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Socio-Scientific Perspectives on COVID-Planned Interventions in the Homeless Population

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Abstract

Homelessness is characterised by a wide range of risk factors of a multidimensional and unstable nature. The COVID-19 pandemic intensified these risk factors associated with homelessness but also prompted the development of prevention and care actions. This study identified and mapped the intervention programmes carried out for people experiencing homelessness in the wake of the COVID-19 pandemic. To achieve the study purpose, a thematic analysis of the scientific literature was conducted following the search strategy and analysis methodology characteristic of informetrics and scientometrics. The sources of information used were WoS, Scopus, PubMed, PsycINFO and ERIC. The paucity of planned actions, most of which have a local impact, reinforces the need to strengthen research that presents robust evidence on this issue. China and Europe are under-represented compared to other types of studies linked to COVID-19 and the prevalence of homelessness. Several clusters are distinguished among the plans: they are carried out in buildings or in geographical areas and according to the impact on the group (preventive, substance-related disorder support, health care and diagnostic). Among the emerging themes, health and social variables are represented, including communication and trust between health, community and homeless groups. The reduction in the thematic dimensionality shows equal planning between health care actions (81.8%) and psychosocial and prevention support (72.8%), an aspect that confirms the importance of joint actions. In this line, among the various clusters of the network analysis, the relationship between hotel, mental health support, substance-related disorder, social intervention and access to permanent housing was found. The studies analysed also highlight social exclusion, stigma, victimisation, living conditions and the risk of contagion among this group. This situation has not gone unnoticed among the studies analysed, which present proposals for the continuation of the projects.

Keywords: homelessness; COVID-19; planned interventions; prevention; health care; mental health; substance-related disorders

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1. Introduction

The World Health Organization, alarmed by the high levels of spread of the virus and the apparent severity, declared on 11 March 2020 that COVID-19 could be characterised as a pandemic [1] and declared a state of alert limiting free movement of citizens, resulting in restrictive lockdown.

The lockdown and social distancing proposed as measures adopted for the prevention of contagion placed homeless people at a disadvantage [2] as well as in the urgent search for emergency health measures to mitigate the problem [3].

In general terms, and in order to ensure social distancing as a preventive measure, emergency accommodation and immediate protection were provided through hotels, public spaces, or shelters, among other options. This temporary measure created an opportunity for reflection on the need for institutional support to facilitate access to permanent housing for this population as an urgent future response [4,5].

Additionally, combined interventions were promoted to enhance inter-institutional coordination across various sectors, such as health and social services. At the health level, measures such as testing, vaccination, and medical care were implemented to enable greater control and prevention of COVID-19 transmission, alongside the promotion of mask usage and the provision of hygiene kits. At the social level, economic measures and eviction moratoriums were introduced to prevent a massive increase in the number of people experiencing homelessness [4–6].

However, these measures were not feasible for the entire group nor sustainable in the long term [6], making them more vulnerable to COVID-19 infection [7] as they are characterised by various aspects such as lack of a suitable place to carry out these measures [8], the need to stay in collective spaces or, indeed, to sleep on the streets [9] and other associated problems of various kinds such as the risk factors associated with drug use or deteriorated mental health [10].

In addition, other elements, such as the need for protection with masks and the difficulty of access to proper food or drinking water, worsened the situation [11], which accounted for the high incidence of contagion in this group according to the study by Bedmar et al. [12].

But beyond the health dimension, the COVID-19 pandemic and its impact on the deterioration of the living conditions of this group has had an impact on the welfare state [13–16], which has led to an increase in the inequality gap in the social and economic sphere, driven especially by the employment–housing binomial [17].

It is undeniable that these factors make it impossible for this group to fully enjoy the rights enshrined in the Universal Declaration of Human Rights.

The Universal Declaration of Human Rights constitutes a globally endorsed framework and a foundational reference for collective action, widely acknowledged as a milestone in the historical evolution of human rights.

Adopted in 1948 by the United Nations General Assembly, it established a shared commitment among states to guarantee fundamental freedoms and universally protected rights, grounded in three core principles: liberty, equality, and human dignity [18].

Article 25.1 guarantees to all human beings ‘the right to a standard of living adequate for health, including food, clothing, housing and medical care, as well as necessary social services’ [18].

Similarly, everyone’s right to property, without distinction as to sex, is recognised (Articles 17.1 and 17.2), a right that was reinforced in Article 11.1 of the International Covenant on Economic, Social and Cultural Rights signed in 1966, which recognised “the right of everyone to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions. States Parties shall take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent”.

From this point of view, the pandemic was a rupture of the established agreement and a form of social exclusion that made it impossible for the homeless to exercise their rights as citizens [19].

This situation weakened the enjoyment of an adequate standard of living, understood as extending beyond the provision of adequate food, clothing, and housing, to include the continuous improvement of living conditions [18].

Nonetheless, the conceptualization of an adequate life requires a multidimensional approach, one that accounts for individual well-being through factors such as physical and mental health, social and labor market participation, and access to education [20], as well as the safeguarding of human dignity [19].

