

Homelessness as a Barrier to Human Rights and Healthcare Provision

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Abstract

The most vulnerable members of our society are often the ones who are most vulnerable to human rights abuses. This paper considers the socio-political context of homelessness within the United Kingdom, and argues that the homeless population is being denied the right to healthcare provision, due to structural barriers, policies and services which are designed to exclude. Homelessness in the UK has more than doubled in the last six years, and whilst it is recognized to be a public health concern, systems are failing homeless people, and leading to increased discrimination, stigma, and exclusion.

Keywords: Homelessness; Healthcare; Public health; Exclusion; Poverty

Introduction

“Homelessness is a serious public health problem that emerges at the intersection of complex socioecological factors” [1]. A recent United Kingdom (UK) Public Accounts Committee report found there were over 9,000 rough sleepers and some 78,000 families living in temporary accommodation [2]. With increases of 134% from 2011 and UK homelessness charity, Crisis are predicting that Britain could witness a 76% increase over the next decade, homelessness has become ‘a national crisis’ for Britain [3]. Whilst there was a large increase in homelessness in the 1990s, particularly in groups such as military veterans, recent welfare and social policy reforms have led to unprecedented levels of homelessness across the UK today, presenting a vital focus for change [4].

Whilst the causes of homelessness are often complex and multidimensional, most charities and housing experts attribute the present growing rates to a combination of the Government’s welfare reforms, reductions in the availability of affordable housing, rising rents, and cuts to councils funding [5]. Whilst the UK Human Rights Act 1998 (HRA1998) does not have an article specifically on housing, other articles relating to safety and freedoms are directly affected by lack of adequate housing, and the United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) states that public policies should ensure an adequate standard of living, including adequate food, clothing and housing. A human-rights based approach is a bottom-up approach whereby the concepts which underpin all the articles of the HRA1998 are operationalised and put into everyday practice without the need for technical knowledge of the Act. For the purpose of this paper, unless stated otherwise, all data listed will be with reference to UK statistics. Housing policy is a devolved matter in the UK, with power devolved from the centre to subnational units [6], although such units have taken divergent approaches to homelessness [7].

Homelessness and Health Inequality

Despite high rates of homelessness and increasing media coverage of its effects, there are many misconceptions about homelessness. It is often falsely assumed that homeless people are only those living on the streets (i.e. rough sleepers) [8]. However, according to the 1996 United Kingdom (UK) Housing Act, the legal definition of homelessness states that a homeless person has:

No accommodation that they are entitled to occupy

or

Accommodation which is not reasonable for them to continue safe occupation.

Despite the Housing Act guidance, there are often significant variations in the number of people classed as homeless, due to variations in the definitions used for data collection and analysis. For example, papers often cite the 2017 estimation of 4,751 rough sleepers in England alone [9]. However, this data was collected on a single autumn night by counting the number of visible homeless people in the area [9]. This strategy is likely to result in underestimations as it will have missed groups such as the ‘the hidden homeless’ [10], who are homeless but may have temporary solutions, and people who are putting extra effort into ‘hiding’ from the authorities due to issues such as failed asylum claims. Official figures generally represent only the ‘literally homeless’; using more inclusive definitions (those that include the marginally and precariously housed) would significantly increase the numbers, change the composition and suggest undefined boundaries to the concept of homelessness [11]. The lack of a consistent operational definition that is sensitive enough to permit subgroup differentiation and simple enough to allow replication [11], limits reliability of these figures further.

Inaccurate estimations and perceptions of composition, size, and needs of the homeless population result in misdirected programming and policy development. There are also concerns that many homeless individuals fall between the gaps in policy and services altogether, or are viewed through a succession of separate and uncoordinated

'professional lenses'. Whilst political and empirical biases mean an accurate and consistent definition of homelessness is disputed, for the purposes of this paper we use the broader definition given in the 1996 UK Housing Act.

