/ckw166.058

Bethell, C.D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice. *Academic Pediatrics, 17* (7), 51-69. Doi: 10.1016/j.acap.2017.04.161.

Blume, S. (2017) In search of experiential knowledge. *Innovation: The European Journal of Social Science Research, 30*(1), 91–103. doi: 10.1080/13511610.2016.1210505

Boesveldt, N., Kuijpers, M., Bochem, M. & Dries, van den S. (2019). *Voorkomen Terugval Utrecht: Eerste meting van vijfjarig onderzoek naar recidive dakloosheid in Utrecht.* Retrieved from: https://onderzoekmobw.socsci.uva.nl/wp-content/uploads/2020/04/Rapportage-2019 Voorkomen-Terugval-Utrecht.pdf

Boesveldt, N., Kuijpers, M., Van der Veen, C., & Otto, M. (2021). Rapportage *Voorkomen Herhaalde Dakloosheid Utrecht: Rapportage derde meting van vijfjarig onderzoek naar recidive dakloosheid in Utrecht, meting 2021.* Retrieved from: https://onderzoekmobw.socsci.uva.nl/wp-content/uploads/2021/10/Boesveldt-2021-Rapportage-Voorkomen-Herhaalde-Dakloosheid-Regio-Utrecht_Derde-Ronde.pdf

Breed, M., & Van Marle, F. (2022). Bewoners aandachtswijken voelen zich klein gehouden door onderzoekers en beleidsmakers. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/bewoners-aandachtswijken-voelen-zich-klein-gehouden-door-onderzoekers-en-beleidsmakers/

Brown, R.T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M.B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *PLoS ONE 11 (5).* doi: 10.1371/journal.pone.0155065

Centers for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Chien, W.T., Clifton, A.V., Zhao, S., & Lui, S. (2019). Peer support for people with schizophrenia or other serious mental illness. *Cochrane Database of Systematic Reviews, 4(4)*, CD010880. doi: 10.1002/14651858.CD010880.pub2

Crouch, E., Jones, J., Strompolis, M., & Merrick, M. (2020). Examining the association between ACEs, childhood poverty and neglect, and physical and mental health: Data from two state samples. *Children and Youth Services Review, 116*. doi: 10.1016/j.childyouth.2020.105155

Curl, A., & Kearns, A. (2014). Financial difficulty and mental wellbeing in an age of austerity: The experience in deprived communities. *Social Policy & Society, 14*, 217-240. doi: 10.1017/S1474746414000475

Daniels, D. (2022). Ervaringsdeskundigen hebben baat bij een systeem. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/ervaringsdeskundigen-hebben-baat-bij-een-systeem/

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123–128. doi: 10.1016/j.wpsyc.2012.05.009

Feantsa (2017). *Recognising the Link between Trauma and Homelessness.* Feantsa Position, retrieved from: https://www.feantsa.org/download/feantsa_traumaandhomelessness030 7347121905294 6810738.pdf

Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Gidugu, V., Rogers, E.S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal, 51*(4), 445–452. doi: 10.1007/s10597-014-9801-0

Green, H.D., Tucker, J.S., Wenzel, S.L., Golinelli, D., Kennedy, D.P., Ryan, G.W., & Zhou, A.J. (2012). Association of childhood abuse with homeless women's social networks. *Child Abuse & Neglect, 36* (1), 21-31. doi: 10.1016/j.chiabu.2011.07.005

Gupta, A., & Holloway, R. (2016). Giving poverty a voice: Families' experiences of social work practice in a risk-averse child protection system. *Families, Relationships and Societies, 5*(1), 163-172. doi: 10.1332/204674316X14540714620166

Haushofer, J., & Feher, E. (2014). On the psychology of poverty. *Science, 344*(6186), 862-867. doi: 10.1126/science.1232491

Hofs, J., 2017. Sociaal werkers onder gemeentelijke regie. Pleidooi voor sociale rechtvaardigheid als basisprincipe voor sociaal werk. *Journal of Social Intervention: Theory and Practice, 26*(3), p.65-71. doi: 10.18352/jsi.542

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1), 80–100.

Jagosh, J., Bush, P. L., Salsberg, J., Macaulay, A. C., Greenhalgh, T., Wong, G., & Pluye, P. (2015). A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health, 15*. doi: 10.1186/s12889-015-1949-1

Jungmann, N., Wesdorp, P., & Madern, T. (2020). *Stress-sensitief werken in het sociaal domein. Inzichten en praktische handvatten voor hulp- en dienstverleners.* Houten: Bohn Stafleu van Loghum.

Keats, H., Maguire, N., Johnson, R., & Cockersell, P. (2012) *Psychologically informed services for homeless people*. Southampton, GB, Communities and Local Government (Good Practice Guide).

Keuzenkamp, S. (2022). Geef Ervaringskennis- en deskundigen een serieuze positie. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/geef-ervaringskennis-en-deskundigen-een-serieuze-positie/

King, A.J., Thy, B.O., & Simmons, M.B. (2018). A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions. *Psychiatric Services, 69*(9), 961–977. doi: 10.1176/appi.ps.201700564

Lancaster, K., Seear, K., Treloar, C. and Ritter, A. (2017) The productive techniques and constitutive effects of "evidence-based policy" and "consumer participation" discourses in health policy processes, *Social Science and Medicine, 176*, 60–68. doi: 10.1016/j.socscimed.2017.01.031

Lee, C.M., Mangurian, C., Tieu, L., Ponath, C., Guzman, D., & Kushel, M. (2017). Childhood Adversities Associated with Poor Adult Mental Health Outcomes in Older Homeless Adults: Results From the HOPE HOME Study. *American Journal of Geriatric Psychiatry, 25*(2), 107-117. doi: 10.1016/j.jagp.2016.07.019

Liu, M., Mejia-Lancheros, C., Lachaud, J., Nisenbaum, R., Stergiopoulos, V., & Hwang, S.W. (2020). Resilience and Adverse Childhood Experiences: Associations With Poor Mental Health Among Homeless Adults. *American Journal of Preventive Medicine, 58* (6), 807-816. doi: 10.1016/j.amepre.2019.12.017

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S., & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry, 14*(1), 39. doi: 10.1186/ 1471-244X-14-39

Loignon, C., Hudon, C., Goulet, E., Boyer, S., De Laat, M., Fournier, N., Grabovschi, C., & Bush, P. (2015). Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project. *International Journal for Equity in Health, 14*(4). doi: 10.1186/s12939-015-0135-5

Luchenski, S., Maguire, N., Aldridge, R. W., Hayward, A., Story, A., Perri, P., ... Hewett, N. (2018). What works in inclusion health: Overview of effective interventions for marginalised and excluded populations. *The Lancet, 391*(10117), 266-280. doi:10.1016/s0140-6736(17)31959-1

Luijben , G., Hertog , F., & van der Lucht, F. (2019). *Armoede, chronische stress en gezondheid in Den Haag, een verkenning op basis van group model building* (vol. 2019-0004). Bilthoven, The Netherlands: Rijksinstituut voor Volksgezondheid en Milieu RIVM, Ministerie van Volksgezondheid, Welzijn en Sport.

Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013). Poverty impedes cognitive function. *Science, 341*, 976-980. doi: 10.1126/science.1238041

Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public Health, 126*, 4-10. doi: 10.1016/j.puhe.2012.05.014.

Marttila, A., Johansson, E., Whitehead, M. et al. (2013). Keep going in adversity – using a resilience perspective to understand the narratives of long-term social assistance recipients in Sweden. *International Journal for Equity in Health 12* (8). doi:10.1186/1475-9276-12-8

Mc Conalogue, D., Maunder, N., Areington, A., Martin, K., Clarke, V., & Scott, S. (2019). Homeless people and health: a qualitative enquiry into their practices and perceptions. *Journal of Public Health, 43*(2), 287–294. doi: 10.1093/pubmed/fdz104

Meriluoto, T. (2018) Turning experience into expertise: technologies of the self in Finnish participatory social policy. *Critical Policy Studies, 12*(3), 294–313. doi: 10.1080/19460171.2017.1310051

Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature. *Clinical Practice and Epidemiology in Mental Health, 8*(1), 22–29. doi: 10.2174/1745017901208010022

Mood, C., & Jonsson, J.O. (2016). The Social Consequences of Poverty: An Empirical Test on Longitudinal Data. *Social Indicators Research, 127*(2), 633-652. doi: 10.1007/s11205-015-0983-9

Movisie (2018). *Ervaringsdeskundigen in het sociaal domein: wie zijn ze en wat doen ze?* Retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2019-11/Startnotitie-Ervaringsdeskundigen-in-het-sociaal-domein.pdf

Movisie (2022). *Werken aan bestaanszekerheid: gemeenten aan de slag vanuit het perspectief van inwoners.* Retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2022-06/Werken-aan-bestaanszekerheid-2022.pdf

Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport (2022). *Nationaal Actieplan Dakloosheid: Eerst een Thuis*. Retrieved from: https://open.overheid.nl/documenten/ronl-bb529bd58adc8061e5c058d2fe9 671197ba 6244f / pdf

National Institute for Budget Education (2022). Retrieved from: https://www.nibud.nl/dossiers/koopkracht - betaalbaarheid/

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T. L., & Gilbert, L. (2017). *Preventing intimate partner violence across the lifespan: A technical package of programs, policies and practices.* Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

O'Donnell, P., Tierney, E., O'Carroll, A., Nurse, D., & MacFarlane, A. (2016). Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *International Journal Equity in Health, 15*, 197. doi: 10.1186/s12939-016-0487-5

Patterson, M.L., Moniruzzaman, A., & Somers, J.M. (2014). Setting the stage for chronic health problems: cumulative childhood adversity among homeless adults with mental illness in Vancouver, British Columbia. *BMC Public Health, 14*, 350. doi: 10.1186/1471-2458-14-350

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews, 3*(3), CD004807. doi: 10.1002/14651858.CD004807.pub2

Pharos (2022). *Discriminatie en Gezondheid: Over de invloed van discriminatie (in de zorg) op gezondheidsverschillen en wat we hieraan kunnen doen.* Retrieved from: https://www.pharos.nl/nieuws/discriminatie-in-de-zorg-onderzoek/

Pharos (2023). Factsheet: *Armoede tijdens de eerste 1000 dagen: cijfers, feiten en gevolgen* Retrieved from: https://www.pharos.nl/factsheets/armoede-tijdens-de-eerste-1000-dagen- cijfers-feiten-en-gevolgen/

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392–411. doi: 10.3109/09638237.2011.583947

Ridley, M., Rao, G., Schilbach, F., & Patel, V. 2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science, 370*, (6522). doi: 10.1126/science.aay0214

Samen Thuis 2030 (2023). *Betekenisvol samenwerken met jongeren met ervaringskennis over (dreigende) dakloosheid: Een handleiding voor beleidsmakers.* Retrieved from: https://www.samenthuis2030.nl/wp-content/uploads/2023/05/Whitepaper_Betekenisvolle_ participatie_van_jongeren_met_ervaringskennis.pdf

Schiffrin, H. H., & Nelson, S. K. (2010). Stressed and Happy? Investigating the Relationship Between Happiness and Perceived Stress. *Journal of Happiness Studies, 11*(1), 33-39. doi:10.1007/s10902-008-9104-7

'S Jongers, T. (2022). *Beledigende Broccoli: Over de Ervaringskennis van Kwetsbare Mensen*. Uitgeverij Van Gennep B.V., The Netherlands.

Smith-Merry, J. (2020). Evidence-based policy, knowledge from experience and validity. *Evidence & Policy, 16*(2), 305-316. Retrieved Mar 19, 2023, from https://bristoluniversitypressdigital.com/view/journals/evp/16/2/article-p305.xml

Statistics Netherlands [Centraal Bureau voor de Statistiek] (2016). *Aantal daklozen in zes jaar met driekwart toegenomen* [Number of homeless people increased by three quarters in six years]. Retrieved from: https://www.cbs.nl/nl-nl/nieuws/2016/09/aantal-daklozen-in-zes-jaarmet-driekwart-toegenomen

Statistics Netherlands [Centraal Bureau voor de Statistiek] (2019a). *Aantal daklozen sinds 2009 meer dan verdubbeld* [Number of homeless people more than doubled since 2009]. Retrieved from: https://www.cbs.nl/nl-nl/nieuws/2019/34/aantal-daklozen-sinds-2009-meer-danverdubbeld

Statistics Netherlands [Centraal Bureau voor de Statistiek] (2019b). Welvaart in Nederland. Retrieved from: https://longreads.cbs.nl/welvaartinnederland-2019/armoede-en-risicogroepen/

Statistics Netherlands [Centraal Bureau voor de Statistiek] (2020). *Slachtofferschap delicten; persoonskenmerken 2012-2019*. Retrieved from: https://www.cbs.nl/nl-nl/cijfers/detail/83096NED

Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26* (10), 1011–1027. doi: 10.1016/S0145-2134(02)00382-4

Sturm, W.E. (2022). *To be Trusted: The Role of the Working Alliance in Probation Supervision* [Doctoral Thesis]. Vrije Universiteit, Amsterdam. Retrieved from: https://research.vu.nl/en/publications/to-be-trusted-the-role-of-the-working-alliance-in-probation-super

Tuynman, M., & Planije, M. (2012). *Monitor Plan van Aanpak Maatschappelijke Opvang. Rapportage 2011: Amsterdam, Rotterdam, Den Haag en Utrecht*. Trimbos Instituut, Utrecht.

Van den Dries, L., Peters, Y., Al Shamma, S., & Wolf, J. (2018). *Dakloze Mensen in Amsterdam: Veranderingen 5,5 jaar na instroom in de Opvang.* Impuls – Onderzoekscentrum Maatschappelijke Zorg, Radboudumc. Retrieved from: https://www.straatconsulaat.nl/wp-content/uploads/2018/11/Rapport-CodaG4-Dakloze-mensen-in-Amsterdam.pdf

Van der Laan, J. (2020). *Giving Voice to Homeless People: homeless people's personal goals, care needs, and quality of life in the Dutch social relief system* [Doctoral dissertation]. Radboud University Medical Center, Nijmegen.

Van der Tier, M., Hermans, K., & Potting, M. (2022). Social workers as state and citizen-agents. How social workers in a German, Dutch and Flemish public welfare organisation manage this dual responsibility in practice. *Journal of Social Work, 22*(3), 595–614. Doi: 10.1177/14680173211009724

VNG & Divosa (2021). *De winst van het sociaal domein: Een slimme investering in bestaanszekerheid, kansengelijkheid en gezondheid.* Retrieved from: https://vng.nl/sites/default/files/2021-04/de-winst-van-het-sociaal-domein_def.pdf

Watson, E. (2019). The mechanisms underpinning peer support: A literature review. *Journal of Mental Health, 28*(6), 677–688. doi: 10.1080/09638237.2017.1417559

Weerman, A. (2016). *Ervaringsdeskundige zorg- en dienstverleners: Stigma, verslaving & existentiële transformatie* [Doctoral dissertation]. Vrije Universiteit Amsterdam. Retrieved from: https://research.vu.nl/ws/portalfiles/portal/42162914/complete+dissertation.pdf

Wewerinke, D., Schel, S., Kuijpers, M., De Vries, J. & Van Doorn, L. (2023). *Iedereen telt mee. Resultaten eerste ETHOS telling dak- en thuisloosheid regio Noordoost Brabant*. Utrecht: Hogeschool Utrecht.

Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy, 76*(1), 106-121. doi: 10.1016/j.healthpol.2005.05.005

Wolf, J. (2016). Krachtwerk. *Methodisch werken aan participatie en zelfregie*. Bussum: Coutinho

Chapter 7

Samenvatting en algemene discussie
Summary and general discussion in Dutch

Het doel van dit proefschrift is onze kennis te vergroten over wat Nederlanders in een situatie van dakloosheid en Nederlanders die leven in langdurige armoede nodig hebben om hun kwetsbare positie te overwinnen, hun leefomstandigheden te verbeteren en deel te nemen aan de samenleving. In dit laatste hoofdstuk zal ik de empirische bevindingen van de vier uitgevoerde studies samenvatten en bespreken, kritisch reflecteren op de sterke punten en beperkingen van deze studies, aanbevelingen doen voor beleid en praktijk, suggesties geven voor toekomstig onderzoek, en afsluiten met een conclusie.

Samenvatting van de belangrijkste bevindingen

Prevalentie en persistentie van risicofactoren voor dakloosheid (hoofdstuk 2)

Deze observationele longitudinale cohortstudie gaf inzicht in de huisvestingsstatus en de prevalentie van een reeks niet-statische risicofactoren voor dakloosheid in de levens van dakloze mensen in Amsterdam. Deze risicofactoren werden in kaart gebracht door middel van face-to-face vragenlijsten afgenomen bij toelating tot de maatschappelijke opvang (MO) in Amsterdam (n=172) en 5,5 jaar later (n=72). De vier condities van het model van sociale kwaliteit (bestaansvoorwaarden, sociale inbedding, maatschappelijke inbedding en zelfregulering; Van der Maesen & Walker, 2012; Wolf & Jonker, 2020) werden gebruikt om de risicofactoren in deze studie te clusteren. Bij toelating tot de MO waren de deelnemers ernstig benadeeld wat betreft alle vier de condities van sociale kwaliteit, en zoals verwacht was geen van de deelnemers duurzaam gehuisvest. Na 5,5 jaar zijn veel deelnemers er met betrekking tot huisvesting substantieel op vooruit gegaan: 69% van de deelnemers was toen duurzaam gehuisvest. Ook werden enige verbeteringen gevonden voor alle vier de condities van sociale kwaliteit, wat te verwachten was gezien de schrijnende situatie van de deelnemers bij binnenkomst in de MO. Ondanks deze verbeteringen veranderde de prevalentie van de meerderheid van de risicofactoren voor dakloosheid niet, en sommige risicofactoren die wel significant afnamen in de loop van de tijd, werden nog steeds vaak gerapporteerd door de deelnemers. Na 5,5 jaar had bijvoorbeeld bijna zestig procent van de deelnemers nog steeds schulden, was driekwart werkloos (76%) en hadden veel mensen niet genoeg geld voor basisbehoeften zoals voedsel (24%), reizen (44%), kleding (61%) en sociale activiteiten (53%). Een kwart van de deelnemers had een slechte kwaliteit van relaties met familieleden (25%), bijna de helft had geen steun van familieleden (47%) en vier tiende had geen steun van vrienden en kennissen (40%). Wat betreft hun fysieke gezondheid meldde bijna een derde (31%) vier of meer fysieke gezondheidsproblemen, een kwart (26%) was ontevreden over hun fysieke gezondheid. Bovendien werden, in vergelijking met de algemene bevolking, hoge niveaus van psychische klachten gerapporteerd: meer dan vier tiende meldde hoge niveaus van depressie (43%), een kwart meldde hoge niveaus van angst (26%) en meer dan een derde meldde hoge niveaus van somatisatie (35%). Overmatig cannabisgebruik werd gemeld door iets meer dan een derde van de deelnemers (34%). Dit betekent dat, naast belangrijke verbeteringen, de persoonlijke situatie van de deelnemers die aanvankelijk dakloos waren, behoorlijk achterbleef, vooral in vergelijking met de algemene Nederlandse bevolking. 5,5 jaar na toelating tot de MO ervaarden de deelnemers nog steeds hoge niveaus van sociale uitsluiting in vergelijking met de algemene Nederlandse bevolking. Dit heeft een negatieve impact op hun kwaliteit van leven en maakt hen ook bijzonder kwetsbaar voor een nieuwe episode van dakloosheid.

De impact van kindermishandeling op de kwaliteit van het dagelijks leven van dakloze mensen (hoofdstuk 3)

Deze studie vergeleek dakloze mensen met en zonder ervaringen met kindermishandeling (EMK) op een uitgebreide reeks factoren die van invloed zijn op de kwaliteit van hun dagelijkse leven. De gegevens werden gebruikt uit een observationele longitudinale multi-site cohortstudie (CODA-G4). De factoren die van invloed zijn op de kwaliteit van het dagelijks leven werden gegroepeerd in de vier condities van het model van sociale kwaliteit. Van de 513 deelnemers rapporteerden 203 deelnemers (40%) één of meer vormen van kindermishandeling.

Bij toelating tot de MO en bij de follow-up (n = 378), 2,5 jaar later, waren de deelnemers met EMK in elk van de vier condities van sociale kwaliteit (leefomstandigheden, interpersoonlijke inbedding, maatschappelijke inbedding en zelfregulering) meer benadeeld, met uitzondering van maatschappelijke inbedding bij de follow-up. Met betrekking tot leefomstandigheden hadden deelnemers met EMK bij aanvang vaker schulden en waren vaker slachtoffer geweest van een geweldsmisdrijf gedurende het afgelopen jaar. Wat betreft sociale inbedding meldden ze significant lagere niveaus van sociaal functioneren, ervaarden ze minder steun van hun familieleden en rapporteerden ze een slechtere kwaliteit van relaties met familieleden, vrienden, kennissen en hun kinderen. Met betrekking tot maatschappelijke inbedding meldden ze meer onvervulde zorgbehoeften en wat betreft zelfregulering waren ze minder tevreden over hun algehele lichamelijke en geestelijke gezondheid, ervaarden ze over het algemeen meer psychische problemen, meldden ze significant hogere niveaus van depressie, angst en somatisatie, en waren ze vaker gebruikers van cannabis.

Bij de follow-up hadden de deelnemers met EMK niet langer vaker schulden, ze meldden niet langer een significant lagere kwaliteit van hun relaties met vrienden, kennissen en kinderen, ze meldden niet langer meer onvervulde zorgbehoeften en waren niet langer minder tevreden over hun geestelijke gezondheid in vergelijking met deelnemers zonder dergelijke ervaringen. In tegenstelling tot bij aanvang meldden ze echter vaker werkloos te zijn geweest gedurende het afgelopen jaar. Desalniettemin meldden deelnemers met EMK nog steeds significant lagere niveaus van sociaal functioneren, ervaarden ze minder steun van familie, vrienden en kennissen en een slechtere kwaliteit van relaties met familieleden, en waren ze nog steeds vaker slachtoffer geweest van een geweldsmisdrijf gedurende het afgelopen jaar. Ze waren ook nog steeds significant minder tevreden over hun lichamelijke gezondheid, meldden nog steeds significant hogere niveaus van depressie, angst en somatisatie en waren nog steeds vaker gebruikers van cannabis.

Wat betreft het tempo van verandering na 2,5 jaar, verbeterden deelnemers met en zonder EMK gemiddeld genomen in een vergelijkbaar tempo op bijna alle factoren. Verschillen in het tempo van verandering werden gevonden voor de werkstatus, kwaliteit van relaties met familieleden en symptomen van depressie en angst. Bij aanvang waren deelnemers met en zonder EMK even vaak werkzaam. Echter, bij de follow-up gaven minder deelnemers met EMK aan dat ze hadden gewerkt gedurende het afgelopen jaar, terwijl het aantal werkzame deelnemers zonder EMK hetzelfde bleef. Ook meldden deelnemers met EMK, hoewel ze bij de follow-up nog steeds achterbleven, een grotere toename in tevredenheid over de kwaliteit van hun relaties met familieleden en een grotere afname in symptomen van depressie en angst in vergelijking met deelnemers zonder EMK. Deze bevindingen lijken aan te geven dat mensen met EMK minstens hetzelfde groeipotentieel en mogelijkheden tot zelfverwezenlijking hebben als mensen zonder EMK.

Voor zover wij weten, is dit de eerste studie die verschillen heeft onderzocht tussen volwassen dakloze mensen met en zonder EMK op een breed scala aan factoren die van invloed zijn op de kwaliteit van hun dagelijks leven gedurende de volwassenheid. Dit was ook de eerste studie die heeft onderzocht in hoeverre EMK een aanhoudende invloed hadden op de levenskwaliteit van dakloze mensen na toegang tot de MO. Samengevat stonden dakloze mensen met EMK er bij toelating tot de MO slechter voor en bleven over het algemeen slechter af 2,5 jaar na toelating tot de MO, in vergelijking met dakloze mensen zonder deze ervaringen. Het is daarom van belang dat er binnen MO-organisaties voldoende kennis en aandacht is voor de uitgebreide en langdurige impact van EMK op het dagelijks leven van dakloze mensen, met name wat betreft hun interpersoonlijke relaties, geestelijke gezondheid en lichamelijk welzijn. De bevindingen van dit onderzoek onderstrepen het belang traumasensitief werken binnen MO-organisaties.

De waarde en werkingsmechanismen van individuele begeleiding door een ervaringsdeskundige voor dakloze mensen (hoofdstuk 4)

Hoewel de inzet van individuele begeleiding door een ervaringsdeskundige (IBE) binnen de MO groeit, is er weinig onderzoek naar de effectiviteit ervan en wordt voornamelijk het perspectief van mensen die dakloos zijn over het hoofd gezien. Naar ons weten was dit de eerste studie die de resultaten en werkzame elementen van IBE voor dakloze mensen heeft onderzocht, vanuit het perspectief van zowel mensen die dakloos zijn als ervaringsdeskundigen. We hielden semigestructureerde interviews met mensen die dakloos zijn (n=10) en ervaringsdeskundigen (n=10). Volgens de deelnemers verbetert IBE het zelfbeeld van cliënten, stimuleert het hun persoonlijke groei en bevordert IBE het gebruik van benodigde zorg en ondersteuning. Wat betreft de werkzame elementen van IBE, kwamen er uit de analyse van de interviews tien elementen naar voren, namelijk: er zijn, begrijpen, toegankelijk en beschikbaar zijn, comfort en persoonlijke verbinding, gelijkwaardigheid, rolmodel, bemoedigen en bekrachtigen, praktische ondersteuning bieden en werken aan betere levensomstandigheden, ondersteunen in contacten met hulpverleners, en cliënten ondersteunen in zorgtrajecten. Hoewel alle resultaten en werkzame elementen zowel door de ervaringsdeskundigen als de mensen die dakloos zijn werden genoemd, werden bepaalde aspecten ervan slechts door één groep genoemd. Het opnemen van beide perspectieven heeft daarom gezorgd voor een vollediger begrip van de waarde en werkzame elementen van IBE. Door de resultaten en werkzame elementen te combineren, ontstonden drie werkingsmechanismen van IBE: Rapport en empathie, Vertrouwelijke en bekrachtigende werkrelatie, en Ondersteuning, begeleiding en bemiddeling. Aangezien deze werkingsmechanismen allen verwijzen naar de kwaliteit van de relatie tussen dakloze mensen en ervaringsdeskundigen, laten de resultaten van deze studie zien dat de kwaliteit van deze relatie cruciaal is voor het succes van IBE. De bevindingen laten ook zien dat dakloze mensen en ervaringsdeskundigen grote waarde hechten aan de resultaten en werking van IBE. Dit impliceert dat IBE een standaard onderdeel van het ondersteuningsaanbod voor dakloze mensen dient te zijn.

Wensen en bijbehorende barrières en ondersteuningsbehoeften van mensen die in langdurige armoede leven (hoofdstuk 5)

Terwijl de perspectieven van veldexperts over de wensen, barrières en ondersteuningsbehoeften van mensen die in langdurige armoede leven cruciaal zijn voor het ontwikkelen van effectieve en passende ondersteuning die hun levenskwaliteit kan verbeteren, zijn deze perspectieven - en hun onderlinge relaties - relatief weinig bestudeerd in onderzoek naar armoedebestrijding. Deze studie onderzocht de wensen van mensen die in langdurige armoede leven, de barrières die zij ervaren bij het realiseren van deze wensen, en de ondersteuning die zij nodig hebben om deze wensen te vervullen, vanuit het perspectief van mensen die zelf in langdurige armoede leven, ervaringsdeskundigen en reguliere professionals.

Er werden digitale semigestructureerde interviews gehouden met mensen in armoede (n=14), ervaringsdeskundigen (n=5) en reguliere professionals (n=5) in vijf gemeenten in Nederland. De gegevens werden geanalyseerd door middel van een combinatie van inductieve en deductieve methoden. De analysen lieten zien dat de wensen gericht waren op het verbeteren van de bestaanszekerheid (bijv. financiële zekerheid, adequate huisvesting, deelname aan de arbeidsmarkt en sociale participatie), het verbeteren van het welzijn van zichzelf en van dierbaren (bijv. fysieke gezondheid, psychisch welbevinden, welzijn van kinderen) en het verbeteren van verbondenheid (bijv. ertoe doen, gehoord en gezien worden, vertrouwen hebben, sociale contacten en sociale steun).

Het realiseren van deze wensen wordt belemmerd door sociaaleconomische barrières (bijv. gebrek aan financiële middelen), ondersteuningsstructuren (bijv. niet-structurele ondersteuning, beperkte beschikbaarheid en toegankelijkheid van ondersteuning en gezondheidszorg, sociale wetgeving, institutioneel wantrouwen), een kloof tussen systeemwereld en leefwereld, en psychologische processen (bijv. chronische stress, trauma, gebrek aan energie, hopeloosheid, angst, gevoelens van minderwaardigheid). Het gebrek aan financiële middelen kwam naar voren als de voornaamste reden waarom mensen die in langdurige armoede leven hun wensen op het gebied van sociaaleconomische zekerheid, welzijn en verbondenheid niet kunnen vervullen.

Wat betreft hun ondersteuningsbehoeften, gaven de deelnemers aan dat er significante veranderingen nodig zijn in beleid en de praktijk. Deze veranderingen behelzen het verhogen van het inkomen van mensen in armoede, het prioriteren van armoedepreventie, het verbeteren van de toegankelijkheid en het gebruik van ondersteunende diensten, het bieden van gepersonaliseerde hulp, het bevorderen van institutioneel vertrouwen, en het overbruggen van de kloof tussen de ervaringen van mensen in armoede en de perspectieven van beleidsmakers en professionals. Daarnaast onderstreepten ze het belang van het betrekken van ervaringsdeskundigen bij de dienstverlening aan mensen die in langdurige armoede leven. Ook benadrukten ze het belang van een holistische aanpak, eigen regie en een goede kwaliteit van de werkrelatie tussen cliënten en professionals, gekenmerkt door vertrouwen, gelijkheid en empathie. En om de kwaliteit van leven van mensen die in langdurige armoede leven effectief te verbeteren, is het cruciaal om deze veranderingen gezamenlijk te implementeren.

