



Centre for
Homelessness Impact

March 2023

What Works Evidence Notes

01 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.

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Person-first language

This report uses person-first language, putting a person before their circumstances.

This is to avoid defining an individual by homelessness, which should be a temporary experience.

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Evidence from across the world on solutions to homelessness

Purpose

This paper provides an overview of the evidence around the relationship between homelessness and mental health, focusing on street homelessness and single homelessness. In addition to looking at research on the links between homelessness and mental health, this paper examines the effectiveness of various approaches to support and prevent mental health problems amongst people experiencing homelessness, and how policy and further research can help improve outcomes in these areas.

Summary

Mental health is the most common support need among households who approach local authorities for homelessness assistance, and people experiencing street homelessness have even greater levels of mental health support needs.

Timely access to mental health services can be problematic, particularly for those living on the streets, and especially if they also experience substance use dependence. In recognition of this, the UK Government's Rough Sleeping Strategy for England 2022 included a commitment of £30m for health interventions, including dual diagnosis workers and mental health support in addition to the funds allocated for people receiving treatment for drugs and alcohol, which includes people with co-occurring mental health needs. The NHS Long-Term Plan for England also set out the intention to reduce the number of people rough sleeping because of, or with, mental ill-health through the provision of specialist rough sleeping mental health services. The UK Government is committed to making sure the needs of those experiencing rough sleeping are taken into account in any future Mental Health and Wellbeing Plan.

Further research needs to be conducted to thoroughly understand the links between mental health and homelessness. However, there is some robust evidence from North America, and from the UK, on the impact of several mental health interventions for people experiencing homelessness, with some models of integrated support being shown to be effective at improving both housing stability and mental health outcomes: Assertive Community Treatment (ACT), Community Engagement and Planning (CEP), and Family Critical Time Intervention. Integrated support models bring

together professionals from several disciplines such as drug and alcohol support, mental health and homelessness outreach services to provide tailored support to assist an individual.

A lack of robust evidence makes it difficult to state whether approaches such as Psychologically Informed Environments are reliably more effective than other standard support at improving the mental health of people who have experienced homelessness.

There are other mental health treatments with some positive evidence, however, most of the evidence is not specific to people experiencing or at risk of homelessness, and doesn't measure housing outcomes. In particular, interventions for people who have experienced trauma may be of particular relevance in relation to homelessness. For example, Individual trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR), had shown to positively impact Post Traumatic Stress Disorder symptoms for people exposed to complex trauma.

Given the existing evidence on mental health and homelessness, recommendations focus on:

- improving the evidence base
- identifying problems earlier amongst those who are experiencing or at risk of homelessness, including children, across a range of settings, and
- facilitating timely access to integrated models of support.

What do we mean by ‘what works’?

There is a wealth of research that can help us to understand the drivers and triggers of homelessness, and the population sub-groups most at-risk¹, but comparatively less evidence on ‘what works’ in helping to reduce homelessness and improve other outcomes². This lack of causal evidence of homelessness interventions means that we know very little about the impacts of most of our actions including the potential for some interventions to even cause harm under some conditions³.

Expanding our understanding of ‘what works’ will mean that we reduce the chances of potentially misallocating precious resources into ways of working that could be improved to ensure people receive the services they need and achieve better outcomes for all⁴.

When we talk about evidence in this context, we refer to specific types of evidence: Impact evaluations are those that try to compare the outcomes in a group with what would have happened in the absence of that intervention; or what is often called a ‘counterfactual’. For example, we might want to know whether Programme A helps to increase employment. To do so, it would be necessary to compare the outcomes of those who receive a specific type of employment support against those of an equal group that didn’t receive it. Different impact evaluation designs use various approaches to make these comparisons.

However, not all impact evaluations are equal.