People who are homeless are widely acknowledged as facing significant health and social inequalities. Homelessness is associated with poorer physical and mental health, and higher rates of multiple and complex needs than the housed population [12]. In many cases conditions overlap and have significant social, financial, and healthcare consequences, showing how homelessness poses substantial costs both to the individual and to society. This can have a significant impact on people's lives in addition to the high demands already faced, and potentially make it harder for them to recover from homelessness. Yet, their needs are continuously overlooked, resulting in inadequate allocation of resources and policies, services and structures that are not designed to meet the needs of this population. Examples may include services which do not accept people who misuse substances, are perceived as 'lacking rehabilitation potential', have 'did not attend' policies that cause homeless people to be discharged when still in need, or services that simply do not gather housing status of their clients.

One example of this is in the UK's Joint Strategic Needs Assessments (JSNA), designed to improve health and wellbeing of local communities by reducing health inequalities. These assessments are used by health and social care commissioners to plan services based on the needs of the local area. An audit of JSNA's found that 30% only provided minimal detail of the health needs associated with homelessness and 14% failed to mention any form of homelessness. The healthcare needs of those most vulnerable are thus at risk from not being considered in local commissioning [13].

Homeless people also face more barriers to accessing health care services than the housed population [14]. This can lead to many conditions going untreated, resulting in the need for more serious interventions at a later stage that could have been avoided if treated sooner [15]. Rough sleepers are, for example, particularly heavy users of acute health services, with Accident and Emergency attendance up to 20 times higher than the general population [16], a cycle exacerbated by the failure of such services to adequately meet the complex needs of this population [17]. This contributes to both a financial strain on the NHS and psychological distress for the patient. In addition, lack of appropriate follow-up care can result in rapid deterioration of conditions and the need for readmission [18].

It is important, however, for change not to be driven by purely by a focus on the costs accrued by health services, but by the holistic health needs of this population [19]. Failure to understand these needs and provide adequate healthcare will result in further marginalisation of an already struggling group of people in society [20].

Homelessness as a Public Health Concern

Homelessness is a vast public health concern, resulting from complex socioecological factors [1]. To begin to effectively tackle this, policy makers must consider a wide range of issues, taking a multidimensional approach. One of the most significant concerns facing the homeless population are health inequalities. One way to address such inequalities may be to take a human rights-based approach. Lynch [21] notes a strong positive correlation between a state's respect for human rights and that state's success in addressing homelessness and poverty, arguing that with the realisation of human rights, conditions of social inclusion, participation and empowerment

are enabled. A human rights discourse requires attention not only to prevent malpractice and protect people from human rights violations, but also as a useful framework to improve the public service provision, through taking and allowing for positive action to fulfill human rights principles [22,23].

The Committee on Economic, Social and Cultural Rights, whose primary objective is to monitor the implementation of the International Covenant on Economic, Social and Cultural Rights, notes that States have a 'core obligation' to ensure that certain non-derogable, 'minimum essential standards' relating to ESCRs are met, including the provision of basic housing, nutrition and healthcare for marginalised or disadvantaged people. In ensuring these minimum standards are met for the homeless population policy design and provision needs to take human rights frameworks into account. The international human rights framework enshrines a number of important principles of human rights-based policy design and service delivery [22].

The integration of human rights into anti-poverty strategies, such as those directed towards the homeless, helps to ensure that vulnerable individuals and groups are treated on a non-discriminatory and equal basis and are not neglected [24]. In mental health services, Psychologists often work with some of the most vulnerable, socially excluded and discriminated against sectors of society, in this case we are specifically referring to the homeless population. Progressive and effective care provision for the homeless could be ensured through a rights-based approach to care and service provision. While, addressing human rights issues are of the utmost professional importance in providing high quality public services [23].

Even though homeless people are among the most vulnerable in our society and research shows they experience higher rates of poor health; they also face more barriers to accessing health care services than the housed population [25]. Barriers include educational and systematic failures to more specific features, individual to the lifestyle of a homeless person (although could be argued the result of system failures). Examples include, logistical access to health care services (particularly primary care), lack of appropriate follow-up care, and individual factors (such as a fear of stigmatisation) that may limit someone from searching for health care [26]. Such barriers can result in many homeless people not receiving the help they need, for conditions that could have been treated with greater time and cost-efficient care. Ultimately, failure to provide personalised care has a huge impact on a person's pathway out of homelessness.

