ARTICLE

Mental health services for single homeless people

Philip Timms & Jenny Drife

Philip Timms is a consultant psychiatrist at the National Psychosis Unit, Maudsley Hospital, London, UK. He established the first mental health outreach team for homeless people in the UK and worked with another such team – the specialist treatment, assessment and referral team (START) – until 2016. Since then he has worked with Pathway in London and Santé Mentale et Exclusion Sociale (SMES) in Brussels, which are non-governmental organisations (NGOs) promoting better healthcare for homeless people. **Jenny Drife** is a consultant psychiatrist with the START community service (South London and Maudsley NHS Foundation Trust, London), working with rough sleepers. She is also Advisor on Homelessness and Mental Health to the Royal College of Psychiatrists. She has previously worked as an addiction psychiatrist and is particularly interested in coexisting mental health problems and substance misuse.
Correspondence Dr Philip Timms. Email: philip.timms@slam.nhs.uk

First received 21 Apr 2020
Final revision 24 Jun 2020
Accepted 9 Jul 2020

SUMMARY

Homelessness has long been associated with high rates of psychosis, alcohol and substance misuse, and personality disorder. However, psychiatric services in the UK have only recently engaged actively with homeless people. This article provides some background information about homelessness and mental illness and describes the elements of inclusion health and some of the models of service for homeless people that have been established over the past 30 years.

LEARNING OBJECTIVES

After reading this article you will be able to:

- describe the barriers to access to care faced by homeless people and their special needs
- understand some innovative models of service that have been developed within homeless services
- incorporate into your daily practice some of the principles of such services.

KEYWORDS

Homelessness; engagement; assertive outreach; social exclusion; multimorbidity.

Homelessness is again in the news, after 10 years of fiscal austerity and reduced housing, health and social services in the UK. It is clear how these factors might make vulnerable people become homeless. But it is also clear that, even in kinder economic times, homelessness is still associated with mental illness. So, what is the role (if any) of psychiatric services in addressing the needs of homeless people?

What is homelessness?

Homelessness is not just about street homelessness. The Housing Act 1996 declares that you can be considered to *not* be homeless if you have the legal right to sleep where you are sleeping. However, it also states that you can be considered to be homeless even if you have a place to sleep, if:

- you cannot gain access to it
- it is a 'moveable structure' and you have no place to legally put it or legally live in it
- it is unreasonable for you to live there – because it is unfit for human habitation or you are at risk of domestic violence
- it is likely that you will become homeless within 56 days.

In practical terms, this means sleeping:

- without a shelter of any kind, sleeping rough (Ministry for Communities, Housing & Local Government 2018)
- in hostels, shelters, refuges or other temporary circumstances (e.g. in institutions such as prisons or hospitals)
- temporarily with family and friends ('sofa surfing')
- in a property but are threatened with eviction
- in unfit housing or extreme overcrowding.

In fact, anyone who is sleeping in a place where they have no legal right to be and has no other appropriate accommodation to resort to is 'homeless'. Figure 1 gives a rough idea of the size of the problem in England (Morse 2017).

Who is homeless?

Single people, families, refugees, migrants may all find themselves homeless. It is clear that the number of homeless people in the UK has increased steadily over most of the past 10 years, with a recent decrease over the past couple of years. But there are no accurate data concerning the changing demographics of UK homeless populations over this time. Government statistics suggest that the vast majority of single homeless people in England are male and over 26 years of age. In autumn 2019, 64% were UK nationals, 22% EU nationals and 4% non-EU nationals (Ministry for Communities, Housing & Local Government 2019). However, there are local variations – in London, for example, EU nationals seem to have out-numbered UK nationals. In this article we are focusing on the needs of single homeless people, as the needs of homeless children and families are different and deserving of a separate article.

Box 1 lists the causes of homelessness reported by Public Health England (2020).

Of course, the make-up of homeless populations changes over time. In the early 1990s, there were still large numbers of older men housed in the large hostels for homeless. These have all now gone and the experience of specialist homeless

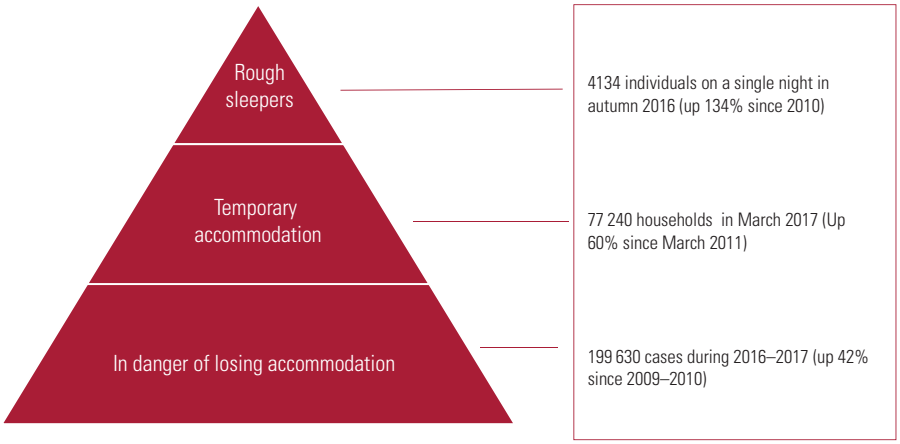

FIG 1 Homelessness in England, 2009–2017 (after Morse 2017: Fig. 1).

teams in London is that they have been seeing increasing numbers of refugees and asylum seekers, although there are no published data to reflect this.

