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Cognitive decline and homelessness

Zaburzenia poznawcze a bezdomność

Abstract

Aim. The aim of the paper is to present the issue of homelessness in the context of cognitive disorders. In Poland, it is relatively rarely discussed, although due to the aging of society, including the population of people experiencing a homelessness crisis, it requires the attention of decision-makers responsible for policy and social assistance.

Methods and materials. The article reviews existing studies. Due to the fact that Polish literature on the subject does not provide extensive material on cognitive disorders among homeless people, reference was made to research carried out abroad, mainly in the United States of America and Canada.

Results and conclusion. The collected data shows that cognitive disorders may lead to and accompany homelessness. Moreover, they extend the duration of homelessness and delay the process of getting out of it. It has also been noted that the longer a person remains without a safe, permanent place to live, the greater the risk of developing dementia symptoms. In turn, remaining in homelessness for an extended time increases the likelihood of deterioration of physical and mental health, and with the length of time in the homeless crisis, the subjective assessment of the health of homeless people clearly

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shows a decrease.
Experiencing cognitive impairment and homelessness at the same time poses a serious threat to the individual, making it difficult to function on many levels. It is necessary to carry out adequate preventive, assistance, and harm reduction activities. They require the appropriate preparation of representatives of social services, especially social workers employed in facilities for homeless people.

Keywords: homelessness, crisis, cognitive decline, elderly person, person in crisis of homelessness.

Abstrakt
Cel. Celem artykułu jest ukazanie problematyki bezdomności w kontekście zaburzeń poznawczych. W Polsce jest to temat stosunkowo rzadko omawiany, choć ze względu na starzenie się społeczeństwa, w tym populacji osób doświadczających kryzysu bezdomności, wymaga zainteresowania decydentów odpowiedzialnych za kształt polityki i pomocy społecznej.
Metody i materiały. W artykule dokonano przeglądu istniejących już opracowań. Ponieważ polska literatura przedmiotu nie dostarcza bogatego materiału na temat zaburzeń poznawczych wśród osób bezdomnych, odwołano się do badań wykonanych za granicą, przede wszystkim w Stanach Zjednoczonych Ameryki Północnej i w Kanadzie.
Wyniki i wnioski. Z zebranych danych wynika, że zaburzenia poznawcze mogą prowadzić do bezdomności oraz jej towarzyszyć. Ponadto wydłużają czas trwania bezdomności i opóźniają proces wychodzenia z niej. Zauważono także, że im dłużej dana osoba pozostaje bez bezpiecznego, permanentnego miejsca do życia, tym bardziej jest narażona na ryzyko wystąpienia symptomów otępiennych. Dłuższe przebywanie w bezdomności zwiększa prawdopodobieństwo pogorszenia się zdrowia fizycznego i psychicznego, a wraz ze stażem pozostawania w kryzysie bezdomności subiektywna ocena zdrowia u osób bezdomnych wyraźnie spada.
Jednoczesne doświadczanie zaburzeń poznawczych i bezdomności jest poważnym zagrożeniem dla jednostki, bo utrudnia jej funkcjonowanie na wielu płaszczyznach. Niezbędne jest prowadzenie działań profilaktycznych, naprawczych i redukujących szkody. Wymagają one odpowiedniego przygotowania przedstawicieli służb społecznych, zwłaszcza pracowników socjalnych zatrudnionych w placówkach dla osób bezdomnych.

Słowa kluczowe: bezdomność, kryzys, zaburzenia poznawcze, osoby starsze, osoby w kryzysie bezdomności.

Introduction

As the preliminary results of the 2021 N*arodowy Spis Powszechny Ludności i Mieszkań* [National Population and Housing Census] indicate, the share of the post-working age population has increased by 5 percentage points (from 16.9% to 21.8%). In ten years, the population aged 60–65 and over has increased by more than 1.8 million, and more than one in five Poles is now over 60 (Główny Urząd Statystyczny [Central Statistical Office], 2021). It is estimated that in 2060, the proportion of people aged 80 and over in the total population of Poland will be 12% (Chabior, Fabiś, & Wawrzyniak, 2014).

The ageing population also refers to the number of people in a state of homelessness. This trend has been noticeable since the beginning of the 2000s. Periodic analyses in Pomerania have shown that in 2003, 2005 and 2007, the average age of homeless people was higher each year, at 47, 48 and 49 years respectively (Dębski, 2008a). According to a nationwide survey on the number of homeless people published in June this year by the Ministry of Family, Labour, and Social Policy, the age of the largest number of homeless people is between 41 and 60. The second largest group are those over 60 years of age (Ministry of Family, Labour, and Social Policy, 2024).

