PAPER 1

Housing and health: a multidirectional relationship

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Purpose

Housing is a fundamental determinant of health and wellbeing. Appropriate housing – affordable, good quality, stable and secure housing – is a key precondition for promoting health and health equity, preventing illness and building healthy and inclusive communities. This paper identifies multiple links between housing and social, psychological, physical and emotional health and wellbeing. It outlines the population-wide implications of these complex linkages and demonstrates a need for integrated health and housing policy.

Introduction

A lack of secure, good quality and affordable housing can be associated with a range of poor mental and physical health outcomes – respiratory diseases, cardiovascular diseases, injuries, mental health problems and infectious diseases. Accordingly, our housing system, in particular the quality and cost of housing, ultimately influences downstream health system costs.

In light of major demographic (ageing population) and climate changes (global warming causing higher temperatures), the design of housing stock is becoming increasingly critical for the health and wellbeing of our population (World Health Organization 2018).

In the context of national, state, and local policy efforts to address housing challenges, it is important for policy makers and the public to understand the health and health equity implications of housing issues. Improving housing quality can not only save lives and reduce disease but it can contribute to quality of life in many ways, and to addressing major global issues such as poverty and climate change.

At the individual level, housing issues are often experienced within the context of life-course events and personal identity factors, which can compound disadvantage. Many of the issues that are important for housing and health are markedly interrelated. It is important to acknowledge these linkages but also consider strategies to address issues independently where necessary.

As described in the recent World Health Organization (WHO) Housing and Health Guidelines (2018), housing is a major entry point for intersectoral public health programs and primary prevention. The (2018) guidelines focus on the housing sector holistically and draw clear linkages between health and not only the housing policy setting, but the energy, community development and urban development policy environments too.

Housing as a basic human need

Housing is central to our lives and to the fulfilment of basic human physiological needs, and thus to protecting and promoting human health and wellbeing.

As Maslow famously posited, human beings are motivated to fulfil their basic needs before they have the capacity to fulfil more advanced, complex needs (Figure 1). These basic needs include food, water, shelter, sleep and warmth. They are all influenced by housing; by the design, quality and location of the home. For example, the location of your house determines your ability to obtain healthy and nutritious food within a convenient distance. Your house also provides the facilities to prepare and serve that food, and possibly the means to grow healthy food. Moving up Maslow's hierarchy, there are housing implications at every step.

Figure 1 - Maslow's hierarchy of needs (Source: Shutterstock.com)

The safety and protection that a house provides can be thought of under three main categories; security from crime and fear; protecting property; and protecting family (Datta 2013). Living in a safe neighbourhood where crime rates are low, impacts personal safety. Vibrancy and activity within a neighbourhood can create passive neighbourhood surveillance, impacting on safety. The design features of a house, such as a smoke detector, security system or security screens also provide safety. Other design features such as sewerage and access to safe drinking water in the home are preconditions for safety from a disease prevention perspective. Moreover, the home is a setting for experiencing and managing other dimensions of personal safety and security such as opportunities to maintain secure employment and thus financial security.

The love and belonging level of the hierarchy encompasses social and relationship needs at a community, friendship, family and intimate level. The location of your home can considerably shape how often and with whom you socialise. There are also socio-economic and cultural connotations to this, depending on the demographic characteristics of your local area.

The configuration and comfort of your home influences how you relate to those within your household. Too much or too little space can affect personal relationships, i.e. overcrowding can trigger conflicts whereas large empty homes can create isolation and loneliness. The home typically incorporates spaces for socialising and even hosting people and thus opportunities to foster and protect relationships outside of the household. Access to Information and Communication Technology services within the household enables connectivity and belonging in the global community, generating a whole range of broader social opportunities.

The esteem level of the hierarchy encompasses both esteem from others and self-esteem (Datta 2013). Appearance and presentation influence how individuals gain both types of esteem. A comfortable and amenity rich home, as well as financial security, influence how we present within and to the community. How we present also shapes our ability to obtain gainful employment. This demonstrates the bilateral relationship between financial security and housing. A house is also a common indicator of individual status, which impacts both forms of esteem.

Self-esteem is shaped by access to quality education and the opportunity to experience professional achievement and personal enrichment (Datta 2013); factors which home and neighbourhood also influence. Esteem-related achievement and enrichment opportunities include activities to help and serve others and the world around us, as well as more self-indulgent activities and interests, like enjoying good food or having a high quality entertainment system to watch movies.