Homelessness and mental health problems

Mental illness

High levels of psychosis have been demonstrated in UK homeless populations over the past 70 years. Psychiatrists started to notice an excess of hospital admissions from homeless hostels, particularly for psychotic illness (Whiteley 1955; Berry 1966). A survey of the population of the Camberwell Reception Centre in south London (Edwards 1968) found that 25% had been admitted to a mental hospital – equal to the proportion of those with alcohol problems, and a challenge to the stereotype of the homeless man as necessarily a drinker. A later survey of a Salvation Army hostel (Timms 1989) found that around one-third of the residents had a psychotic disorder – as did a similar proportion of those seeking admission. An Oxford hostel survey (Marshall 1989) found that hostel residents identified by staff as having a mental health problem of some sort showed disturbed behaviour 'not significantly different from that expected in moderately to severely handicapped psychiatric inpatients' – and almost half had 'scores equivalent to those in most severely handicapped inpatients'.

More recently, a larger survey (Homeless Link 2014) found that 80% of homeless people reported a mental health problem, 48% having received a diagnosis. Levels of psychosis in homeless hostels have, over the years, been around 30%. There have been no recent survey-based estimations of mental health needs in homeless populations in the UK. However, significant numbers of people with schizophrenia continue to become homeless and present to specialist 'homeless' services, in spite of significant contacts with generic mental health services (Timms 2016a).

Substance misuse

Substance misuse is more common among homeless people. Of 186 000 homeless individuals (including those living in temporary accommodation) in England in 2015, approximately half also experienced substance misuse (Bramley 2015). It also seems to be more severe in those who are rough sleeping (Gill 2003). In total, 62% of homeless people assessed in 2018–2019 had a recorded drug or alcohol need (an increase from 22% in 2014–2015), with the change almost entirely due to an increase in drug use (Weal 2020). The use of

BOX 1 Causes of homelessness

Structural factors

- Poverty
- Social inequality
- Housing supply and affordability
- Unemployment or insecure employment
- Problems with access to Social Security benefits

Individual factors

- Poor physical health
- Poor mental health
- Experience of violence, abuse or neglect
- Drug and alcohol problems
- Relationship breakdown
- Experience of care/prison
- Bereavement
- Being a refugee

(Public Health England 2020)

synthetic cannabinoid receptor agonists (SCRAs, or 'spice') is prevalent in some homeless populations (Advisory Council on the Misuse of Drugs 2019), but opiates, crack cocaine and heroin continue to be widely used and to present greater harms (Weal 2020). In England and Wales, opiates (particularly heroin or morphine) are the substances most frequently named in the death certificates of homeless people. Such drug-related deaths increased by 55% between 2017 and 2018.

Homeless people receiving treatment for drug and alcohol problems

In 2018–2019, 9861 people who presented to drug and alcohol services in England were recorded as having 'no fixed abode'. This is the highest number yet recorded, but presentations have not increased as sharply as the number of people sleeping rough who have drug or alcohol problems. As many as 12 000 people may be going without treatment (Weal 2020). Engagement with such services can be difficult – one survey noted that 'homeless people […] are often poor at attending appointments and need flexible approaches' (Advisory Council on the Misuse of Drugs 2018). This survey also suggested that 'hostel-based clinics, assertive outreach and other targeted approaches are effective but need extra resources' – which are lacking. For those with coexisting mental illness and substance misuse, current UK guidance (for all, not just homeless people) is that care may be best provided in a single integrated service. Sequential models, which prioritise one disorder over the other until one is stabilised, are not recommended (Strang 2017). And substance misuse often prevents access to mental health support (Canavan 2012).

Brain injury

Cognitive impairment is underrecognised in homeless populations. A recent Canadian study suggested premature onset of cognitive impairments and accelerated cognitive ageing in homeless people. The authors cited traumatic brain injury and alcohol use as modifiable risk factors (Gicas 2020). Moderate or severe traumatic brain injury appear to be 10 times more common in homeless people compared with the general population. The presence of a traumatic brain injury is associated with poorer self-reported health, higher suicidality and higher rates of contact with health services and the criminal justice system (Stubbs 2020).

Shared antecedents

Rough sleeping, substance misuse and mental health problems have common risk factors. There is a well-documented association between multiple adverse childhood experiences (ACEs) and the likelihood of substance misuse as an adult (Advisory Council on the Misuse of Drugs 2018). Similar associations have been shown in homeless adults (Larkin 2018) and in those with mental illness (Hughes 2017). The higher the count of ACEs, the higher the chance of experiencing three or more 'primary disadvantage domains', such as homelessness, poor mental health, substance misuse and interpersonal violence.

The need for specialist homelessness and mental health services

We know that mainstream services do not effectively address the health problems of homeless people (Canavan 2012). Surveys of homeless populations have consistently demonstrated underuse of psychiatric services.

Barriers are inevitable in a fee-for-service or insurance-based system, but specialist services for homeless people develop even in countries with universal health coverage. And homelessness is dangerous. Around 726 people died while homeless in England and Wales in 2018, with an average age at death of 45 years for men and 43 years for women (Cream 2020).

Barriers to engagement with services

Barriers to engagement can be political, structural problems within services, practitioner attitudes and barriers felt by deprived individuals themselves.

A European study noted little involvement of mental health staff in the care of homeless people, with low levels of active outreach and case finding. Service inclusion criteria often exclude homeless people and services do not, generally, coordinate well with each other (Canavan et al 2012). Other barriers reported by homeless people include (Purkey 2019):

- stigmatising and shaming by health services
- the requirement that housing be obtained before treatment can be started
- a lack of flexibility for patients who show up late or miss appointments
- reluctance to use a harm reduction approach for substance use problems
- general practitioner (GP) services demanding an address as a condition of registering with a GP practice (Burrows 2016).