The ageing of homeless people has serious consequences. Firstly, it weakens the chances of returning to both the labour market and "domesticity." Secondly, it can lead to a deterioration in health, including the onset of cognitive disorders. It is important to emphasise that as early as the first decade of the 21st century, staff at homeless shelters were increasingly reporting cases of dementia (Dębski, 2008b). Despite this, almost 70% of people without their shelter considered themselves to be health-conscious, and more than 55% rated their health as very good or good (Dębski, 2008b).

The fact that homeless people are getting older is becoming a serious challenge for social work and social policy. In addition, their population is increasing. It is estimated that in 2024, there will be 31,042 people, while in 2019, there were 30,330 (Ministry of Family, Labour and Social Policy, 2019).

The aim of this paper is to examine homelessness in the context of cognitive impairment. This is a rather niche issue. The material presented shows the connections between cognitive dysfunctions and homelessness and attempts to answer the question of which of them is the cause and which is the accompanying phenomenon.

Causes of the homelessness crisis

Homelessness can be considered with the entire population of people experiencing it, as well as the situation of an individual. Such a dualism was pointed out by Andrzej Przymeński, who emphasised that it is both a complex social phenomenon and the per-

sonality state of a homeless person (Przymeński, 1997). This state has its causes. National and foreign literature on the subject suggests that it is rarely caused by a single specific event. Sometimes it can be the result of sudden natural disasters, but it is usually a combination of various factors, dependent and independent of the activities undertaken by a given person.

According to a study commissioned by the Ministry of Family, Labour, and Social Policy as part of a nationwide survey of the number of homeless people in 2017, the three most common reasons for losing one's roof over one's head were: eviction, deregistration (45%), family conflicts (36.39%), and addiction (29.2%). Two years later, the most common reasons were family conflicts, addictions (mainly alcohol) and evictions. They affected 32%, 28% and 26% of the respondents, respectively. The next most common reasons were relationship breakdown (18%) and debt (17%). Interestingly, health-related reasons, i.e., illness and mental disorders other than addictions, only affected 4% of homeless people. This year's report indicates alcohol addiction (19%), family conflict (17%) and eviction or deregistration from an apartment (11%). Health problems and disabilities affected 7% of the respondents (Ministry of Family, Labour, and Social Policy, 2017, 2019, and 2024).

The issues of events contributing to homelessness are already fairly well recognised in both domestic and foreign literature. Among domestic studies, the typology of causes distinguished by Monika Oliwa-Ciesielska and A. Przymeński can be identified. The authors divided them into two main categories. The first included microsocial factors, including:

- socialisation in primary groups – semi-orphanhood, running away from home due to violence, low educational, and financial status of parents, their addictions and criminal past;
- family situations concerning the family of origin and procreation – conflicts, lack of support, divorce, separation, women fleeing with children from violence;
- obtaining means of subsistence – unemployment, lack of a permanent job, and health conditions preventing taking up employment;
- micro-legal factors – evictions, being thrown out of the house, lack of registration;
- way of life – alcoholism, prison, seasonal work that does not provide stability;
- health status – illness, intellectual disability, lack of care.

The second group includes macro-social factors, including:

- competitive labour market – worsening employment conditions for people in a weak position in the labour market;
- shortage of housing available to the poor – lack of social housing;
- the predominance of structural mechanisms of social exclusion over mechanisms of social reintegration concerning children from orphanages or people in prisons;

– gaps in the social security system – lack of a guarantee of a minimum standard of living (Oliwa-Ciesielska, Przymeński, 2010).

The reasons mentioned require reflection. First of all, it is worth bearing in mind that some of them can occur simultaneously and can also be interdependent. For example, the evictions singled out in ministerial reports were not in themselves the reasons for leaving the apartment. They were triggered by the inability to pay the rent regularly*. This, in turn, could be due to poverty, job loss, low level of education, lack of professional qualifications or deteriorated health. According to Adam Lech, in most cases, we can talk about "individual causes meeting with unfavourable external circumstances, independent of people" (Lech, 2007, p. 70).

Secondly, it is often difficult to determine which events can be considered causes of homelessness and which are factors that perpetuate it. As an example, Anna Duracz-Walczak mentions the situation of people who are unable to manage their own lives due to age, physical and intellectual disabilities, chronic illness (including mental illness), and addiction to mind-altering substances. For them, becoming homeless is intertwined with its consequences (Duracz-Walczak, 2002).