Interpretatie van de bevindingen

Bestaanszekerheid

Hoofdstuk 2 laat zien dat, naast de geboekte vooruitgang, de meerderheid van de aan bestaanszekerheid gerelateerde risicofactoren voor dakloosheid 5,5 jaar na toelating tot de MO nog steeds aanwezig was. Zo waren de meeste deelnemers werkloos, hadden veel deelnemers schulden en onvoldoende middelen om te voorzien in hun basisbehoeften. Bovendien bleef een derde van de deelnemers precair gehuisvest. Deze zwakke sociaaleconomische omstandigheden gingen gepaard met een lagere kwaliteit van leven: deelnemers ervaarden een slechte kwaliteit van de relatie met familieleden, misten vaak steun van familie en vrienden, en hadden een slechte lichamelijke en geestelijke gezondheid. Aangezien uit onderzoek blijkt dat beperkte financiële middelen, een beperkt sociaal ondersteuningsnetwerk en een gebrek aan zinvolle dagelijkse activiteiten risicofactoren voor terugkerende dakloosheid zijn (Boesveldt et al., 2019; Boesveldt et al., 2021), lijken veel deelnemers een vergroot risico te lopen om opnieuw dakloos te worden.

De resultaten beschreven in hoofdstuk 5 benadrukken ook de negatieve impact van bestaansonzekerheid op de kwaliteit van leven. Het gebrek aan financiële middelen en het ontbreken van de middelen om bestaanszekerheid te verwerven (bijvoorbeeld geen betaalde baan hebben en het hebben van schulden) ondermijnden de wensen van mensen die in langdurige armoede leven in alle levensdomeinen. Veel deelnemers aan deze studie benadrukten het belang van voldoende inkomen om deel te kunnen nemen aan de samenleving, zoals het kunnen betalen van vervoerskosten om sociale contacten te bezoeken, voor gezondheidszorg, gezonde voeding en voor de basisbehoeften van hun kinderen. Anderen gaven aan dat financiële stress een negatieve invloed had op hun sociale relaties, hun opvoedingsvaardigheden en hun lichamelijke en geestelijke gezondheid.

Structurele factoren

Het onderzoek in hoofdstuk 5 biedt inzicht in de structurele barrières die mensen belemmeren bij het verwerven van bestaanszekerheid. Deelnemers aan dit onderzoek gaven aan dat zaken als een te laag minimumloon, te lage uitkeringen, hoge kosten van de verplichte basiszorgverzekering en uitsluiting van verschillende vormen van gezondheidszorg uit de basiszorgverzekering hen ervan weerhielden om bestaanszekerheid te verwerven. Bovendien werd de toegang tot sociale ondersteuningsdiensten belemmerd door de complexiteit van de regels voor toegang hiertoe en de bureaucratisering van deze dienstverlening. Dit schaadde de kwaliteit van leven van de deelnemers en ondermijnde ook hun mogelijkheden om mee te doen in de samenleving. Een deelnemer zocht bijvoorbeeld geen ondersteuning bij het vinden van werk, uit angst voor de financiële onzekerheid die het hebben van werk door de complexe regelgeving met zich mee kan brengen. Een andere deelnemer kon zelfs niet samenwonen met haar partner en kinderen, omdat de regels voor ontvangen van een uitkering samenwonen voor hen financieel onhaalbaar maken.

Dat de eerder genoemde structurele factoren mensen belemmeren bij het verkrijgen van bestaanszekerheid, is ook beschreven in eerdere onderzoeken (Gupta & Holloway, 2016; Loignon et al., 2015; Movisie, 2022; O'Donnell et al., 2016; Williamson et al., 2006). Gevoelens van schaamte, het gebrek aan een menselijke benadering en de respectloze behandeling die mensen soms ervaren vanuit sociale dienstverleners, zorgen er ook voor dat mensen niet altijd de benodigde steun zoeken en ontvangen (Pharos, 2023; Pharos, 2022). Ook de bevindingen dat kwetsbare sociaaleconomische omstandigheden samenhangen met een lagere kwaliteit van leven komen overeen met eerdere onderzoeksresultaten. Eerdere studies vonden een verband tussen bestaansonzekerheid en bijvoorbeeld een slechtere fysieke en mentale gezondheid (Curl & Kearns, 2014; Marmot & Bell, 2012; Ridley et al., 2020), hogere niveaus van stress (Haushofer & Fehr, 2014), lagere niveaus van zelfregulering en gevoelens van controle (Evans & Kim, 2012; Price et al., 2002), verminderd cognitief functioneren (Mani et al., 2013), en meer spanningen in relaties met familie en andere belangrijke personen (Johnsen & Watts, 2014; Mood & Jonsson, 2016). Ook is gevonden dat chronische stress door langdurige armoede samenhangt met minder rationele besluitvorming, wat kan leiden tot een (verdere) verslechtering van de mentale en fysieke gezondheid (Beenackers et al., 2016; Jungman et al., 2020; Schiffrin & Nelson, 2010; Wolf, 2016).

De resultaten van onze studies benadrukken het belang van een structureel en adequaat sociaaleconomisch vangnet voor mensen in kwetsbare omstandigheden. Het verkrijgen en behouden van bestaanszekerheid in Nederland is op dit moment moeilijk. In de afgelopen jaren worden steeds meer mensen geconfronteerd met bestaansonzekerheid, zoals blijkt uit het groeiende aantal mensen dat genoodzaakt is om gebruik te maken van de voedselbank (135.000 in 2016 versus 160.500 in 2020). Door stijgende inflatiecijfers en met name de sterk stijgende energieprijzen wordt verwacht dat dit aantal nog verder zal toenemen. Momenteel heeft 1 op de 3 huishoudens moeite om de eindjes aan elkaar te knopen (NIBUD, 2022), wat laat zien dat naast huishoudens die al in armoede leefden vóór de energiecrisis, ook middenklasse huishoudens het momenteel financieel moeilijk hebben.

Ervaringen met kindermishandeling en trauma

De bevindingen gerapporteerd in hoofdstuk 3 laten zien dat, ten tijde van hun dakloosheid, wat op zichzelf een traumatische ervaring is, dakloze mensen met EMK nog verder op achterstand staan dan dakloze mensen zonder EMK. Deze resultaten sluiten aan bij onderzoek onder dakloze mensen naar de associatie tussen ingrijpende jeugdervaringen (IJE) en negatieve uitkomsten met betrekking tot lichamelijke en mentale gezondheid (Brown et al., 2016; Lee et al., 2017; Liu et al., 2020; Patterson et al., 2014), de kwaliteit van sociale netwerken (Green et al., 2012) en slachtofferschap (Stein et al., 2002). In aanvulling op eerdere onderzoeken laten onze bevindingen zien dat dakloze mensen met EMK ook meer onvervulde zorgbehoeften ervaren, vaker werkloos zijn (bij follow-up) en meer schulden hebben (bij toelating tot de MO). Deze bevindingen bevestigen de grote verzameling aan literatuur dat aantoont dat EMK en IJE in het algemeen sociale steunsystemen verslechteren, lichamelijke en mentale gezondheidsproblemen uitlokken die op hun beurt weer risicofactoren zijn voor dakloosheid.

Wanneer mensen dakloos zijn, lopen ze een verhoogd risico op verdere traumatisering, omdat dakloosheid hen bijzonder kwetsbaar maakt voor letsel, ongelukken en geweld (Feantsa, 2017), zoals ook beschreven wordt in hoofdstuk 3. In vergelijking met de algemene bevolking, van wie in 2012 (jaar van de dataverzameling; Centraal Bureau voor de Statistiek, 2020) 3% slachtoffer was van een gewelddadig misdrijf, waren de studiedeelnemers veel vaker slachtoffer van een gewelddadig misdrijf: 9% van de deelnemers zonder EMK en 30% van de deelnemers met EMK rapporteerden in het afgelopen jaar slachtoffer te zijn geweest van een gewelddadig misdrijf. Dit wijst op de vicieuze cirkel tussen trauma en dakloosheid: traumatische ervaringen maken mensen kwetsbaar om dakloos te worden en dakloosheid kan de blootstelling aan traumatische ervaringen vergroten (Feantsa, 2017).

Onze bevinding dat factoren die van invloed zijn op de kwaliteit van leven van dakloze mensen met EMK in de loop der tijd over het algemeen in een vergelijkbaar tempo verbeteren, en soms zelfs in een groter tempo, in vergelijking met mensen zonder EMK, wijst erop dat mensen met EMK op zijn minst hetzelfde potentieel voor groei en zelfverwezenlijking lijken te hebben. Echter, de resultaten laten ook zien dat, 2,5 jaar toetreding tot de MO, deelnemers met EMK over het algemeen nog steeds slechter af waren dan deelnemers zonder dergelijke ervaringen. MO-organisaties dienen zich hiervan bewust te zijn zodat zij de specifieke problemen van mensen die trauma hebben ervaren succesvoller aan kunnen pakken, bijvoorbeeld door middel van traumasensitief werken.

Recentelijk nemen steeds meer studies naar EMK een breder scala aan IJE mee, waaronder ook blootstelling aan geweld buitenshuis, leven in onveilige buurten, dakloosheid, pesten, discriminatie op basis van ras of etniciteit, en armoede (Bethell et al., 2017). Deze bredere set van IJE lijkt beter geschikt om de situatie van kinderen uit verschillende achtergronden mee te nemen en met name die van kinderen die in armoede leven en kinderen van kleur. Het is belangrijk dat hulpverleners die traumasensitief werken ook kennis hebben van het brede scala aan IJE.

Peer support, ervaringsdeskundigheid en de inclusie van het cliënten-perspectief

De resultaten beschreven in hoofdstuk 4 tonen aan dat individuele begeleiding door een ervaringsdeskundige (IBE) dakloze mensen helpt om hun kwetsbare situatie te overwinnen. Dit gebeurt door het opbouwen van rapport en het tonen van oprechte empathie, door het creëren van een vertrouwelijke en bekrachtigende werkrelatie, en door het bieden van ondersteuning, begeleiding en bemiddeling. Omdat al deze werkingsmechanismen betrekking hebben op de kwaliteit van de relatie tussen dakloze mensen en ervaringsdeskundigen, laten de resultaten van deze studie zien dat deze kwaliteit bepalend is voor het succes van IBE.

De gevonden baten van IBE voor dakloze mensen komen overeen met de positieve uitkomsten van de inzet van ervaringsdeskundigen en mensen met ervaringskennis in het algemeen (waar naast IBE bijvoorbeeld ook lotgenotencontact en ondersteuningsgroepen onder vallen) die zijn gevonden bij mensen met psychische problemen, zoals meer hoop, empowerment, zelfwaardering, zelfeffectiviteit, zelfmanagement en het gevoel begrepen te worden door de ervaringswerker (Chien et al., 2019; King, Thy & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al, 2013; Repper & Carter, 2012). De in eerder onderzoek gevonden baten zoals verbeterde sociale inclusie en toename van maatschappelijke betrokkenheid (Chien et al., 2019; King, Thy & Simmons, 2018; Lloyd-Evans et al., 2014; Pitt et al, 2013; Repper & Carter, 2012) werden niet ondersteund door onze studie. Dit kan worden verklaard door het feit dat dakloze mensen nog meer sociale uitsluiting ervaren in vergelijking met mensen met psychische problemen. Naast het hebben van psychische problemen zijn dakloze mensen vaak meer benadeeld op andere gebieden, zoals sociale relaties, fysieke gezondheid, toegang tot materiële middelen en gezondheidszorg, huisvesting, risico op trauma en slachtofferschap en het ervaren van stigma en discriminatie.

De door ons gevonden werkzame elementen van IBE komen ook overeen met resultaten uit eerder onderzoek onder ervaringsdeskundigen die dakloze mensen individueel ondersteunen in voorzieningen voor dakloze mensen (Barker, 2018). Hoewel dit eerdere onderzoek iets andere termen en categorisaties hanteerde, namelijk: 1) de relatie tussen de ervaringsdeskundige en cliënt (bijvoorbeeld positieve waardering, normalisering, empowerment); 2) fungeren als rolmodel (bijvoorbeeld positieve zelfevaluatie door sociale vergelijking, leren van coping technieken); en 3) ervaringsgerichte ondersteuning (informatieve ondersteuning betreffende zorgtrajecten, emotionele ondersteuning) (Barker, 2018; Barker, Maguire, Bishop & Stopa, 2019). In aanvulling op dit eerdere onderzoek vond onze studie dat deelnemers het zeer waardeerden dat de ervaringsdeskundigen 'er zijn' door gemakkelijk bereikbaar, toegankelijk en beschikbaar te zijn. De in onze studie gevonden werkingsmechanismen van IBE zijn moeilijk te vergelijken met studies die de werkingsmechanismen van IBE binnen de geestelijke gezondheidszorg onderzochten. Die studies omvatten namelijk allerlei verschillende soorten geestelijke gezondheidszorginstellingen en ervaringszorg en representeren voornamelijk het perspectief van ervaringsdeskundigen in plaats van het perspectief van cliënten (Watson, 2017). Voor zover bekend heeft slechts één studie de werkingsmechanismen van IBE binnen de geestelijke gezondheidszorg vanuit het perspectief van cliënten onderzocht (Gidugu et al., 2015). Deze studie vond vergelijkbare resultaten: cliënten profiteerden met name van praktische, emotionele en sociale ondersteuning, van het "iemand hebben waar je op kan rekenen, een vriend, en iemand om mee om te gaan", en waardeerden het hebben van een niet-behandelingsgerichte, normaliserende relatie. Deze bevindingen benadrukken het belang van het toepassen van krachtgerichte benaderingen zoals 'Krachtwerk' (Wolf, 2016). 'Krachtwerk' onderstreept bijvoorbeeld het belang van het opbouwen van een vertrouwensrelatie met cliënten, het uitgaan van de sterke punten, talenten en mogelijkheden van cliënten, en nemen van hun behoeften, toekomstwensen en doelen als uitgangspunt voor de geboden ondersteuning.

In lijn met de bevindingen van hoofdstuk 4, meldden de deelnemers aan de studie beschreven in hoofdstuk 5 dat mensen die in langdurige armoede leven ook grote waarde hechten aan een vertrouwelijke en gelijkwaardige werkrelatie. Ze willen gehoord en gezien worden, het gevoel hebben dat ze ertoe doen, zonder vooroordelen. Het opbouwen van een dergelijke band wordt gezien als een cruciale voorwaarde voor mensen die in langdurige armoede leven om professionele hulp te vragen en te accepteren en om vooruit te komen. Het vereist van professionals dat ze tijd nemen voor hun cliënten, geduldig en transparant zijn, afspraken nakomen en ook enkele van hun persoonlijke worstelingen delen als dit bijdraagt aan het herstel van hun cliënten. Het belang van een vertrouwelijke en gelijkwaardige werkrelatie is

ook aangetoond in onderzoek onder andere groepen die baat hebben bij ondersteuning in hun hersteltraject, zoals dakloze jongvolwassenen die gebruik maken van opvangvoorzieningen (Altena, 2019) en mensen die begeleid worden door reclasseringsambtenaren (Sturm, 2022).

