Mental Health

January 2022

What Works
Evidence Notes

06 Mental Health

Evidence from across the world on solutions to homelessness
What Works Evidence Notes
This series draws together research evidence from across the world of what we know about how best to relieve and prevent homelessness.
The notes are deliberately short to provide a summary for busy people of findings of research from different fields. They will be updated regularly as our knowledge of what works advances.

About the Centre for Homelessness Impact
The Centre for Homelessness Impact champions the creation and use of better evidence for a world without homelessness. Our mission is to improve the lives of those experiencing homelessness by ensuring that policy, practice and funding decisions are underpinned by reliable evidence.

Written by Guillermo Rodriguez-Guzman, Sarah Argodale, Nick Bartholdy and Tim Gray

January 2022

What Works Evidence Notes

Topics in this series:

01 Drugs and Alcohol
02 Prevention
03 Welfare and Single Homelessness
04 Immigration Status
05 Employment
06 Mental Health
07 Institutional Discharge
08 Legislation

Evidence from across the world on solutions to homelessness
Purpose

This paper looks at the evidence around the relationship between homelessness and mental health, with a focus on street homelessness and single homelessness. In addition to looking at statistical and research evidence on the links between homelessness and mental health, this paper examines evidence on the effectiveness of various approaches to treatment and prevention of mental health problems amongst people experiencing homelessness. The paper goes on to identify some areas where further research or changes in approach are needed.

Overview

Most studies in the UK and abroad show that people experiencing street homelessness have much higher rates of mental ill health than the general population. There is also evidence that children living in temporary accommodation are at greater risk of developing mental health problems which may be long lasting.

Timely access to mental health services can be problematic for people experiencing homelessness and particularly for those living on the streets, especially if they also experience problematic substance use. Any treatment of mental illness for people experiencing homelessness must involve provision of safe, stable accommodation. However, for some people, housing alone is insufficient to resolve mental health issues.

The evidence to date is not clear that existing approaches such as Psychologically Informed Environments, Trauma Informed Care, Cognitive Behaviour Therapy or Intensive Case Management are reliably more effective than other standard support at improving the mental health of people who have experienced homelessness. This gap suggests the need to develop and test other approaches. In addition, it will be crucial to test better ways to screen people’s risk of developing mental health problems as this will help practitioners provide the right support to those who need it. Such screening could be done for cohorts including people sleeping out for the first time, children in temporary accommodation, victims of domestic abuse and hostel residents.

Research evidence does suggest that some models of integrated support can be effective at improving outcomes for people. For example, there is some evidence supporting the effectiveness of Community Engagement and Planning (CEP), which involves a coalition approach to planning, co-leading, and monitoring training and implementation. This intervention can reduce poor mental health-related quality of life.

The Challenge: key issues and recent trends

An overview of studies’ conducted in seven western countries including the UK showed that prevalence of diagnosed mental health problems are higher among people experiencing homelessness, with 12.7% having a psychotic illness, 11.4% having major depression and 23.1% having a personality disorder, among other diagnoses. A recent Scottish study looking at the relationship between homelessness and health showed that someone experiencing homelessness has 5 to 20 times more mental health admissions than someone not experiencing homelessness. This compares with UK data suggesting that fewer than 1% of the general population has a psychotic mental health illness2, with about 4% reporting post-traumatic stress disorder (PTSD) and 3% with diagnosed depression.3

People experiencing homelessness are also more likely to have co-occurring mental health, physical health and substance use issues which result in an increased risk of mortality.4

In the UK there is evidence that children who have lived in temporary accommodation5 for over a year are three times more likely to have mental health problems, including depression and anxiety, compared to their peers.

4 Tweed, E. et al. (2021). Health of people experiencing co-occurring homelessness, imprisonment, substance use, sex work and/or severe mental illness in high-income countries: a systematic review and meta-analysis. J Epidemiol Community Health. 75.
Recent trends
Mental health is the most common support need for those who approach local authorities for homelessness assistance. For example, in Q2 2021 in England, 26% of the households owed a prevention or relief duty reported a mental health need. This proportion has been slowly rising each quarter since in Q2 2018 when 22% reported a mental health support need. Homelessness data from Scotland also shows an increase in mental health needs. In 2011, 13% of those assessed as homeless or threatened with homelessness had a mental health need and in 2021, that figure was 27%.