The fictitious case history in Box 2 shows some of these barriers in action.

Specialist mental health services

Specialist mental health services for homeless people have emerged pragmatically, drawing from assertive

BJPsych Advances (2021), vol. 27, 104–114 doi: 10.1192/bja.2020.54

BOX 2 One narrative of homelessness

John was born in London. His father had mental health problems, but died when John was 5. After that, his mother's drinking got worse and she became unable to look after him. He was put on the at-risk register and sent to live with his grandmother. He never really settled with her, and she found him difficult to handle. After he moved to secondary school, he started playing truant, drinking and using cannabis. His gran could not cope with his behaviour anymore and he was taken into care aged 13. After 6 months he went to live with relatives outside London, who also found him a handful. He was bullied at his new school, started fighting more and was expelled when he was 15, which was the end of his education.

He came back to London to see his old friends, using whatever drugs he could get hold of, and started to inject. He received his first custodial sentence, aged 17, in a young offender institution, when he started to hear voices telling him to harm himself and was found to be positive for hepatitis C. He has since had two admissions to psychiatric hospital, under section 2 of the Mental Health Act 1983, with a diagnosis of 'drug-induced psychosis'. He did not attend the follow-up appointment offered by the community mental health team and was discharged from their service. After another prison sentence, the friends he had been staying with would not have him back, so he found himself sleeping rough at the age of 26. He has tried to register with a GP but has been told that he cannot do so unless he has an address.

outreach practice. But what might be a suitable theoretical model for such services? The notion of 'inclusion health' has been proposed to describe a service model that will address the needs of any socially excluded population – including homeless people.

Inclusion health

This term includes a range of services and policies that aim to prevent and redress health and social inequities among vulnerable and excluded populations (Luchenski 2018). Five themes inform such work: equity, comorbidity, outreach, engagement and multisectoral collaborative working.

Equity

A Welsh GP coined the inverse care law – that disadvantaged populations have less access to health and social services than the more privileged (Tudor 1971). In contrast, the overriding principle of inclusion health is that of equity – that all should have equal access to health services. This is not a value that underpins every healthcare system, but it does seem to be something that most healthcare professionals feel in their bones – whether or not they believe that it is practical or economic.

Comorbidity

For all disadvantaged populations, 'When sorrows come, they come not single spies, but in battalions' (Shakespeare, *Hamlet*, IV, v). Physical and mental health problems coexist with multiple emotional, social and financial problems. So, multiple morbidity – particularly the 'tri-morbidity' of physical health problems, mental health problems and substance misuse – is the norm rather than the exception (McDonagh 2011). This pattern does not fit well with traditional healthcare provision, which (with the honourable exception of general practice) divides practitioners according to the organ or system in which they specialise. So, more inclusive services have tended to be both multidisciplinary and to include non-healthcare personnel.

Outreach

Many surveys have found that, despite high levels of physical and mental pathology, homeless people are less likely to use services. Some view this as a capricious refusal of services, due to the fecklessness of the disadvantaged. But, mysteriously, homeless people appear to be quite happy to use services that are delivered in a less formal way, in or close to their normal environment (Morse 1996).

Engagement

Healthcare providers are often frustrated by the fact that many homeless people seem to find it hard to engage with them, even when doing so would be to their benefit. At the same time, there is little attention given in medical and nursing training to the issue of how you do engage a prospective patient in a therapeutic – that is to say, helpful and supportive – relationship. This seems to be independent of the practical problems described above and has recently been explored within the developing notion of multiple trauma (see 'Trauma-informed care' below).

Multisectoral collaborative working

The multiple deficits that exist in a homeless person's life are not susceptible to a single model of intervention from a single profession or service. So, services for homeless people tend to be particularly cross-sectoral. This type of collaboration is easy in theory but can be difficult in practice. Different sectors will often have conflicting priorities and values, even though their shared aim is an improvement in a person's welfare (Timms 1998).

Practical features of specialist mental health services

Assertive outreach

Assertive outreach services were set up to approach those with severe and enduring mental illness who do not, for whatever reason, engage well with standard services (Seymour 1998). The characteristics of such services are outlined in Box 3. These are similar, but not identical, to the characteristics of homeless mental health services. For example, in the UK, we have never come across a homeless mental health service where workers had a caseload of 10 or fewer. But otherwise this description seems to fit pretty well.

Classic assertive outreach seeks to engage better with those who are not doing well with an existing service. In contrast, specialist homeless services strive to engage with those who have limited or no contact with existing health or social services. Homeless populations generally have high levels of psychosis, so this has been a major focus for outreach. Homeless people with alcohol and personality problems tend to find their way to psychiatric services, those with psychosis do not (Priest 1976). The first major task, therefore, is how to approach the potential patient. And this will depend on the level of outreach – primary, secondary or tertiary.

Primary outreach

A specialist health service approaches and engages directly with a potential patient – on the street, in hostels and night shelters or in day centres. Project Help, in New York, provided such an emergency service (Tsemberis 1993), but reported difficulties. These included little knowledge of the person's history, little or no privacy, unwanted interference from passers-by and, sometimes, agitation and distress on the part of the person concerned. Consequently, such assessments were often mainly observational.