De resultaten van hoofdstuk 4 en 5 wijzen eveneens op de noodzaak dat professionele ondersteuning, sociale beleidsmaatregelen en regelgeving gebaseerd zijn op de behoeften en wensen van cliënten, in plaats van een "one size fits all" benadering. Een dergelijke persoonsgerichte aanpak doet recht aan de sterke behoefte aan autonomie en zeggenschap en versterkt de zelfwaardering van dakloze mensen en mensen die in langdurige armoede leven. Een persoonsgerichte aanpak is tevens een van de kernprincipes van de Housing First benadering, welke een goed onderzochte en bewezen effectieve strategie is om dakloosheid op te lossen (Aubry et al., 2015; Baxter et al., 2019).

De bevindingen beschreven in hoofdstuk 4 en 5 voorzien tevens in de algemene behoefte aan meer kennis over de meerwaarde van ervaringsdeskundigen, ervaringskennis- en deskundigheid, de effectieve mechanismen daarachter, en de vereiste voorwaarden om deze deskundigheid en ervaring succesvol te integreren binnen teams, organisaties en beleidsontwikkeling binnen sociale ondersteuningsdiensten en de MO (Movisie, 2018; Keuzenkamp, 2022). Zoals hoofdstuk 5 heeft laten zien, benadrukten mensen die in langdurige armoede leven het belang van de betrokkenheid van ervaringsdeskundigen bij het ontwikkelen en uitvoeren van beleidsvormingsprocessen.

Methodologische overwegingen

7

Sterktes

Dit proefschrift draagt bij aan de bestaande kennis over de maatschappelijke positie van dakloze mensen en mensen die in langdurige armoede leven, de risicofactoren in hun leven en hun wensen voor de toekomst. De resultaten bieden belangrijke aanknopingspunten voor passend sociaal beleid en voor verdere verbetering van de werkmethodieken van sociale professionals en ervaringsdeskundigen. Een algemeen sterk punt van dit proefschrift betreft het gebruik van gedegen onderzoeksdesigns, zoals de longitudinale studies die in hoofdstuk 2 en hoofdstuk 3 zijn toegepast. Deze longitudinale designs stelden ons in staat om veranderingen in de levensomstandigheden van de deelnemers over de tijd te volgen in plaats van achteraf op deze veranderingen te reflecteren. Bovendien waren er voor het onderzoek dat wordt gerapporteerd in hoofdstuk 3 longitudinale gegevens beschikbaar voor een relatief grote groep dakloze mensen ($n = 513$) met een hoog responspercentage (74%) bij de follow-upmeting 2,5 jaar later. Er is veel inspanning geleverd om de deelnemers grondig te volgen. Zo kregen de deelnemers een vergoeding voor hun deelname (van €15 voor het eerste interview tot €30 voor de follow-up na 2,5 jaar), werden zij geïnterviewd op de locatie van hun keuze en in de taal van hun keuze wanneer Nederlands niet haalbaar was (bijvoorbeeld Engels, Spaans of Arabisch), werden de contactgegevens van deelnemers en informatie over hun sociale netwerken verzameld via wie de deelnemer kon worden benaderd als direct contact met de deelnemer niet mogelijk was, werd voor elke deelnemer dezelfde interviewer toegewezen voor alle interviews, en werd hen verzekerd dat hun informatie vertrouwelijk zou blijven.

Een ander sterk punt van dit proefschrift is de betrokkenheid van ervaringsdeskundigen in verschillende fasen van het onderzoeksproces in de studie beschreven in hoofdstuk 5. Ervaringsdeskundigen waren betrokken bij het ontwikkelen van informatiebrieven, het ontwikkelen van dataverzamelingsinstrumenten, het verzamelen van de data en een membercheck. Dit hielp bij het vergroten van het begrip van de onderzoekers met betrekking tot de levensomstandigheden en dagelijkse problemen van mensen die in langdurige armoede leven. Dit maakte de studie responsiever met betrekking tot de behoeften van de deelnemers, wat heeft bijgedragen aan het overbruggen van de kloof tussen onderzoek en praktijk. Bovendien onderzochten alle studies die in dit proefschrift zijn opgenomen expliciet het perspectief van de cliënt, wat cruciaal is voor een juist begrip van hun behoeften en hun levensomstandigheden. De studie die wordt beschreven in hoofdstuk 4 was de eerste die kwalitatief de resultaten en werkzame elementen van IBE binnen de MO heeft onderzocht, vanuit het perspectief van zowel mensen die dakloos zijn als ervaringsdeskundigen.

Beperkingen

De beperkingen van de studies in dit proefschrift dienen ook erkend te worden. De eerste beperking betreft de mate waarin onze bevindingen kunnen worden gegeneraliseerd naar de totale populatie van dakloze mensen in Nederland. De onderzoekspopulaties beschreven in hoofdstuk 2 en 3 bestaan uit dakloze mensen die voldeden aan de criteria voor toegang tot de MO in de vier grootste steden in Nederland (G4) in 2011. Mensen die aan deze criteria voldoen hebben al dan niet gedwongen hun thuissituatie verlaten, zijn niet in staat om zich staande te houden in de samenleving, verblijven legaal in Nederland en hebben regionale binding of wonen al twee jaar of langer in de regio van binnenkomst (Tuynman & Planije, 2012). Dakloze mensen die niet aan deze criteria voldeden, zoals mensen zonder identiteitsbewijs of zonder legale verblijfsvergunning (voornamelijk niet-geaccepteerde asielzoekers), en arbeidsmigranten (voornamelijk uit Centraal- en Oost-Europese landen) met minder dan twee jaar arbeidsverleden, werden uitgesloten van de MO. Dakloze mensen die wel aan de criteria voldeden voor toegang tot het MO maar hier geen gebruik van maakten zijn ook niet vertegenwoordigd in deze studies. De prevalentie van risicofactoren, de prevalentie van IJE, evenals de situatie met betrekking tot de constitutionele factoren van sociale kwaliteit kan verschillen tussen de dakloze mensen die toegang kregen tot de MO en degenen die om de eerder genoemde redenen geen gebruik maakten van de MO. We merken ook op dat de resultaten beschreven in hoofdstuk 4, afkomstig uit een onderzoek uitgevoerd in residentiële opvangvoorzieningen, mogelijk niet volledig overdraagbaar zijn naar IBE in andere soorten voorzieningen voor dakloze mensen (zoals noodopvang of nachtopvang), of andere vormen van ondersteuning door mensen met ervaringskennis binnen voorzieningen voor dakloze mensen (zoals lotgenotengroepen onder leiding van ervaringswerkers- of deskundigen of informele lotgenotenondersteuning).

De tweede beperking heeft betrekking op de mate waarin de onderzoekspopulaties beschreven in hoofdstuk 2 en 3 representatief waren voor de totale populatie van dakloze mensen in de MO in de G4 in 2011. Wat betreft de onderzoekspopulatie beschreven in hoofdstuk 3, werd ongeveer 20% van de 2.084 dakloze volwassenen (ouder dan 23 jaar, n = 410) en 11% van de 976 dakloze jongvolwassenen (18-22 jaar, n = 103) die in 2011 de MO in de G4 binnenkwamen, bij aanvang geïnterviewd (Tuynman & Planije, 2012). Om informatie te verkrijgen over de representativiteit van de onderzoekspopulatie, vergeleek van der Laan (2020) de studie deelnemers met de totale populatie dakloze (jong)volwassenen die in 2011 de MO in de G4 binnenkwamen. Hieruit bleek dat de volwassen deelnemers representatief waren qua geslacht en leeftijd. De jongvolwassenen waren representatief wat betreft leeftijd, maar jonge mannen waren oververtegenwoordigd (60%) in vergelijking met de totale populatie dakloze jongvolwassenen die de MO in de G4 binnenkwamen (49%). Gegevens over andere kenmerken van de totale populatie waren niet beschikbaar. Daarnaast zouden de wervingsprocedures toegepast in hoofdstuk 4 en 5 kunnen hebben geleid tot enige selectiebias. Bijvoorbeeld, cliënten die, vanuit het perspectief van de werver (bijv. een ervaringsdeskundige medewerker, het dagelijkse personeel, de manager, poortwachter), als minder in staat werden beschouwd om te reflecteren op hun persoonlijke ervaringen, door hen niet geselecteerd kunnen zijn om deel te nemen aan dit onderzoek. Het is onbekend of deze selectiebias, mogelijk ook om andere redenen, heeft plaatsgevonden en of dit invloed heeft gehad op de resultaten. Ook in de studie beschreven in hoofdstuk 4 zouden cliënten met een grote waardering voor hun ervaringsdeskundige begeleider of cliënten die relatief veel baat hebben gehad bij IBE meer bereid kunnen zijn geweest om deel te nemen, wat zou kunnen leiden tot een positievere kijk op IBE. In de studie beschreven in hoofdstuk 5 zouden poortwachters bijvoorbeeld kunnen hebben gekozen voor professionals die bekend staan om hun empathische betrokkenheid bij cliënten, of deze professionals waren meer bereid om mee te doen, wat zou kunnen leiden tot een niet representatieve steekproef van professionals.

Verder onderzochten we het verlies van deelnemers met betrekking tot de studies beschreven in hoofdstuk 2 en 3. Wat betreft hoofdstuk 2 was het verlies van deelnemers in de Amsterdamse cohortgroep bij de follow-up hoog (58%). Om selectief verlies van deelnemers bij de follow-up te onderzoeken, hebben we deelnemers aan het laatste interview (n = 72) vergeleken op demografische variabelen zoals gerapporteerd bij de eerste meting met deelnemers die niet meededen aan het laatste interview (n = 100). Er werden geen verschillen gevonden tussen deelnemers die alleen de vragenlijst bij aanvang hadden ingevuld in vergelijking met deelnemers die zowel de vragenlijst bij aanvang als ook bij de follow-up na 5,5 jaar hadden ingevuld wat betreft leeftijd, geslacht, opleidingsniveau, lichamelijke en geestelijke gezondheidsklachten, en cannabis- en alcoholgebruik (Van den Dries et al., 2018). Wat betreft hoofdstuk 3 was het verlies aan deelnemers bij de follow-up relatief laag (26%), maar bij deze studie was er sprake van een hoger verlies aan deelnemers bij de follow-up onder mannelijke deelnemers, deelnemers die jonger waren en deelnemers met een laag opleidingsniveau. Het is onbekend of en in welke richting dit selectieve verlies aan deelnemers bij de follow-up onze bevindingen zou kunnen hebben beïnvloed, aangezien we geen informatie hebben over hun de scores op de onderzoeksvariabelen bij de follow-up.

Een andere beperking met betrekking tot de onderzoeksopzet in hoofdstuk 2 en 3 heeft betrekking op het effect van 'regressie naar het gemiddelde'. De baseline-interviews werden afgenomen kort na het moment dat de deelnemers dakloos waren, terwijl de follow-up-interviews 2,5 jaar of 5,5 jaar na deze stressvolle en vaak traumatische situatie plaatsvonden. Hierdoor valt het te verwachten dat de meeste deelnemers op de meeste uitkomstmaten verbetering zouden hebben vertoond tegen de tijd van de follow-up-interviews. Ook is het goed om te noemen dat de studiedata in hoofdstuk 2 en 3 zijn verzameld tussen 2011 en 2017. Het Centraal Bureau voor de Statistiek (CBS) schat dat het aantal dakloze mensen in het afgelopen decennium is sterk gestegen (Centraal Bureau voor de Statistiek, 2019a; Centraal Bureau voor de Statistiek, 2016) en uit recent onderzoek blijkt dat de cijfers van het CBS waarschijnlijk nog een onderschatting zijn van het daadwerkelijke aantal mensen dat getroffen wordt door dakloosheid (Wewerinke et al., 2023). Dit geeft aan dat de resultaten van dit onderzoek in het huidige tijdsgewricht nog relevanter zijn.

Aanbevelingen

Implicaties voor beleid en praktijk

Naar aanleiding van de resultaten van dit proefschrift, zouden een aantal zaken prioriteit moeten krijgen om de leefomstandigheden van dakloze mensen en mensen die in langdurige leven te verbeteren, en om te voorkomen dat mensen nog verder worden benadeeld door deze kwetsbare omstandigheden:

- Het versterken van de bestaanszekerheid
- Het bieden van toegankelijke, geïntegreerde ondersteuning en continuïteit van zorg
- Het betrekken van ervaringsdeskundigen in praktijk en beleid
- Een mensgerichte benadering
- Trauma-geïnformeerde benaderingen
- Het voorkomen van Ingrijpende Jeugdervaringen (IJE)

Versterken van de bestaanszekerheid

Gezien de resultaten van dit proefschrift, dient hoge prioriteit te worden gegeven aan het versterken van de bestaanszekerheid. Volgens artikel 25 van de Universele Verklaring van de Rechten van de Mens heeft ieder mens het recht om te leven in bestaanszekerheid: '*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*' (College voor de Rechten van de Mens, 2016, blz. 8). Volgens de Nederlandse grondwet (Artikel 20) is de overheid verantwoordelijk voor de bestaanszekerheid van haar burgers.

Om de bestaanszekerheid van mensen die zich in een sociaaleconomisch kwetsbare positie bevinden te versterken, dient de nationale en lokale overheid in de eerste plaats de structurele factoren aan te pakken die deze sociaaleconomische onzekerheid veroorzaken. Op basis van de resultaten van onze studies lijken sterke structurele maatregelen nodig die zich richten op woonzekerheid, voldoende en stabiel inkomen en het verbeteren van de toegang tot en kwaliteit van sociale ondersteuningsdiensten. Bij het oplossen van de huidige wooncrisis zouden deze overheden bijvoorbeeld prioriteit kunnen geven aan het vergroten van het aantal betaalbare woningen. Ook leeft driekwart van de mensen die van een uitkering leven in armoede, wat aangeeft dat de uitkeringen te laag zijn om in bestaanszekerheid te kunnen leven (CBS, 2019b). Daarom dient de hoogte van uitkeringen niet alleen de minimale benodigde kosten van levensonderhoud te dekken, maar zou het mensen ook in staat moeten stellen wat spaargeld op te bouwen om financiële tegenvallers op te vangen, en mensen in staat moeten stellen om daadwerkelijk sociaal deel te kunnen nemen. Dit geldt ook voor het minimumloon: het dient daadwerkelijk toereikend te zijn voor een sociaaleconomisch zeker bestaan en om sociaal te kunnen participeren. De nationale overheid zou ook de kosten van de basiszorgverzekering verder kunnen verlagen voor mensen met een laag inkomen en hen toegang kunnen geven tot verschillende vormen van zorg die momenteel zijn uitgesloten van de basiszorgverzekering.