Finally, the fifth level of Maslow's hierarchy incorporates self-actualisation needs. These include realising personal talent and potential, but arguably also encompass having the freedom to explore spontaneity, spirituality and creativity, in order to evolve the self (Datta 2013). The location, quality and security of housing shape and influence many dimensions of self-esteem and self-actualisation needs.

Housing: a social determinant of health and wellbeing

Building on the notion that quality housing is a basic human right and is central to our lives, it is clear that housing is a mechanism through which social and economic inequities translate to health inequities (Braubach & Savelsberg 2009). Housing provides not only the benefit of shelter but also, through location, facilitates and/or influences access to a further bundle of goods and services, such as employment, education, and social connections (Baker et al 2014; Pollack et al 2010).

Differential access to housing, income security and employment can worsen health inequities (Commission on Social Determinants of Health 2008). The relationship between housing and health equity is complex and incorporates a multi-dimensional interplay between the local housing context and broader social and economic inequities. Housing affordability, quality (of both the dwelling and the neighbourhood), stability and security are therefore important influencers of both health and health equity.

There are multiple direct and indirect pathways connecting housing and both health and health equity. A recent report by Toronto Health (2016 p.17) provides some examples of these:

> The high cost of housing and insufficient supply of good quality affordable, supportive, and accessible housing in combination with social and economic inequities such as poverty can result in people living in poorer quality housing or neighbourhoods with less access to factors important for health;

> The high cost of housing and low supply of affordable housing can create affordability issues leading to reduced expenditures on food, food insecurity, and food bank usage which can impact health;

> Social and economic inequities such as discrimination and violence/abuse can lead to housing instability such as couch surfing, overcrowding, and homelessness which can in turn affect health;

> Substance use can lead to evictions and homelessness either directly or indirectly through poverty and unemployment. This can either cause new, or amplify existing, mental and/or physical health issues;

> Physical disabilities or chronic illnesses can lead to social and economic inequities such as unemployment and poverty, which in combination with an insufficient supply of accessible, affordable housing can amplify these health issues, make their treatment and management more challenging, or lead to further health issues.

The WHO's (2011) Social Determinants of Health Sectoral Briefing Series 1 – Housing: Shared Interests in Health and Development paper identifies the following key policy goals that commonly address the linkages between housing and health:

1. Sound construction: Dwellings provide adequate shelter from natural elements and hazardous substances. Dwellings should be of sound construction, in a reasonable state of repair, weatherproof and adequately ventilated.
2. Safety and security: Housing ensures personal and household privacy, safety and security. Housing should allow occupants to live without fear of intrusion, provide safety, and allow safe entry and exit.
3. Adequate size: Dwellings provide space appropriate to household size and composition. Dwellings should have space for individual and common purposes within accepted crowding ratios, and allow separations between uses.
4. Basic services available: Reasonable levels of basic services are available at the dwelling. Clean water, sanitation, waste disposal, access infrastructure and power should be available.
5. Affordability: Housing costs are reasonable and affordable. Accommodation costs should be within accepted affordability limits to secure housing for all.
6. Accessibility: The location of the dwellings allows access to social services, services and space for activities of daily life, and economic opportunities. Residential locations allow access to opportunities for education, purchasing or growing food, purchasing other necessities for daily living, recreation, and employment.

7. Tenure: Tenure arrangements ensure reasonable continuity of occupation. Terms of occupation provide stability for individuals, households, communities and areas or neighbourhoods.

8. Protection from climate change: Dwellings protect occupants from climate change. Dwellings should protect people from extreme weather events and contribute to the reduction of greenhouse gas emissions.

More recently, and in light of an ageing population and climate change, the WHO Housing and Health Guidelines (2018) draw on new and emerging evidence for reducing the health risks associated with poor housing, with a focus on four areas:

1. Inadequate living space (crowding)
2. Low and high indoor temperatures
3. Injury hazards in the home
4. Accessibility of housing for people with functional impairments.

Housing affordability, stability and security

Housing affordability relates to an individual's ability to pay for their housing. When people struggle to meet the cost of housing it is often described as housing affordability stress (HAS). HAS is commonly defined as a situation where housing costs exceed 30 per cent of a low-income household's income (AHURI 2011). Housing stability on the other hand, can be defined as the extent to which an individuals' customary access to housing of reasonable quality is secure and maintained.