When considering potential way markers, GP services act as a gateway to other health care services, therefore, difficulties in accessing them has a broader effect for limiting access to a wider range of services. Geographical location of services can restrict access and make some services inaccessible (e.g. if they require transport to travel to them). Once reached, further barriers often include: lack of education by the staff of the documentation needed to register (e.g. not widely known that a permanent address is not necessary), long waiting lists for services, difficulty in registering with a new GP if they move away, delays in transferals of notes preventing the individual from receiving the medication they need [27]. This removes the consistency of care and likely reduce the motivation for an individual to seek help further.

Once these barriers have been crossed, new barriers emerge in the way of uncoordinated and often ineffective care. Multiple adversities faced by homeless individuals often in addition to pre-existing, untreated conditions can result in dual and sometimes multiple

diagnoses. These can have overlaying symptoms, making it difficult to access the services the individual needs.

Meaning homeless people often fall between the gaps or get 'bounced' between serviced. As such, close and consistent coordination between multiple services is required. However, this is rarely seen [26] and repeatedly cited the barrier to an individual accessing the help they need. Services instead focus on treating the organic symptoms and underestimate the impact of psychological and behavioural outcomes. As psychological symptoms may underlie the continuation of behaviours that promote an individual remaining homeless (e.g. risk-taking, offending and substance use behaviours), their recognition through specialised rehabilitation services is important for treatment success [27].

Further, the transient and chaotic life circumstances faced by homeless people can make the requirements of health care systems difficult to comply with. Arranging and managing appointments for specific times comes with its inherent difficulties, however, non-compliance often results in discharge [28].

Unsurprisingly, some homeless people may have their own reasons for not accessing healthcare. They may be reluctant because they have had negative or hostile responses previously. They may have a negative self-image or a lack of self-esteem resulting in a lack of confidence to seek care. They may have a fear of being stigmatised and/or stereotyped based upon a lack of awareness by healthcare providers.

They may be unwilling to acknowledge their own health care needs or not see their own health as a priority [29]. There are a multitude of reasons why an individual may be deterred from accessing, all of which are likely strengthened by the barriers previously mentioned, and in worse case scenarios can lead to the dehumanising of individuals with complex needs and resulting in abusive and inhumane treatment in healthcare systems [30].

Healthcare professionals' lack of education on how complex health needs may present in the homeless population can lead to progressive deterioration of health. Failure to support homeless people's healthcare needs can lead to extended or repeated periods of homelessness with continual deterioration of health. With the growing number of homeless individuals and the understanding of the vulnerabilities that it brings, highlighting the lack of adequate health care (that could in turn contribute to an individual remaining homeless) should be the top of policy-makers agenda.

For policies to have a lasting impact, they must involve people with lived experience, in the development to ensure collaborative and integrative services that holistically cater to individual's needs. Timely access to services, increased flexibility in processes, and reduction in systemic barriers is essential to address the extremely pressing healthcare needs faced by the homeless population as a whole. Policies need to ensure the full range healthcare services are accessible to, which can be difficult in service contexts where the drive towards standardisation of processes makes tailored strategies more difficult to devise and implement. Education and awareness training would be beneficial for healthcare professionals, focusing on the risks and challenges associated with homeless health, taking into account shared and individual experiences which can be of vital importance to service uptake.

A Human Rights Based Approach to Policy Design

The OHCHR's conceptual framework enshrines a number of important principles of human rights-based policy design and service delivery [21], promoting a human rights-based approach to poverty reduction strategy as holistic in nature, encompassing civil and political rights as well as economic, social and cultural rights. Policies, programs and services should also be fair and non-discriminatory, participatory and empowering, and, transparent and accountable. A human rights-based approach is the process by which human rights can be protected in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy (FREDA). If those working in provision of psychological care are educated in these human rights-based approaches and these principles are implemented, barriers may begin to break down and allow for a more inclusive care system for this section of the population to appear.