One of the most critical challenges during the COVID-19 pandemic was the temporary closure of shelters, soup kitchens, and day centers, which severely impacted the realization of social rights for individuals experiencing homelessness [3].

This issue is substantiated by various studies and recommendations from international organizations, which concur that these measures resulted in the restriction of essential services without adequate alternatives, constituting a direct violation of the right to housing, social protection, and health [21–24].

The limited access of this population to social and health care services—due to factors such as lack of documentation or the complexity of administrative procedures—left many individuals experiencing homelessness in a state of neglect [25]. This situation significantly increased their exposure to the risks associated with the COVID-19 pandemic, particularly as a result of persistent inequalities in access to health care and social protection [17].

In response, efforts to provide alternative accommodation—such as repurposing private dwellings, hotels, or boarding houses [26]—posed significant implementation difficulties, particularly with respect to ensuring physical distancing, hygienic conditions, and adequate nutrition, given the structural barriers faced by this population.

The negative outcomes disproportionately affected this group, leading to a marked deterioration in both physical and mental health and a profound erosion of human dignity. These impacts were further compounded by intensified social stigmatization and the breakdown of interpersonal relationships [27,28].

Furthermore, the pandemic exposed the limitations of inclusive policy frameworks, particularly regarding access to employment and the structural neglect of long-term housing exclusion [29,30].

In conclusion, the COVID-19 pandemic represented a critical inflection point for the comprehensive evaluation of systemic interventions addressing homelessness in its multifaceted complexity.

Yet beyond the immediate crisis, homelessness remains a persistent and unresolved challenge in contemporary societies, owing to the heterogeneous nature of the phenomenon—which encompasses a spectrum of situations ranging from street homelessness to the structural inability to access adequate and dignified housing within specific sociocultural contexts [31].

In this scenario, it is undeniable that spaces for reflection must be opened that promote the adoption of effective social and institutional responses that are adjusted to the needs of the reality in each specific context, as well as consistent collaboration between institutions related to social policy. These actions must be agreed upon by the various agents involved and be sustainable over time in order to strengthen the processes of social inclusion and guarantee the universality of human rights.

Faced with this situation, from the beginning of the pandemic, the deployment of scientific resources and scientific publications generated to provide a comprehensive response

to COVID-19 was an unprecedented milestone [32,33], generating new knowledge about COVID-19 that grew exponentially, especially in bio-medical-scientific journals [33].

Science and innovation have pursued solutions to the pandemic from diverse disciplinary perspectives; however, notable gaps remain across several areas of study, including homelessness.

Multiple studies [34,35] underscore the scarcity of scientific publications that provide empirical evidence on the impact of the pandemic on individuals experiencing homelessness, despite the fact that this population was significantly affected by the crisis.

Moreover, in general terms, existing research highlights the variability of collected data, the challenges in tracking and recruiting individuals from this population, and other methodological constraints as key factors contributing to the complexity observed in studies on homelessness [36,37].

In this context, the following research question emerges in the present study: What evidence exists regarding the programmed and planned actions implemented for individuals experiencing homelessness in response to the COVID-19 pandemic?

It must be emphasised that science should be directed towards enhancing human well-being, and the COVID-19 pandemic represents an undeniable opportunity to implement optimal measures for addressing and preventing homelessness.

Consequently, the generation of scientific knowledge and the available empirical evidence regarding interventions with this population can guide policymakers and practitioners in developing effective responses aimed at homelessness prevention [2,29].

In this context and given that no previous studies have been found that compile evidence along these lines, the purpose of this study is to synthesise and characterise the different programs of intervention implemented towards the homeless in response to the scenario arising from the COVID-19 pandemic.

The findings presented herein may serve as a foundation for informed decision-making by professionals responsible for and engaged with this issue, facilitating the development of strategies aimed at combating homelessness and promoting the social inclusion of this population.

2. Methodology

To achieve the study objective, a thematic analysis of the scientific literature was conducted following the search strategy and analysis methodology characteristic of informetrics and scientometrics [38–41].

2.1. Data Sources & Research Strategy

This study was based on articles published in scientific journals, included in the databases Web of Science Core Collection, Scopus (www.scopus.com (accessed on 3 April 2025)), PubMed (https://pubmed.ncbi.nlm.nih.gov (accessed on 3 April 2025)), PsycINFO and ERIC (the latter two were accessed through the EBSCOhost platform, https://search.ebscohost.com (accessed on 3 April 2025)) that dealt with aspects related to programmes implemented for homeless people in response to the COVID-19 situation.

To retrieve the documents, the following search equation was run on the title and abstract fields, with no limits on the publication date, on 3 April 2025: (homelessness OR homeless) AND (SARS-CoV-2 OR coronavirus OR COVID OR COVID19 OR COVID-19) AND (plan OR planning OR program OR programme OR project OR protocol).