The relationship between housing affordability and health is also bi-directional. To attain and maintain sustainable housing, people need adequate, coordinated and timely support for their health. Equally, to maintain good health, people need to be in affordable, adequate and secure dwellings (Mallett et al 2011).

Housing is, for many people, their major expenditure and largest ongoing household cost. As such, housing affordability influences the quality of an individual's life. Housing has a marked impact on people's health and wellbeing and financial resilience (Baker et al 2015). When affordable housing is not available to low-income households, resources needed for food, medical or dental care, transport, and other necessities are often diverted to housing costs.

Evidence shows that unaffordable housing is related to poorer mental health (Bentley et al 2011). Affordable, stable and safe housing supports mental health by limiting stressors related to financial burden or frequent moves, particularly for lower income households. Affordable housing can have mental health benefits by offering residents control over their environment and providing residential stability. Financially vulnerable households are at greater risk of eviction or other forced movement through the housing market, which can lead to poorer health and wellbeing outcomes (Bentley et al 2015). Residential instability and multiple moves among adolescents and children have a compounding negative effect on mental wellbeing. Repeated residential mobility has been associated with reduced social connectedness for children and their families (Tama & Newman 2010).

The housing continuum encompasses a broad range of housing policy responses that government can consider, to address access and affordability in many environments (AHURI 2017), with a broad range of implications for health and wellbeing. Such responses range from targeting those experiencing homelessness through to social housing tenants, first home buyers and beyond. It is important to recognise that these different tenure circumstances do not exist in isolation but are interconnected and shape one another, and people do not necessarily move through them in a linear manner.

Homelessness for example, is considered the crisis domain of the housing continuum, and the health implications of homelessness are markedly pronounced. For people experiencing homelessness, meeting just basic physiological needs, such as warmth, shelter and access to nutritious food can be a struggle. As a result, people with lived experience of homelessness experience higher levels of poor physical and mental health, alcohol and illicit drug use/abuse, injury, violence, self-harm and incarceration.

Conclusion

The complex interconnectedness of health and housing issues demonstrates a need for integrated health and housing policy. Housing is central to the satisfaction of human needs at all levels; it is a basic human right and should therefore be prioritised as such in the policy context. Housing is critically important for social, psychological, physical and emotional, health and wellbeing.

Housing, including the provision of affordable, stable and secure housing, needs to be well-built, well-located and suited to the needs of its residents. This is important for the promotion of health and prevention of illness, at the individual, community and population level. Ensuring everyone lives in healthy and safe dwellings has implications for national, regional and local governments and policy.

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HEALTH, HOUSING AND HOMELESSNESS

A collaborative, thought leadership paper series

PAPER 2

The determinants of housing outcomes

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Purpose

The purpose of this paper is to conceptualise the drivers of particular housing experiences, to explain why some people have positive housing outcomes while others do not. The attached Determinants of Housing Outcomes (Figure 2) conceptual framework has been developed to facilitate this understanding. It articulates the complex, multi level factors that influence housing (in)stability. The framework describes the policy touch points or levers that typically lead to housing stress, housing instability, and/or homelessness. These things occur at the societal (in Australia this includes Federal, State/Territory, and Local Governments), community and individual level. The framework is intended to inform primary prevention strategies to address housing instability and homelessness, including integrated multi-sectoral policy responses.

South Australian housing policy context

The launch of Our Housing Future 2020-2030 marks a renewed focus among the South Australian housing sector, towards breaking down barriers that see many people in continued housing stress. The strategy recognises the opportunity to shift our thinking about housing as part of a broader ecosystem of government services and overall community wellbeing. With this in mind, strategies to address poor housing outcomes must consider their root causes/determinants.

Summary of the framework

As depicted in the Dahlgren and Whitehead (1991) social determinants of health model (Figure 1), the social determinants of health are social, economic, behavioural, and environmental. Many of the determinants of health lie outside the control of the health care system. By applying the social determinants of health model lens, Figure 2 proposes a framework for identifying the determinants of housing outcomes.

Figure 1 - Dahlgren and Whitehead - The social determinants of health
(Source: **http**://www.euro.who.int/__data/assets/pdf_file/0018/103824/E89384.pdf)

The determinants of housing outcomes can be similarly described as (but not limited to) social, environmental, economic, cultural and political. The model can inform partnership opportunities within the housing/homelessness sectors, as well as between these and other sectors, i.e. health, built environment, social services, correctional services; to better identify and address issues that may lead to housing crises.