The international human rights framework enshrines a body of rights which promote human dignity. The OHCHR describes equality and non-discrimination as two of the core principles of international human rights law. Lynch argues that policies, programs and services for the alleviation and eradication of homelessness (and promotion of social inclusion) should be founded on this human rights premise of non-discrimination and participation [22-23].

The principle of non-discrimination refers to a general prohibition on discrimination; it is an established method of human rights protection [31]. The UN Human Rights Committee defines the term "discrimination" stating that it 'should be understood to imply any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on equal footing, of all rights and obligations' [32]. Discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status [33]. Non-discrimination reappears frequently both in UN documents, such as the UN Charter and the UDHR, and in regional statements of human rights. The HRA 1998 incorporates most of the provisions of the European Convention on Human Rights (ECHR) into domestic law. The Act sets out positive obligations for public bodies (including the NHS), providing that the delivery of services must be offered in non-discriminatory ways [23]. However, the primary organising factor for many healthcare strategies today is the financial cost of provision, with the human cost often lost in political wranglings.

In the UK, local and city councils are continuously highlighting their investments to prevent and promote pathways out of homelessness, and in 2007, The Department of Health published a framework for enacting human rights based approach in healthcare provision [34], yet outcomes remain poor for the most financially insecure members of society. If an individual prolongs seeking treatment, due to any number of reasons, conditions can develop and what may have at first appeared a simple health issue that could have been easily treated can have much more serious consequences. Homeless individuals use primary care services much less than the general population but attend Accident and Emergency services four times as often [35] at a cost 1.5 times higher than the average. Length of homelessness is also related to increased cost.

Unless the government invests in healthcare and support services for homeless individuals, homelessness will continue to increase whilst their health deteriorates [36]. It will instead incur much greater financial strain in the long-term, instead governments should invest in prevention of homelessness. Preventing and quickly resolving homelessness is far more cost effective than dealing with it once it has occurred. Recent economic healthcare evaluations in the UK calculated the minimum cost saving of preventing someone's homelessness compared to accepting a homelessness duty as between £1,300 and £7,700 [37]. Too often, a potentially salvageable situation that need not escalate into sustained or recurrent homelessness becomes a downward spiral [38,39]. Yet, 40% of Local Authorities have inadequate tools to prevent homelessness in their area [36].

System Change is Possible

Many initiatives recognising the barriers faced by homeless people and creating new ways of providing care. For example, Enhancing Healthcare for the Homeless (ECHO) steering group have provided accessible GP registration services and educated the staff on the procedures involved with registration when someone has no fixed address. This allows quicker access to primary care for homeless people new to the area. They noted successes in developing strong links across a wide range of people and organisations (e.g. statutory agencies, voluntary organisations, community groups, private sector organisations, GPs, hostel staff and residents). Their steps to providing an accessible healthcare service have resulted in a reduction in the use of emergency care services.

Initiatives such as ECHO provide a basis from which developments can be made. With knowledge of the logistical issues that prevent individuals from accessing the healthcare they need, understanding of the changes that need to be made to ensure a non-discriminatory approach to homeless healthcare. The implementation of non-discrimination has two key features in relation to people experiencing homelessness. First imposing an immediate obligation on governments to ensure that all legislation prohibits discrimination of any kind against homeless people and is itself non-discriminatory, laws should be amended to prohibit any discrimination on the grounds of social status including a person's status as being homeless [22]. Secondly, the right imposes a further substantive obligation on governments to take positive steps to address the special needs of people experiencing homelessness, to enable this population to realise all their rights and freedoms [40]. Also, relevant here is that under the ICESCR, the right to health is subject to 'progressive realisation', which means states such as the UK, must take steps towards achieving this right to the maximum of its available resources [41].

These steps should include development of all legislative, educative, financial, social and administrative measures and a use of all state resources available in implementation [21]. One method of implementation could be to educate those developing policy designed to alleviate homelessness, and the professionals providing health care to such a group of individuals, in human rights frameworks such as those published by UN bodies such as the OHCHR and the CESCR. In discussing the FREDA values, Curtice and Exworthy contend that even if the language seems unusual, clinicians should already be familiar with these values [42-49]. Positively, there have been a number of wider efforts to promote the rights of the homeless population by such organisations as FEANTSA's (the European Federation of National Organisations Working with the Homeless) Working Group on

Housing Rights. Housing Rights Watch alongside FEANTSA have produced and promoted a 'Homeless Bill of Rights'.