For the selection of search terms used in the query, searches were conducted in the MeSH thesaurus (https://www.ncbi.nlm.nih.gov/mesh/ (accessed on 10 March 2025)), ERIC (https://eric.ed.gov/?ti=all (accessed on 10 March 2025)), and PsycINFO (https://www.apa.org/pubs/databases/training/thesaurus (accessed on 10 March 2025)) with

the purpose of identifying the widest variability of terms related to homelessness, COVID-19, and planned interventions.

This equation retrieved 848 bibliographic records, 277 in the Web of Science Core Collection, 289 in Scopus, 178 in PubMed, 82 in PsycINFO and 22 in ERIC.

2.2. Data Import and Screening

The retrieved records were downloaded and imported into a database. Subsequently, 118 records that did not correspond to journal articles (such as erratum, letters, comments, meeting abstracts, book chapters) and 455 duplicates were removed. After this process, the database had 275 bibliographic records.

The records were reviewed by RAM and DMF to determine which articles were relevant to the aim of the study. This review was conducted through the title and abstract, and if necessary, the full paper.

A total of 253 articles were discarded as they were found to be false positives retrieved by the search equation but unrelated to the purpose of the study. There were recurrent articles that focused on COVID-19 but did not focus on homelessness or the implementation of a programme for homeless people. For example, articles focusing on testing, isolation, vaccination, vaccine, migrants, sex workers, mental health or drug use were discarded. Also, there were articles that focused on homelessness but did not analyse programmes or did not focus on the COVID-19 pandemic. On the other hand, case studies, reviews and non-experimental studies (such as surveys and observational studies) were also discarded. Thus, the total number of articles included in the current study was 22.

2.3. Data Treatment and Analysis

Due to the small number of articles located that met the study criteria, an analysis of scientific information was carried out on the objective, place and country of the studies, their success and implications, and a thematic specification of the studies.

The analysis was carried out using categories that emerged from the information provided by the articles. This qualitative analysis was carried out following Taylor-Bogdan's [42] approach of analysis in progress. It is posited that each article consists of a set of topics, and each topic is the normalised result of a group of related words. The themes that emerged from this text analysis were agreed upon by R.A.M. and D.M.F.

Full documents were reviewed, as well as the keywords of the authors of the articles and the descriptors that emerged from the classifications generated by the MeSH on Demand tool[1]. This tool provides a list of article descriptors standardised according to the hierarchy of the Medical Subject Headings thesaurus.

This allows the content of the articles to be reviewed and contrasted on the basis of the specific nature of the thesaurus descriptors. Moreover, since each descriptor is located within the hierarchical structure of the thesaurus, it is possible to observe which words are close: by synonymy, breadth or concreteness. This aspect supports the identification of the topics of each article.

Four core topics were identified as the focus of the 22 studies: Prevention (see studies in Table 2), Substance-Related Disorders (see studies in Table 3), Health Care (see studies in Table 4), and Diagnostics (see studies in Table 5); four additional topics related to the core ones were vaccination, isolation and quarantine, mental health, and social intervention; and six topics referred to the success and implications arising from the results of the documents (see Table 6).

The network analysis and visualization software VOSviewer (www.vosviewer.com (accessed on 25 June 2025)) was used to examine the relationships between the topics extracted from the articles (countries, places, thematics, and success and implications

topics) (Figure 1). The graphical representation employs the fractionalization method to normalise the strength of the links between elements [43] and the VOS clustering technique to group vectors into different colors [44].

Dimensionality reduction of the variability of identified topics was performed to observe the occurrence and bivariate association (see Table 7) between health care and other supports (prevention and psychosocial). A contingency analysis was conducted for this purpose (Pearson's Chi-Squared statistical significance was set at an alpha level of 5%, p-value < 0.05).

3. Results and Discussion

The present exploratory study identified 22 scientific articles addressing structured interventions targeting individuals experiencing homelessness in response to the COVID-19 pandemic.

As noted in previous sections, this represents a limited body of scientific literature, which contrasts sharply with the volume of research produced within the biomedical sciences [33].

It is likely that research funding was predominantly allocated to urgent health care responses to the COVID-19 pandemic [32,33], resulting in imbalances across various fields of study, including homelessness.

As can be seen, science and innovation pursued the search for solutions to the pandemic from different approaches, but with mismatches in various fields of study, including homelessness. Various studies [34,35] highlight the scarcity of scientific publications that provide evidence on the impact of the pandemic on homeless groups.

Therefore, there is a perennial need to reinforce research on this problem by applying the results obtained in the specific policies to be adopted for the homeless population [45,46].

The results are presented according to the identified study dimensions: country, location, thematic areas, prevention strategies, substance use disorders, health care, diagnostics, and emerging issues.

3.1. Country Analysis

Regarding the place and area of action, more than ¾ of the studies have been carried out in the USA and Canada. These results align with the study by Levesque et al. [47], which also identified the USA and Canada as the leading producers of literature on homelessness and COVID-19.