The framework recognises crosscutting influences, including the intergenerational transfer of life circumstances, and considers how these influences shape the position an individual may end up in, and thus their propensity for housing stress and crisis.

DETERMINANTS OF HOUSING OUTCOMES

MARKET · POVERTY · CULTURE · HUMAN RIGHTS · DISCRIMINATION · EQUITY · POLITICS

NATIONAL AND INTERNATIONAL FACTORS

Federal Government Policy and political cycles · Welfare policy · National Housing and Homelessness Agreement · Global economic forces · Housing Policy

HOUSING STRUCTURAL FACTORS

Location · Housing market · Landlord rights · Housing affordability · Availability of services · Housing supply and design · Housing quality · Tenant rights

COMMUNITY AND SOCIAL ENVIRONMENTS

Safety and crime · Access to services · Institutions · Community · Employment · Stigma
Household wealth and finances · Social connections · Neighbourhood

INDIVIDUAL CHARACTERISTICS, FACTORS AND BEHAVIOURS

Disability · Mental and physical health · Substance use
Pets · Trauma · Identity · Family and relationship structures
Gender · Lifestyle · Domestic and family violence
Culture and beliefs · Criminal behaviour

PEOPLE'S HOUSING OUTCOMES

LIFE COURSE/AGE

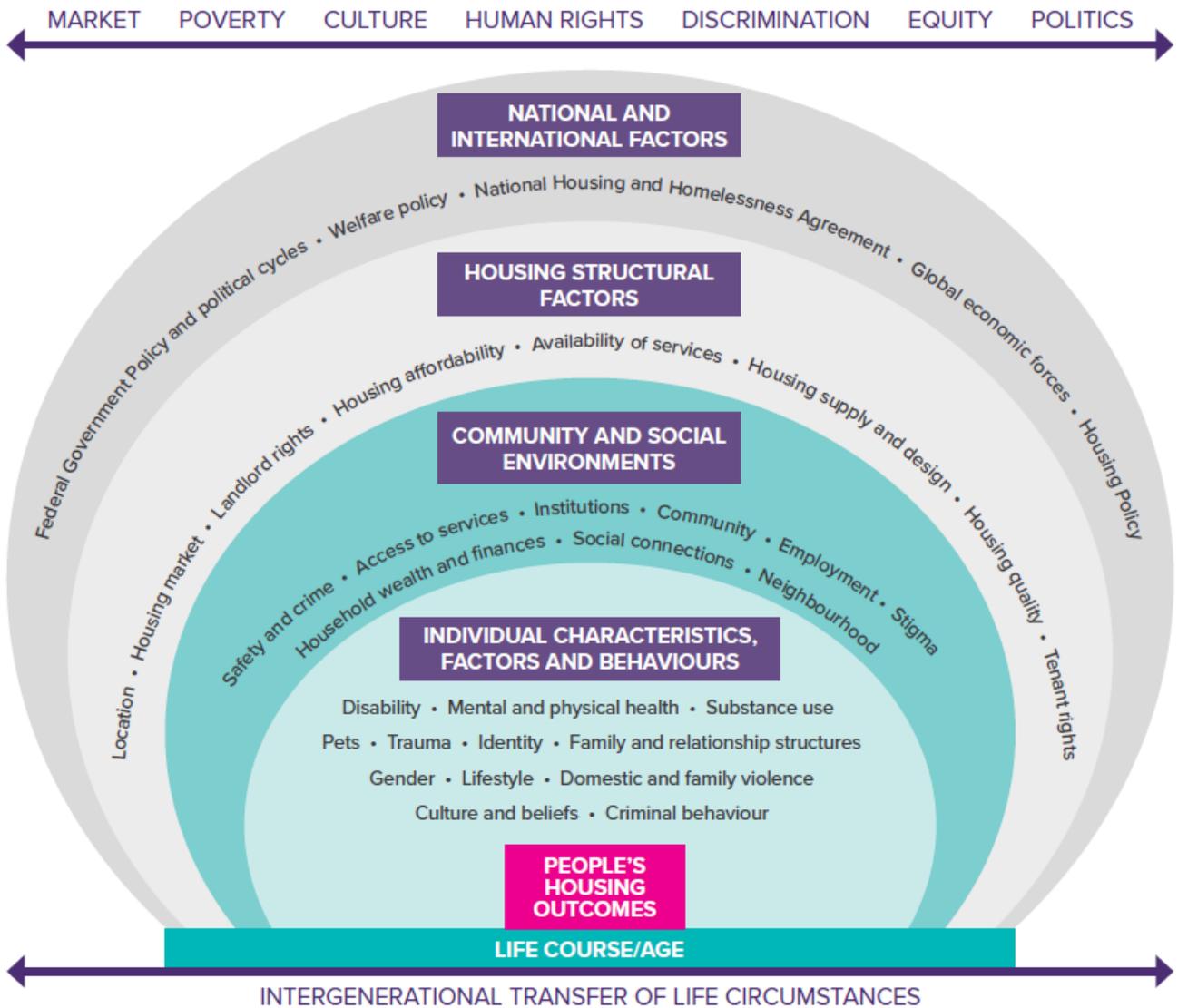INTERGENERATIONAL TRANSFER OF LIFE CIRCUMSTANCES

Figure 2 - Determinants of housing outcomes

PAPER 3

Preventing homelessness: adapting a public health model

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Purpose

This paper explores the application of a public health prevention continuum to better understand opportunities for preventing homelessness through identifying its root causes. The paper is intended as a thought leadership piece to stimulate discussion and debate within the homelessness and housing sectors. It is intended to support initiatives focusing on ending homelessness, such as the Adelaide Zero Project, by conceptualising what types of approaches may be required to reduce the number of people experiencing homelessness. A housing prevention continuum, which attempts to document the major factors influencing housing outcomes across the entire housing continuum, is presented. This captures the range of structural and systemic changes that may be required to effectively improve the prevention of homelessness. The paper reflects the parallels between the housing/homelessness and health systems, particularly when working towards a strengthened focus on primary prevention and systemic factors that go beyond traditional attention to crisis responses and individual factors.

NB: The terms primary, secondary and tertiary prevention are used often in both the homelessness and public health fields. Each field applies these terms in different ways, leading to different understandings. This paper uses the public health meaning and interpretation of these prevention terms. See page 3, for further information.