We place varying levels of confidence in research findings depending on how they are set up and reported on. Among other things, we have greater confidence in findings when: a) studies use control groups, comparing outcomes of those who receive an intervention to those who do not, b) there are many evaluations of an intervention, giving us a wider range of research to draw on, c) studies are from a variety of contexts with varying policy landscapes, and d) research is conducted in a large group of people that we can observe for a long period.

There is great value in other types of evidence too - both qualitative research and experiences help inform how services could be designed and to understand how well they are implemented, and why they worked or not. Bringing together all these epistemologies and perspectives will help us to create a more complete picture of what works, where, for whom, why and how.

1 Bramley, G., Fitzpatrick, S. (2018) Homelessness in the UK: who is most at risk?, *Housing Studies*, 33:1, 96-116, DOI: 10.1080/02673037.2017.1344957

2 Halpern, D. (2020). *Using Evidence to End Homelessness* (L. Teixeira & J. Cartwright, Eds.; 1st ed.). Bristol University Press. DOI: 10.2307/j.ctv10kmc3j

3 Keenan, C., Miller, S., Hanratty, J., Pigott, T., Hamilton, J., Coughlan, C., Mackie, P., Fitzpatrick, S., Cowman, J. (2021) Accommodation-based interventions for individuals experiencing, or at risk of experiencing, homelessness. *Campbell Systematic Reviews*. <https://doi.org/10.1002/cl2.1165>

4 Rodriguez-Guzman, G., Hume, S., McKie, P., Nwosu, C., Piggott, H., White, J. Accelerating Learning - Lessons and Reflections from the First Randomised Controlled Trials in Homelessness in the UK. *European Journal of Homelessness*, 15(3), 171-186

The Challenge: key issues and recent trends

- Mental health needs are the most common type of support needs seen in the population affected by homelessness. People experiencing street homelessness are likely to have high instances of mental health problems.
- Mental health problems may be a factor contributing towards homelessness, but the experience of homelessness itself creates many mental health issues.
- People experiencing homelessness often have difficulty accessing the support they need for dealing with mental health problems.

An overview of studies⁵ conducted in seven western countries, including the UK, showed that prevalence of diagnosable mental health problems, predominantly among men in emergency accommodation such as shelters and hostels, are higher compared to people of the same age in the general public. Specifically, suggested rates include 12.7% of the sample having a psychotic illness, 11.4% having major depression and 23.1% having a personality disorder, among other presentations of mental distress. A Scottish study⁶ looking at the relationship between homelessness and health showed that someone experiencing homelessness has almost a five times higher rate of admission to mental health specialities than their peers in the most deprived areas, and a 20 times higher rate than their peers in the least deprived areas than someone not experiencing homelessness. This compares with UK data suggesting that fewer than 1% of the general population has a psychotic illness⁷, with about 4% reporting post-traumatic stress disorder (PTSD) and 3% with diagnosed depression.⁸



5 Fazel, S. et al. (2008). The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis. *PLoS Medicine*. 5(12).

6 Knowles, J. et al (2018), *Health and Homelessness in Scotland Social Research*, Scottish Government

7 Public Health England. (2016). *Psychosis Data Report Describing variation in numbers of people with psychosis and their access to care in England*

8 Mind. (2021). *Mental health facts and statistics*.

According to the Rough Sleeping Questionnaire (RSQ) 2020⁹, at least 43% of people sleeping rough reported having a mental health need prior to first sleeping rough, and 17% reported having developed a mental health need after. Even though that doesn't determine cause or effect, it illustrates that mental health problems could be a factor in causing homelessness, and the experience of homelessness itself can create mental health issues. 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.¹⁰ Importantly however, research also emphasises the importance of appreciating that mental ill-health is neither necessary nor sufficient as a cause of homelessness and therefore must be viewed in relation to a more holistic picture.¹¹¹²

In the UK there is evidence that children who have lived in temporary accommodation¹³ for longer than a year are three times more likely to have mental health problems, including depression and anxiety, compared to their peers.