BOX 3 Characteristics of an assertive outreach service for homeless people

- Multidisciplinary – including doctors, nurses and social workers as a minimum, but also with psychologists, housing workers, vocational trainers and peer support workers as necessary
- Case-load of fewer than 10 patients per case worker
- Intensive frequency of patient contact, up to 4 times per week
- Emphasis on engagement and creating a therapeutic relationship
- No time limit on services
- Can provide or access specific evidence-based treatments
- Working with patients in their own environment and with their social network
- A supportive team approach

Secondary outreach

A mental health service works collaboratively with another organisation (usually voluntary sector) that provides direct services to homeless people, such as a street outreach team, a day centre or hostel. That mental health service can then take advantage of the existing relationship between the partner organisation and the homeless person. Such outreach services usually know the person best and can provide a longitudinal perspective on their predicament. And, as they are already known to the homeless person, any approach or assessment can be made less intimidating for the individual. Such collaboration is often long-term, particularly when a street assessment is the culmination of a process of attempted engagement (Barreto 2019).

Tertiary outreach

A specialist mental health facility focusing on homeless people sits within normal hospital structures or clinics. This can work for some, but does tend to select a better-engaged subgroup of homeless people (Tomison 1987).

Accessibility

Barriers to accessibility can be geographical, temporal or cultural. A homeless person will often not be able to travel to a clinic or hospital, so a local service will clearly be more accessible. Extended opening hours or flexible appointment times may be the only way of establishing and maintaining contact – for example a homeless person may only be accessible at their sleeping site, outside normal working hours. Formality (and, sometimes, officiousness) is always off-putting. A less formal approach can help to bridge the social distance that exists between the homeless person and the service provider.

Flexibility

All services strive to be flexible, but this will be constrained by structural limitations – clinic times, availability of senior staff, set working hours, and so on. This may not matter so much for a domiciled population with some flexibility of its own and the resources to get to (sometimes geographically remote) health services. However, those who cannot travel are less likely to use services. And, as mentioned above, registering with a primary care

BJPsych Advances (2021), vol. 27, 104–114 doi: 10.1192/bja.2020.54

provider is still a significant obstacle for homeless people (Burrows 2016).

Integration with other provider systems

This is often problematic. Different agencies are run from different budgets, with different priorities and targets. However, there is some evidence that more integrated services can work better – better even than 'parallel' services which, on paper, deliver the same component of service (McHugo 2004). As already mentioned, sequential models prioritising one disorder over another until each is stabilised are not recommended (Strang 2017). In practice, integrated services remain the exception rather than the rule, so substance misuse continues often to prevent access to mental health support (Canavan 2012). More integrated services are currently being funded by Public Health England and NHS England but have yet to be evaluated.

Generalist/multiprofessional provision

Homeless services are usually generalist in nature. Where multimorbidity is the norm and the individual usually presents with multiple needs of different kinds at a single point in time, it may not be clear which problem needs highest priority. A service provider for homeless people can incorporate other disciplines within a single team, collaborate closely with other agencies or base a range of services at a single geographical location. Importantly, the patient should not have to go from one service to another to get the help that they need. It will also usually be easier for patients to form a trusting relationship with one service rather than several.

Relationship-focused provision

Many homeless people have had poor experience with health services in the past. They may be, at best, ambivalent to the idea of engaging with any such service again. On the other hand, if the service provider can demonstrate that they are a safe and competent presence, then a fruitful relationship can be established – and this seems to improve outcomes (Chinman 2000). The currency of this way of working is time – hence, the benefit of small caseloads.

Use of peer advocates

The use of peer advocates, also called intentional peer support (IPS), was pioneered in the USA and The Netherlands but has recently become a feature of some services in the UK (Barker 2017).

Unique characteristics of specialist mental health services for homeless people

Many mainstream services would see themselves as working in the ways described above. So, what makes homeless services different? There is surprisingly little discussion of this in the literature but, to us, certain characteristics stand out, more by emphasis than by absolute difference.

Continuity

The continuous-relationship model (Morse 1996) describes a service that is continuous from the point of first contact, on the street or in some other homeless milieu, to the point where the individual has moved into settled accommodation and so can be safely referred to a mainstream service. This eliminates the need for changes in team as a person moves from the street to temporary accommodation and then to permanent accommodation. But it does run against the recent trend for increasingly specialist services, strung together in flow diagrams as 'pathways'.

Relationship-building

Relationship-building is the establishment and maintenance of a trusting and meaningful relationship between outreach worker and patient. This has been described in five stages:

- establishing contact and credibility
- identifying people with mental illness
- engaging
- carrying out assessments and treatment planning
- maintaining a longer-term, continuing service.

Practical and psychological tasks are involved when a worker establishes themselves – and their team – as a safe, helpful presence in the person's life. At first, their emphasis will be on sorting out basic, practical problems for the person, while demonstrating their reliability and safety. This is done through turning up on time, listening, not promising more that the worker or team can offer, trying to attend to the patient's priorities, as far as possible, and not meeting rejection with defensiveness or 'retaliatory' rejection. Other issues include:

- the apparently paradoxical task of accommodating dependency needs, while helping the person to become more independent
- setting clear and firm limits, while maintaining flexibility
- acknowledging and dealing with the refusal or avoidance of assistance and treatment – without rancour or rejection (Kuhlman 1994: pp. 51–74).

Critical time intervention

A New York initiative (Susser 1997), critical time intervention (CTI) provided extra input for homeless people with mental illness moving from one form of accommodation to another – usually from a large night shelter to a single-room occupancy hotel. This reduced the drop-out rate from services (and nights spent homeless) by two-thirds. Gains over the control group were maintained over the 18 months following the withdrawal of the CTI service.