Thirdly, it is worth looking at the reasons for losing one's roof over one's head through the prism of gender. Men predominate in the entire homeless population. In Poland, they account for 80% of people without shelter. This is one of the reasons why most studies focus on the situation of men. There is still a lack of literature on female homelessness, although the topic is increasingly being discussed**. The available analyses show that the causes of homelessness are similar in women and men, but occur with different frequencies. Women usually indicated eviction, as well as experiencing domestic violence and family conflicts (Mikołajczyk, 2018, Bretherton, Mayock, 2021). The abuse of intoxicants (alcohol and drugs) was also common, both by the women themselves, members of their families or other people in their social environment (Choi, Synder, 1999).

Fourthly, the causes of homelessness can change over the years. As Beata Szluz points out, "some of them recede into the background and new ones emerge" (Szluz,

* More examples of the co-occurrence and interdependence of events leading to homelessness can be found, e.g., in the study by M. Oliwa-Ciesielska, *Piętno nieprzypisania: Studium o wyizolowaniu społecznym bezdomnych* [Stigma of non-assignment: Study on the social isolation of the homeless] (Oliwa-Ciesielska, 2004).

** The need to study female homelessness was discussed, among others, during the *Pokonać bezdomność* [Overcoming homelessness] conference, organised on November 27–28, 2023, by the Polish National Federation for Solving the Problem of Homelessness and the Department of Social Prevention and Social Work of the Institute of Pedagogy of the Maria Grzegorzewska Academy of Special Education.

2010, p. 46). This observation applies, for example, to gambling addiction, which was only identified in a ministerial study in 2019 (Ministry of Family, Labour, and Social Policy, 2019).

At this point, it is worth citing analyses of the causes of homelessness in the USA carried out over almost fifty years, between 1970 and 2019. Their authors considered the contents of 80 empirical articles describing the predictors contributing to homelessness in the United States of America. Among other things, they noticed that crime, which was initially recorded very frequently, began to receive increasingly fewer indications over time. Today, the greatest increase has occurred in the use of psychoactive substances (alcohol and drugs), mental illnesses (which include all debilitating illnesses that make daily functioning difficult, including post-traumatic stress disorder PTSD, schizophrenia, psychosis, bipolar disorder, anxiety disorders and depression), as well as unemployment and poverty (low income, job loss, living below average economic standards) (Giano et al., 2020).

Finally, fifthly, the systematic study of the causes of homelessness has important practical applications. The identification of these causes should be used when designing measures to help and prevent homelessness and when shaping adequate social policy (including housing, social assistance and social work).

Cognitive impairment in people experiencing homelessness – cause or effect?

The literature on the subject provides limited information on the health of people without their shelter (Bielerzewska et al., 2011). The few available sources highlight a number of physical ailments and conditions, such as parasitic skin diseases, and ulcers (Dalkowska, Furga, 2023), as well as tuberculosis, hypertension, circulatory failure, digestive system diseases and tumours (Lech, 2007; Chwaszcz, 2008). Studies on mental health in the broadest sense are scarce and in need of updating.

Research carried out by Sławomir Sidorowicz in the late 1990s shows that nearly 90% of homeless people suffered from mental disorders, including mental illness, personality disorders and alcohol addiction (Sidorowicz, 1997). According to Rev Jan Śledzianowski, almost 11% of shelter residents admitted to suffering from mental illnesses, including neurosis, depression, schizophrenia, epilepsy, anxiety, and delusions (Śledzianowski, 2006).

Cognitive disorders, understood as disorders of memory, thinking, orientation, understanding, learning ability or making choices (Bilikiewicz, Matkowska-Białko, 2004) are rarely distinguished as a separate disease entity in the characteristics of homeless people. There are at least three reasons for this. The first is the limited ability of people

without their shelter to use publicly funded health services due to a lack of entitlement (no health insurance). These people also lack the financial means to use commercial medical services. The lack of access to specialists (or sporadic access) makes it difficult to make an accurate diagnosis. This leads to the second reason: dementia-related illnesses are often confused with depression. It has been demonstrated that they can co-occur, be misdiagnosed, or that symptoms of depression can precede the onset of cognitive impairment (Bilikiewicz, Matkowska-Białko, 2004). Thirdly, it happens that people who assess the disorders of homeless clients do not have specialist training (Lech, 2007). This situation may apply, for example, to employees of non-governmental organisations without training in psychiatry or psychopathology. Some studies show that the staff of homeless shelters are mainly social workers and accountants. There is a lack of funds for full-time psychologists, addiction therapists and psychiatrists. Out of 45 facilities surveyed, only four employed a psychiatrist, and the average time the psychiatrist spent working was less than two hours (Bielerzewska et al., 2011).