Mental health support needs are even greater for those experiencing street homelessness. For example, CHAIN data recording street homelessness in London for Q2 2021 shows that 30% of those who were new to the streets had mental health needs, compared to 41% of people who were intermittently street homeless and 49% of those who were living on the streets, showing how the prevalence of mental ill-health is higher among those experiencing homelessness for longer.

This CHAIN data focuses mostly on more extreme types of mental illness, so the prevalence of mental health vulnerabilities is considerably higher once other conditions like depression are included. Findings from the Rough Sleeping Questionnaire (RSQ) suggested that more than 8 in 10 people sleeping out had a mental health support need. Anxiety and depression are the most common conditions among this group (close to 70%); but other conditions such as PTSD, psychosis and bipolar disorder are also common.

Access to Support
Experiencing homelessness can make accessing mental services much more difficult. While 85% of respondents to the RSQ indicated they were registered with a GP that does not mean they were receiving adequate treatment. In the same survey, only 29% of those who indicated they had mental needs had received mental health services within the last three months. Common barriers include:

- The availability of specialist support at the right time (and place): Local authority housing options services attempting to get mental health services for people experiencing homelessness often report that they struggle to achieve this, owing to the overstretched nature of mental health services in many areas or the stigma associated with street homelessness.
- Access to adult social services for people experiencing homelessness with care needs, especially if there is the potential for disputes between local authorities about where an individual is ‘ordinarily resident’ for the purposes of the Care Act 2014, or is resistant to seeking help.
- Care pathways are often narrowly focused on single issues, making it harder for someone with multiple diagnoses to access the appropriate services, often requiring people to address one of their needs before being eligible to receive the support they need in another area. This can often lead to people with mental health and substance abuse issues receiving treatment for neither.

The common requirement to stop using substances before engaging with mental health services has been identified as one of the key deficiencies in the homelessness system. This echoes findings from surveys indicating that people who experience homelessness and have multiple needs are often bounced around between care services, being told to address their mental health issue before their substance abuse or vice versa.

---

6 Department for Levelling Up, Communities and Housing. (2021) Homelessness statistics.
8 Requested from St Mungo’s CHAIN data
9 The Rough Sleeping Questionnaire is conducted by the Department for Levelling Up, Housing and Communities in Local Authorities across England: Department for Levelling Up, Housing and Communities. (2020). Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England.
What we know about what works

1. Housing

An obvious way of improving or maintaining someone’s mental health and wellbeing is to ensure they are adequately housed. Systematic reviews on the health effects of improvements in an individual’s housing situation suggest a promising impact on self-reported physical and mental health, as well as perceptions of safety, crime and social and community participation.

For people experiencing homelessness who have higher support needs, the evidence is more mixed, but better housing outcomes have been shown to decrease the prevalence of symptoms associated with some mental disorders. A CHI review found that accommodation-based interventions with moderate and high support improved health outcomes (including mental health) in comparison to no-intervention but these impacts were considerably smaller than those observed for housing stability. But some individual studies looking specifically at mental health did see long-term improvements in mental health associated with better housing: After being housed for three years, people showed reductions in mood disorders (from 20% to 12%), in anxiety disorders (11% to 5%) and substance use (70% to 55%), although levels of psychotic disorder reductions in mood disorders (from 20% to 12%), in anxiety disorders (11% to 5%) and substance use (70% to 55%), although levels of psychotic disorder remained stable.

2. Integrated Services

Joint mental health and housing services are reported as superior to mental health care alone. A systematic review reported that mental health support with housing had an effect size of 0.67 for a housing outcome. This compared with an effect size of 0.47 for Assertive Community Treatment (ACT), a case management approach which employs a multidisciplinary team to support an individual. Among those with serious mental illness, Community Engagement and Planning (CEP), a coalition approach to plan, co-lead, and monitor training and implementation, reduced poor mental health-related quality of life but not depression after 12 months. Authors believe factors that contributed to CEP’s success included multi-sector collaboration, task sharing, relationship building across sectors, and building staff knowledge and capacity to work with those with mental illness.