One might argue that this is simply good practice anyway, but doing it in a planned and structured way did seem to make a significant difference. It involved home visits, individual support, support for caregivers, and negotiation and mediation with caregivers when problems arose. Formal handovers to local agencies were negotiated and the process lasted between 7 and 9 months. Case-loads were typically held at 15 or fewer. This meant that the individual could establish a new network of dependent relationships so that the withdrawal of the original service provider, with its attendant dependencies and support, would have less impact.

Some new models of service

Housing First

Housing First is not a specifically psychiatric intervention, although it was originated by a Canadian psychologist (Tsemberis 2010). It turns on its head the usual approach to rehousing vulnerable and homeless individuals, where first-stage accommodation usually has to be shared and has often been of low quality – such as night shelters or hostels – and the individual has to 'earn' access to more independent accommodation.

It offers permanent housing, in a single step, to homeless individuals and families without any preconditions to entry, such as not drinking, accepting treatment or otherwise participating in rehabilitation or treatment regimes. Treatment goals are developed with the individual once they have moved into their accommodation. Supportive services (such as mental health, alcohol and substance misuse services) are offered to the newly housed individual, to address those problems that had initially led to their homelessness.

Psychologically informed environments

Psychologically informed environments (PIEs) are a new model of psychological service that has recently emerged from the homeless sector and the Royal College of Psychiatrists (Johnson 2011). It seeks to address the high levels of psychological disturbance (not just mental illness) in the various settings in which homeless people are served and housed. And it does this by introducing psychological expertise to such environments. Both individual and group therapy are offered. Staff are encouraged to practice reflectively, with regular staff meetings with a psychologist. An online guide is available to facilitate the development of such projects (Department of Communities and Local Government 2012).

Trauma-informed care

Homeless people and those with mental health problems are both more likely to have had (often multiple) traumas early in their lives. On top of this, homelessness itself can be traumatic, and being homeless increases the risk of further victimisation and trauma. As a consequence, many homeless people find it hard to engage with services because of a lack of trust and the rekindling of previous traumatic experiences. Problems with managing emotions and adhering to social norms can create difficulties after a move to settled housing, where closer contact with other people is unavoidable. Trauma-informed care (TIC) is not a separate 'therapy' but seeks to embed an awareness of these issues in a range of services, from mental health to housing (Hopper 2010).

Enhanced access to psychotherapy

The LifeWorks project in London provided psychodynamic psychotherapy services to homeless people under the umbrella of a voluntary sector housing provider (Cockersell 2018). These services were provided in GP surgeries, offices and day centres. Accessibility was maximised by the absence of any criteria apart from the desire to come to therapeutic sessions. Outcomes seem to have been good – including reduced use of emergency services – and it even appears to be economically effective.

For people still sleeping out, or not engaged with other housing services, a 'pre-treatment' approach (Conolly 2018) has provided a twice-weekly drop-in service at a specialist GP surgery for homeless people. This provides the basic elements of any sort of therapy – safety, a trusting relationship, speaking the same language and establishing clear boundaries. These tentative, 'getting to know each other' contacts can then progress to more formal psychotherapy sessions.

Enhanced capacity assessments and compulsory admission to hospital

Most services for homeless people aim to increase access to services and reduce social exclusion, with the active participation of the individual concerned. However, these individuals sometimes refuse services offered – and thereby imperil their health,

BJPsych Advances (2021), vol. 27, 104–114 doi: 10.1192/bja.2020.54

their safety and (occasionally) the safety of others. Workers are faced with a dilemma. Do they compromise the person's immediate autonomy, for instance by involuntary hospital admission? Or continue to try to promote engagement with services (Rowe 2001), even when such an approach has failed over many months?

Legislation that regulates mandatory hospital admission, such as the Mental Health Act 1983, requires that signs and symptoms of mental disorder must be identified to justify such an infringement of ordinary liberties. However, outreach teams have noted that such symptoms can be hard to elicit on the street. Consequently, individuals who seem to have an obvious impairment (at least, to those who know them best) do not get the assessment and treatment they need.

One way ahead may be to change the focus from symptoms to whether the individual has the capacity (as defined in the Mental Capacity Act 2005) to make an informed choice – such as a decision to refuse services or to stay on the street. A capacity assessment can be used to assess whether a person is able, or unable, to make such a choice. It does not replace an assessment of symptoms but complements it. If capacity is compromised regarding a vital decision concerning health and well-being, this should be considered as significant evidence in the assessment for involuntary hospital admission. A consortium of agencies in London has established guidance in this area for non-medical and medical workers (Clowes 2017).

Effectiveness of specialist services

There is evidence for the effectiveness of specialist services, even though outcomes are usually assessed using proxy measures rather than direct assessments of mental state or functionality.

Assertive outreach

Assertive outreach has not been shown to be clearly advantageous for general UK community populations (Weaver 2003), possibly owing to lack of fidelity to the model and comparison services already having some of the characteristics of assertive outreach teams. However, the primary outcome measure of such studies was usually hospital admission. They did manage to show significant improvements in secondary measures, such as engagement. And this may well pay off in work with homeless people. A randomised study in the USA (McBride 1998) found that homeless people who received assertive community treatment seemed to gain accommodation more quickly than those who received case management, out-patient treatment or services from a drop-in centre. Help with finding and maintaining housing was especially predictive of less time spent homeless.

Another US study (Lehman 1999) found that assertive community treatment for homeless people was both more cost-effective than a standard service and 'significantly more effective in producing more days of stable housing […] at significantly lower in-patient and emergency room costs and significantly higher out-patient costs'. The balance of cost shifted from hospital to community services.