- 9 Department for Levelling Up, Housing and Communities. (2020). Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England.
- 10 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. Hossain, M. et al. (2020). Prevalence of mental disorders among people who are homeless: An umbrella review. *International Journal of Social Psychiatry*. 66(6). Singh, A. et al. (2019). Housing Disadvantage and Poor Mental Health: A Systematic Review. *American Journal of Preventive Medicine*. 57(2). Aldrige, R. (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. *The Lancet*. 391(10117).
- 11 Montgomery, A. E, Metraux, S., & Culhane, D. (2013). Rethinking homelessness prevention among persons with serious mental illness. *Social Issues and Policy Review*, 7(1), pp.58-82
- 12 Sullivan, G. M., Burnam, A., & Koegel, P. (2000). Pathways to homelessness among the mentally ill. *Social Psychiatry and Psychiatric Epidemiology*, 35(10), 444–450
- 13 Harker, L. (2006) Chance of a lifetime The impact of bad housing on children's lives

Recent trends

Mental health is the most common support need for those who approach local authorities for homelessness assistance.¹⁴ For example, in Q2 2022 in England, 26.4% of the households owed a prevention or relief duty reported a mental health need.¹⁵ While this represents a half-point decrease from the previous measurement period, this percentage has been slowly rising each quarter since 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 2022, that figure was 29%.¹⁶

Mental health support needs are even greater for those experiencing street homelessness. In October-December 2022, 49% of those seen experiencing street homelessness in London had a mental health support need, according to CHAIN data. Also,

findings from the UK Government's Rough Sleeping Questionnaire (RSQ) suggested that more than 8 in 10 people sleeping out had a mental health support need.¹⁷ 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.

The prevalence of mental ill-health is higher among those experiencing homelessness for longer. CHAIN data recording street homelessness in London for April-June 2022 shows that 27% of those who were new to the streets had mental health needs, compared to 44% of people who were intermittently street homeless and 49% of those who were living on the streets.¹⁸



- 14 Department for Levelling Up, Communities and Housing. (2021) Homelessness statistics.
- 15 Department for Levelling Up, Communities and Housing. (2022). Statutory Homelessness April to June (Q2) 2022: England.
- 16 Scottish Government. (2021). Homelessness in Scotland: 2020 to 2021.
- 17 Department for Levelling Up, Housing and Communities. (2020). Understanding the Multiple Vulnerabilities, Support Needs and Experiences of People who Sleep Rough in England.
- 18 Requested from St Mungo's CHAIN data

Existing government support

NHS England has a Long-Term Plan that includes several commitments to improve mental health, including £30m for specialist mental health services for people experiencing rough sleeping. In addition, in the Rough Sleeping Strategy 2022 the UK Government committed £30m for health interventions in England, including dual diagnosis workers and mental health support. The strategy also allocates £186.5m for the Rough Sleeping Drug and Alcohol Treatment Grant, which includes people with co-occurring mental health needs, and a £53m investment into housing support for people receiving drugs and alcohol treatment. The UK Government is

also committed to making sure the needs of those experiencing rough sleeping are taken into account in any future Mental Health and Wellbeing Plan.

Among the programmes supporting mental health and wellbeing is the Supporting Families Programme with an investment of £695m over three years, funding local authorities to work with families with multiple connected problems, such as family breakdown, poor mental health and substance misuse, and Op COURAGE, a preventative programme supporting mental health and addiction services for military veterans.

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 health needs had accessed mental health services within the previous 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 2014¹⁹, 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 not receiving treatment for either.

¹⁹ The Care Act defines the local authorities responsibilities to help prevent, reduce and delay people in the community (including carers) having care and support needs.

The common requirement to stop using substances before engaging with mental health services has been identified as one of the key challenges in the homelessness system.²⁰ This echoes findings from surveys indicating that people who experience

homelessness and have multiple needs are often bounced between care services, being told to address their mental health issue before their substance abuse or vice versa.²¹²²

What works to improve mental health and housing outcomes for people experiencing or at risk of homelessness?