Introduction

Every individual that experiences homelessness travels their own 'pathway', and, whilst homelessness is essentially about not having housing ('houselessness'), it is almost always complicated by many other factors. With this in mind, it is clear that preventing homelessness should not be the role of the homelessness sector alone. Addressing the root causes of homelessness requires cross-sector collaboration, including:

> health
> mental health
> disability

> housing
> education
> criminal justice

> employment
> drug and alcohol, and
> domestic and family violence services.

Primary prevention strategies, as widely understood in the health system, prevent people from falling off the cliff, as depicted in Figure 1. When the primary causes of health problems are adequately addressed – through explicit focus on determinants of health – the health system can be taken to be working effectively to prevent individuals from falling (off the cliff) into a position where secondary or tertiary prevention or early intervention measures are required. This in turn reduces pressure on emergency health services that step in at the bottom of the cliff fall (Figure 1).

Identifying and implementing a range of primary prevention strategies to address, or end, homelessness is an enormous task[1]. Such an approach has been discussed at various times in the past, and been a cornerstone of prior national homelessness policy, for example The Road Home: a national approach to reducing homelessness (Commonwealth of Australia 2008). A comprehensive mapping process to identify the varied routes and key transition points into and out of homelessness is required, to envision how change to support this can be enacted in the complex and intersecting systems around homelessness. Preventing an individual experiencing housing stress from falling into crisis is a typical preventative approach to homelessness in the current (Australian) system. Applying a public health model for illness prevention (primary, secondary and tertiary prevention) may enable a broader framework for identifying prevention mechanisms that can be used across the full spectrum of the housing and homelessness system.

Figure 1: Prevention in public health
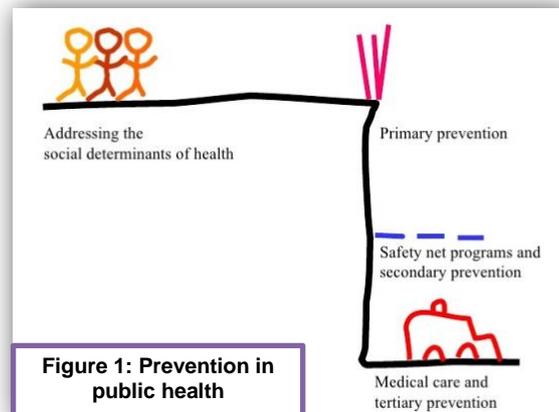
Reforms of the homelessness sector have historically been point-in-time updating of contracts and services. Generally, reforms have focussed on specialist homelessness services (SHS) and on early intervention and crisis (considered secondary and tertiary prevention respectively). Moves to reform the homelessness system need an increased focus on the housing continuum, intersecting sectors and primary prevention.