A review of the literature published abroad provides a slightly broader, but still incomplete, picture of the issue of cognitive impairment among the adult population experiencing homelessness. The term "adult" refers to respondents aged 50 and more. There is no consensus among authors on the age at which homelessness begins. Jay Sokolovsky and Carl Cohen argue that men over 50 who have been experiencing a crisis for years face physical and mental disabilities and complain of health problems, including cognitive impairments, comparable to a group 10 to 20 years older. Furthermore, many of them consider their life to be over. The authors also believe that people aged 50 and over have little chance of overcoming homelessness (Cohen, Sokolovsky, 1989).

The results of various studies indicate that the homeless population is more likely to experience a higher level of cognitive impairment than the general population. In Oakland, it is estimated to be even three to four times higher. Analyses of war veterans show that the incidence of Alzheimer's disease or other dementia was higher in those who were homeless or at risk of homelessness (Booth, Dasgupta, Forchuk, & Shariff, 2024)[*].

Factors leading to cognitive impairment in homeless people include: comorbidities such as vascular diseases, substance abuse (most commonly alcohol), traumatic brain injury, neurodevelopmental disorders, and mental illnesses (Backer, Howard, 2007; Hurstak et al., 2017). At the same time, the impact of adverse life events on the cognitive functioning of people who have lost their homes, for example, due to eviction, is emphasised (Crane, Warnes, 2001). This raises the question of what happens first:

[*] In the United States of America, war veterans are a large, distinct group of people experiencing homelessness, *cf.* Levinson, Ross, 2007.

does homelessness cause cognitive impairment, or does cognitive impairment lead to homelessness?

According to data from the USA, more than half of people experiencing homelessness are over 50 years old. Interestingly, it has been observed that not all of them lost their homes as a result of dramatic family and individual events related to addiction, violence, mental illness, and cognitive impairment. Increasingly, the causes of homelessness, especially among older Americans, can be seen in socioeconomic factors such as inadequate living conditions, little family and community support, and low levels of social security (Piña-Escudero et al., 2021).

However, researchers from Canada have come to different conclusions. Their analyses indicate that mental health and cognitive function disorders were reported in almost half of older homeless men before they experienced homelessness. The most commonly diagnosed disorders included psychotic and affective disorders and dementia. Attention was also drawn to the relatively high percentage (37%) of those who had never been diagnosed before and who, at the time of the exploration, were experiencing both a crisis of homelessness and cognitive impairment. At the same time, changes in the diagnosis of the disease were emphasised. After a six-month hospital stay, more than 36% of patients received a new diagnosis. Initially diagnosed as depression, the condition was eventually identified as cognitive impairment (Joyce, Limbos, 2009).

The question posed in the subtitle of this part of the article is difficult. The research carried out so far has produced contradictory answers. Although the connection between the homelessness crisis and cognitive disorders is visible, it is not possible to clearly indicate which of the conditions is primary to the other. This issue is unlikely to be resolved clearly and conclusively. The life trajectories of people without a roof over their heads are so diverse that there will always be cases that contradict the published statistics.

Homelessness is considered an extremely difficult life situation, a threat to human existence (Podgórska-Jachnik, 2014) and the most severe form of social exclusion (Dobrzeniecki-Łukasiewicz, 2023). In addition to considering the causes, it requires the search for effective solutions to prevent it and limit its effects. This is particularly important in the case of homeless people who also experience disabilities, various types of disorders or addictions.

Support for people in a homelessness crisis and with cognitive disorders

People diagnosed with dementia and other cognitive impairments need adequate and comprehensive support. The most important aspects are shelter or 24-hour care in suitable facilities, as well as psychological and legal support and social work (Drobnik

et al., 2010). This catalogue can be extended to include the relevant social welfare benefits. All these measures seem to be necessary when the aforementioned disorders are accompanied by the experience of homelessness.