While, these organisations are encouraging all cities within the EU to endorse this bill, we need to take into account the current needs of homeless people, such as improved and more needs-specific healthcare provision. There have been advances in bridging this gap between any healthcare provision for general population and those more vulnerable individuals whose needs are not being met. The Health and Social Care Act 2012 introduced the first legal duties on health inequalities, with specific duties on NHS England and Clinical Commissioning Groups, as well as duties on the Secretary of State for Health to take measures to reduce inequality. In 2013, in the context of the growing focus on addressing health inequalities, a revised set of Standards was produced to encompass other vulnerable groups (e.g. sex workers and migrants) as well as homeless people [43].

Despite these positive efforts, problems remain in relation to equal access of healthcare. If strategies towards the homeless population are moulded around existing frameworks developed by the human rights regime, possibly we may begin to create a more holistic response. We must promote an individualised response for a group with vulnerabilities. As laid down in the *Minority Schools in Albania Advisory Opinion*, equality in law precludes discrimination of any kind. It is recognised that in order to attain a result which establishes an equilibrium between different situations 'some differential treatment may be required.

The homeless population need to be seen as a specific group needing specific treatment and protections. This would begin to create an equilibrium in provision of care with the housed population. Combining this 'perfect equality' (equality in law) with the protection of cultural and social differences brought about by the minority population within the state would lead to 'true equality' between the majority and the minority' [44].

This somewhat expansive approach to equality has helped to widen the scope, and in many ways increase group protections not previously accounted for in a number of instances, as it 'allows for a wider range of group-based considerations to come into view in new and distinctive ways' [44]. Potentially including special and more effective measures in care provision for homeless people. The specific needs of the homeless population are too often overlooked resulting in policy which is flawed by design and therefore fails to meet the needs of this population. Applying a 'true equality' approach would hopefully alleviate inequality and help meet needs. For psychologists, human rights reflect formalized systems which if implemented have the potential to ensure that people's basic needs are satisfied [23]. Therefore, taking such systems into account (and incorporating such norms) could go far in improving the quality of care and begin to reduce barriers to access.

We can begin to address change by reducing social exclusion of the homeless population through implementation of the right to participation. There are clear and casual links between homelessness and social exclusion, continual and significant social exclusion of the homeless population has exacerbated barriers to accessing healthcare [21]. A potentially progressive step in improving homeless-specific services may be to include those experiencing it in the processes of developing these services and programmes. This exclusion can be tackled in some way by consideration of participation. The human rights framework enshrines a right for all people to participate in decision-making processes which affect them [45]. Using this approach

can improve health outcomes and deliver better quality, 'person-centered' healthcare [49].

The UNCESCR advocates that a 'policy or program that is formulated without the active and informed participation of those affected is most unlikely to be effective' (2002). This requires positive action to ensure marginalised individuals and groups, such as those experiencing homelessness or poverty, are consulted with and included in development and implementation of public policies and programmes [24]. Homelessness and coinciding social exclusion can be significantly reduced by governmental implementation of obligations to respect, protect and fulfil human rights [21].

Furthermore, the participation of homeless people in decision-making and policy formation at all levels—from international to local—is instrumentally important in mitigating social exclusion, a reoccurring finding in homelessness research [21]. Meaningful and informed participation of homeless people can enhance programmatic development by informing governments and service providers about people's needs and the most effective way to address them. Inclusion in the process will not only create needs-specific programmes and progressive policy, while enhancing a sense of individual autonomy and self-esteem. This approach would be significant in bridging the gap and reduce some of barriers faced in accessing healthcare.

Conclusion

Given the current politically austere climate, with ever-increasing welfare cuts, decreases in affordable housing and a society that is designed to marginalise those most vulnerable, it is no surprise that rates of homelessness are on the increase. Plans for further welfare cuts in the hope of reducing public expenditure will only marginalise this population further.