Onder beleidsmakers groeit het bewustzijn van het verband tussen sociaaleconomische zekerheid, armoede en dakloosheid en de noodzaak tot actie. De Vereniging van Nederlandse Gemeenten (VNG) en de Vereniging van leidinggevenden in het Sociaal Domein (Divosa) hebben reeds opgeroepen tot versterking van het sociaal domein (VNG & Divosa, 2021). Ook hebben drie Nederlandse ministeries onlangs het Nationaal Actieplan Dakloosheid Eerst een Thuis gelanceerd met daarin vele voorstellen voor structurele oplossingen om dakloosheid te beëindigen (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid, en Ministerie van Volksgezondheid, Welzijn en Sport, 2022). Dit plan benadrukt ook het belang van het versterken van financiële zekerheid en onderstreept het belang van woonzekerheid door middel van de implementatie van Wonen Eerst als een systemische benadering. Deze benadering houdt in dat Wonen Eerst niet alleen beschikbaar is voor dakloze mensen met de meest intensieve zorgbehoeften, maar voor alle mensen in een situatie van dakloosheid.

Het bieden van toegankelijke, geïntegreerde ondersteuning en continuïteit van zorg
De bevindingen van dit proefschrift wijzen ook op de noodzaak om de toegang tot sociaaleconomische ondersteuning, geestelijke gezondheidszorg, fysieke gezondheidszorg en ondersteuningsprogramma's ter versterking van familiebanden te optimaliseren. Zo zou bijvoorbeeld de complexiteit van de regelgeving met betrekking tot het verkrijgen en behouden van sociaaleconomische ondersteuning vereenvoudigd moeten worden. Hoofdstuk 5 benadrukt het belang van ondersteuning die toegankelijk, zichtbaar en begrijpelijk is. Ondersteuningsdiensten zouden dit kunnen bevorderen door bijvoorbeeld een helder overzicht te bieden van alle bestaande vormen van ondersteuning en regelgeving, de toegang tot ondersteuning eenvoudig te maken en niet veel administratief werk te vereisen, professionals in staat te stellen gemakkelijk bereikbaar te zijn en zich te richten op wat mensen echt nodig hebben. Bovendien dienen dienstverleners zich bewust te zijn van de negatieve impact die bestaansonzekerheid heeft op de kwaliteit van het dagelijks leven, mensen te ondersteunen bij het omgaan met deze onzekerheid en bij te staan in het versterken van hun sociaaleconomische situatie. Bestaansonzekerheid gaat vaak hand in hand met andere problemen, zoals fysieke problemen, mentale gezondheidsproblemen en instabiliteit binnen het gezin. Gegeven deze onderlinge samenhang, zouden overheidsinstellingen en zorgorganisaties mensen holistisch moeten benaderen en geïntegreerde, interdisciplinaire ondersteuning moeten bieden, in plaats van gefragmenteerde ondersteuning (Luijben et al., 2019; Marttila et al., 2013). Het Nationaal Actieplan Dakloosheid Eerst een Thuis adresseert dit eveneens door het belang van op maat gemaakte ondersteuning die snel en integraal wordt aangeboden te nadrukken (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022).

Gezien de complexiteit en de persistentie van de problemen waarmee dakloze mensen en mensen die in langdurige armoede leven geconfronteerd worden, dient ondersteuning zolang als nodig te worden geboden om stabiele huisvesting en bestaanszekerheid te bereiken en te behouden. Dit staat haaks op de manier waarop huidige sociale ondersteuningsdiensten zijn ingericht: deze neigen de complexiteit van de problematiek over het hoofd te zien, leggen over het algemeen korte-termijn ondersteuningstrajecten op en eisen concrete en meetbare resultaten (Hofs, 2017; Van der Tier et al, 2022).

Het betrekken van ervaringsdeskundigen in praktijk en beleid
Dit proefschrift benadrukt het belang van het betrekken van ervaringsdeskundigen in de dagelijkse praktijk en bij het ontwikkelen van beleid. Het onderzoek beschreven in hoofdstuk 4 toonde aan dat ervaringsdeskundigen, naast het direct ondersteunen van cliënten, ook betrokken zijn bij het onderwijzen van professionals over bepaalde uitdagingen waarmee cliënten worden geconfronteerd in hun dagelijks leven en in hun herstelproces. Ervaringsdeskundigen worden ook regelmatig gevraagd om andere professionals te informeren en bij te staan bij het omgaan met deze uitdagingen. Het implementeren van ervaringsdeskundigheid als aanvulling op de standaardzorg zou de zorgverlening binnen de MO en sociale ondersteuningsdiensten voor mensen in armoede verder kunnen bevorderen, mits organisaties ervoor zorgen dat de positie van ervaringsdeskundigen effectief wordt geïmplementeerd binnen hun organisaties. Organisaties zouden bijvoorbeeld een duidelijke functieomschrijving met relevante competenties voor ervaringsdeskundigen moeten gebruiken en ervoor moeten zorgen dat zij deze competenties (die zij hebben verkregen door hun levenservaring en opleiding) kunnen benutten, in plaats van taken toegewezen te krijgen waar andere professionals het te druk voor hebben (zoals het regelen van vervoer voor cliënten bij verhuizing; Davidson et al., 2012). Verder suggereren de resultaten van dit onderzoek dat organisaties ervoor moeten zorgen dat ervaringsdeskundigen voldoende tijd hebben om er voor cliënten te zijn, bijvoorbeeld door het voorkomen van te hoge caseloads. Organisaties zouden er ook voor moeten zorgen dat ervaringsdeskundigen formeel beschikbaar mogen zijn voor cliënten buiten kantooruren of nadat cliënten een opvang of ondersteuningsprogramma hebben verlaten, als zij denken dat dit cliënten ten goede kan komen. Tegelijkertijd zouden organisaties ervaringsdeskundigen moeten ondersteunen bij het behouden van een gezonde balans tussen werk en privé, aangezien onderzoek aantoont dat rol- en tijdsgrenzen een zorg kunnen zijn voor ervaringsdeskundigen die cliënten ondersteunen (Gidugu et al., 2015; Miyamoto & Sono, 2012). Het recent gepubliceerde 'Kwaliteitssysteem voor Ervaringsdeskundigen' kan organisaties ondersteunen bij het implementeren van de positie van ervaringsdeskundigen binnen hun diensten (Vereniging voor Ervaringsdeskundigen, 2022; Daniels, 2022).

Om beleid effectief af te stemmen op de behoeften van dakloze mensen en mensen die in armoede leven, is kennis over de impact van dakloosheid en armoede op het leven van mensen van essentieel belang. Er wordt betoogd dat veel beleidsmakers geen persoonlijke ervaring hebben met dakloosheid of armoede, wat nadelige gevolgen heeft voor de effectiviteit van sociaal beleid en interventies ('S Jongers, 2022). Dit benadrukt de kritische noodzaak om expliciet de stemmen van mensen met ervaringskennis op te nemen. De resultaten van dit proefschrift geven aan dat ervaringsdeskundigen een belangrijke rol kunnen spelen in het uiten van de behoeften van dakloze mensen en mensen die in armoede leven, om ervoor te zorgen dat het beleid relevant is voor degenen die het moeten ondergaan. Het opnemen van het perspectief van mensen met ervaringskennis is zeer belangrijk: het helpt beleidsmakers om deze ervaringen beter te begrijpen en beleid te creëren dat aansluit op de context waarin het zal worden toegepast (Meriluoto, 2018). In Nederland groeit het bewustzijn onder beleidsmakers over de noodzaak van de betrokkenheid van mensen met ervaringskennis in het beleidsvormingsproces. Het Nationaal Actieplan Dakloosheid Eerst een Thuis is bijvoorbeeld tot stand gekomen in samenwerking met mensen met ervaringskennis, en de noodzaak van co-creatie wordt binnen dit actieplan expliciet benadrukt (Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport, 2022). Echter is het niet automatisch zo dat, alleen omdat mensen met ervaringskennis vertegenwoordigd zijn in het beleidsvormingsproces, zij automatisch gehoord zullen worden of in staat zullen zijn om op zo'n manier te communiceren dat hun ervaringskennis effectief wordt ontvangen (Blume, 2017; Lancaster et al 2017; Meriluoto, 2018). Samen Thuis 2030, een collectief van personen met ervaringskennis en onafhankelijke belangenbehartigers, benadrukt ook dat dit proces niet automatisch verloopt en pleit voor zinvolle participatie. Onlangs hebben zij een handleiding ontwikkeld voor beleidsmakers over hoe zij op een zinvolle manier kunnen samenwerken met mensen met ervaringskennis met betrekking tot dakloosheid (Samen Thuis 2030, 2023).

Een mensgerichte benadering

Hoofdstuk 4 en 5 pleiten voor het toepassen van een meer mensgerichte benadering binnen de MO en sociale ondersteuningsdiensten. Professionals zouden bijvoorbeeld voldoende tijd en geduld moeten hebben om echt te luisteren, en de geboden diensten zouden open en transparant moeten zijn en gebaseerd op vertrouwen en gelijkheid. Deze aanbevelingen zijn in lijn met de bevindingen uit eerdere onderzoeken (Luchenski et al., 2018). Ten eerste vereist dit dat reguliere professionals en ervaringsdeskundigen voldoende tijd beschikbaar hebben voor hun cliënten. Organisaties zouden daarom kritisch moeten reflecteren op de caseload van hun professionals en deze verminderen indien nodig. Dit zou reguliere professionals en ervaringsdeskundigen de gelegenheid geven om hun cliënten te behandelen als mensen in plaats van nummers. De implementatie van deze verandering hangt echter af van het feit of gemeenten of andere overheidsfinanciers dit belang erkennen en indien nodig hiervoor extra financiering bieden.

De resultaten van dit proefschrift suggereren ook dat cliënten baat zouden hebben bij dienstverlening die meer gebaseerd is op gelijkwaardigheid. Organisaties zouden bijvoorbeeld alle professionals kunnen scholen over het belang van een werkrelatie die uitgaat van vertrouwen en gelijkheid, en professionals kunnen aanmoedigen om minder terughoudend te zijn bij het delen van hun persoonlijke ervaringen met cliënten. Hoewel het delen van persoonlijke ervaringen met cliënten nog vrij ongebruikelijk is binnen sociale ondersteuningsdiensten, de MO en de geestelijke gezondheidszorg, wordt betoogd dat het delen van deze ervaringen gunstig kan zijn voor cliënten (Weerman, 2016). Echter, zoals ervaringsdeskundigen in hoofdstuk 4 al aangaven, zouden ze hun persoonlijke ervaringen alleen moeten delen als ze denken dat dit hun cliënten te goede komt.

Naast de werkrelatie tussen de cliënt en de professional, moet ook gelijkheid worden bevorderd in de werkprocessen en het beleid van de overheid en zorgorganisaties. Beleidsmaatregelen zoals overheidsbrieven met een autoritaire toon, de eis dat mensen die een bijstandsuitkering ontvangen elk bankafschrift moeten rechtvaardigen en het kogelvrije glas in sommige ontmoetingsruimtes, zorgt ervoor dat mensen zich als criminelen voelen en zouden logischerwijs vermeden moeten worden (Jungmann et al., 2020). Een op vertrouwen gebaseerde relatie zou juist baat hebben bij meer soepelheid in regelgeving, en een overheid en organisaties die vertrouwen in plaats van controleren.

Bovendien benadrukken de bevindingen van hoofdstuk 4 en 5 ook het belang van het toepassen van krachtgerichte benaderingen zoals "Krachtwerk" (Wolf, 2016), die bijvoorbeeld benadrukken hoe belangrijk het is om uit te gaan van de sterke punten en capaciteiten van de cliënt, het opbouwen van een vertrouwensrelatie met hen, het ondersteunen van de cliënt in zijn/haar herstelproces, en het nemen van de behoeften en doelen van de cliënt als uitgangspunt voor de geboden ondersteuning.

Trauma-geïnformeerde benaderingen

Zoals beschreven in hoofdstuk 3, bleven deelnemers met EMK 2,5 jaar na toelating tot de MO over het algemeen slechter af in vergelijking met deelnemers zonder EMK, met name met betrekking tot hun sociaaleconomische situatie, hun mentale en fysieke gezondheid en hun relaties met andere mensen. Deze resultaten geven aan dat dakloze mensen met EMK baat kunnen hebben bij extra ondersteuning op deze gebieden. Trauma-geïnformeerde benaderingen lijken essentieel om de langetermijngevolgen van trauma aan te pakken en verdere traumatisering door dakloosheid te voorkomen (Feantsa, 2017). Trauma-geïnformeerde benaderingen erkennen de relatie tussen traumatische ervaringen en hun gevolgen, zoals problematisch drugs- en alcoholgebruik, persoonlijkheidsstoornissen, zelfmoordpogingen en instabiliteit in het gezin. Deze gevolgen zorgen er vaak voor dat getraumatiseerde mensen niet krijgen wat ze nodig hebben en hun levensomstandigheden niet kunnen verbeteren (Feantsa, 2017). Trauma Informed Care (TIC; Hopper et al, 2010) en Psychologically Informed Environments (PIE; Keats et al, 2012) bieden kaders die MO-voorzieningen kunnen helpen bij het optimaliseren van hun ondersteuning voor mensen die belast zijn met trauma. Zo zouden MO-voorzieningen zicht moeten richten op de cliënt, het creëren van een fysiek veilige omgeving en ervoor zorgen dat hun diensten de cliënten niet opnieuw traumatiseren, bijvoorbeeld door het gebruik van strikte of autoritaire regels. Medewerkers zouden getraind moeten zijn in het bieden van trauma-geïnformeerde zorg en in het opbouwen van therapeutische relaties. Daarbij is het van belang dat professionals betrouwbare, zorgzame en langdurige relaties met hun cliënten opbouwen en daarbij uitgaan van een krachtgerichte benadering. Ook moet er voldoende ruimte zijn voor het gegeven dat getraumatiseerde mensen de effecten van hun trauma's soms proberen te managen door middel van bijvoorbeeld zelfbeschadiging, middelenmisbruik, of ‘moeilijk’ gedrag. Tegelijkertijd is het van belang om medewerkers te ondersteunen bij de emotionele stress die komt kijken bij het werken met mensen die getraumatiseerd zijn, om burn-out te voorkomen. Bovendien lijkt een gendergerichte aanpak binnen de MO belangrijk, omdat trauma op mannen gemiddeld een andere uitwerking heeft dan op vrouwen. Uit eerder onderzoek blijkt ook het belanglijk is dat dienstverleners IJE, instabiliteit in het gezin, mentale gezondheid, middelenmisbruik en dakloosheid integraal moeten aanpakken, aangezien deze zaken onderling samenhangen (Mc Conalogue et al., 2019).

Speciale aandacht moet uitgaan naar kinderen die in MO-voorzieningen verblijven. Voor deze kinderen is de dakloosheid een actuele IJE en daarom zouden MO-voorzieningen moeten streven naar het zo veel mogelijk verminderen van traumatische stress bij deze kinderen. Beleidsmakers en woningcorporaties zouden bijvoorbeeld prioriteit kunnen geven aan kinderen bij het toewijzen van huisvesting voor dakloze mensen.