In the current welfare system, there are still not enough facilities that provide safe accommodation and access to specialists such as doctors (especially psychiatrists), addiction therapists and nurses at the same time. For several years now, there have been shelters for the homeless with care services. According to the provisions of the *Ustawa z 12 marca 2004 roku o pomocy społecznej* [Act of March 12, 2004, on social assistance], amended in 2023, people who, due to age, illness or disability, require partial, but not 24/7 care and assistance in meeting essential needs (*Obwieszczenie* [Announcement], 2023, art. 48 a.2b). After staying there, the client can live in a social welfare home, but in this case, they cannot stay in the shelter for more than four months. The practice of leaving a homeless shelter and moving to a nursing home is not very common. A report diagnosing the situation of the homeless in Warsaw shows that this was the case for only 1.7% of beneficiaries (*Diagnoza sytuacji osób doświadczających…* [Diagnosis of the situation of people experiencing…], 2022). For those who need 24-hour care, places in care and treatment centres or nursing and care homes will be necessary. This is also not a frequent activity – in 2021, it was noted that in Warsaw, a homeless client was placed in a care and treatment centre or nursing and care home only 12 times (ibid.).

For many years, there have been discussions about different ways of helping people without a roof over their heads. More and more often, voices are criticising the traditional model, the so-called ladder model. It involves the client going through various levels of support: from street work, through night accommodation, hostels, and training flats, to social or council housing. It should be noted that this route is time-consuming and, as a result, discouraging (*cf.* e.g., Olech, 2011).

The amendment to the *Ustawa z 12 marca 2004 roku o pomocy społecznej*, which will come into force on November 1, 2023, includes a provision on the right of people in a homelessness crisis to support in a training or supported flat. This right is also granted to people with mental disorders or those leaving foster care due to age, disability or illness. However, the legislator emphasises that it does not apply to those who require 24-hour care, but only support in their daily functioning. This means that people in a homelessness crisis will not be able to benefit from this form of support if they are experiencing severe dementia symptoms. In training flats, living services, social work and learning to develop or consolidate independence and skills in self-service and social roles in integration with the local community are provided to enable independent living. In supported housing, on the other hand, living services, social work, and assistance in performing activities necessary for daily functioning and realising social contacts are provided to maintain or develop the independence

of the person at the level of their psychophysical abilities. However, the legislator emphasises that supported housing is intended in particular for people with physical disabilities or mental disorders, as well as for the elderly or chronically ill (*Obwieszczenie* [Announcement], 2023, art. 53.1, 53.4–6). It is worth noting that cognitive impairment is not considered a separate condition entitling the applicant to apply for any of the apartments, although it is included in their catalogue. Currently, there are no studies that would present the experiences of customers and specialists in using and organising the described services.

Placing people in a state of homelessness in small-scale accommodation is part of the growing trend of deinstitutionalisation. It also refers to the alternative support method to the hierarchical method, i.e., "housing first" (HF). Such measures were initiated in New York in the 1990s. They involve helping people who are chronically homeless and who also have mental disorders and are addicted to psychoactive substances (so potentially also have cognitive disorders). The assistance includes the client staying in an apartment (not a facility) and 24/7 support from a psychiatrist, doctors of other specialisations, nurses, a career counsellor or a social worker. It should be noted that the client decides the frequency and extent of cooperation with professionals. Studies on the effectiveness of the HF method conducted in the USA and Canada show that people covered by it more often than people in traditional programmes undertook treatment, were less often hospitalised, saw their future positively and were able to maintain a stable housing situation (Olech, 2011). This method is also practised in Poland, although it is not always implemented in the same way as the original. Sometimes access to medical services is limited to one visit per week or the apartments are not fully equipped. However, given the optimistic results from abroad, it is worth testing and developing.

The issue of guaranteeing a safe place to stay while providing specialised support to the homeless and people with cognitive disorders is being discussed and recommended in many countries. In Canada, for example, it is recommended that specialised community care programmes be set up (including strengthening the role of community nurses) to improve the integration of clients into the local community (Daiski, 2007). Anti-stereotyping measures, such as social campaigns, are also necessary. It is important to provide information about the symptoms of dementia on the one hand, and about the fact that homelessness is not a choice on the other. At this point, it is worth referring to the situation in which a person with cognitive impairment leaves home and is unable to return. No data shows the scale of this phenomenon, but such a scenario of becoming homeless seems likely. One way to stop this from happening is for family members or a social services representative to prepare an ICE card (in the form of a chain to wear around the neck, a piece of paper to keep with documents, or the phone number

of a loved one saved in the phone). However, for this to be possible, the person must receive support from their loved ones or be a client of a social services centre.