The USA leads with 12 (54.55%) studies, followed by Canada, where six (27.27%) have been carried out. The remaining four studies have each been carried out in four other countries (Australia, Germany, Hungary and South Africa) (see Tables 1–4).

These studies reflect a low number of studies from Europe, as well as no reported work from Asia, which is in line with and in contrast to the world ranking in coronavirus research, led by the USA (as in this paper) and China (which reports no work in this study) [48] and which, in the case of Europe, is surprising since the report 'Overview of Homelessness & Housing Exclusion in Europe' [17] shows worrying data that warns of the existence of almost one million people in a situation of homelessness in the European Union.

Other similarities and differences among the countries where these projects were conducted include the fact that, according to the World Bank [49], in 2020, all countries were classified as high-income, except South Africa, which was categorised as upper-middle-income. As shown in Table 1, prior to the onset of the pandemic, all countries except Hungary had a national homelessness strategy [5]. In Canada, one area of focus is funding innovative projects. Additionally, during the pandemic, economic efforts were directed towards the homeless population [22,50]. Although data from Germany are not

available on this matter, a previous study [51] identified Germany as the country allocating the highest proportion of its income to its poorest 10% of the population (with 20.5% of GDP devoted to social benefits and transfers—double that of the USA and above the 17.6% for Continental Europe).

Therefore, it can be observed that the countries where these programs were implemented have consistent social policies regarding income distribution to the most disadvantaged populations [51], which persisted and even increased during the COVID-19 pandemic.

Table 1. National strategies and additional investment.

Country	National Strategies for Combatting Homelessness	Additional Investment due to COVID-19
USA	2018-present [5] * - Home, Together (2018) - Expanding the Toolbox (2020) - All In (2022)	The Relief and Economic Security Act (2020) pledged USD 4 billion (USD) [22].
Canada	2019-present [5] * Reaching Home: Canadas Homelessness Strategy is a community-based	Additional CAD 157.5 million (CAD) on Canada's Homelessness Strategy [22].
Australia	2018-Present [5] * There is no official homelessness strategy, but the National Housing and Homelessness Agreement (NAHA) requires state and territory governments to have a publicly available housing and homelessness strategy in place.	The combined additional funding in the five Australian states is AUD 229 million [22].
Germany	Current programme [5] The National Action Plan Against Homelessness, "Together for a home," approved in April 2024.	-
Hungary	There is no reported homelessness strategy at the national level (OECD, 2024) [5].	-
South Africa	There is no official strategy specifically for people experiencing homelessness; however, the National Department of Human Settlements (NDHS) has a housing strategy in place (https://www.dhs.gov.za/ (accessed on 25 June 2025)).	Allocations were made to a solidarity fund to help combat the spread of the virus, with assistance from private contributions, and support municipal provision of emergency water supply, increased sanitation in public transport, and food and shelter for the homeless [50].

* From strategies in place prior to 2020.

3.2. Place-Based Analysis

Whether because they are affected by outbreaks, infections or comorbidities, because of the difficulty in accessing this vulnerable population or because of the very purpose of the programme and the agents involved, the actions are carried out in various locations. Thus, programmes are mainly presented in buildings (63.63% of the studies): hotels (n = 7), shelters (n = 3), hospitals (n = 2), clinic (n = 1) and stadiums (n = 1) compared to 36.37% carried out in cities (n = 4), counties (n = 3) or regions (n = 1) (see Tables 2–5).

It is pleasantly surprising that the programmes in hotels are not exclusive to isolation and quarantine as regards COVID-19 but that they are the only two programmes that implement permanent access to housing and where the main actions on mental health (n = 2) [52,53] and substance-related disorders (n = 4) [54–57] are carried out. It is also worth noting that the two programmes focusing on Diagnosis are carried out in shelters. With regard to the programmes carried out in municipalities, counties or regions, there is a tendency towards health or health education actions, without working on aspects related to mental health, addictions or social reintegration. Thus, studies on Health Education (n = 5) [58–62], Telemedicine (n = 2) [63,64] and Health Care Model (n = 1) [65] are found in these contexts.

These bivariate results (place and purpose) enhance the understanding of actions based on the implementation setting. The work by Levesque et al. [22] identified common

infection control and prevention measures exclusively in shelters and hostels within high-income countries (such as physical distancing, isolation and quarantine, testing, etc.).

3.3. Thematic Analysis

The thematic analysis identified four blocks of content as the backbone of the study (Prevention, Substance-related disorders, Health Care and Diagnostic), although there are also mixed studies that address several associated themes. We found ten studies focusing on Prevention (Table 2), five studies focusing on Substance-related disorders (Table 3), five studies related to Health Care (Table 4) and two studies linked to Diagnostic (Table 5).

Broadly speaking, prevention is identified as a priority strategy for addressing homelessness through comprehensive, sustained policy measures [66].