Het voorkomen van Ingrijpende Jeugdervaringen (IJE)

Naast dat trauma-geïnformeerde benaderingen van essentieel belang lijken binnen de MO, zou het nog waardevoller zijn om trauma en IJE te voorkomen. De preventie van IJE zou uiteraard in de kindertijd moeten plaatsvinden. Onderzoek heeft een verband aangetoond tussen kinderarmoede en IJE: kinderen die in armoede leven krijgen vaker en ernstiger te maken met IJE (Anda, Butchart, Felitti, & Brown, 2010). Ook is armoede in de kindertijd gerelateerd aan een slechtere mentale en fysieke gezondheid op volwassen leeftijd, en, zelfs na het corrigeren voor de aanwezigheid van andere IJE, met meer fysieke ellende (Crouch et al, 2020). Onderzoek wijst ook uit dat het verminderen van armoede de meest effectieve manier is om IJE te voorkomen (Luchenski, 2018). Dit zou stress bij ouders verminderen en kan dus helpen de kans op kindermishandeling en blootstelling aan geweld thuis te verminderen (Fortson, et al., 2016; Niolon et al., 2017).

Om de leefomstandigheden van gezinnen die in bestaansonzekerheid leven te verbeteren, de prevalentie van IJE te verminderen en de negatieve doorwerking van kinderarmoede op het volwassen leven te verminderen, zijn structurele maatregelen nodig. Naast het versterken van de bestaanszekerheid van gezinnen, vereist de preventie van IJE een veelomvattende set aan strategieën (American Centers for Disease Control and Prevention, 2019). Deze strategieën beslaan alle vier de condities van sociale kwaliteit: versterking van financiële ondersteuning voor gezinnen (bestaansvoorwaarden), zorgen voor een goede start voor kinderen (bestaansvoorwaarden en maatschappelijke inbedding), promoten van sociale normen die beschermen tegen geweld en ellende (maatschappelijke inbedding), het verbinden van jongeren met zorgzame volwassenen en activiteiten (sociale inbedding), ouders en jongeren vaardigheden aanleren met betrekking tot stressmanagement, emotieregulatie en omgaan met alledaagse uitdagingen, en interventies om directe en lange termijnschade te verminderen (zelfregulering).

Toekomstig onderzoek

In het licht van het resultaat dat dakloze mensen met EMK slechter af waren in vergelijking met dakloze mensen zonder deze ervaringen, met betrekking tot een breed scala aan factoren die van invloed zijn op de kwaliteit van hun dagelijks leven, zou het nuttig zijn om onderzoek te doen naar de toepassing van trauma-geïnformeerd werken binnen de MO. Een dergelijke studie zou kunnen helpen vaststellen of en onder welke voorwaarden trauma-geïnformeerd werken effect heeft op de kwaliteit van leven van dakloze mensen die verblijven in de MO.

Omdat de bevindingen beschreven in hoofdstuk 2, 3 en 4 maar beperkt generaliseerbaar zijn naar de totale populatie dakloze mensen in Nederland, zou toekomstig onderzoek moeten streven naar een bredere en inclusievere representatie van mensen die dakloosheid ervaren in Nederland. Bijvoorbeeld, mensen die geen toegang hebben tot de MO, zoals mensen zonder identiteitsbewijs of zonder legale verblijfsvergunning, of mensen met onzekere en ontoereikende huisvesting. Dit zou verder inzicht kunnen geven in wat mensen in een situatie van dakloosheid nodig hebben om hun leefomstandigheden te verbeteren en deel te nemen aan de samenleving.

De bevindingen van dit proefschrift benadrukken de noodzaak om het perspectief van mensen met ervaringskennis en ervaringsdeskundigen mee te nemen bij het uitvoeren van onderzoek en het formuleren van onderzoeksagenda’s. Deze aanpak vereist echte samenwerking, waarbij onderzoekers luisteren en leren van de mensen voor wie zij hun onderzoek willen uitvoeren, en niet, zoals soms gebeurt, hun eigen normen (bijvoorbeeld met betrekking tot gezond gedrag of coping stijlen) via hun onderzoek proberen op te leggen aan anderen (Breed & Van Marle, 2022). Onderzoekers die de leefsituatie van mensen die sociale uitsluiting ervaren willen verbeteren, zouden bijvoorbeeld hun onderzoeksvragen direct bij de betrokkenen kunnen verzamelen, hun onderzoek daar vervolgens op moeten richten en samen met de betrokkenen kijken hoe dit onderzoek het beste kan worden uitgevoerd. Op dit gebied kan veel worden geleerd van community-based participatory research (Jagosh et al., 2015).

Tot slot mag (verder) onderzoek nooit een reden zijn om beleidsmaatregelen die de leefomstandigheden en sociale ondersteuning voor mensen in kwetsbare posities verbeteren, uit te stellen.

Conclusie

Dit proefschrift heeft onze kennis vergroot van wat dakloze mensen die gebruik maken van MO-voorzieningen en mensen die leven in langdurige armoede in Nederland nodig hebben. Het biedt richtlijnen voor beleid en voor verdere professionalisering en kwaliteitsverbeteringen van de ondersteuning die wordt geboden aan dakloze mensen en mensen die in langdurige armoede leven. De resultaten onderstrepen het belang van brede en geïntegreerde beleidsmaatregelen om de bestaanszekerheid te versterken, en benadrukken de noodzaak om het perspectief van mensen met ervaringskennis en ervaringsdeskundigen te betrekken bij de ontwikkeling van dit beleid. Ons onderzoek benadrukt ook de noodzaak om ervaringsdeskundigen in te zetten in dienstverlening aan dakloze mensen en mensen die in langdurige armoede leven, en om een meer mensgerichte benadering toe te passen.

Literatuur

Altena, A.M. (2019). *Homeless young adults using shelter facilities: Their needs and the effectiveness and appropriateness of interventions and services* [Doctoral dissertation]. Radboud University Medical Center. Retrieved from: https://repository.ubn.ru.nl/bitstream/handle/2066/203564/203564.pdf?sequence=1

Aubry, T., Nelson, G., & Tsemberis, S. (2015). Housing First for People With Severe Mental Illness Who Are Homeless: A Review of the Research and Findings From the At Home-Chez soi Demonstration Project. *Canadian Journal of Psychiatry, 60*(11):467-74. doi: 10.1177/070674 371506001102

Barker, S. L. (2018). *Peer support and homelessness* [Doctoral dissertation]. University of Southampton. Retrieved from: https://eprints.soton.ac.uk/429021/1/Barker_PhD_Thesis_ Final.pdf. doi: 10.5258/SOTON/D0649

Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. L. (2019). Expert viewpoints of peer support for people experiencing homelessness: A Q sort study. *Psychological Services, 16*(3), 402–414. doi: 10.1037/ser0000258

Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology & Community Health, 73*(5), 379-387. doi: 10.1136/jech-2018-210981

Beenackers, M. A., Groeniger, J. O., Kamphuis, C. B. M., & van Lenthe, F. J. (2016). The role of financial strain and self-control in explaining income inequalities in health behaviors. *European Journal of Public Health, 26*. doi: 10.1093/eurpub/ckw166.058

Bethell, C.D., Carle, A., Hudziak, J., Gombojav, N., Powers, K., Wade, R., & Braveman, P. (2017). Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice. *Academic Pediatrics, 17* (7), 51-69. doi: 10.1016/j.acap.2017.04.161.

Blume, S. (2017) In search of experiential knowledge. *Innovation: The European Journal of Social Science Research, 30*(1), 91–103. doi: 10.1080/13511610.2016.1210505

Boesveldt, N., Kuijpers, M., Bochem, M. & Dries, van den S. (2019). *Voorkomen Terugval Utrecht: Eerste meting van vijfjarig onderzoek naar recidive dakloosheid in Utrecht.* Retrieved from: https://onderzoekmobw.socsci.uva.nl/wp-content/uploads/2020/04/Rapportage-2019 Voorkomen-Terugval-Utrecht.pdf

Boesveldt, N., Kuijpers, M., Van der Veen, C., & Otto, M. (2021). Rapportage *Voorkomen Herhaalde Dakloosheid Utrecht: Rapportage derde meting van vijfjarig onderzoek naar recidive dakloosheid in Utrecht, meting 2021.* Retrieved from: https://onderzoekmobw.socsci.uva.nl/wp-content/uploads/2021/10/Boesveldt-2021-Rapportage-Voorkomen-Herhaalde-Dakloosheid-Regio-Utrecht_Derde-Ronde.pdf

Breed, M., & Van Marle, F. (2022). Bewoners aandachtswijken voelen zich klein gehouden door onderzoekers en beleidsmakers. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/bewoners-aandachtswijken-voelen-zich-klein-gehouden-door-onderzoekers-en-beleidsmakers/

Brown, R.T., Goodman, L., Guzman, D., Tieu, L., Ponath, C., & Kushel, M.B. (2016). Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. *PLoS ONE 11 (5).* doi: 10.1371/journal.pone.0155065

Centers for Disease Control and Prevention (2019). *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Centraal Bureau voor de Statistiek (2016). *Aantal daklozen in zes jaar met driekwart toegenomen*. Retrieved from: https://www.cbs.nl/nl-nl/nieuws/2016/09/aantal-daklozen-in-zes-jaarmet-driekwart-toegenomen

Centraal Bureau voor de Statistiek (2019a). *Aantal daklozen sinds 2009 meer dan verdubbeld*. Retrieved from: https://www.cbs.nl/nl-nl/nieuws/2019/34/aantal-daklozen-sinds-2009-meer-danverdubbeld

Centraal Bureau voor de Statistiek (2019b). *Welvaart in Nederland*. Retrieved from: https://longreads.cbs.nl/welvaartinnederland-2019/armoede-en-risicogroepen/

Centraal Bureau voor de Statistiek (2020). *Slachtofferschap delicten; persoonskenmerken 2012-2019*. Retrieved from: https://www.cbs.nl/nl-nl/cijfers/detail/83096NED

Chien, W.T., Clifton, A.V., Zhao, S., & Lui, S. (2019). Peer support for people with schizophrenia or other serious mental illness. *Cochrane Database of Systematic Reviews, 4(4)*, CD010880. doi: 10.1002/14651858.CD010880.pub2

Crouch, E., Jones, J., Strompolis, M., & Merrick, M. (2020). Examining the association between ACEs, childhood poverty and neglect, and physical and mental health: Data from two state samples. *Children and Youth Services Review, 116*. doi: 10.1016/j.childyouth.2020.105155

Curl, A., & Kearns, A. (2014). Financial difficulty and mental wellbeing in an age of austerity: The experience in deprived communities. *Social Policy & Society, 14*, 217-240. doi: 10.1017/S1474746414000475

Daniels, D. (2022). Ervaringsdeskundigen hebben baat bij een systeem. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/ervaringsdeskundigen-hebben-baat-bij-een-systeem/

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123–128. doi: 10.1016/j.wpsyc.2012.05.009

Feantsa (2017). *Recognising the Link between Trauma and Homelessness.* Feantsa Position, retrieved from: https://www.feantsa.org/download/feantsa_traumaandhomelessness030 7347121905294681073\8.pdf

Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities.* Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Gidugu, V., Rogers, E.S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal, 51*(4), 445–452. doi: 10.1007/s10597-014-9801-0

Green, H.D., Tucker, J.S., Wenzel, S.L., Golinelli, D., Kennedy, D.P., Ryan, G.W., & Zhou, A.J. (2012). Association of childhood abuse with homeless women's social networks. *Child Abuse & Neglect, 36* (1), 21-31. doi: 10.1016/j.chiabu.2011.07.005

Gupta, A., & Holloway, R. (2016). Giving poverty a voice: Families' experiences of social work practice in a risk-averse child protection system. *Families, Relationships and Societies, 5*(1), 163-172. doi: 10.1332/204674316X14540714620166

Haushofer, J., & Feher, E. (2014). On the psychology of poverty. *Science, 344*(6186), 862-867. doi: 10.1126/science.1232491

Hofs, J., 2017. Sociaal werkers onder gemeentelijke regie. Pleidooi voor sociale rechtvaardigheid als basisprincipe voor sociaal werk. *Journal of Social Intervention: Theory and Practice, 26*(3), p.65-71. doi: 10.18352/jsi.542

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homelessness services settings. *The Open Health Services and Policy Journal, 3*(1), 80–100.

Jagosh, J., Bush, P. L., Salsberg, J., Macaulay, A. C., Greenhalgh, T., Wong, G., & Pluye, P. (2015). A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health, 15*. doi: 10.1186/s12889-015-1949-1

Jungmann, N., Wesdorp, P., & Madern, T. (2020). *Stress-sensitief werken in het sociaal domein. Inzichten en praktische handvatten voor hulp- en dienstverleners.* Houten: Bohn Stafleu van Loghum.

Keats, H., Maguire, N., Johnson, R., & Cockersell, P. (2012) *Psychologically informed services for homeless people*. Southampton, GB, Communities and Local Government (Good Practice Guide).

Keuzenkamp, S. (2022). Geef Ervaringskennis- en deskundigen een serieuze positie. *Sociale Vraagstukken*. Retrieved from: https://www.socialevraagstukken.nl/geef-ervaringskennis-en-deskundigen-een-serieuze-positie/

King, A.J., Thy, B.O., & Simmons, M.B. (2018). A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions. *Psychiatric Services, 69*(9), 961–977. doi: 10.1176/appi.ps.201700564

Lancaster, K., Seear, K., Treloar, C. and Ritter, A. (2017) The productive techniques and constitutive effects of "evidence-based policy" and "consumer participation" discourses in health policy processes, *Social Science and Medicine, 176*, 60–68. doi: 10.1016/j.socscimed.2017.01.031

Lee, C.M., Mangurian, C., Tieu, L., Ponath, C., Guzman, D., & Kushel, M. (2017). Childhood Adversities Associated with Poor Adult Mental Health Outcomes in Older Homeless Adults: Results From the HOPE HOME Study. *American Journal of Geriatric Psychiatry, 25*(2), 107-117. doi: 10.1016/j.jagp.2016.07.019

Liu, M., Mejia-Lancheros, C., Lachaud, J., Nisenbaum, R., Stergiopoulos, V., & Hwang, S.W. (2020). Resilience and Adverse Childhood Experiences: Associations With Poor Mental Health Among Homeless Adults. *American Journal of Preventive Medicine, 58* (6), 807-816. doi: 10.1016/j.amepre.2019.12.017

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S., & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry, 14*(1), 39. doi: 10.1186/ 1471-244X-14-39

Loignon, C., Hudon, C., Goulet, E., Boyer, S., De Laat, M., Fournier, N., Grabovschi, C., & Bush, P. (2015). Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: The EQUIhealThY project. *International Journal for Equity in Health, 14*(4). doi: 10.1186/s12939-015-0135-5

Luchenski, S., Maguire, N., Aldridge, R. W., Hayward, A., Story, A., Perri, P., ... Hewett, N. (2018). What works in inclusion health: Overview of effective interventions for marginalised and excluded populations. *The Lancet, 391*(10117), 266-280. doi:10.1016/s0140-6736(17)31959-1

Luijben , G., Hertog , F., & van der Lucht, F. (2019). *Armoede, chronische stress en gezondheid in Den Haag, een verkenning op basis van group model building* (vol. 2019-0004). Bilthoven, The Netherlands: Rijksinstituut voor Volksgezondheid en Milieu RIVM, Ministerie van Volksgezondheid, Welzijn en Sport.

Mani, A., Mullainathan, S., Shafir, E., & Zhao, J. (2013). Poverty impedes cognitive function. *Science, 341*, 976-980. doi: 10.1126/science.1238041

Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public Health, 126*, 4-10. doi: 10.1016/j.puhe.2012.05.014.