Mental health interventions:

Even though further research needs to be conducted to understand the links between mental health and homelessness and the specific interventions that can improve mental health and housing outcomes for people experiencing or at risk of homelessness, there is some evidence that suggests that some integrated models of care can be effective, as Table 1 shows. It is important to notice that most of the studies on homelessness come from North America. Due to differences in the housing and health system and social safety nets, among other differences between countries, the transferability of findings must be treated carefully.



²⁰ Public Health England. (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions.

²¹ Cream, J. et al. (2020). Delivering health and care for people who sleep rough. The King's Fund.

²² Miller, S., Keenan, C., Hanratty, J., et al. Improving access to health and social services for individuals experiencing, or at risk of experiencing, homelessness. Campbell Systematic Reviews

Table 1:

Integrated intervention	Population	Description	Impact on housing outcomes	Impact on mental health outcomes
Assertive Community Treatment (ACT)	Adults with severe mental illness and at high risk for homelessness	Person-centred approach with a multidisciplinary team, low ratio of user/staff, direct community-based services, and 24 hrs coverage	+ Housing stability	+ Improvement in psychiatric symptoms ? hospitalisation
Community Engagement and Planning (CEP)	People receiving homeless services, outpatient mental health, substance abuse treatment and other community-based services	Coalition approach to plan, co-lead, and monitor training and implementation	- Homelessness risk	+ Improvement in mental health-related quality of life ? depression

1. Assertive Community Treatment (ACT):

ACT offers treatment and rehabilitation using a person-centred approach to people with severe mental health problems. It is distinguished from traditional case management approaches as it provides a multidisciplinary team, a low ratio of user/staff enabling more intensive contact, directly providing community-based services, and 24-hour coverage. The effectiveness of ACT compared to traditional case management is well documented

for populations with severe mental health problems. While it is more costly to administer, some studies have found that it can be more cost-effective because it decreases hospitalisation and emergency services. However, the effect on hospitalisation usage²³ for people experiencing homelessness is not conclusive.

23 Summary of indicators that include: percentage hospitalized during follow-ups, mean days in hospital

A systematic review reported that for people experiencing homelessness and with severe mental health problems, ACT treatment had a 37% greater improvement in housing stability²⁴ and 26% self-reported mental health symptom improvement compared with traditional case management.²⁵

- Population: people experiencing homelessness with severe mental health illness
- Intervention: Assertive community treatment
- Known impact: + housing stability, - mental health symptoms
- Unknown impact: hospitalisation

2. Community Engagement Planning:

Community Engagement and Planning (CEP) is a coalition approach to plan, co-lead, and monitor training and implementation. A study in the United States found that CEP improved mental health-related quality of life and risk of homelessness²⁶, but not depression after 12 months.²⁷ Authors believe factors contributing to CEP's success included multi-sector collaboration, task sharing, relationship building across sectors, and staff knowledge and capacity to work with people with mental illness.

- Population: people receiving homeless services, outpatient mental health, substance abuse treatment and other community-based services
- Intervention: Community Engagement Planning
- Known impact: + Improvement in mental health-related quality of life, - homelessness risk

Unknown impact: depression

Housing support interventions:

One way of improving or maintaining someone's mental health and well-being is to ensure that they are adequately housed. Systematic reviews on the health effects of improvements to an individual's housing situation suggest a promising impact on self-reported physical and mental health, as well as perceptions of safety, concern around crime and social and community participation.²⁸ In addition, there is some evidence to suggest that joint mental health and housing services are reported as superior to mental health care alone.²⁹ However, we need more robust and up-to-date studies to understand the mechanisms behind it and the size of the benefits.