Preventive measures are also among the tasks and challenges for social workers with clients who are both homeless and cognitively impaired. The aim is to strengthen the role of social workers, community organisers and nurses who can recognise the risk of both developing neurodegenerative disorders and homelessness (e.g., rent arrears). However, they need to be adequately prepared for this. The recognition of cognitive impairment symptoms can also be carried out in shelters for people in a state of homelessness. David P. Joyce and Marjolaine Limbos advocate implementing special programmes for the facilities offered, which would consist of conducting short screening tests (Joyce, Limbos, 2009). They also emphasise the importance of access to primary health care and community-based services.

Some of the measures mentioned go beyond the competencies of a social worker and require cooperation between the healthcare sector and social services (or, more broadly, social policy, including housing policy), with the community,s involvement. Although they may seem difficult, they should be publicised and discussed. Due to demographers' alarming forecasts regarding ageing, there is a risk that their implementation will become urgent and mandatory.

Conclusion

The content of the paper is only a sketch of the rather poorly recognised issue of cognitive impairment among people in the crisis of homelessness. Although there are few scientific studies on the subject, this does not mean that it can be ignored. The ageing of the homeless population, as well as of the entire Polish society, is a fact. It can therefore be assumed that the incidence of dementia will increase. It is, therefore, essential to include it in social policy assistance programmes.

Exploratory studies in Canada and the USA indicate that cognitive impairment prolongs the duration of homelessness and can delay recovery. At the same time, a longer time without a safe, permanent place to live can contribute to the development of dementia symptoms (Hurstak et al., 2017). Polish researchers have also come to a similar conclusion. According to them, a longer period of homelessness increases the likelihood of losing physical and mental health. In addition, after four years in a state of homelessness, the subjective assessment of the health of homeless people deteriorates (Bielerzewska et al., 2011). It is also worth noting that cognitive impairments make it difficult to make decisions, set priorities, plan activities and implement them consistently. For this reason, it is particularly difficult for some clients to navigate the support

structures (social welfare centres, homeless shelters, soup kitchens, counselling centres, clinics) to improve their life situation (Hurstak et al., 2017).

The paper presented is a contribution to the discussion on cognitive disorders among people experiencing homelessness. Further considerations and actions are required to investigate the scale of the phenomenon, to sensitise and prepare the staff of homeless facilities for the initial recognition of disorders, and to clarify cooperation and information exchange between the non-governmental sector, the health service and social welfare organisations.

References

Backer, T. E., Howard, E. A. (2007). Cognitive impairments and the prevention of homelessness: Research and practice review. *The Journal of Primary Prevention*, *28(3–4)*, 375–388. DOI: 10.1007/s10935-007-0100-1.

Bielerzewska, K., Chojnacka, M., Kocyłowska, A., Kruk, M., Sawicka, A., Sochocki, M. J., & Stefaniak-Łubianka, M. (2011). Raport Grupy Eksperckiej ds. Zdrowia [Report of the Expert Group on Health]. In: R. Stenka (Ed.), *Raport z fazy diagnozy: Kondycja i dobre praktyki pomocy ludziom bezdomnym w sześciu obszarach: streetworking, praca socjalna, mieszkalnictwo i pomoc doraźna, partnerstwa lokalne, zdrowie, zatrudnienie i edukacja* (pp. 273–316). Gdańsk: Pomorskie Forum na rzecz Wychodzenia z Bezdomności.

Bilikiewicz, A., Matkowska-Białko, D. (2004). Zaburzenia funkcji poznawczych a depresja [Cognitive impairment and depression]. *Udar Mózgu: Problemy Interdyscyplinarne*, *6(1)*, 27–37.

Booth, R. G., Dasgupta, M., Forchuk, C., & Shariff, S. Z. (2024). Prevalence of dementia among people experiencing homelessness in Ontario, Canada: A population-based comparative analysis. *International Journal of Population Data Science, 9(5)*. DOI: 10.23889/ijpds.v9i5.2482.

Bretherton, J., Mayock, P. (2021). *Women's homelessness: European evidence review*. Brussels: FEANTSA. DOI: 10.15124/yao-3xhp-xz85.

Chabior, A., Fabiś, A., &Wawrzyniak, J. K. (2014). *Starzenie się i starość w perspektywie pracy socjalnej* [Ageing and old age from a social work perspective]. Warszawa: Centrum Rozwoju Zasobów Ludzkich.

Choi, N. G., Snyder, L. J. (1999). *Homeless families with children: A subjective experience of homelessness*. New York: Springer Publishing Company.

Chwaszcz, J. (2008). *Osobowościowe i społeczne wyznaczniki funkcjonowania bezdomnych mężczyzn* [Personality and social determinants of functioning of homeless *men*]. Lublin: Towarzystwo Naukowe Katolickiego Uniwersytetu Lubelskiego Jana Pawła II.