What is the effect of a specialist community team on hospital admissions?

A UK study compared hospital admissions of homeless people in Birmingham before and after the introduction of a specialist community mental health team for homeless people (Commander 1997). The number of admissions remained much the same. The team felt that they had prevented many admissions, but there was a much higher rate of compulsory admission. One possibility was that the team was identifying people with severe mental illness on the street who had previously been overlooked. The rate of follow-up post-discharge was significantly higher – but it was usually done by the homeless team itself.

Does admission to hospital help?

In spite of a therapeutic pessimism noted by many of those who work in this area, a number of small studies have demonstrated the effectiveness of psychiatric interventions in homeless populations. An early London study (Graham 1999) noted such pessimism. Staff believed that 'admission would be difficult, the psychiatric outcome poor and that people would return to the streets soon after discharge'. However, over 90% of those with psychosis were able to remain in touch with mental health teams – admittedly, the small sample ($n = 12$) meant that all this could be was a proof of principle. But, overall, it was a glimmer of hope in an area deemed hopeless.

Another small study ($n = 24$) at Bellevue Hospital in New York (Caro 1993) showed significant symptom reduction between admission and discharge from hospital. Again, the view was pessimistic: 'Homeless people frequently make choices to refuse medication and psychotherapy, in a world where most people cannot be trusted'. This highlighted a problem that would only start to be formally addressed with the introduction of trauma-informed care (see below).

In 2016, the specialist treatment, assessment and referral team (START) in London (Timms 2016b) looked at 37 consecutive compulsory hospital admissions from the street. A year later, 75% of

MCQ answers
1 a 2 d 3 b 4 e 5 c

those detained and treated were still in touch with psychiatric services, 70% were still in accommodation and most were now registered with a GP. Proxy measures to be sure, but significant ones. Two problems were noted. A small number of patients were admitted twice because, on the first occasion, the ward staff did not view them as being sufficiently mentally ill. The notion that homelessness is a 'lifestyle choice' was sometimes invoked. And, as in Birmingham, it proved difficult to refer patients on to local services.

Housing First

Effectiveness studies were built into the Housing First model from the start. These have demonstrated that, compared with a conventional rehabilitation pathway, homeless people with mental health problems who received Housing First assistance spent less time in hospital, and less time homeless, than those offered a conventional 'ladder-type' rehabilitation service (Gulcur 2003). Some concerns were voiced that the comparison services in such studies were unlike those in the UK and Europe. In Finland, their homelessness services already included supported housing and floating support – which reflected UK practice – and were already seen to be effective. They used Housing First in a niche role, replacing emergency shelter accommodation in which homeless people with complex needs had tended to stay for long periods of time. So, they used the Housing First model as an adjunct to existing effective services (Pleace 2017), not as a replacement for them. A recent nuanced report looking at how this works in a UK context suggests that, although it does not work for everybody, Housing First offers some advantages over more conventional models of rehousing (Pleace 2019).

Prevention

The principal drivers of homelessness are outside the control of mental health services. However, tertiary prevention is something they can do. A London homeless service found that 60% of its referrals had had previous contact with the local National Health Service (NHS) mental health trust (Timms 2016a). Moreover, the majority had had significant contacts with local psychiatric services. This suggests that there are significant problems with the follow-up care offered by mainstream services – and that this could be a useful focus for quality improvement.

What doesn't work?

An early review (Hopper 1990) found that many services would screen and identify mentally ill homeless persons – and then provide referrals, but with little other help. These services proved ineffective. Signposting is alluring because it seems to be both cheap and to make good use of existing resources. But, unsurprisingly, it often does not work well for homeless people (Hopper 1990). The offer of advice/signposting assumes that the homeless person has the necessary resources to take advantage of this information – and often they do not.

Conclusions

Homeless people tend to have several concurrent and interacting physical, mental and social problems, and find it hard to access appropriate services. Psychosis and substance misuse are far more prevalent than in the general population. Psychiatric services for homeless people have pioneered versions of assertive outreach, psychological initiatives, joint working with voluntary sector services and relationship-focused practice – and have demonstrated effectiveness. These technical innovations have been combined with an acute awareness of the reality and impact of social exclusion, and a commitment to inclusion health. The recent response to the COVID-19 pandemic in the UK has shown that we can get homeless people off the streets if we really want to. Health, housing and Social Services have worked together, like never before. If this crisis can stimulate the incorporation of inclusion health principles into our mental health services, both housed and homeless people will stand to gain.

Author contributions

Both authors collaborated in planning the overall shape of the article. P.T. wrote the section on new services; J.D. wrote the section on comorbidities and drug and alcohol problems. Both authors participated in the final editing and agree to be accountable for the accuracy and integrity of the work.

Declaration of interest

None.

ICMJE forms are in the supplementary material, available online at https://doi.org/10.1192/bja.2020.54.

References

Advisory Council on the Misuse of Drugs (2018) *What Are the Risk Factors which Make People Susceptible to Substance Misuse Problems and Harm? (Vulnerability and Drug Use Report)*. Home Office (https://www.gov.uk/government/publications/vulnerabilities-and-substance-use-acmd-report).

Advisory Council on the Misuse of Drugs (2019) *Drug Related Harms in Homeless Populations and How They Can Be Reduced*. Home Office (https://www.gov.uk/government/publications/acmd-report-drug-related-harms-in-homeless-populations).

Barker SL, McGuire N (2017) Experts by experience: peer support and its use with the homeless. *Community Mental Health Journal*, **53**: 598–612.