For people experiencing homelessness who have greater support needs, the evidence is mixed. Still, better housing outcomes have been shown to decrease the prevalence of symptoms associated with some mental health problems. A Centre for Homelessness Impact review found that accommodation-based interventions with moderate and high support improved health outcomes (including mental health) compared to no

24 Summary of indicators that include: percentage experiencing any homelessness, days on the street, days not in stable housing, days of homelessness, and percentage not in active housing

25 Coldwell C M, and Bender W S (2007) The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. American Journal of Psychiatry 164, 393-399 DOI: 10.1176/appi.ajp.164.3.393

26 Defined as homelessness, living in a shelter, or having at least 2 risk factors (at least 2 nights experiencing homelessness, food insecurity, eviction, financial crisis)

27 Castillo, E. et al. (2017). Improving Depression Care for Adults With Serious Mental Illness in Underresourced Areas: Community Coalitions Versus Technical Support. Psychiatr Serv. 69(2).

28 Thomson, H. et al. (2001). Health effects of housing improvement: systematic review of intervention studies. BMJ. 323(7306).

29 McHugo et al., (2004). A randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. Schizophr Bull. 30(4).

intervention.³⁰ Still, these impacts were considerably smaller than those observed for housing stability.

One individual study looking specifically at mental health outcomes of men living on the streets or using overnight shelters in Germany did see long-term improvements in mental health associated with better housing. Notably, after considerable improvements in housing wherein people were housed for three years, they 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 remained stable.³¹

Family Critical Time Intervention

The amount of research on children experiencing homelessness is scarce and the quality of most of the existing evidence doesn't allow for sound conclusions.³² However, research suggests that Family Critical Time Interventions can have a positive impact. This type of intervention is based on the integration of programmes for adults with mental illness experiencing homelessness, providing

housing support and limited-time case management to connect families with community services.

Although the results were scattered, they suggest that it has the potential to improve mental health and school outcomes in children from 1.5 to 16 years old.³³

Intervening to prevent mental health problems in childhood is a crucial opportunity. A global review found that the onset of initial mental health problems occurs before age 18 in almost half (48%) of individuals, and these are risk factors for adult mental health concerns.³⁴ A range of impacts across the life course can be averted through prevention and early treatment of mental distress.

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.³⁵

30 In contrast, the pooled effect sizes for housing stability were above 0.7 which can be considered large. Keenan, C. et al. (2020). Accommodation-based programmes for individuals experiencing or at risk of homelessness. Centre for Homelessness Impact.

31 Fichter, M and Quadflieg, N. (2005). Three year course and outcome of mental illness in homeless men. *European Archives of Psychiatry and Clinical Neuroscience*. 255.

32 Herbers, J.E., Cutuli, J.J. (2014). Programs for Homeless Children and Youth: A Critical Review of Evidence. In: Haskett, M., Perlman, S., Cowan, B. (eds) *Supporting Families Experiencing Homelessness*. Springer, New York, NY. https://doi.org/10.1007/978-1-4614-8718-0_10

33 Shinn, M., Samuels, J., Fischer, S.N., Thompkins, A. and Fowler, P.J. (2015), Longitudinal Impact of a Family Critical Time Intervention on Children in High-Risk Families Experiencing Homelessness: A Randomized Trial. *American Journal of Community Psychology*, 56: 205-216. <https://doi.org/10.1007/s10464-015-9742-y>

34 Solmi et al. (2021): Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*.

35 Digby, A. and Fu, Emily. (2017). Impacts of homelessness on children – research with teachers. Shelter.

Common approaches where more evidence is needed

Psychologically-Informed Environments

Psychologically-informed environments³⁶ (PIE) 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, robust evaluations are needed on the effectiveness and cost-effectiveness of the intervention.