Homelessness and health

There are many multi-directional linkages between the health and homelessness sectors. Homelessness can cause, and be caused by, health-related problems. Individuals experiencing homelessness often experience more than one, if not many, health and health-related problems. People experiencing homelessness are among some of the most vulnerable people in our society and often have poor access to health services. The tenuous nature of the relationship between individuals and access to the health system can compound health conditions and lead to more adverse health outcomes, including:

> poorer physical health
> poorer mental health
> increased alcohol and illicit drug use
> injury
> self-harm.

Lack of post-housing support for individuals, such as in navigating health (including mental health) systems, and lack of access to appropriate services can lead to individuals cycling through homelessness due to difficulties in sustaining tenancies (Baker et al. 2020).

It is easy to see then that homelessness is an important public health issue. Prevention strategies applied in similar ways to determinants of health frameworks, may offer some important ways forward for both identifying, and then working to address, the root causes of homelessness (Gaetz and Dej 2017).

Housing, or more specifically, the lack of appropriate, affordable and secure housing (described sometimes, more simply, as 'adequate housing'), is a key determinant of health. Housing is the central hub of everyday living. The interactions between housing and people's lives demonstrate the multitude of ways that housing impacts directly on health, as well as through other pathways, recognised as the determinants of health. Health and homelessness

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[1] For example, the Adelaide Zero Project recognises the dynamic nature of homelessness and has localised the Functional Zero approach (as opposed to Absolute Zero) (Turner, Albanese and Pakeman 2017). A community reaches Functional Zero when the average capacity of its housing system is greater than the existing need.

have a multi-directional relationship – one can cause, and be caused, by the other (see *Paper 2 – The determinants of housing outcomes*, of this series). Therefore, there is significant opportunity to think more broadly about the interaction between health issues and their relationship to homelessness.

A model for preventing homelessness

Individual circumstances create varied combinations of determinants that may lead to homelessness. As demonstrated in the Determinants of Housing Outcomes framework (Paper 2 of this series), these causes can be broadly grouped under three levels, which correspond to how health determinants (and inequalities) are considered:

> Structural – economic and societal

> Systems – policy and service delivery inadequacies

> Individual – personal circumstances and relationships.

These factors have been acknowledged in the work of other health, housing and homelessness groups, such as in the Canadian Observatory on Homelessness' review A New Direction: A Framework for Homelessness Prevention (Gaetz and Dej 2017). The Framework suggests that resistance to broad scale prevention strategies for addressing homelessness has been the result of a lack of conceptual and methodological applications, because the evidence takes a long time to accumulate. While there is consensus that prevention efforts need to be focused at structural, systems and individual levels, most research focuses on individual interventions to support people at imminent risk. In many cases this is a model of tertiary or secondary prevention and early intervention, rather than primary prevention as understood in public health spheres. A focus on the individual issues results in continued failures in addressing structural and systematic strategies for preventing homelessness.

The definition of prevention is well understood in the health sector; however, there is seemingly no consensus on what prevention for homelessness entails. Prevention strategies within the health system are generally grouped in three tiers; primary, secondary and tertiary prevention:

> **Primary prevention** strategies alter behaviours and exposure by addressing the structural (risk) factors and reinforcing protective factors. Examples of a protective factor might be introducing healthier food options into community settings, or seatbelts to prevent injury through a car accident. Primary prevention typically includes population wide strategies and considers the whole community. Examples of primary prevention strategies in health include: immunisation, road safety rules such as speed limits to reduce road accidents, and legislative and environmental changes to smoking in public places to reduce exposure. For homelessness such strategies would include poverty reduction, anti-violence work and early childhood work. Primary prevention can also include selected strategies to targeted groups at higher risk of experiencing homelessness, for example people with low incomes and Aboriginal communities.