Cohen, C., Sokolovsky, J. (1989). *Old men of the Bowery: Strategies for survival among the homeless*. New York: Guilford Press.

Crane, M., Warnes, A. M. (2001). Older people and homelessness: Prevalence and causes. *Geriatric Rehabilitation*, *16(4)*, 1–14.

Daiski, I. (2007). Perspectives of homeless people on their health and health needs priorities. *Journal of Advanced Nursing*, *58(3)*, 273–281. DOI: 10.1111/j.1365-2648.2007.04234.x.

Dalkowska, B., Furga, A. (2023). Owrzodzenia kończyn dolnych u osób w kryzysie bezdomności [Lower limb ulcers in people experiencing homelessness]. *Probacja*, *3*, 283–300. DOI: 10.5604/01.3001.0053.8643.

Dębski, M. (2008a). Kondycja zdrowotna osób bezdomnych [Health condition of homeless people]. In: M. Dębski, S. Retowski (Eds.), *Psychospołeczny profil osób bezdomnych w Trójmieście* (pp. 233–267). Gdańsk: Uniwersytet Gdański.

Dębski, M. (2008b). Sytuacja osób bezdomnych w województwie pomorskim w *świetle* wyników badań socjodemograficznych [The situation of the homeless in the Pomeranian Voivodeship in the light of the results of sociodemographic research]. In: M. Dębski, S. Retowski (Eds.), *Psychospołeczny profil osób bezdomnych w Trójmieście* (pp. 32–67). Gdańsk: Uniwersytet Gdański.

Diagnoza sytuacji osób doświadczających bezdomności na terenie miasta stołecznego Warszawy [Diagnosis of the situation of people experiencing homelessness in the capital city of Warsaw]. (2022). Retrieved from: https://wsparcie.um.warszawa.pl/problematyka-bezdomnosci-w-warszawie.

Dobrzeniecki-Łukasiewicz, R. (2023). *Bezdomność i bezdomni w opinii społeczeństwa polskiego* [Homelessness and the homeless in the opinion of Polish society]. Warszawa: Wydawnictwo Naukowe PWN. DOI: 10.53271/2023.172.

Drobnik, J., Susło, R., Steciwko, A., Krzesinska-Nowacka, A., Kurpas, D., Sapilak, B., & Muszyńska, A. (2010). Instrumenty zabezpieczenia społecznego osób z chorobami otępiennymi na terenie Dolnego Śląska [Social security instruments for people with dementia in Lower Silesia]. *Family Medicine & Primary Care Review*, *12(1)*, 15–18.

Duracz-Walczak, A. (2002). Przyczyny wchodzenia w bezdomność i pozostawania bezdomnym [Reasons for becoming homeless and remaining homeless]. In: A. Duracz-Walczak (Ed.), *W kręgu problematyki bezdomności polskiej: Praca zbiorowa* (pp. 40–44). Warszawa – Gdańsk: Stowarzyszenie Pomocy Bezdomnym, Regionalne Centrum Informacji i Wspomagania Organizacji Pozarządowych.

Giano, Z., Williams, A., Hankey, C., Merrill, R., Lisnic, R., &Herring, A. (2020). Forty years of research on predictors of homelessness [Czterdzieści lat badań nad predyktorami bezdomności]. *Community Mental Health Journal*, *56(4)*, 692–709. DOI: 10.1007/s10597-019-00530-5.

Główny Urząd Statystyczny [Central Statistical Office]. (2021). *Informacja o wstępnych wynikach Narodowego Spisu Powszechnego Ludności i Mieszkań 2021* [Information on the preliminary results of the 2021 National Population and Housing Census]. Retrieved from: https://stat.gov.pl/spisy-powszechne/nsp-2021/nsp-2021-wyniki-wstepne/informacja-o-wstepnych-wynikach-narodowego-spisu-powszechnego-ludnosci-i-mieszkan-2021,1,1.html.

Hurstak, E., Johnson, J. K., Tieu, L., Guzman, D., Ponath, C., Lee, C. T., Jamora, C. W., & Kushel, M. (2017). Factors associated with cognitive impairment in a cohort of older homeless adults: Results from the HOPE HOME study. *Drug and Alcohol Dependence*, *178*, 562–570. DOI: 10.1016/j.drugalcdep.2017.06.002.