Trauma Informed Care (TIC)

The working definition of TIC set out by the Office for Health Improvement and Disparities, based on the definition developed by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), states that trauma-informed practice aims to increase practitioners' awareness of how trauma can impact individuals and communities, and their ability to feel safe with health and care services. It has six main principles: safety, trust, choice, collaboration, empowerment and cultural consideration.³⁷

As with PIEs, despite the popularity of the TIC approach, there is little quantitative evidence that its implementation improves outcomes.³⁸ Qualitative evidence highlights the importance of taking both PIE and TIC approaches to improve the acceptability of services to users, emphasising the relevance of strong relationships between with staff, including people with lived experiences, and ensuring the flexibility.³⁹

36 Breedvelt. (2016). *Psychologically Informed Environments: A Literature Review*. Mental Health Foundation.

37 <https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice>

38 Purtle, J. (2018) Systematic Review of Evaluations of Trauma-Informed Organizational Interventions That Include Staff Trainings. *Trauma Violence Abuse*. 21(4); Unick, G. et al. (2019) Organizational trauma-informed care: Associations with individual and agency factors. .

39 Miller, S., Keenan, C., Hanratty, J., et al. Improving access to health and social services for individuals experiencing, or at risk of experiencing, homelessness. *Campbell Systematic Reviews*

Psychosocial Interventions

There is little conclusive evidence that psychosocial interventions⁴⁰ improve mental health outcomes for people experiencing homelessness. The main relevant review focuses on people with severe mental illness⁴¹ and problematic substance use, but, in spite of including ⁴¹ trials, it 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.⁴²

Other quantitative reviews focusing on young people experiencing homelessness⁴³⁴⁴ found that psychological interventions (CBT, motivational interviewing, family therapy) did not definitively improve outcomes related to depression, delinquent behaviour or substance use. However, the findings do provide reasonable grounds to suggest that family therapy may assist in the reduction of substance use.⁴¹ This is further supported by the narrative synthesis which also indicates that family therapy could have an impact on reducing substance use.

Case Management

A systematic review showed that neither standard nor intensive case management models seem to have a substantial impact on mental health outcomes. However, other models of case management, like ACT, were shown to have a moderately positive impact on mental health outcomes compared to other supportive services.⁴⁵ More research is needed on case management models to understand their ideal target populations and the key elements and implementation strategies.



40 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

41 Include diagnosis of schizophrenia, schizoaffective disorder, and other psychotic disorders.

42 Hunt, G. et al. (2019). Psychosocial interventions for people with both severe mental illness and substance misuse. Cochrane Database of Systematic Reviews. 12.

43 Noh, D. (2018). Psychological Interventions for Runaway and Homeless Youth. Journal of Nursing Scholarship. 50(5).

44 Xiang, X. (2012). A Review of Interventions for Substance Use Among Homeless Youth. Research on Social Work Practice. 23(1).

45 Ponka, D. et al. (2020). The effectiveness of case management interventions for the homeless, vulnerably housed and persons with lived experience: A systematic review. PLoS One. 15(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 and targeted support for people at risk of mental health problems such as victims of domestic abuse .

A more strategic programme focusing on prevention would cover prevention as well as treatment:

- **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.⁴⁶ Strategies for mental health promotion are related to improving quality of life, the potential for health and protective factors rather than amelioration of symptoms and deficits. A review from the Victorian Health Promotion Foundation⁴⁷ highlights that primary prevention activities can be effective by reducing people's exposure to risk factors and/or increasing their exposure to protective factors.⁴⁸
- **Secondary prevention:** early identification and treatment of mental illness 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:** the implementation of programmes intended to assist people already living with mental health problems to stay well and manage symptoms as much as possible. It is often carried out in community rather than clinical settings.

46 World Health Organisation. (2002). Prevention and Promotion in Mental Health.

47 Carbone, S. (2020). Evidence review: The primary prevention of mental health conditions. VicHealth.

48 Although the evidence base in this space is nascent, there are examples of promising practice, including parenting programmes to reduce child neglect and abuse; or social and emotional development programmes programs delivered through schools, universities, workplaces and online can increase protective factors such as healthy behaviours, social and emotional skills, self-care skills and resilience, and prevent mental health and substance use conditions. Resources summarising the relevant evidence for primary prevention include Mental Health Foundation (2016) and evidence reviews by the What Works Centre for Wellbeing.