The reviewed scientific literature indicates that, to prevent homelessness, it is essential to prioritise sustainable policies—including affordable housing, subsidies, safe shelters, and eviction moratoria—and to incorporate individuals experiencing homelessness into public health plans, thereby promoting protection for both this population and society at large [66–69].

3.3.1. Prevention

Prevention programmes focus mainly on health education actions, although there is one study that develops a prevention project from the Peer Support Worker [70]. Eight studies link prevention with access to vaccination (Table 2).

In more detail, the works of Komaromy et al. [71], Rosecrans et al. [72], and Wang et al. [73] developed actions of isolation in hospitals, hotels and shelters, respectively. Other problems were worked on in the study by Komaromy et al. [71] related to substance abuse and mental illness, and in the study by Wang et al. [73] related to other conditions (diabetes, heart failure, HIV/AIDS, mental illness. . .).

Loutfy et al. [74] developed a COVID-19 outbreak prevention programme between Women's College Hospital in Toronto and shelters and congregate living settings coordinated by a Community Response Team that proved feasible. Other vaccination-related actions were implemented by Yi et al. [62] in a low-threshold clinic with access to inner-city areas and in collaboration with community organisations and housing. In another vaccination programme, Rosen et al. [60] describe the Housing of Health programme in the city of Los Angeles.

These studies highlight the success of the programmes due to partnerships between the health organisation and community organisations, as well as community work from a specific, empathetic and communicative approach towards homeless people.

Similarly, other prevention models report communication actions such as Specht et al. [61] who present an information campaign with inclusive material towards people experiencing homelessness in Berlin (Germany). Osman et al. [59] focus on young people experiencing homelessness in the USA; Hollingdra et al. [58] carried out community strategies in Aboriginal groups in the Torres Strait (Australia); and Isabel et al. [70] included a homeless peer support worker in a clinical team as a link between the health and socio-community area for homeless people.

They all highlight communication and cooperation in the success of the programmes, which is vital for analysing their status and evaluation, and the concept of trust is worked on and highlighted in all four studies as an element of success. Specht et al. [61] integrated this involvement and trust and included homeless people as experts in the planning, implementation and evaluation of the project. Osman et al. [59] integrate the ongoing involvement of homeless youth to build trust in vaccines. Hollingdra et al. [58] describe assertive outreach strategies and trust bonds as elements of the programme's success; and

Isabel et al. [70] describe how peer support worker-built relationships and trust between the medical team and homeless people.

Table 2. Prevention studies.

Cite	Topic	Place	Location
[58]	COVID-19 vaccination outreach service for the homeless	Region	Torres Strait Islands, Australia
[70]	Peer support workers in a primary and community care clinic that serves the homeless	Clinic	Montreal, Canada
[71]	Isolation in a hospital building (safety-net hospital) for COVID-infected homeless people	Hospital	Boston, USA
[74]	COVID-19 Community Response Team, a partnership between hospitals and shelters as part of an outbreak prevention program	Hospitals and shelters	Toronto, Canada
[59]	Cross-sector partnership to enhance COVID vaccine confidence among Youth Experiencing Homelessness	County	Minneapolis, USA
[72]	Multiagency COVID-19 isolation and quarantine site tailored for people experiencing homelessness	Hotel	Baltimore, USA
[60]	COVID-19 vaccination program to promote the vaccine for the homeless	County	Los Angeles, USA
[61]	Inclusive COVID-19 information material to strengthen infection prevention and control for the homeless	City	Berlin, Germany
[73]	Temporary medical respite shelter for the homeless	Shelter	Chicago, USA
[62]	Community pop-up clinic to achieve high levels of vaccination among residents (homeless people)	City	Vancouver, Canada

3.3.2. Substance-Related Disorders

There are five programmes whose main focuses are on homeless people with Substance-related disorders (Table 3). On the one hand, Markus et al. [55] gathered homeless people in a stadium as a temporary shelter. While the other four studies were conducted in hotels. The mission of each was as follows: to prevent COVID-19 infections in addicted homeless people [53,57]; isolation (or quarantine) due to an outbreak of infections in a shelter [54]; and as a place for addiction treatment [56]. Although only one study carried out in San Francisco addresses addiction treatment, the other studies also take direct action on this issue.

In fact, addictions are one of the major risk factors associated with homelessness and along with physical and mental health have been of interest in explaining homelessness [75,76] without losing sight of others such as socio-demographic and lifestyle factors [77,78], easily identifiable aspects that allude to purely personal circumstances but which, nevertheless, have a socio-structural dimension and conditioning factor [77,78]. Furthermore, during the COVID-19 period, the study by Corey et al. [79] identified 57 studies reporting substance use among individuals experiencing homelessness.

Therefore, it is not surprising to see this multidimensional alignment in the studies of Tan et al. [57] and Huggett et al. [53], which not only integrates mental health and addiction intervention aspects of homelessness but also integrates housing services (i.e., transition to permanent housing) and integration with other socio-community actions.