A lack of understanding of the needs of this population has placed excessive strains on the NHS and inadequate allocation of resources. Healthcare professionals lack education on how the effects of such deficits display and are experienced by the homeless population, and those who work in the sector lack education on how to support these people. This leads to inaccessible healthcare.

Through educating care givers, applying the principles of the human rights discourse outlined above and fulfilling obligations of specialised consideration for this population, there is real potential for change leading to more nuanced and effective services. The right to equality and freedom from discrimination is an integral component of the international human rights normative framework and is entrenched in both ICCPR and ICESCR. While encouraging participation of the homeless population in service and policy development could have positive effects in the alleviation of barriers to accessing healthcare and create effective systems.

Knowledge of the barriers faced by individuals to accessing primary healthcare (knowledge of/education in existing human rights frameworks) and understanding of the higher rates of poor health experienced by this population should promote action to change these systems given the multiple adversities and vulnerabilities faced by this life. Lack of insight by policy makers of the neurological deficits faced by the homeless population has left their needs misunderstood and underestimated. We must recognise the role we play as a society in the prevalence of homelessness if we expect to see a change.

Cases

Minority Schools in Albania, Advisory Opinion, ICGJ 314 (PCIJ 1935).

The Belgian Linguistic case (No. 2) (1968) 1 EHRR 252

Treaties and Legislation

Human Rights Act (1998)

International Covenant on Economic, Social and Cultural Rights (1966)

The Health and Social Care Act 2012

References

1. Mackelprang JL, Harpin SB, Grubenhoff JA, Rivara FP (2014) Adverse outcomes among homeless adolescents and young adults who report a history of traumatic brain injury. *Am J Public Health* 104: 1986-1992.
2. <https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/462/462.pdf>
3. <https://www.crisis.org.uk/ending-homelessness/health-and-wellbeing/drugs-and-alcohol/>
4. Downie M, Gousy H, Basran J, Jacob R, Rowe S, et al. (2018) Everybody In: How to end homelessness in Great Britain. Lack of awareness and its impact in traumatic brain injury. *Neuro Rehab* 17: 285-296.
5. <http://www.independent.co.uk/news/uk/home-news/homelessness-number-of-rough-sleepers-in-england-rises-at-unprecedented-rate-a6895826.html>.
6. www.researchbriefings.parliament.uk/ResearchBriefing/Summary/RP03-84#fullreport
7. <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7201>
8. <https://www.britishcouncil.org/voices-magazine/three-myths-about-homelessness-uk>
9. Homeless Link (2017) Analysis of rough sleeping statistics for England 2016.
10. <https://www.york.ac.uk/media/chp/documents/2010/A%20Review%20of%20Single%20Homelessness%20in%20the%20UK%202000%20-%202010%20-%20summary.pdf>
11. Argeriou M, McCarty D, Mulvey K (1995) Dimensions of homelessness. *Public Health Rep* 110: 734-741.
12. Perry J, Craig TK (2015) Homelessness and mental health. *Trends Urol Men's Health* 6: 19-21.
13. <https://www.mungos.org/publication/needs-know-including-single-homelessness-joint-strategic-needs-assessments/>
14. <https://www.homeless.org.uk/facts/homelessness-in-numbers/health-needs-audit-explore-data>
15. <http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf>
16. Cheallaigh C, Cullivan S, Sears J (2017) Usage of unscheduled hospital care by homeless individuals in Dublin, Ireland: a cross-sectional study. *BMJ* 7: e016420.
17. Baggett TP, O'connell JJ, Singer DE, Rigotti NA (2010) The unmet health care needs of homeless adults: a national study. *Am J public health* 100: 1326-1333.
18. BRUCE CV (1988) Homelessness, Health, and Human Needs. (1stedn), Institute of Medicine (US) Committee on Health Care for Homeless People. Washington (DC)
19. Zlotnick C, Zerger S, Wolfe PB (2013) Health care for the homeless: what we have learned in the past 30 years and what's next. *Am J public health* 103: S199-S205.
20. <https://www.mungos.org/app/uploads/2017/07/Addressing-complex-needs-improving-services-for-vulnerable-homeless-people-1.pdf>