Marttila, A., Johansson, E., Whitehead, M. et al. (2013). Keep going in adversity – using a resilience perspective to understand the narratives of long-term social assistance recipients in Sweden. *International Journal for Equity in Health 12* (8). doi:10.1186/1475-9276-12-8

Mc Conalogue, D., Maunder, N., Areington, A., Martin, K., Clarke, V., & Scott, S. (2019). Homeless people and health: a qualitative enquiry into their practices and perceptions. *Journal of Public Health, 43*(2), 287–294. doi: 10.1093/pubmed/fdz104

Meriluoto, T. (2018) Turning experience into expertise: technologies of the self in Finnish participatory social policy. *Critical Policy Studies, 12*(3), 294–313. doi: 10.1080/19460171.2017.1310051

Miyamoto, Y., & Sono, T. (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature. *Clinical Practice and Epidemiology in Mental Health, 8*(1), 22–29. doi: 10.2174/1745017901208010022

Mood, C., & Jonsson, J.O. (2016). The Social Consequences of Poverty: An Empirical Test on Longitudinal Data. *Social Indicators Research, 127*(2), 633-652. doi: 10.1007/s11205-015-0983-9

Movisie (2018). *Ervaringsdeskundigen in het sociaal domein: wie zijn ze en wat doen ze?* Retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2019-11/Startnotitie-Ervaringsdeskundigen-in-het-sociaal-domein.pdf

Movisie (2022). *Werken aan bestaanszekerheid: gemeenten aan de slag vanuit het perspectief van inwoners*. Retrieved from: https://www.movisie.nl/sites/movisie.nl/files/2022-06/Werken-aan-bestaanszekerheid-2022.pdf

Ministerie van Binnenlandse Zaken, Ministerie van Sociale Zaken en Werkgelegenheid & Ministerie van Volksgezondheid, Welzijn en Sport (2022). *Nationaal Actieplan Dakloosheid: Eerst een Thuis*. Retrieved from: https://open.overheid.nl/documenten/ronl-bb529bd58adc8061e5c058d2fe9 671197ba 6244f / pdf

Nationaal Instituut voor Budgetvoorlichting (2022). Retrieved from: https://www.nibud.nl/dossiers/koop kracht - betaalbaarheid/

Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T. L., & Gilbert, L. (2017). *Preventing intimate partner violence across the lifespan: A technical package of programs, policies and practices.* Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

O'Donnell, P., Tierney, E., O'Carroll, A., Nurse, D., & MacFarlane, A. (2016). Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *International Journal Equity in Health, 15*, 197. doi: 10.1186/s12939-016-0487-5

Patterson, M.L., Moniruzzaman, A., & Somers, J.M. (2014). Setting the stage for chronic health problems: cumulative childhood adversity among homeless adults with mental illness in Vancouver, British Columbia. *BMC Public Health, 14*, 350. doi: 10.1186/1471-2458-14-350

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews, 3*(3), CD004807. doi: 10.1002/14651858.CD004807.pub2

Pharos (2022). *Discriminatie en Gezondheid: Over de invloed van discriminatie (in de zorg) op gezondheidsverschillen en wat we hieraan kunnen doen.* Retrieved from: https://www.pharos.nl/nieuws/discriminatie-in-de-zorg-onderzoek/

Pharos (2023). Factsheet: *Armoede tijdens de eerste 1000 dagen: cijfers, feiten en gevolgen* Retrieved from: https://www.pharos.nl/factsheets/armoede-tijdens-de-eerste-1000-dagen- cijfers-feiten-en-gevolgen/

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392–411. doi: 10.3109/09638237.2011.583947

Ridley, M., Rao, G., Schilbach, F., & Patel, V. 2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science, 370*, (6522). doi: 10.1126/science.aay0214

Samen Thuis 2030 (2023). *Betekenisvol samenwerken met jongeren met ervaringskennis over (dreigende) dakloosheid: Een handleiding voor beleidsmakers.* Retrieved from: https://www.samenthuis2030.nl/wp-content/uploads/2023/05/Whitepaper_Betekenisvolle_ participatie_van_jongeren_met_ervaringskennis.pdf

Schiffrin, H. H., & Nelson, S. K. (2010). Stressed and Happy? Investigating the Relationship Between Happiness and Perceived Stress. *Journal of Happiness Studies, 11*(1), 33-39. doi:10.1007/s10902-008-9104-7

'S Jongers, T. (2022). *Beledigende Broccoli: Over de Ervaringskennis van Kwetsbare Mensen*. Uitgeverij Van Gennep B.V., The Netherlands.

Smith-Merry, J. (2020). Evidence-based policy, knowledge from experience and validity. *Evidence & Policy, 16*(2), 305-316. Retrieved Mar 19, 2023, from https://bristoluniversitypressdigital.com/view/journals/evp/16/2/article-p305.xml

Stein, J.A., Leslie, M.B., & Nyamathi, A. (2002). Relative contributions of parent substance use and childhood maltreatment to chronic homelessness, depression, and substance abuse problems among homeless women: mediating roles of self-esteem and abuse in adulthood. *Child Abuse & Neglect, 26* (10), 1011–1027. doi: 10.1016/S0145-2134(02)00382-4

Sturm, W.E. (2022). *To be Trusted: The Role of the Working Alliance in Probation Supervision* [Doctoral Thesis]. Vrije Universiteit, Amsterdam. Retrieved from: https://research.vu.nl/en/publications/to-be-trusted-the-role-of-the-working-alliance-in-probation-super

Tuynman, M., & Planije, M. (2012). *Monitor Plan van Aanpak Maatschappelijke Opvang. Rapportage 2011: Amsterdam, Rotterdam, Den Haag en Utrecht*. Trimbos Instituut, Utrecht.

Van den Dries, L., Peters, Y., Al Shamma, S., & Wolf, J. (2018). *Dakloze Mensen in Amsterdam: Veranderingen 5,5 jaar na instroom in de Opvang.* Impuls – Onderzoekscentrum Maatschappelijke Zorg, Radboudumc. Retrieved from: https://www.straatconsulaat.nl/wp-content/uploads/2018/11/Rapport-CodaG4-Dakloze-mensen-in-Amsterdam.pdf

Van der Laan, J. (2020). *Giving Voice to Homeless People: homeless people's personal goals, care needs, and quality of life in the Dutch social relief system* [Doctoral dissertation]. Radboud University Medical Center, Nijmegen.

Van der Tier, M., Hermans, K., & Potting, M. (2022). Social workers as state and citizen-agents. How social workers in a German, Dutch and Flemish public welfare organisation manage this dual responsibility in practice. *Journal of Social Work, 22*(3), 595–614. doi: 10.1177/14680173211009724

Vereniging voor Ervaringsdeskundigen (2022). Kwaliteitssysteem voor Ervaringsdeskundigen. Retrieved from: https://vved.org/kve/

VNG & Divosa (2021). *De winst van het sociaal domein: Een slimme investering in bestaanszekerheid, kansengelijkheid en gezondheid.* Retrieved from: https://vng.nl/sites/default/files/2021-04/de-winst-van-het-sociaal-domein_def.pdf

Watson, E. (2019). The mechanisms underpinning peer support: A literature review. *Journal of Mental Health, 28*(6), 677–688. doi: 10.1080/09638237.2017.1417559

Weerman, A. (2016). *Ervaringsdeskundige zorg- en dienstverleners: Stigma, verslaving & existentiële transformatie* [Doctoral dissertation]. Vrije Universiteit Amsterdam. Retrieved from: https://research.vu.nl/ws/portalfiles/portal/42162914/complete+dissertation.pdf

Wewerinke, D., Schel, S., Kuijpers, M., De Vries, J. & Van Doorn, L. (2023). *Iedereen telt mee. Resultaten eerste ETHOS telling dak- en thuisloosheid regio Noordoost Brabant*. Utrecht: Hogeschool Utrecht.

Williamson, D. L., Stewart, M. J., Hayward, K., Letourneau, N., Makwarimba, E., Masuda, J., Raine, K., Reutter, L., Rootman, I., & Wilson, D. (2006). Low-income Canadians' experiences with health-related services: Implications for health care reform. *Health Policy, 76*(1), 106-121. doi: 10.1016/j.healthpol.2005.05.005

Wolf, J. (2016). Krachtwerk. *Methodisch werken aan participatie en zelfregie*. Bussum: Coutinho

Chapter 8

Description of the research data management

This thesis is based on the results of three research projects involving human participants. All three research projects comply with the criteria for approval by an accredited Medical Research Ethics Committee. Upon consultation, the accredited Medical Review Ethics Committee region Arnhem-Nijmegen concluded that the three research projects were exempt from formal review (Chapter 2 and 3: file number 2010-321, chapter 4: file number 2018-5007, and Chapter 5: file number 2020-7030). Chapter 2 and 3 were part of a research project funded by the Dutch Ministry of Health, Welfare and Sport, and by the municipality of Amsterdam. Chapter 4 was part of a research project funded by the Academic Collaborative Center Impuls Participation and Social Care. The research project related to Chapter 5 was was funded by the Netherlands Organization for Health Research and Development (ZonMw).

These projects are stored on the Radboudumc server of the Department of Primary and Community Care at the following locations: H:\OZ-Maatschappelijkezorg\MZ-Netwerkondersteuning, H:\OZ-Maatschappelijke zorg\Algemene projectmap\MZ-Ervaringskennis, and H:\OZ-Maatschappelijke zorg\Algemene projectmap\MZ-Armoede. After the conclusion of all project-related activities, including the defense of this thesis, these projects will be moved to the department research storage: \\umcsanfsclp01\elg_restore\maatschappelijke zorg.

Regarding the projects related to chapter 4 and 5, participants were interviewed once, either face-to-face or digitally, by an interviewer using an audio recorder. Written or orally recorded informed consent was obtained. The written informed consent forms were stored in the department archive (Radboudumc, building M245, room -2.053), closet numbers 26, 28, 29, and 30. The orally recorded informed consents were stored at H:\OZ-Sleutelbestanden\MZ-Netwerkondersteuning. The audio recordings were transcribed by employees from TipTopTranscriptions who had signed a confidentiality agreement with the Radboudumc. The interview transcripts were uploaded in ATLAS.ti., and data management and monitoring were performed within this program. The audio recordings and transcripts of the interviews were stored at the following locations: H:\OZ-Maatschappelijke zorg\MZ-Ervaringskennis, and H:\OZ-Maatschappelijke zorg\MZ-Armoede. The privacy of the participants is warranted by use of encrypted and unique individual participant codes. This code corresponds with the code mentioned in the audio recording. The code was stored separately from the study data.

Regarding the project related to chapter 2 and 3, participants were interviewed four times by research assistants using paper questionnaire booklets at baseline and 6, 18, and 30 months. Regarding chapter 2, participants were also interviewed a fifth time at 66 months. At baseline, the booklet contained the written informed consent. Paper data were stored in the department archive (Radboudumc, building M245, room -2.053), closet numbers 26, 28, 29, and 30. All paper data were entered into the computer by use of SPSS (SPSS Inc., Chicago, Illinois, USA). Data management and monitoring were performed within SPSS. The privacy of the participants in this project is warranted by use of encrypted and unique individual participant codes. This code corresponds with the code on the questionnaire booklets. The code was stored separately from the study data.

The data will be saved for 15 years after the data were collected within the three projects (June 1, 2014, June 1, 2017, July 1, 2019, and July 1, 2021). Using these participant data in future research is only possible after renewed permission by participants as recorded in the informed consent. The datasets analyzed during these three projects are available from Judith Wolf (judithwolf@radboudumc.nl) on reasonable request.

Chapter 9

Curriculum Vitae

Over de auteur

Sandra Schel werd geboren op 17 februari 1984 in Nijmegen en groeide op in Kekerdom. Na het behalen van haar eindexamen VWO aan het Canisius College Nijmegen in 2002 begon ze aan de opleiding Psychologie aan de Radboud Universiteit Nijmegen. Zij volgde daar succesvol de afstudeerrichting Arbeids- en Organisatiepsychologie en de afstudeerrichting Klinische Psychologie. Tijdens haar afstudeerrichting Klinische psychologie liep Sandra stage bij Overwaal, Expertisecentrum Angst, Dwang en PTSS, onderdeel van Pro Persona in Nijmegen (toen geheten Polikliniek Angst bij GGZ Nijmegen). Naast haar studie volgde zij het interdisciplinaire Honoursprogramma van de Radboud Universiteit en was zij voorzitter van de studentenraad van het Honoursprogramma. Na afronding van haar studie in 2008 werkte zij als psycholoog bij de Polikliniek van Overwaal. Zij behandelde daar patiënten met (ernstige) angst- en dwangstoornissen en PTSS door middel van cognitieve gedragstherapie en EMDR, voerde psychodiagnostisch onderzoek uit en superviseerde er stagiairs. Tevens coördineerde zij daar de uitvoering van een multicenter gerandomiseerde studie naar een stepped care behandeling van mensen met een paniekstoornis met agorafobie.

Tijdens haar werk als psycholoog merkte Sandra dat haar interesse steeds meer verschoof naar het uitvoeren van wetenschappelijk onderzoek. In 2012 maakte zij de overstap naar Forensisch Psychiatrisch Centrum de Pompestichting in Nijmegen om daar te gaan werken als onderzoeker. Zij deed daar onder andere longitudinaal onderzoek naar de kwaliteit van leven van patiënten binnen de langdurige forensisch psychiatrische zorg, ontwikkelde een korte vragenlijst om de kwaliteit van leven van deze patiënten te meten en nam deel aan een Europees samenwerkingsverband (in het kader van een COST-subsidie) dat onderzoek deed naar de karakterieken van patiënten binnen de langdurige forensisch psychiatrische zorg. Daarnaast werkte zij mee aan de ontwikkeling en implementatie van een richtlijn voor delictanalyse in de forensisch psychiatrische zorg. Tijdens deze baan groeide haar interesse voor het onderzoeken van oplossingen voor maatschappelijke problemen zoals armoede en dakloosheid en het onderzoeken van determinanten van psychologische kwetsbaarheid en succesvolle participatie. In 2018 startte zij haar promotietraject bij Impuls – onderzoekscentrum maatschappelijke zorg, onderdeel van de afdeling Eerstelijnsgeneeskunde van het Radboudumc in Nijmegen. Naast de werkzaamheden voor haar promotie deed zij daar, in het kader van Horizon 2020 project ‘Home_EU’, onderzoek naar nationaal, regionaal en lokaal dakloosheidsbeleid in acht Europese landen. Ook deed zij kwalitatief onderzoek naar de ondersteuningsbehoeften van mensen die vanuit een woonvoorziening (begeleid) zelfstandig gaan wonen.

Momenteel is Sandra werkzaam als docent-onderzoeker bij het lectoraat Wonen en Welzijn aan Hogeschool Utrecht. Zij leidt daar het ETHOS-Light telonderzoek waarbij de aard en omvang van dak- en thuisloosheid in 55 gemeenten in kaart wordt gebracht op basis van de Europese ETHOS-Light classificatie van dak- en thuisloosheid. Ook is zij namens het lectoraat partner in een Europese studie naar de toepassing van ETHOS-Light in verschillende Europese landen. Sandra woont in Nijmegen samen met haar partner Tim en hun twee kinderen, Max en Julie.