Other projects worked on harm reduction. Thus, Brothers et al. [54] and Samuel et al. [56] present medical and pharmacological support programmes for the safe supply of

drugs and alcohol to homeless people in hotels, and Marcus et al. [55] apply this model in a sports stadium. At this point, it is relevant to note that the Brothers et al. [54] study, in which the sample was isolated by COVID infection, presents negative results (such as: overdose, intoxication and sale or shared use of substances); while the Samuel et al. [56] project highlights the success of pharmaceutical administration and counselling and in the work of Marcus et al. [55], in addition to the administration of methadone, communication with homeless people is also important.

As has been previously underlined, the works of Samuel et al. [56] and Marcus et al. [55] highlight the value of counselling and communication with this vulnerable group, suffering from addiction and unprotected by COVID. There is scientific evidence that supports the promotion and development of this variable as a protective factor in addictions and health education, and there is a relationship between the non-application of these actions (counselling and communication) and an increase in the problems associated with drugs, as highlighted in the work of Brothers et al. [54].

Table 3. Substance-Related Disorders studies.

Cite	Topic	Place	Location
Brothers et al. (2022) [54]	Hotel isolation for the COVID-infected homeless with a health care team	Hotel	Halifax, Canada
Huggett et al. (2021) [53]	Hotel-based protective housing intervention to reduce the incidence of COVID-19 in the homeless	Hotel	Chicago, USA
Marcus et al. (2020) [55]	Stadium-based homeless shelter	Stadium	Tshwane, South Africa
Samuel et al. (2022) [56]	Prescribed buprenorphine program partnership among Behavioural Health Services Pharmacy and Shelter in Place (SIP) hotels to Opioid Use Disorder homeless	Hotel	San Francisco, USA
Tan et al. (2025) [57]	Shelter-in-place hotel program to provide non-congregate shelter to people experiencing homelessness and vulnerable to SARS-CoV-2 infections	Hotel	Kingston, Canada

3.3.3. Health Care

There are five programmes with the main focus on homelessness with Health Care (Table 4). Two are developed in hotels [52,80], two others present Telemedicine projects [63,64] and, only one study, not only of this size, but of all the current study, where besides implementing a community health centre for homeless people, a programme was developed between agents in the city of Boston, where state public health agencies, municipal leaders, and homeless service providers intervened [65].

In Baggett et al.'s [65] research, the authors developed a model of care for COVID-19 in Boston for this vulnerable population, in which communication was crucial to decision-making in order to protect and intervene, with particular relevance to the information provided by homeless people in the course of infections.

The Fuchs et al. [52] and Montgomery et al. [80] articles feature hotel-based systems of care. Fuchs et al. [52] developed a hotel-based care programme for over 1000 homeless people with medical and mental health support that reduced hospital burdens and was able to address mental health needs.

Békási et al. [63] and Meray et al.'s [64] telemedicine programmes report positive results in monitoring and assisting homeless people, including those who are digitally excluded. Békási et al. [63] and Meray et al. [64] highlight that the programme made it

possible to isolate and quarantine homeless people without the need for hospitalisation, thus relieving some of the burden on overburdened hospitals and social systems.

Table 4. Health care studies.

Cite	Topic	Place	Location
Baggett et al. (2020) [65]	Health Care (COVID-19 care model) for the Homeless Program	City	Boston, USA
Békási et al. (2022) [63]	Telehealth for the homeless using shelters	City	Budapest, Hungary
Fuchs et al. (2021) [52]	Hotel-based COVID-19 isolation care system for the homeless	Hotel	San Francisco, USA
Meray et al. (2022) [64]	Telemedicine Homeless Monitoring Project	County	Miami, USA
Montgomery et al. (2021) [80]	Isolation hotel for the homeless with COVID-19 and a noncongregate hotel for PEH without COVID-19 but at risk of severe illness	Hotel	Atlanta, USA

3.3.4. Diagnostic

There are two main programmes targeting homeless people with Diagnosis (Table 5). Both are developed in shelters with the aim of preventing and anticipating a coronavirus outbreak. The study by Akingbola et al. [81] through sewage surveillance enabled early detection before clinical detection of cases and Aranda et al. [82], through frequent, rapid antigen-based tests (BinaxNOW), located cases for immediate isolation among infected persons.

Table 5. Diagnostics studies.

Cite	Topic	Place	Location
Akingbola et al. (2023) [81]	Wastewater surveillance in homeless shelters	Shelter	Toronto, Canada
Aranda et al. (2022) [82]	COVID-19 antigen-based tests (BinaxNOW) in homeless shelters	Shelter	San Francisco, USA

3.4. Emerging Issues

The objectives reflect diverse study interests, with some studies being mixed. However, the following variables emerge in relation to the success of the programmes. We can group these emerging variables into health and social variables (Table 6). On the one hand, regarding health variables, six studies focus on achieving safe environments for rehabilitation (whether in a hospital, hostel or hotel setting), the two studies on diagnosis focus on the success of early detection of infection, and the two studies on telemedicine focus on monitoring and telecare. Regarding social variables, the communication variable emerges in six studies, both between the social and health care area and homeless people, and within the social and health care group. In the same respect, four other studies show that the variable of trust between social agents and homeless people is a success. Finally, two studies highlight access to permanent housing as one of the aims.