Barreto E, Bento A, Leonori L, et al (2019) *Dignity and Well-Being: Practical Approaches to Working with Homeless People with Mental Health Problems*. SMES Europa.

Berry C, Orwin A (1966) 'No fixed abode': a survey of mental hospital admissions. *British Journal of Psychiatry*, **112**: 1019–25.

Bramley G, Fitzpatrick S, Edwards J, et al (2015) *Hard Edges: Mapping Severe and Multiple Disadvantage*. Lankelly Chase Foundation.

Burrows M, Edgar R, Fitch (2016) *More Than a Statistic: A Peer-Led Consultation with People Experiencing Homelessness for the London Homeless Health Programme*. Healthy London Partnership.

Canavan R, Barry MM, Matanov A, et al (2012) Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. *BMC Health Services Research*, **12**: 222.

Caro Y, Nardacci D, Silbert H et al (1993) Hospital assessment. In *Intensive Treatment for the Homeless Mentally Ill* (eds S Katz, D Nardacci & A Sabatini). American Psychiatric Press.

Chinman MJP, Rosenheck R, Lam JA (2000) The case management relationship and outcomes of homeless persons with serious mental illness. *Psychiatric Services*, **51**: 1142–7.

Clowes E, Timms P, Bax A, et al (2017) *Mental Health Service Assessments for Rough Sleepers: Tools and Guidance: Tools and Guidance*. Pathway.

Cockersell P (2018) Applying psychology as a response to the impact of social exclusion. In *Social Exclusion, Compound Trauma and Recovery: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs* (ed P Cockersell). Jessica Kingsley Publishers.

Commander M, Odell S, Sashidharan S (1997) Psychiatric admission for homeless people: the impact of a specialist community mental health team. *Psychiatric Bulletin*, **21**: 260–3.

Conolly J (2018) Pre-treatment therapy approach for single homeless people. In *Social Exclusion, Compound Trauma and Recovery: Applying Psychology, Psychotherapy and PIE to Homelessness and Complex Needs* (ed P Cockersell). Jessica Kingsley Publishers.

Cream J, Fenney D, Williams E, et al (2020) *Delivering Health and Care for People Who Sleep Rough – Going Above and Beyond*. King's Fund.

Department of Communities and Local Government (2012) *Psychologically Informed Services for Homeless People: Good Practice Guide*. DCLG (https://www.pathway.org.uk/wp-content/uploads/2013/05/Psychologically-informed-services-for-Homeless-People.pdf).

Edwards G, Williamson V, Hawker A, et al (1968) Census of a reception centre. *British Journal of Psychiatry*, **114**: 1031–9.

Gicas KM, Jones AA, Thornton AE, et al (2020) Cognitive decline and mortality in a community-based sample of homeless and precariously housed adults: 9-year prospective study. *BJPsych Open*, **6**: e21.

Gill B, Meltzer H, Hinds K (2003) The prevalence of psychiatric morbidity among homeless adults. *International Review of Psychiatry*, **15**: 134–40.

Graham ZC, Salton-Cox FS, White PD (1999) The outcome of rough sleepers with mental health problems admitted to a psychiatric ward. *Psychiatric Bulletin*, **23**: 164–6.

Gulcur L, Stefancic A, Shinn M, et al (2003) Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in Continuum of Care and Housing First programmes. *Journal of Community and Applied Social Psychology*, **13**: 171–86.

Homeless Link (2014) *The Unhealthy State of Homelessness: Health Audit Results 2014*. Homeless Link.

Hopper K, Mauch D, Morse G (1990) *The 1986–1987 NIMH-Funded CSP Demonstration Projects to Serve Homeless Mentally Ill Persons: A Preliminary Assessment*. National Institute of Mental Health.

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

Hughes K, Bellis MA, Hardcastle KA, et al (2017) et alThe effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health*, **2**: e356–66.

Johnson R, Haigh R (2011) Social psychiatry and social policy for the 21st century: new concepts for new needs – the 'Enabling Environments' initiative. *Mental Health and Social Inclusion*, **15**: 17–23.

Kuhlman T (1994) *Psychology on the Streets: Mental Health Practice with Homeless Persons*. John Wiley & Sons, pp. 51–74.

Larkin H, Lee E, Esaki N, et al (2018) The effects of protective factors and adverse childhood experiences on behavioral health services use: findings from a population-based sample. *Social Work in Health Care*, **57**: 548–62.

Lehman AF, Dixon L, Hoch JS, et al (1999) Cost-effectiveness of assertive community treatment for homeless persons with severe mental illness. *British Journal of Psychiatry*, **174**: 346–52.

Luchenski S, Maguire N, Aldridge RW, et al (2018) What works in inclusion health: overview of effective interventions for marginalised and excluded populations. *Lancet*, **391**: 266–80.

Marshall M (1989) Collected and neglected: are Oxford hostels for the homeless filling up with disabled psychiatric patients? *BMJ*, **299**: 706–9.

McBride TD, Calsyn RJ, Morse GA, et al (1998) Duration of homeless spells among severely mentally ill individuals: a survival analysis. *Journal of Community Psychology*, **26**: 473–90.

McDonagh T (2011) *Tackling Homelessness and Exclusion: Understanding Complex Lives*. Joseph Rowntree Foundation.

McHugo GJ, Richard R, Bebout RR, et al (2004) A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin*, **30**: 969–82.

Ministry for Communities, Housing & Local Government (2018) *Guidance – Homelessness Data: Notes and Definitions*. GOV.UK.