3. Early years

Intervening to prevent mental health problems in childhood is a key opportunity. A global review found that the onset of the first mental disorder occurs before age 18 in almost half (48%) of individuals, and these are a risk factor for adult mental disorders. A range of impacts across the life course can be averted through both prevention and early treatment of mental disorders.

This raises particular concerns about the quality of life for children of families experiencing homelessness and living in temporary accommodation, who may experience overcrowding, disruption to education, poor housing conditions, and insecurity, leading to a deterioration in their mental health.

4. Primary, secondary and tertiary prevention

Most of the work around mental health is focused on treatment, rather than the different mechanisms to prevent mental ill-health from taking place. There is a substantial gap around the role of screening (primary prevention) and targeted support for people at risk of mental health problems such as victims of domestic abuse (secondary prevention).

A more strategic programme focusing on prevention would cover four dimensions:

- **Primary prevention:** to stop mental health problems before they occur and promote good mental health for all. This may also include the idea of mental health promotion. Strategies for mental health promotion are related to improving the quality of life, potential for health and protective factors rather than amelioration of symptoms and deficits.

- **Secondary prevention:** early identification and treatment of mental disorders by supporting those at higher risk of mental health problems. Examples include programmes which support those who have experienced trauma or those who have been victims of crime, domestic violence or adverse childhood experiences. An important group to consider are the children of families in temporary accommodation who have been shown to have greater vulnerabilities to mental health problems.

- **Tertiary prevention:** helping people already living with mental health problems to stay well and reduce relapses. These types of programmes aim to reduce and manage symptoms as much as possible. It is often carried out in community rather than clinical settings.

- **Treatment involves specific interventions aimed at reducing the symptoms and addressing the causes of mental health problems.**

A review from the Victorian Health Promotion Foundation highlights that primary prevention activities can be effective by reducing people’s exposure to risk factors and/or increasing their exposure to protective factors. While this is not directly under the remit of DLUHC, it could offer fertile ground for collaboration with other departments such as DHSC due to the relationship between mental health and homelessness.

As an example of secondary prevention, we know that domestic abuse is often underreported, and usually identified once a ‘trigger event’ occurred, prompting the person who experienced abuse to seek support.
Although services are available in England for victims which include free and confidential support, counselling and other resources, better early detection and intervention systems are needed to signpost people at risk. More thorough screenings for domestic abuse could be included as part of housing options assessments and/or through social landlords either working within LAs’ own housing stock or registered providers. For example, Peabody, as one of the funding partners of DAHA Alliance and one of the largest Housing Associations, could be a suitable partner.

These types of screening and secondary prevention activities could also be targeted at other groups at higher risk of suffering mental health issues such as prison leavers or care leavers, although this does imply the need for access to resources to take action if a problem is identified.

Common interventions that appear to have little or no impact

5. Psychologically-informed environments

Psychologically-informed environments grew from the awareness that services were ill equipped to respond to the psychological and emotional needs of people experiencing homelessness. The five key areas to the PIE approach are 1) developing a psychological framework, 2) the physical environment and social spaces, 3) staff training and support, 4) managing relationships, 5) evaluation of outcomes. There is, however, still a lot of variability and ambiguity on the definition and implementation of PIEs. Despite their growing popularity no robust evaluations exist of their effectiveness or cost effectiveness.

6. Trauma Informed Care (TIC)

The definition of TIC set out by the National Centre for Trauma Informed Care (USA), has four components: 1) acknowledge the impact of trauma and recovery, 2) identify trauma signs and symptoms, 3) use knowledge of trauma to improve practice, and 4) avoid and prevent re-traumatisation. As with PIEs, despite the popularity of the TIC approach, there is little empirical evidence that its implementation improves outcomes. In fact, some studies have found that service delivery and respect did not improve.