As can be seen, the variables of communication and trust are highly relevant to the viability of the success of the programmes reported, even more so if it is taken into account that the data on homeless people could be greater given that those subjects who are outside the system and are difficult to access are not counted, due to the difficulty in monitoring and recruiting this group, which are variables that influence the complexity shown in the studies on homelessness [36].

Table 6. Emerging variables on programme success.

Variable	Article [Cite]
Access to permanent housing	[53,57]
Communication	[55,56,60,62,65,74]
Trust	[58,59,61,70]
Early detection of contagion	[81,82]
Safe environment for rehabilitation	[52,54,71–73,80]
Screening and care	[63,64]

3.5. Thematic Relationships

The topic co-occurrence network (Figure 1) illustrates the thematic connections within the research, highlighting node linkages between the USA and hotels; between vaccination, prevention, and trust; and among safety, isolation, vaccination, and prevention. Additionally, it reveals associations between hotels, mental health support, substance-related disorders, social intervention, and access to permanent housing. Notably, certain topics, although not clustered within a specific group, exhibit a high node density, such as Canada (16 nodes) and communication (12 nodes).

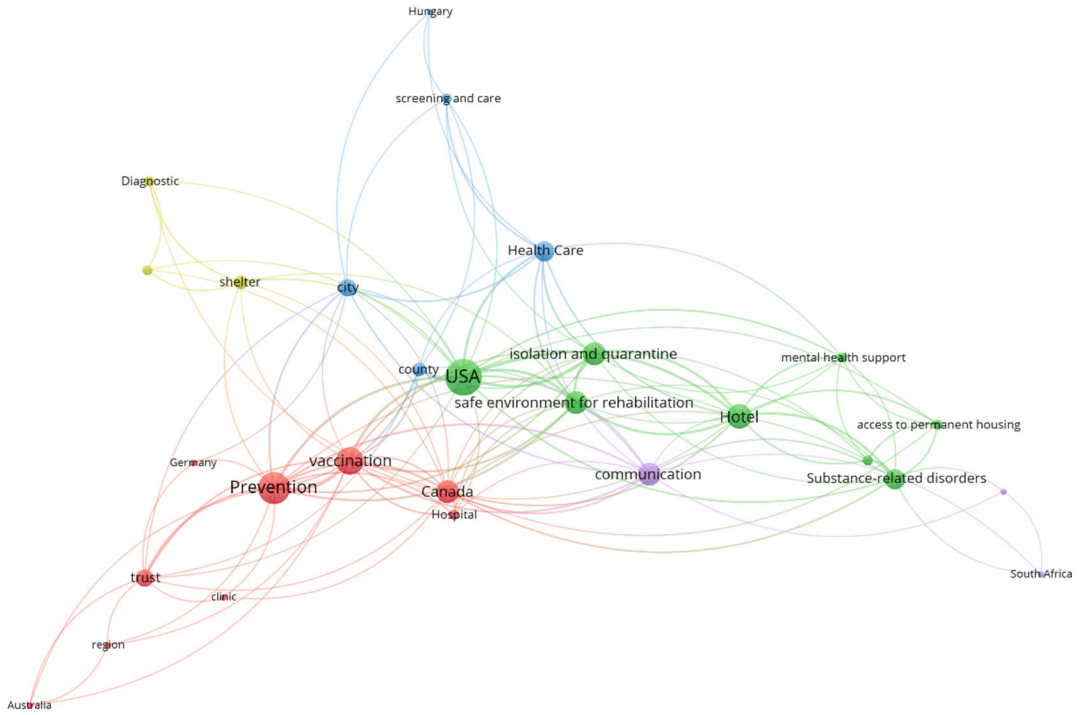


Figure 1. Topics network.

With regard to the type of care, actions have been counted from two perspectives (Table 7): health care (18 articles, 81.8%) and other supports (prevention and psychosocial), with 16 articles (72.8%). There are six studies (27.3%) on health intervention, but without other contributions, and four papers (18.2%) with preventive or psychosocial/community intervention, but without health care contribution. The association with the highest co-occurrence is between prevention and health support (n = 8; 36.4%).

Our results enhance the understanding of studies on homelessness and COVID-19, as the work by Ahillan et al. [83] identified non-pharmaceutical interventions—although without providing detailed data—indicating that the main governmental strategies and

policies focused on "mass testing, adaptation of health care service delivery, provision of alternative housing, promotion of personal hygiene (hand sanitation and mask use), and interinstitutional communication."

Table 7. Association between health care and other support.