Publicaties

Schel, S.H,H.†, Scholten, L.†, Van den Dries, L., Fransen-Kuppens, G.A.J., De Vet, R., & Wolf, J.R.L.M. The wishes, perceived barriers, and support needs of people living in persistent poverty. (Submitted).

Schel, S.H.H., Van den Dries, L., Van der Laan, J., Van de Mheen, D., & Wolf, J.R.L.M. Initially homeless people in the Netherlands: Housing status, prevalence of risk factors and changes in this prevalence 5.5 years after shelter entry. (Revision submitted).

Schel, S.H.H., Van den Dries, L., Van der Laan, J., Van Straaten, B., Van de Mheen, D., Al Shamma, S., & Wolf, J.R.L.M. (2023). The link between childhood abuse experiences and homeless people’s quality of life: A longitudinal study. *Journal of Child & Adoloscent Trauma. doi: 10.1007/s40653-023-00582-6*

Wewerinke, D., **Schel, S**., Kuijpers, M., De Vries, J. & Van Doorn, L. (2023). *Iedereen telt mee. Resultaten eerste ETHOS telling dak- en thuisloosheid regio Noordoost Brabant*. Utrecht: Hogeschool Utrecht.

Schel, S., Kuijpers, M., Wewerinke, D., Scheepers, A., De Vries, J. & Van Doorn, L. (2023). *Iedereen telt mee. Resultaten eerste ETHOS telling van dak- en thuisloosheid in regio Brabant Noordoost-Oos*t. Utrecht: Hogeschool Utrecht.

Wewerinke, D., Kuijpers, M., **Schel, S**., De Vries, J. & Van Doorn, L. (2023). *Iedereen telt mee. Resultaten eerste ETHOS telling van dak- en thuisloosheid in regio Meierij en Bommelerwaard*. Utrecht: Hogeschool Utrecht.

Wewerinke, D., **Schel, S.**, De Vries, J., & Van Doorn, L. (2023). Een beter beeld van dak- en thuisloosheid met behulp van ETHOS-Light. *Tijdschrift voor Sociale Vraagstukken*: https://www.socialevraagstukken.nl/anders-tellen-geeft-een-beter-beeld-van-dakloosheid/

Schel, S., Wewerinke, D., De Vries, J., & Van Doorn, L. (2023). Nieuwe telling van dak- en thuisloosheid. *Sociaal Bestek*: https://sociaalbestekpremium.nl/sociaal-bestek-2023-editie-3

Schel, S. H. H., van den Dries, L., & Wolf, J. R. L. M. (2022). What Makes Intentional Unidirectional Peer Support for Homeless People Work? An Exploratory Analysis Based on Clients' and Peer Workers' Perceptions. *Qualitative Health Research*. doi: 10.1177/10497323221083356

Schel, S.H.H., Bouman, Y.H.A., Schaftenaar, P., Smeekens, M.V., Smeijers, D., & Bulten, B.H. (2018). *Relevante factoren voor kwaliteit van leven voor (ex) forensisch psychiatrische patiënten: aanbevelingen en handvatten voor het verbeteren van de objectieve en subjectieve kwaliteit van leven van forensisch psychiatrische patiënten*. In opdracht van: Kwaliteit Forensische Zorg.

Huband, N., Furtado, V., **Schel, S.,** Eckert, M., Cheung, N., Bulten, E., & Völlm, B. (2018). Characteristics and needs of long-stay forensic psychiatric inpatients: a rapid review of the literature. *International Journal of Forensic Mental Health, 17,* 45-60. doi: 10.1080/14999013.2017.1405124

Eckert, M., **Schel, S.H.H.,** Kennedy, H.G., & Bulten, B.H. (2017). Patient characteristics related to length of stay in Dutch forensic psychiatric care. *The Journal of Forensic Psychiatry & Psychology, 28*, 863-880. doi: 10.1080/14789949.2017.1332771

Schel, S.H.H., Bouman, Y.H.A., Vorstenbosch, E.C.W., & Bulten, B.H., (2017). Development of the forensic inpatient quality of life questionnaire: Short Version (FQL-SV). *Quality of Life Research, 26*, 1153-1161. doi: 10.1007/s11136-016-1461-9

Schel, S.H.H., Bouman, Y.H.A., Braun, P.C., & Bulten, B.H. (2016) Kwaliteit van leven van patiënten in de langdurige forensische psychiatrie. *Tijdschrift voor Psychiatrie, 58*, 863-871.

Schel. S.H.H., Bouman, Y. H.A., & Bulten, B.H. (2015). Quality of Life in Long-Term Forensic Psychiatric Care: Comparison of self-report and proxy assessments. *Archives of Psychiatric Nursing, 29(3),* 162-167. doi: 10.1016/j.apnu.2015.01.004

Schel, S.H.H., Bouman, Y.H.A., Vorstenbosch, E.C.W., & Bulten, B.H. (2015). *Forensic inpatient Quality of Life Questionnaire – Short Version* (English, Dutch, Italian and German version).

Vrinten, M., Keulen-de Vos, M.E., **Schel, S.**, Cima, M., & Bulten, E. (2015). *De delict analyse in de forensische zorg: ontwikkeling van een richtlijn*. In opdracht van: Kwaliteit Forensische zorg.

†These authors contributed equally to the study

Chapter 10

PhD Portfolio

PhD candidate: S.H.H. Schel
Department: Impuls – Netherlands Center for Social Care Research, Department of Primary and Community Care
Graduate School: Radboud Institute for Health Sciences
PhD period: October 1, 2018 – March 22, 2024
Supervisors: Prof. dr. J.R.L.M. Wolf
Co-supervisors: Dr. L. van den Dries

TRAINING ACTIVITIES	**Year(s)**	**ECTS**
Courses & workshops		
• Introduction day, Radboudumc	2018	0.5
• Graduate School specific introductory course	2018	0.75
• Course *Kwalitatieve onderzoeksmethoden in de gezondheidszorg*, Radboudumc	2018	1
• Course *eBROK: Basiscursus Regelgeving en Organisatie voor Klinisch Onderzoekers*, Radboudumc	2019	1.5
• Course *Presentation skills*, Radboud University	2019	1.5
• Course *Statistics for PhD candidates by using SPSS*, Radboud University	2019	2
• Course *Scientific writing for PhD candidates*, Radboud University	2019	3
• Course *Scientific Integrity*, Radboudumc	2021	1
Seminars & lectures		
• Seminars and colloquia at the Department of Primary and Community Care	2018-2022	1
• Radboud Research Rounds	2018-2022	1
• Project Meeting for Horizon 2020 project 'Home_EU', Marseille	2018	1.25
• Oral presentation: Study of policies on homelessness in 8 EU countries, for the project team		
• Oral presentation: Study of policies on homelessness in 8 EU countries, for Secretary-General for Regional Affairs and the Housing-First team of Marseille		
• 'Refereerbijeenkomst' Department of Primary and Community Care. Oral presentation: De kracht van ervaringszorg in de maatschappelijke opvang	2020	0.2
• Wetenschappelijke integriteit voor onderzoekers, Department of Primary and Community Care	2021	0.1

TRAINING ACTIVITIES	**Year(s)**	**ECTS**
Symposia & congresses		
• Jaarcongres Participatie en Herstel, Utrecht, Logacom	2018	0.5
• Symposium 'Inclusief Onderzoek', online, Universiteit van Maastricht	2021	0.1
• Symposium 'Behandelen met eigen ervaring', online, Logacom	2021	0.1
Other		
-		
TEACHING ACTIVITIES		
Lecturing		
• Training research assistants who conducted interviews	2019-2021	0.2
Supervision of internships/other		
• Supervising research assistants who conducted interviews	2019-2021	0.2
TOTAL		15.9

Dankwoord

Dit proefschrift was niet tot stand gekomen zonder de hulp en steun die ik van veel mensen heb mogen ontvangen. Ik wil iedereen die hier direct aan heeft bijgedragen graag bedanken en een aantal mensen in het bijzonder.

Allereerst wil ik graag alle mensen die hebben meegedaan aan de onderzoeken bedanken. Zonder jullie bereidheid en openhartigheid was dit proefschrift niet tot stand gekomen. Ook wil ik graag de medewerkers van de organisaties bedanken die me hebben geholpen bij het werven van deelnemers en het verzamelen van de data.

Judith, bedankt voor de mogelijkheid die je me hebt gegeven om op dit onderwerp te mogen promoveren. Met jouw waardevolle feedback en enorme kennis en ervaring heb je er voor gezorgd dat mijn studies tot een hoger niveau werden getild.

Linda, veel dank voor je begeleiding als co-promotor. Ik bewonder jouw analytisch vermogen, jouw werk- en denksnelheid en je nuchtere houding. Ik heb veel gehad aan jouw feedback tijdens het schrijven van de artikelen en je was altijd betrokken, zowel op werkvlak als privé.

Sara, jij bent de meest betrokken, kritische en oprechte persoon die ik ken en ik ben heel dankbaar dat ik je bij Impuls heb mogen leren kennen. Heel veel dank voor je jarenlange interesse, kritische noten, en je enorme steun. Ik vind het heel bijzonder dat jij nu ook mijn paranimf bent.

En natuurlijk al mijn andere (voormalig) collega's van Impuls: Irene, Pauline, Renée, Loes, Annabel, Lincy, Michelle, Marieke, Evelien, Nicoline en Milou. Bedankt voor jullie collegialiteit, gezelligheid en interesse. Annabel, Lincy en Loes wil ik graag speciaal bedanken voor de verbinding die we hielden tijdens de beperkingen door de coronamaatregelen, dat was ontzettend waardevol. Loes, bedankt ook voor de interessante gesprekken tussendoor, voor alle ondersteuning en de gezellige uitjes ook na jouw vertrek bij Impuls. Lincy, zet hem op met de laatste loodjes. Annabel wat fijn dat we toch weer collega's zijn, dit keer bij de HU!

Geachte leden van de manuscript commissie, Prof. dr. Koen Hermans, Prof. dr. Arnt Schellekens en dr. Catelijne Akkermans, en geachte overige leden van de promotiecommissie, veel dank voor de tijd die jullie hebben genomen voor het lezen en de beoordeling van het manuscript en voor uw bereidheid te willen opponeren.

Coauteurs Prof. dr. Dike van de Mheen, dr. Jorien van der Laan en dr. Barbara van Straaten, veel dank voor al het werk dat jullie voor de CODA-G4 studie hebben verricht en de fijne samenwerking bij de twee artikelen die ik over de CODA-data heb geschreven. Prof. dr. Maud Graff, bedankt voor je ondersteunende gesprekken in je rol als mentor tijdens mijn PhD-traject.

Reinier Akkermans, veel dank voor je adviezen voor de statistische analyses. Ook wil ik de leden van de werkgroep kwalitatief onderzoek bedanken voor het meedenken met de kwalitatieve analyses.

Fijne collega's van Hogeschool Utrecht, ik ben er trots op dat ik samen met jullie mag werken aan onderzoek en onderwijs dat bijdraagt aan het voorkomen en terugdringen van dakloosheid in Nederland. Lia, wat fijn dat je mij de kans gaf om bij jouw lectoraat te komen werken aan het ETHOS-Light telonderzoek. Marte, veel dank voor je steun tijdens de laatste loodjes van mijn proefschrift, ik hoop dat we nog lang mogen samenwerken. Dorieke, wat een geluk dat ik je heb leren kennen. In de tijd dat we nu samenwerken ben je veel meer dan alleen een collega geworden. Ik bewonder jouw bevlogenheid, enorme kennis op het thema, jouw positieve energie, oprechtheid en jouw intrinsieke motivatie om het grote onrecht van dak- en thuisloosheid uit te bannen. Veel dank voor al jouw steun tijdens de laatste loodjes van mijn proefschrift.

Daarnaast hebben er ook een aantal mensen indirect en mogelijk ook onbewust bijgedragen aan de totstandkoming van dit proefschrift. Meike, bedankt voor de gezellige etentjes, je interesse en vertrouwen. Onze besprekingen van de grenzen van het wetenschappelijk paradigma werkt altijd prettig relativerend. Mareike, wat fijn dat wij zo nu en dan een mooie wandeling maken of een hapje eten. Deze ontspanning en steun kon ik goed gebruiken. Rianne, bedankt voor je interesse en onze gezellige wijnavondjes. Birgit, bedankt voor alle gezellige uitjes en weekendjes weg, met en zonder de kids. Het is heerlijk om op die manier te kunnen ontspannen!

Elvira, wat kennen we elkaar al lang! Wat fijn om te weten dat jij er nog steeds voor mij bent als dat nodig is. Bedankt voor je altijd aanwezige vertrouwen en interesse. Ik ben heel trots op wat wij, sinds onze kennismaking met de academische wereld, allebei hebben bereikt. Ik ben heel blij dat jij mijn paranimf bent!

Nettie en Jos, bedankt voor jullie interesse in mijn werk en de zorg voor onze kinderen die jullie regelmatig op jullie nemen. Nettie, wat ontzettend fijn dat wij al jaren op jou kunnen rekenen als vaste oppas, zodat wij onze carrières vorm kunnen geven. Jos, jij hebt je tijdens de Corona lockdown ontpopt als zeer competente basisschooldocent, dat vond ik bijzonder en mooi om te zien. Wat ben ik blij dat je bij de verdediging van mijn proefschrift aanwezig kan zijn! Ik ben jullie erg dankbaar voor alles!

Lieve mama en papa, bedankt voor al jullie steun, zonder jullie was ik nooit zo ver gekomen. Jullie hebben me altijd aangemoedigd om me verder te ontwikkelen en toen ik zelf moeder werd hielpen jullie me hierbij door regelmatig op mijn kinderen te passen. Mam, jij weet maar al te goed hoe belangrijk een veilige basis en bestaanszekerheid zijn. Door jou leerde ik al vroeg dat mensen in een kwetsbare positie zoals dakloosheid daar niet zelf voor kiezen en dat opeenstapeling van pech iedereen kan overkomen. En dat we elkaar dan moeten helpen, zowel op persoonlijk vlak als door het maken van het juiste beleid. Ik ben je ontzettend dankbaar voor alles en ben heel blij dat je mijn moeder bent! Pap, wat is het fijn om een vader te hebben die al trots op mij was zonder MSc. of Dr. titels. Jouw nuchtere kijk op de wereld helpt mij om met beide benen op de grond te blijven staan. Wat fijn dat jij mijn vader bent!

Lieve Tim, ik prijs mij ontzettend gelukkig met jou aan mijn zijde. Wat fijn dat jij er altijd voor me bent. Samen zorgden we voor de ruimte om dit proefschrift te schrijven en af te ronden naast mijn baan bij Hogeschool Utrecht. Ondertussen hielp je me te focussen op wat ik naast het werk belangrijk vind in het leven. Talloze keren luisterde jij naar mijn frustraties over hoe de wereld in elkaar zit en hoe dat moet veranderen. Bedankt voor al je liefde, humor, geduld en fijne wandelingen. Ik kijk uit naar de rest van ons leven samen en met de liefste kinderen! Max en Julie, wat houd ik veel van jullie. Ik kijk ontzettend uit naar de extra vrije tijd die ik nu weer met jullie door kan brengen!