24 There is moderate evidence from seven studies that cueing improves discussion of, disclosure of and referrals to services provided for DV among some populations. Cueing generally refers to providing information about a patient prior to a clinical encounter that will “cue” or propel the provider to investigate issues of DV” (NICE. (2013). Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence).
25 "There is moderate evidence from five studies that universal screening or routine enquiry for DV in pregnancy, when supported by staff training and organizational support, improves screening practices and documentation of DV. Pregnant and postpartum women are often screened for domestic abuse because pregnancy is seen to be a risk factor for onset of abuse, and the health concerns of both woman and foetus are at stake” (NICE, 2013) (p96). This is backed up by Jewkes (2014) (“What works to prevent violence against women and girls?”), a literature review which finds that “screening interventions clearly increase identification of women experiencing intimate partner violence (p18).
26 Daha. (2021). Who we are & why we do it.
28 Trauma-Informed Care Implementation Resource Centre. (2021). What is trauma-informed care?
30 Burge et al. (2021) Evaluating Trauma Informed Care training for services supporting individuals experiencing homelessness and multiple disadvantage.
7. Psychosocial Interventions
There is little evidence that psychosocial interventions improve mental health outcomes for people experiencing homelessness. The main relevant review focuses on people with severe mental illness and problematic substance use – and includes approaches such as assertive community treatment (ACT), intensive care management (ICM), cognitive behavioural therapy (CBT), motivational interviewing and contingency management – but, in spite of including 41 trials, did not find any conclusive evidence suggesting that a specific type of approach fared better than treatment as usual in terms of maintaining treatment, reduction in substance use or improving mental or global state. Other reviews focusing on young people experiencing homelessness (Noh, 2009 and Xiang, 2012) found that psychological interventions (CBT, motivational interviewing, family therapy) did not improve outcomes related to substance use, depression or delinquent behaviour.

8. Case Management
A systematic review showed that no model of case management had a substantial impact on mental health outcomes, even those that provide comprehensive service support including for mental health needs (i.e. ICM and ACT) over and above other models of standard support.

Implications for policy, practice and research

The strong links and interrelationship between homelessness and mental health make it clear that a more effective approach to tackling mental ill-health is likely to have an impact on reducing homelessness and vice versa.

Given the fact that existing evidence suggests that many of the common interventions to address mental health issues have little or no impact, much more focus should be placed on secondary and primary prevention activities to pick problems up earlier amongst those who are experiencing or at risk of homeless, including children.

Some initial ideas include:

- More work should be done to test targeted mental health interventions within hostels, housing first projects and local authority temporary accommodation. Given that commonly used interventions (e.g. CBT, Intensive Case Management, Assertive Community Treatment, Contingency Management) don’t seem to outperform business as usual provision, it will be important to develop and test new models of mental health support aimed at people experiencing homelessness.

- Set up trials to introduce screening mechanisms and targeted interventions for key groups at risk of homelessness and developing mental health problems. Special attention could be given to victims of domestic abuse and children living in temporary accommodation at risk of developing mental health problems such as depression and anxiety.

31 NICE states that psychosocial interventions include: contingency management, behavioural couples therapy, community reinforcement approach, social behaviour network therapy, cognitive behavioural relapse prevention-based therapy, and psychodynamic therapy.


Based on the evidence that many people experiencing street homelessness have an underlying mental health vulnerability, screening could be tested within outreach and No Second Night Out services to identify mental health issues amongst those sleeping out for the first time. Rapid access to peer and community support, counselling and psychotherapy should then be provided where this is clinically indicated, alongside housing solutions, in order to test if this is effective in reducing returns to street homelessness and the risk of mental health problems worsening.

Provision of a dedicated pot of funding aimed at people with care and support needs experiencing street homelessness could help to remove the barriers to access to support for this group. This could include a social prescribing or cash transfers programme.

Related to the above, some funding could be ‘ring fenced’ for cases where ordinary residence or immigration status are unclear or mental health issues make care assessments more difficult.