Ministry for Communities, Housing & Local Government (2019) *Rough Sleeping Snapshot in England: Autumn 2019*. GOV.UK (https://www.gov.uk/government/publications/rough-sleeping-snapshot-in-england-autumn-2019/rough-sleeping-snapshot-in-england-autumn-2019).

Morse GA, Calsyn RJ, Miller J, et al (1996) Outreach to homeless mentally ill people: conceptual and clinical considerations. *Community Mental Health Journal*, **32**: 261–74.

Morse A (2017) *Homelessness (Report by the Comptroller and Auditor General 13 September 2017) (HC 308)*. National Audit Office.

Pleace N (2017) The action plan for preventing homelessness in Finland 2016–2019: the culmination of an integrated strategy to end homelessness? *European Journal of Homelessness*, **11**(2): 1–21.

Pleace N, Bretherton J (2019) *The Cost Effectiveness of Housing First in England*. Housing Link.

Priest RG (1976) The homeless person and the psychiatric services: an Edinburgh survey. *British Journal of Psychiatry*, **128**: 128–36.

Public Health England (2020) *Health Matters: Rough Sleeping*. GOV.UK (https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping#rough-sleeping-and-its-causes).

Purkey E, MacKenzie M (2019) Experience of healthcare among the homeless and vulnerably housed a qualitative study: opportunities for equity-oriented health care. *International Journal for Equity in Health*, **18**: 101.

Rowe M, Frey J, Bailey MSW, et al (2001) Clinical responsibility and client autonomy: dilemmas in mental health work at the margins. *American Journal of Orthopsychiatry*, **71**: 400–7.

Seymour E (1998) *Keys to Engagement: Review of Care for People with Severe Mental Illness who are Hard to Engage with Services*. Sainsbury Centre for Mental Health.

Strang J, Independent Expert Working Group (2017) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. Department of Health.

Stubbs JL, Thornton AE, Sevick JM, et al (2020) Traumatic brain injury in homeless and marginally housed individuals: a systematic review and meta-analysis. *Lancet Public Health*, **5**: e19–32.

Susser E, Valencia E, Conover S, et al (1997) Preventing recurrent homelessness among mentally ill men: a 'critical time' intervention after discharge from a shelter. *American Journal of Public Health*, **87**: 256–62.

Timms PW, Fry AH (1989) Homelessness and mental illness. *Health Trends*, **21**: 70–1.

Timms P (1998) Partnership and conflict: working relationships between voluntary and statutory agencies providing services for homeless people. In *Housing: Participation and Exclusion. Collected Papers from the Socio-Legal Studies Annual Conference* (ed D Cowan). Routledge.

Timms P, Craig TKJ (2016a) Deinstitutionalisation, imprisonment and homelessness (letter). *BJPsych*, **209**: 349–50 (doi: 10.1192/bjp.209.4.349a).

Timms P, Perry J (2016b) Sectioning on the street – utility or futility? *BJPsych Bulletin*, **40**: 302–5.

Tomison A (1987) Rootlessness and mental disorder. *British Journal of Clinical and Social Psychiatry*, **5**: 5–8.

Tsemberis S, Cohen NL, Jones RM (1993) Conducting emergency psychiatric evaluations on the street. In *Intensive Treatment of the Homeless Mentally Ill* (eds SE Katz, D Nardacci, A Sabatini). American Psychiatric Press.

Tsemberis S (2010) Housing first: ending homelessness, promoting recovery, and reducing costs. In *How to House the Homeless* (eds IG Ellen, B O'Flaherty): 37–56. Russell Sage Foundation.

Tudor HJ (1971) The inverse care law. *Lancet*, **297**: 405–12.

Weal R (2020) *Knocked Back: Failing to Support People Sleeping Rough with Drug and Alcohol Problems is Costing Lives*. St Mungo's.

Weaver T, Tyrer P, Ritchie J, et al (2003) Assessing the value of assertive outreach: qualitative study of process and outcome generation in the UK700 trial. *BJPsych*, **183**: 437–45.

Whiteley JS (1955) Down and out in London: mental illness in the lower social groups. *Lancet*, **2**: 608–10.

MCQs

Select the single best option for each question stem

1 Between 2010 and 2018 the number of street homeless people in the UK:

a more than doubled
b remained the same
c reduced slightly
d reduced by half
e tripled.

2 A person cannot be considered homeless if they are:

a sleeping out, on the street or in a park
b about to be released from prison, without accommodation to go to
c sleeping on a friend's floor
d able to access to accommodation to which they have a right to access
e a patient in hospital, without accommodation to go to.

3 As regards mental health services for homeless people:

a it is not possible to perform a Mental Health Act assessment on the street
b there is a wide network of voluntary sector agencies engaged with street homeless people
c psychiatric patients do not subsequently become homeless
d psychological services cannot be offered to homeless people
e discharge, from a ward, to the local homeless persons' unit is an effective way of addressing a patient's housing problems.

4 As regards homeless people:

a homelessness among people with psychosis is often a lifestyle choice
b work with homeless people can be effectively limited to office hours
c voluntary sector agencies provide little input to the mental healthcare of homeless people
d the outcome for the treatment of psychosis in homeless people is poor
e primary care can be hard to access for homeless people.

5 As regards mental health work with homeless people:

a multi-agency working is not necessary
b signposting is an effective way of using limited resources
c a capacity assessment is often necessary in Mental Health Act assessments of homeless people
d the best place to assess a homeless person is on an in-patient ward
e multimorbidity is unusual in homeless populations.

BJPsych Advances (2021), vol. 27, 104–114 doi: 10.1192/bja.2020.54