		Other Support			Total
		Psychosocial Support	Prevention	No Other Support	
Health	Diagnostic	0 (0)	0 (0)	2 (9.1)	2 (9.1)
	Health support	4 (18.2)	8 (36.4)	4 (18.2)	16 (72.7)
	No health action	2 (9.1)	2 (9.1)	0 (0)	4 (18.2)
Total		6 (27.3)	10 (45.5)	6 (27.3)	22 (100)

Pearson's chi-squared = 7333; $p = 0.119$. Note: n (%).

4. Limitations

In general terms, and as a limitation of the study, the research shows a lack of published articles on actions planned during the COVID-19 pandemic aimed at homeless people, which hinders a broad view of the regularisation of successful practices that promote their reduction and improve their quality of life.

This lack of studies has been observed in previous studies, such as those of [34,35], who alluded to a greater effort in the study of health and clinical studies. There is probably an economic conditioning factor focused on the development of vaccines or hospital research rather than on research in scientifically marginalised groups.

On the other hand, the review on homelessness and nature [84] indicates that, although interdisciplinary studies exist, they remain fragmented and generally urban and qualitative, with no coherent routes to policy.

In this sense, more studies are needed to better understand the regular patterns of success in this population and to generate evidence for viable strategies and policies to address their social and health impacts.

However, the results of this study show thematic issues, which can be translated into variables for reflection and analysis by researchers and social and political decision-makers.

5. Conclusions

The studies, in addition to presenting a programme of help for homeless people, show relevant evidence of social exclusion (either through hotels or hospital sections run for this group) and the impact of the COVID-19 pandemic on this group, aggravating their state of vulnerability, living conditions and risk of contagion. This situation was aggravated by mental health problems, drug use, mood disorders and negative feelings.

In view of the above, a greater effort of scientific and research resources is needed to provide a comprehensive response to the phenomenon of homelessness.

Our study corroborates the existing knowledge gap in the scientific literature concerning homelessness and the pandemic, as previously highlighted by other researchers [34,35].

In this regard, rigorous science-based knowledge enhances the understanding of the phenomenon and can facilitate the development of public policies aimed at housing integration, health care provision, and the enforcement of social rights and social justice [85,86].

The pandemic exacerbated the situation of this group and, although there were numerous scientific publications of a scientific-medical nature, the lack of research into homelessness was more than notable and was necessary for the search for relevant solutions.

It is therefore irrefutable that science and innovation must provide evidence for the promotion of actions aimed at the prevention and avoidance of homelessness, a situation that has

not gone unnoticed among the studies analysed, which present proposals for the continuation of the projects. For example, housing models are proposed as a useful strategy for community mitigation of health problems, drug use and social reintegration [53,57,70–72,74,80] or the development of structural alliances between the health sector and social agents after the pandemic [55,56,59,63,72,74].

It is undeniable that the scientific evidence provided by these studies is aligned with science at the service of improving people's well-being, and therefore, the generation of constant scientific knowledge that is at the forefront of reality becomes a key factor in tackling homelessness. For this reason, the scientific community has a commitment to society and is committed to offering unbeatable responses [87], guaranteeing the Welfare State and the enjoyment of human rights in their entirety.

Scientific research provides rigorous data on the realities of homelessness, including its impact on health, social exclusion, and human dignity [46]. Dissemination of these findings not only supplies policymakers and practitioners with evidence-based knowledge to design informed policies and programs but also presents an opportunity to raise public awareness about homelessness, thereby facilitating stigma reduction and the promotion of human rights for this population [88].

The need to promote preventive and comprehensive actions that involve all of the agents responsible for social policies is urgent, prioritising courses of action that enable the fight against homelessness in all its complexity in order to guarantee the full social inclusion of citizens, something that has become evident in this study.

Thus, the studies reported are mostly local actions to address the emergency, without implications for the quality of life through economic income, promotion of employment, elimination of digital barriers or the enjoyment of housing, something that is lacking in the phenomenon associated with homelessness [17,27].

We can also add actions to raise social awareness and prevent stigmatisation and victimisation of homeless people. The study carried out only reports one piece of research on the subject [61], highlighting the lack of research on this issue.

There is a need to provide studies that allow for an exhaustive knowledge of the complexity of the phenomenon of homelessness, given that the evidence shows that there are few studies in this field [34] and in modern society, this problem continues to be a challenge in the search for solutions due to the nature of the phenomenon itself, which encompasses situations of a heterogeneous nature [28].

In this task, the contributions of science and the need for innovative evidence based on the generation and transfer of knowledge can facilitate coherent and effective decision-making so that future actions present viable and successful solutions in the fight against homelessness.

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Notes

[1] https://meshb.nlm.nih.gov/MeSHonDemand?_gl=1*iayy3h*_ga*MTI2NjQ1MzgyMC4xNzQ2Njk3ODMx*_ga_P1FPTH9PL4*czE3NDcwNTc3MzMkbzMkZzEkdDE3NDcwNTc3NDEkajAkbDAkaDA.*_ga_7147EPK006*czE3NDcwNTc3MzMkbzMkZzEkdDE3NDcwNTc3NDEkajAkbDAkaDA (accessed on 4 May 2025).

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