What works with other relevant groups?

There are other mental health treatments with some positive evidence, however, most of the evidence is not specific to people experiencing or at risk of homelessness, and doesn't measure housing outcomes. Even though this evidence needs to be considered carefully as the needs and context may vary, evidence on specific sub-populations can help shed some light on what could work. For example, looking at interventions for people who have experienced trauma (given this may be of particular relevance in relation to homelessness), there is some evidence of positive outcomes.

For example, a systematic review found that trauma-focused cognitive behavioural therapy(TF-CBT) can be effectively used as therapy for PTSD and mental health comorbidities in people exposed to complex trauma, like veterans, refugees, victims of childhood sexual abuse, war and domestic violence, improving PTSD symptoms and depressive symptoms.⁴⁹ Trauma-focused care works to understand the impact of specific traumas on a person's life, identifying coping mechanisms.

Systematic reviews have also shown that Eye Movement Desensitisation and Reprocessing is associated with a decrease in PTSD symptoms,

and symptoms of depression and anxiety. EMDR is a psychotherapy treatment that aims to alleviate the distress associated with traumatic memories. This therapy is based on the Adaptive Information Processing (AIP) model, which views current symptoms as a result of not adequately processed traumatic experiences that have been encoded in state-specific dysfunctional form. The therapy involves transforming problematically stored experiences into an adaptive resolution, promoting psychological health.⁵⁰

Interpersonal psychotherapy (IPT), a psychological treatment that focuses on improving interpersonal functioning, has also been shown to have a positive impact on PTSD symptoms in trauma survivors. However, the results are very diverse, suggesting substantial imprecision.⁵¹

Another type of intervention with some evidence is mindfulness. Systematic reviews have shown that this non-trauma based intervention can reduce depressive symptoms and can sometimes improve PTSD symptoms, particularly reducing avoidance. Still, the effects are generally smaller than for the interventions previously described⁵² and many of the studies lack methodological rigour.⁵³

49 Coventry PA, Meader N, Melton H, Temple M, Dale H, Wright K, et al. (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. PLoS Med 17 (8): e1003262. <https://doi.org/10.1371/journal.pmed.1003262>

50 Solomon, R. M., and Shapiro, F. (2008). EMDR and the adaptive information processing model potential mechanisms of change. J. EMDR Pract. Res. 2, 315–325. doi: 10.1891/1933-3196.2.4.315

51 Coventry PA, Meader N, Melton H, Temple M, Dale H, Wright K, et al. (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. PLoS Med 17 (8): e1003262. DOI: 10.1371/journal.pmed.1003262

52 Coventry PA, Meader N, Melton H, Temple M, Dale H, Wright K, et al. (2020) Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. PLoS Med 17 (8): e1003262. DOI: 10.1371/journal.pmed.1003262

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Implications for policy, practice and research

The strong links and inter-relationship 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 existing evidence, our recommendations are to:

- Promote the implementation of evidence-based integrated approaches, such as assertive community treatment (ACT), and community engagement and planning (CEP), and explore the implementation of Integrated Care Systems (ICSs). Integrated support models bring together professionals from several disciplines such as drug and alcohol support, mental health and homelessness outreach services to provide tailored support to assist an individual.

- Extend the evidence and robustly evaluate mental health interventions for people experiencing homelessness in the UK, and promote the inclusion of housing outcomes when evaluating mental health interventions
- Put a greater emphasis on prevention work. Mental health screening mechanisms for groups at risk or experiencing homelessness could be introduced and evaluated.
- Explore and evaluate interventions to remove the barriers to access to support for people with care and support needs experiencing street homelessness.





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