21. Lynch P (2005) Homelessness, Human Rights and Social Inclusion. *Alt Law J* 30: 116-119.
22. Lynch P (2005) Homelessness, Poverty and Discrimination: Improving Public Health By Realising Human Rights. *Deakin Law Rev* 10: 233-259.
23. Kinderman P (2007) Human Rights and Applied Psychology. *J Comm Applied Social Psychol* 17: 218-228.
24. <https://www.ohchr.org/Documents/Publications/PovertyReductionen.pdf>
25. Warnes M (2001) The responsibility to care for single homeless people. *Health Soc Care Community* 91: 436-44.
26. Cope DN, Mayer NH, Cervelli L (2005) Development of systems of care for persons with traumatic brain injury. *J Head Trauma Rehabil* 20: 128-142.
27. Degeneffe CE, Boot D, Kuehne J, Kuraishi A, Maristela FD, et al. (2008) Community based interventions for persons with traumatic brain injury: A primer for rehabilitation counsellors. *J App Rehab Counselling* 39: 42-52.
28. <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.886.4744&rep=rep1&type=pdf>
29. McMillan TM, Ledder H (2001) A survey of services provided by community neurorehabilitation teams in South East England. *Clin Rehab* 15: 582-588.
30. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf
31. <https://philpapers.org/rec/HOLHRT-2>
32. http://www.un.org.vn/en/publications/cat_view/130-un-viet-nam-joint-publications/208-human-rights-joint-un-publications.html
33. <https://www.un.org/WCAR/durban.pdf>
34. http://www.hscbusiness.hscni.net/pdf/Human_rights_in_healthcare_2nd_edition_DOH.pdf
35. Nat MJW, Charlotte NET, Nicola SO, Debbie JK (2004) Homelessness and health: what can be done in general practice? *J R Soc Med* 97: 170-173.
36. <https://www.homeless.org.uk/connect/blogs/2018/sep/20/annual-review-2018>
37. https://england.shelter.org.uk/__data/assets/pdf_file/0008/297224/VFM_in_housing_options_and_homelessness_services_full_report_Oct_2010.pdf
38. Bousman CA, Twamley EW, Vella L, Gale M, Norman SB, et al. (2010) Homelessness and neuropsychological impairment: preliminary analysis of adults entering outpatient psychiatric treatment. *J Nerv Ment Dis* 198: 790-794.
39. Harvey PD (2012) Clinical applications of neuropsychological assessment. *Dialogues Clin Neurosci* 14: 91-99.
40. Bremner AJ, Duke PJ, Nelson HE, Pantelis C, Barnes TR (1996) Cognitive function and duration of rooflessness in entrants to a hostel for homeless men. *The British journal of Psychiatry. Br J Psychiatry* 169: 434.
41. Whiteford M, Simpson G (2016) There is still a perception that homelessness is a housing problem": Devolution, homelessness and health in the UK. *Housing, Care Support* 19: 33-44.
42. Pentassuglia G (2015) Ethno-cultural Diversity and Human Rights: Legal Categories, Claims, and the Hybridity of Group Protection. *Polar Law* 6: 250-317.
43. <https://www.escri-net.org/resources/poverty-and-international-covenant-economic-social-and-cultural-rights-10-may-2001>
44. http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=5427&context=fss_papers
45. <https://www.refworld.org/pdfid/4538838e10.pdf>
46. Ajayi T (2008) Drug misuse and dependence: UK guidelines on clinical management. *Psychiatrist* 32: 360.
47. [https://www.refworld.org/publisher,CESCR,,SEN,,0.html](https://www.refworld.org/publisher/CESCR,,SEN,,0.html)
48. Jones P (2013) Groups and Human Rights, In Holder C, Reidy D (eds) *Human Rights: The Hard Questions* (CUP) 102.
49. Curtice MJ, Exworthy T (2010) FREDa: A human rights-based approach to healthcare. *The Psychiatrist* 34: 150-156.