Joyce, D. P., Limbos, M. (2009). Identification of cognitive impairment and mental illness in elderly homeless men: Before and after access to primary health care. *Canadian Family Physician*, *55(11)*, 1110-1111.

Lech, A. (2007). *Świat społeczny bezdomnych i jego legitymizacje* [*The social world of the homeless and its legitimisation*]. Katowice: Wydawnictwo Naukowe Śląsk.

Levinson, D., Ross, M. (Eds.). (2007). *Homelessness handbook*. Great Barrington: Berkshire Publishing Group.

Mikołajczyk, M. (2018). *Rodziny bezdomnych matek: Charakterystyka i działania pomocowe* [Families of homeless mothers: Characteristics and support measures]. Warszawa: Wydawnictwo Akademii Pedagogiki Specjalnej.

Ministerstwo Rodziny, Pracy i Polityki Społecznej [Ministry of Family, Labour, and Social Policy]. (2017). *Ogólnopolskie badanie liczby osób bezdomnych – Edycja 2017* [National survey on the number of homeless people – 2017 edition]. Retrieved from: https://www.gov.pl/web/rodzina/edycja-2017-i.

Ministerstwo Rodziny, Pracy i Polityki Społecznej [Ministry of Family, Labour, and Social Policy]. (2019). *Ogólnopolskie badanie liczby osób bezdomnych – Edycja 2019* [National survey on the number of homeless people – 2019 edition]. Retrieved from: https://www.gov.pl/web/rodzina/edycja-2019-i.

Ministerstwo Rodziny, Pracy i Polityki Społecznej [Ministry of Family, Labour, and Social Policy]. (2024). *Ogólnopolskie badanie liczby osób bezdomnych – Edycja 2024* [National survey on the number of homeless people – 2024 edition]. Retrieved from: https://www.gov.pl/web/rodzina/ogolnopolskie-badanie-liczby-osob-bezdomnych---edycja-2024.

Obwieszczenie Marszałka Sejmu Rzeczypospolitej Polskiej z dnia 7 kwietnia 2023 r. w sprawie ogłoszenia jednolitego tekstu ustawy o pomocy społecznej [Announcement of the Marshal of the Sejm of the Republic of Poland of 7 April 2023 on the publication of the consolidated text of the Social Welfare Act]. (2023). Dz. U. 2023.901.

Olech, P. (2011). Metoda drabinkowa a metoda najpierw mieszkanie w rozwiązywaniu problemu bezdomności [The ladder method versus the housing first method in solving the problem of homelessness]. *Forum o Bezdomności bez Lęku*, *4*, 185–200.

Oliwa-Ciesielska, M. (2004). *Piętno nieprzypisania: Studium o wyizolowaniu społecznym bezdomnych* [Stigma of non-assignment: Study on the social isolation of the homeless]. Poznań: Wydawnictwo Naukowe Uniwersytetu Adama Mickiewicza.

Oliwa-Ciesielska, M., Przymeński, A. (2010). Zapobieganie bezdomności – teoretyczne i praktyczne inspiracje [Homelessness prevention – theoretical and practical inspirations]. *Forum o Bezdomności bez Lęku*, *2*, 75–92.

Piña-Escudero, S. D., López, L., Sriram, S., Longoria Ibarrola, E. M., Miller, B., & Lanata, S. (2021). Neurodegenerative disease and the experience of homelessness. *Frontiers in Neurology*, *11*, 562218. DOI: 10.3389/fneur.2020.562218.

Podgórska-Jachnik, D. (2014). *Praca socjalna z osobami bezdomnymi* [Social work with the homeless]. Warszawa: Centrum Rozwoju Zasobów Ludzkich.

Przymeński, A. (1997). Geografia i skala zjawiska bezdomności w Polsce [Geography and scale of homelessness in Poland]. *Roczniki Naukowe Caritas*, *1*, 29–56.

Sidorowicz, S. (1997). Psychospołeczne aspekty bezdomności [Psychosocial aspects of homelessness]. In: T. Kamiński (Ed.), *Caritas–Bezdomność* (pp. 103–118). Warszawa: Pro Caritate.

Szluz, B. (2010). *Świat społeczny bezdomnych kobiet* [The social world of homeless women]. Warszawa – Rzeszów: Bonus Liber.

Śledzianowski, J. (2006). *Zdrowie bezdomnych* [Health of the homeless]. Kielce – Wrocław: Zakład Profilaktyki Społecznej i Resocjalizacji Akademii Świętokrzyskiej, Towarzystwo Pomocy im. św. Brata Alberta.