> **Secondary prevention** occurs after exposure has already occurred. In health this includes screening mechanisms like cancer screening or monitoring BMI for overweight. Secondary prevention in relation to homelessness would include detecting and addressing the causes of homelessness at an early stage by ensuring adequate housing options. Examples include coordination assessment, diversion from a shelter, case management and improved screening.

> **Tertiary prevention** in health is about softening the impact caused by a disease or health problem or preventing it from becoming worse, such as rehabilitation or chronic disease management. For homelessness, tertiary prevention considers strategies for addressing the issue as quickly as possible, and ensuring people experiencing homelessness do not have a repeat experience. Wrap around services, such as using a Housing First model, are examples of tertiary prevention for homelessness.

A comprehensive approach to prevention means working at each of these levels and tiers at all times to apply an integrated systems approach. Table 1 provides examples of the ways in which prevention thinking and strategies implemented across the health continuum could be transferred to the housing tenure continuum.

Table 1: Prevention across the housing tenure continuum

(Adapted from *Preventing chronic disease: a strategic framework*, National Public Health Partnership, 2001)

NB: This table explores prevention across the housing insecurity continuum, with a focus on people with low or lost income as the prevalent reason for experiencing homelessness. Other factors and examples would be more relevant when considering the adequacy of housing outcomes.

Level of prevention	Primary prevention	Secondary prevention and early detection	Management and tertiary prevention
When is prevention implemented in a housing system?	Before there is evidence of housing insecurity.	After someone is experiencing housing insecurity, but before homelessness.	After someone is experiencing homelessness. To reduce the time someone experiences homelessness or to prevent someone experiencing multiple episodes of homelessness.
Examples	**Stable and secure housing** • Home ownership, with or without mortgage • Renting privately with long-term lease • Social housing with long-term lease	**Housing insecurity** • Rental stress • Mortgage stress • Renting privately with short-term lease	**Homelessness** • Couch surfing • Boarding and rooming house • Emergency accommodation • Crisis accommodation • Rough sleeping • Long-term homelessness • Repeated episodes of homelessness
Nature of housing intervention	To keep someone in stable and secure housing: • Affordability • Appropriateness, including housing quality • Availability • Accessibility • Financial security	To stop someone experiencing housing insecurity: • Identification of issues/barriers • Early interventions • Control of risk factors	To address housing insecurity and/or homelessness and prevent further experiences: • Case management • Housing First approach – e.g. rapid rehousing programs (timeliness of interventions)
Intervention examples	• Laws/regulation of borrowing (consumer credit legislation) • Financial literacy • Financial counselling • Affordable housing options	• Financial counselling • Financial literacy • Rental or mortgage support • Health support – disability/mental health	• Long-term housing support – Housing First / Aspire program / Rapid rehousing programs / • Support to access housing – 'Doorways' model / private rental assistance/ Private Rental Liaisons • Housing First – Permanent Supportive Housing
Role of health and housing sectors	• Enabling • Co-design • Knowledge translation • Mediation • Service (re)orientation • Strategic partnerships Advocacy	• Data collection/analysis • Identifying emerging issues and trends • Service delivery • Tenancy support and intervention • Person-centred approaches • Capabilities • Capacity building • Facilitation • Resources	• Deliver services – Housing allocations • Wraparound support, post housing support • Data collection • Identifying emerging issues and trends • Service delivery • Tenancy support and intervention • Facilitation

Conclusions

This paper has proposed a prevention framework for consideration by the housing and homelessness sectors. It depicts prevention across the housing tenure continuum, drawing heavily on the concepts of prevention as applied in the public health and health promotion fields. The framework suggests that to prevent homelessness at the population level, action is required at all levels of the prevention continuum. By translating this approach to relevant housing, homelessness and health policy and practice, potential future opportunities for intervention along the continuum can be better realised.

While the homelessness system operates mainly in tertiary prevention, there is great capacity among the sector to advocate and provide knowledge translation for primary and secondary prevention. The purpose of this paper is not to suggest what the appropriate policy and service responses should be, but rather to encourage consideration of the broader factors at play in the housing and homelessness sectors, among individuals and agencies within these sectors, and also within other sectors in control of many of the levers that shape housing outcomes.

Importantly, and by drawing on a model of the Determinants of Housing Outcomes (Paper 2 of this series), this paper offers an opportunity to stimulate both new and renewed discussion, for identifying strategies and interventions towards preventing homelessness at every stage of the continuum.

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